

Advance Questions for S. Ward Casscells, III, M.D.
Nominee for the Position of Assistant Secretary of Defense for Health Affairs

Defense Reforms

The Goldwater-Nichols Department of Defense Reorganization Act of 1986 and the Special Operations reforms have strengthened the war fighting readiness of our Armed Forces. They have enhanced civilian control and clearly delineated the operational chain of command and the responsibilities and authorities of the combatant commanders, and the role of the Chairman of the Joint Chiefs of Staff. They have also clarified the responsibility of the Military Departments to recruit, organize, train, equip, and maintain forces for assignment to the combatant commanders.

Do you see the need for modifications of any Goldwater-Nichols Act provisions?

No, only to enhance it where we might find an opportunity to do so.

If so, what areas do you believe might be appropriate to address in these modifications?

Duties

What is your understanding of the duties and functions of the Assistant Secretary of Defense for Health Affairs?

The ASD for Health Affairs assists the Under Secretary of Defense for Personnel and Readiness and the Secretary of Defense in promoting and safeguarding the health of military personnel and their families, retirees and others eligible for DoD health benefits. The role is primarily one of setting health policies, in consultation with other ASDs, the services and their Surgeons General. These health policies include deployment health, both physical and mental. The ASD also has an important, though less direct, role in health education and research. Health Affairs is directly responsible for managing TRICARE, and the Uniform Services University.

What background and experience do you possess that you believe qualifies you to perform these duties?

As a practicing doctor, teacher, researcher, university administrator, and Army Reserve colonel with two tours of duty in the last two years, including most recently in Iraq, I have an appreciation of the breadth, complexity, and urgency of DoD health issues. As I have had limited management experience I will need the guidance of DoD civilian and military leaders, and input from the troops and their families. In addition I will ask for help from colleagues at CDC, NIH, FDA, HHS, State, the World Health Organization, Red Cross, industry and others who can help. In particular, I will seek guidance from Senate and House members and their staffs, whose expertise and dedication I have come to appreciate in working with them on military health research since 1995.

As a doctor as a patient I know that good medical care is comprehensive, coordinated, compassionate, efficient, preventive, and respectful of patient's privacy, time, and authority.

Do you believe that there are actions you need to take to enhance your ability to perform the duties of the Assistant Secretary of Defense for Health Affairs?

Yes, I need to learn more about DoD regulations and finances, in order to accelerate decision-making so as to get benefits and answers to injured troops and other beneficiaries.

If confirmed, what duties and functions do you expect that the Secretary of Defense would prescribe for you?

In addition to force protection, readiness, deployment health, and TRICARE, the Secretary of Defense may call on the ASD (HA) for advice on civil/military operations and global health issues. The DoD has played an increasingly frequent and important role in disaster readiness and response, both in the US and abroad. Health care is a critical part of this effort, and indeed the provision of health care and assistance in capacity-building (education and facilities) is proving to be a bridge to peace and a currency of diplomacy.

In carrying out your duties, how will you work with the following:

- A. The Under Secretary for Personnel and Readiness.**
- B. The Under Secretary of Defense (Comptroller).**
- C. The Assistant Secretaries for Manpower and Reserve Affairs of the Services.**
- D. The Assistant Secretary of Defense for Reserve Affairs.**
- E. The Surgeons General of each of the Services.**
- F. The TRICARE Lead Agents.**
- G. The TRICARE Support Contractors.**
- H. The Designated Providers' Chief Executive Officers (i.e., Uniformed Services Treatment Facility CEOs).**
- I. Beneficiary Groups.**
- J. Department of Veterans Affairs.**
- K. Centers for Medicare and Medicaid Services**

If confirmed as ASD(HA) I will have the opportunity and duty to work closely with, and learn from, leaders in all the offices and organizations listed above. I know many of them, and will

request meetings with the others, in person. Like most people, I have learned that most problems arise from poor communication. Success requires regular, frank meetings with partners and those we serve, consensus on near-term and long-term goals, simple, fair and transparent processes, and accountability. I am not embarrassed to ask for help, but also not afraid to stand up for the soldiers, sailors, airmen, Marines, and their families.

Major Challenges and Problems

In your view, what are the major challenges that will confront the Assistant Secretary of Defense for Health Affairs?

The office is tasked, with continuously improving the quality of health services while also reducing inefficiencies. The challenges range from finding better ways to prevent and treat battlefield injuries to better ways to assess and treat subtle, complex, important conditions like post-traumatic stress and head injuries. Also important is our readiness for potential threats such as epidemic diseases, especially as troops increasingly work and live in areas such as Asia and Africa where emerging infectious diseases often arise. Other important issues are safety (in the hospital at work and at home), obesity and autism.

Administrative issues include the challenges of joint medical command, BRAC, the role of outsourcing, interaction with other DoD offices, DHHS, DHS, and the Veterans Administration. Finally, the office must assist with the recruitment and retention of dedicated and talented health care personnel. Every satisfied military medical professional can be encouraged to tell our story.

If confirmed, what plans do you have for addressing these challenges?

My limited experience to date with DoD health care needs input from a broader group of providers, administrators and especially beneficiaries. I need to review the data the office has gathered, ask for briefings, and get out in the field to ask questions and see for myself. But it seems likely that there are opportunities for improving services such as care of PTSD and TBI, disability determination, extremity injuries and prosthetics. There may also be ways of improving, simplifying, and safeguarding electronic medical records, and making them portable - for care by private physicians or by the Veterans Administration. It may also be important to do more to foster innovation, to encourage and empower self-care, and to protect whistleblowers.

What do you consider to be the most serious problems confronting the Assistant Secretary of Defense for Health Affairs?

The most important immediate issue is identifying the extent, causes, and correction of the problems that have been brought to light at Walter Reed Army Hospital. I also understand that the important work of the Mental Health Task Force has recommendations due in May, and the Task force on the Future of Military Healthcare will have their work completed late this year.

If confirmed, what management actions and time lines would you establish to address these problems?

Several commissions are addressing these issues and if confirmed I will do all I can to assist them and to be guided by their reports. If confirmed I plan to be a strong influence in ensuring our wounded warriors and families are well cared for after they receive care and in ensuring swift implementation of improvements recommended.

Priorities

If confirmed, what broad priorities would you establish for policy and program actions which must be addressed by the Assistant Secretary of Defense for Health Affairs?

The rank order of priorities of the problems noted above, and others I may become aware of, needs to be determined once I have had the opportunity – if confirmed – of studying the issues from the inside.

Walter Reed Army Medical Center

Concern over outpatient facilities and care for severely wounded service members at Walter Reed Army Medical Center has been a highly visible issue over the past several weeks.

Based on your experience, do you believe the issues raised about care and facilities at Walter Reed could be occurring at other military medical hospitals or facilities?

I do not know. I visited Walter Reed's main hospital to see patients and attend conferences several times over the past two years but did not see Building 18. What I did see there, and at the naval hospitals at Bethesda, Balboa, and Portsmouth, and Army hospitals such as Beaumont and Evans, and at our facilities in Hawaii, Bangkok, Cairo, Doha, and Kuwait, and when I was a patient in Ibn Sina (the 10th Combat Support Hospital) in Baghdad, is excellent inpatient care and satisfied patients. The areas were clean but not deluxe, or even very cheering. I did not see or hear about the very real, intolerable problems in Building 18. That shows how management issues and priorities can be missed unless you look systematically, and listen carefully.

I did experience first hand some errors and delays with my benefits, but not the unacceptably slow, complex, and stingy disability system outlined in recent press accounts. Ongoing patient and family surveys, a vigilant press, staff reports up the chain of command and outside it when justified, are critical to our providing the care our troops deserve.

If confirmed, what actions would you take to examine care for the wounded from the battlefield until discharge from DOD medical treatment?

Battlefield care is excellent. I know that from the data, from what I have seen as a doctor and as a patient in Iraq. The civilian trauma and public health doctors are learning from lessons we learned in Iraq and Afghanistan. Still, it requires vigilance, innovation, and incentives for continuous improvement.

What would you expect your role to be in support of ongoing study of these issues by the Presidential Commission and the DOD Independent Review Group?

To assist them in any way they request, and if not, then to ask to be involved. It is important for the groups to hear from my office, if confirmed, to provide perspective, and for us to hear from them.

TRICARE

If confirmed, what would be your short-term and long-term goals for TRICARE?

TRICARE is the best health plan in the country and it must only get better. My plan would be to look for opportunities to make the link stronger between the direct care system and our vast purchased care network even stronger in order to make the benefit better, more seamless, of higher quality, and look for opportunities to make it more affordable. One of TRICARE's strengths is that it is very inexpensive for the beneficiary compared to other health plans. I believe we need to look for ways to leverage the best public and private sector ideas to make our system an example the beneficiaries and our nations' taxpayers can be proud of.

If confirmed, how would you strengthen the partnership between the Department and the TRICARE support contractors that is necessary for the successful delivery of health care within the TRICARE Program?

I will have a wholehearted commitment to TRICARE. In the past few years, key performance measures for TRICARE have improved dramatically -- for example, claims processing and customer satisfaction. Enrollment, especially for our retiree population has also increased. A key feature of my commitment will be to seek further improvements in the program, building on its many successes. There may be even more opportunities to learn from commercial health plan experience by building even stronger bonds with our many contract partners, to coordinate TRICARE with other Federal health care programs, and to better capitalize on the unique capabilities of military medicine for the good of the Nation and the world.

Do you have any views on how health care support contracts could be restructured to incentivize effective disease management programs and cost-efficient delivery of health care services?

It is a good example of how opportunities with the private sector can be leveraged. We will continue to use an outcome-based approach where the government states the desired outcomes and the bidders determine how to meet these outcomes using, where possible, commercial best business practices. The timeframes for implementation of the contracts should assume that no significant benefit changes will occur during the procurement cycle. While contracts will be designed, awarded and administered centrally, regional oversight of healthcare will be delegated to the Regional Directors affirming the principle that healthcare is best administered and monitored locally. In structuring our support to the military, we cannot diminish the capabilities

of the direct care system – and those skills that only military medical providers can and should do.

There continues to be concern expressed by TRICARE beneficiaries about the adequacy and availability of health care providers in some areas of the country. While health care support contracts have access standards and timeliness requirements to ensure beneficiaries have access to appropriate providers within a reasonable period of time, this does not always happen. In addition, many beneficiaries who choose the TRICARE Standard option report a lack of availability of health care providers willing to accept new TRICARE patients.

From all reports, the TRICARE contracts are working well and have very robust networks. If a local problem exists, I will work to understand what it is and take steps to ensure network adequacy is improved.

What recommendations, if any, do you have for improving the number and adequacy of providers under the TRICARE program?

I would begin by asking why some doctors are reluctant to contract with TRICARE. As a recent TRICARE provider at the University of Texas, I think the contracts can be simplified. I would take aggressive steps to appeal to health systems in the states through both our networks managers, our TRICARE regions and through our Governors. I would also appeal to professional associations to help educate those provider networks on the service they could be providing for our nations' men and women in uniform. We may also be able to do more to recognize and welcome new providers, such as presentations of awards by local service members. In general, the average participation rate of providers accepting the TRICARE reimbursement rate is 96 percent. Our managed care support contractors are aggressively recruiting additional providers to join our networks. Where there are areas that are lacking certain specialties, the contractor together with the TRICARE Regional Offices initiates an action plan to address the concerns of those providers in the locality. In addition, TMA is in the process of implementing legislation to provide for locality-based reimbursement rates for those services that are lacking in certain areas. This authority will improve healthcare access for all beneficiaries by targeting providers who are currently not participating in the TRICARE program.

Commitment to Military Retirees

By law, the DOD and the military departments must provide health care through the Military Health Care System to those who have retired from the uniformed services and their eligible family members.

What is your view of the importance of delivering health care services to military retirees and their family members in ensuring the overall readiness of U.S. Forces?

The commitment to delivering the highest quality care to all of our over 9 million beneficiaries is paramount. The retired service members and their families, which is the vast majority of those we care for, are an integral part of clinical experience base that our providers and staff require in our Medical Treatment Facilities and in our Graduate Medical Education programs to develop, maintain and advance their clinical skills.

Of course, military facility health care is a finite resource. The entitlement to payment for civilian health care services under TRICARE, now available to retirees over 65 as well as under 65, provides assurance of comprehensive coverage for our retirees even when military providers are not available.

Resourcing Medical Benefits

Last year, DOD proposed an initiative referred to as “Sustain the Benefit” aimed at achieving savings in the Defense Health Program. This proposal would have phased in significant increases in TRICARE fees for military retirees under the age of 65 and increased copayments for prescriptions filled in retail drug stores for all categories of beneficiaries. A substantial portion of the projected savings were based on the assumption that retirees would elect to use their civilian employer’s or some other health care plan in lieu of TRICARE.

If confirmed, would you support initiatives designed to save costs by discouraging retired military personnel from using their military health benefit?

The increasing cost of healthcare for the department is of great concern as it reduces its ability to fund other high priorities. Congress directed the Task Force on the Future of Military Healthcare which is now well into its deliberations and I have reviewed their charter. A key area of their review is the health care cost share structure between the beneficiaries and the government and I will carefully review their recommendations as we develop future initiatives along with other key stakeholders in the Department, in Congress and with our coalitions and associations.

Do you have other ideas to achieve savings in the Defense Health Care Program?

As I have reviewed the Military Healthcare System, there may be continuing efforts we can take to find cost savings. I will continue to work to improve the TRICARE contracts to assure we are getting best value and, I believe, as all other healthcare systems have found, that we can incrementally improve our pharmacy benefits management to assure we are providing the most effective drugs at the best possible price. I also think that advancing the concept of shared services between the Services’ medical departments and the Health Affairs/TRICARE Management Activity, as outlined in Secretary England’s governance improvement memo makes sense. I see value in making incremental, sensible and reasonable steps to improve governance, provides an excellent opportunity to reduce administrative duplication, create more effective partnerships and services, and be more efficient. I strongly believe that faster and more effective implementation of our electronic health record, AHLTA, can also save time and money and improve quality.

Adequate financing of the Defense Health Program has long been an issue. The President's budget request for Fiscal Year 2008 includes \$486.3 million in efficiency savings from military hospitals. The Surgeons General have testified that they cannot achieve savings of this magnitude. These so-called "efficiency wedges" have been used over the past 2 years by the Department in an attempt to force savings in military hospitals.

Do you feel that these efficiency wedges remain an acceptable financing approach?

If confirmed, I will examine the financing of the Defense Health Program in detail to determine the best way and mechanisms we can use to assure that we adequately fund all elements of our system. I strongly believe that efficiencies can be promoted if we provide incentives for operating jointly, more efficiently, and with higher quality.

What steps would you take, if confirmed, to more accurately project the cost of, and appropriately resource, both the military hospitals and private sector care contracts within the Defense Health Program?

If confirmed, I fully understand my responsibilities to oversee the Defense Health Program appropriation. Since 2001, the Military Health System has not required emergency supplementals appropriations or reprogrammings (with exception of Hurricane recovery, The War on Terror and Avian Influenza) – which I believe clearly demonstrates that we have benefited from Congressional and Departmental financial support. Looking to the future, I do understand that in the fall of 2006, the department as well as OMB and external actuarial experts, did a thorough analysis of the private sector care requirements for the Department. I will review that effort. In addition I will continue to evaluate the Services' financial requirements to make sure that they are provided adequate resources to accomplish their complex and demanding missions.

Conversion of Military Medical Billets to Civilian Positions

Conversion of certain military billets to civilian positions has been a key objective of the Department's transformation objectives. The Committee has been concerned that in the area of medical services, which are needed in wartime and peacetime, such conversions could place both the quality and the effectiveness of military health care including care of the battlefield wounded, at risk.

What is your understanding of the extent to which civilian substitution for military medical billets has taken place in the Army, Navy and Air Force?

In all efforts to become more efficient we must balance appropriate numbers of providers and medical personnel against the mission. We must also ensure a proper mix of specialists and military providers and support personnel. At the same time we need to avoid waste while maintaining depth in our forces for handling contingencies. It is my understanding that the military to civilian conversion effort was a consequence of a long and detailed examination, called appropriately, the Medical Readiness Review. This review was done with the military departments as well as other OSD. The analysis included an assessment of the cost of

conversions, availability of civilian replacements with proper skills and credentials, and the potential impact on the quality of and access to healthcare. Experience has shown that the Army successfully converted a considerable number of its military medical billets in the 1990's and today civilian staffing at the MTFs often exceeds 50%. The Navy and Air Force have done fewer conversions. If confirmed I will oversee this conversion process, in collaboration with the service surgeons to assure that we do this effectively.

If confirmed, will you examine the extent to which military to civilian conversions played a role in the understaffing of critical support positions at Walter Reed Army Medical Center, as well as a reevaluation of conversion goals for all three service medical departments?

I am unaware of any shortage in critical clinical positions but if confirmed I will work closely with the Surgeons General to assure that any such issues are effectively and immediately addressed.

Military Health Professional Recruiting and Retention

The DOD is facing severe shortages of military medical professionals needed for its peacetime and wartime missions. The Department relies on a combination of bonuses and incentives to recruit and retain military health care professionals to provide care to military members and their families.

What are your views on the adequacy of existing bonus and pay incentive programs for both active and reserve components?

There is a delicate balance between being a steward of the tax-payers' money, in which role we must justify every increase in spending with proof that the increase will have a payback, versus being a champion for the uniformed health care providers. As we analyze the effects the war has on our professional population, we need to be able to use effective, competitive and fair financial tools to be able to fill our gaps in the Active and Reserve forces. The importance of balancing efforts to recruit and retain the right numbers of qualified professionals to meet mission requirements is enormous. Having less than the optimum number of uniformed health care professionals may result in increased private sector care costs and lower medical force morale. It is important to properly manage recruiting, pay, and retention programs to ensure appropriate balance for Department missions and beneficiary needs. As a provider in the Reserve force, I will bring a unique and current perspective to this issue.

Based on your service in the Army Reserve, do you have any recommendations about the effectiveness of incentives for medical personnel to join the reserve forces?

I am not aware of barriers to recruiting and retention, especially in my current status. If those circumstances arise and I see shortfalls or barriers, I will work to understand what they are and take action to fix them.

Seamless Transition of Disabled Service Members

Recent hearings in both the House and Senate have examined the challenges faced by service members who are undergoing disability evaluation and transitioning from the Department of Defense to the Department of Veterans Affairs for health care services.

What are the critical elements necessary for a seamless transition of health services from one agency's responsibility to another?

The critical elements for a seamless transition of health services from one agency to another are: a full understanding of medical care capabilities within both agencies by all medical providers involved; clear communications of the transition plan between providers in each agency and with the patient and patient's family; timely transfer of all pertinent medical records before or at the time of transfer of the patient; and, ongoing communication after the transfer of the patient between the medical providers in each agency and with the patient and patient's family.

How can the transition for disabled service members between DOD and the Department of Veterans Affairs be improved, especially in the area of health care?

Improvements in the transition of health care between DoD and VA can be achieved by early and concise communications to Service members and their families about the DoD and VA benefits and programs they are entitled to based on their military status and service. Two efforts would facilitate the early and concise communication we desire. The first would be to establish a program that assigns a specific DoD-VA team comprised of medical staff to support each patient and his/her family during the transition process. The second initiative would be to establish a single, user friendly disability evaluation system that is evidence based, medically endorsed, and most importantly, consistent with the civilian disability system.

Do you have any views about improvements that can be made quickly to the Physical Disability Evaluation System, specifically the medical evaluation board process?

DoD's Physical Disability Evaluation System is designed to evaluate an individual's loss of capability to function once the medical condition has reached maximum benefit from continued medical care. The period of time necessary to make that assessment varies widely from person to person, and is dependent on individual rates of healing and response to restorative therapies. The medical evaluation board process requires that maximum benefits of medical care be completed. A change that would streamline the process would require care providers to make an early, initial medical prediction of capability after maximum benefits of medical care are complete, and, once the patient's medical condition is stable, then proceed with the disability benefits determination based on that assessment. This would require frequent re-evaluation of medical capability as the healing process is continuing, and possible redetermination of benefits.

Traumatic Brain Injury

In Iraq and Afghanistan, our troops are facing the threat of Improvised Explosive Devices (IED). Because of improved body armor, troops are surviving IED blasts, but frequently suffer traumatic brain injuries (TBI) from the concussive effects of the blasts.

What tools are needed by medical personnel to adequately diagnose and treat TBI on the battlefield, and do you think the services have the capabilities in Iraq and Afghanistan?

Our medical personnel are doing a superb job identifying and treating the severe TBI incidents on the battlefield. Far forward surgical care is saving lives, and neurosurgical care is a significant contributor. In August 2006 we started using the Military Acute Concussion Assessment (MACE), along with a clinical practice guideline, to help identify and document mild and moderate TBI. Educating troops and their leadership about the importance of this evaluation as soon as possible after even a mild injury, as well as educating medical providers on this new tool, is our current challenge.

What is your understanding of the ability of medical personnel to diagnose and treat TBI in CONUS medical facilities?

One constant in medicine is "to make a diagnosis, the doctor must consider it." Our medical personnel are very aware of the potential for TBI in our personnel, both at home and on the battlefield. There is no easy, definitive test, (such as a blood test) available today to quantify the nature and extent of injury associated with TBI. However, we are extending the use of the MACE as a tool used throughout the DoD system, and it will certainly help identify patients who had TBI and determine if they still have symptoms. The majority of mild TBI does not require specific treatment other than time to heal, but we now believe we must document the incident and an assessment of acute signs and symptoms as close to the time of injury as possible. Treatment for persistent symptoms is available in our neurology clinics.

Should DOD have a comprehensive plan for prevention, diagnosis, and treatment of TBI, and if confirmed, what actions would you take to develop such a plan?

DoD is implementing a comprehensive plan to identify and treat TBI. Use of the MACE whenever a Service member is dazed, stunned or knocked out will document these events and trigger education for the patient and medical follow-up. DoD will be asking individuals if they experience any trauma to the head on the annual Periodic Health Assessment. These questions will also be added to the Post Deployment Health Assessment and the Post Deployment Health Reassessment. Understanding what the causes of these injuries are will direct a comprehensive preventive program.

What is your understanding of the adequacy of the DOD physical evaluation system and its ratings to fairly address the conditions that result from traumatic brain injuries?

The DoD Physical Evaluation Board evaluates impaired function and rates individuals against established criteria for disability compensation. When that disability is severe, the system

works very well. As we shape a comprehensive DoD/VA system to assess, diagnose and treat mild and moderate TBI, we may need to modify the disability evaluation system.

Post Traumatic Stress Disorder

Army leaders testified recently that some military doctors are reluctant to diagnose service members with Post Traumatic Stress Disorder (PTSD) because of their concern that it could stigmatize them, resulting in possible harm to careers.

What is your understanding of the scope of the problem of diagnosing and treating PTSD in the Armed Forces?

The biggest problem with diagnosing and treating PTSD in the Armed Forces is the same as the civilian world - having the individuals recognize they have a problem and then seek care. DoD is educating its personnel about PTSD. DoD also assesses service member concerns and symptoms of PTSD and related mental health issues upon return from deployments and again three to six months later. Individuals who identify symptoms are medically evaluated and referred for further diagnosis and treatment if needed. PTSD and other mental health conditions are treatable.

If confirmed, what actions would you take to ensure that health care providers are appropriately trained and guided in diagnosing PTSD?

DoD and the VA have developed clinical practice guidelines for the diagnosis and treatment of PTSD. Continuing Medical Education is a requirement for all practicing physicians and DoD has many educational resources available to not only ensure our providers have the expertise to diagnose PTSD, but that our Service members and their families will be educated.

What steps would you take, if any, to help destigmatize PTSD and other mental health conditions?

The first step to de-stigmatize PTSD and other mental health conditions is education of our military population. A major next step would be to validate that those who seek and receive mental health care are successful in continuing their military careers. Concerns about loss of status with peers, leaders, and family members, and loss of military career are the two major causes for individuals not seeking care for PTSD and other mental health conditions.

The Army's Mental Health Advisory Team (MHAT) has made 3 separate assessments over the past several years detailing the immediate effects of combat on mental health conditions of U.S. soldiers deployed to Iraq. The most recent study, MHAT III, found that multiple deployers reported experiencing higher levels of acute stress, and that overall levels of combat stressors are increasing. Some reports allege that the DOD is deliberately underdiagnosing PTSD due to a shortage of resources.

Acute stress and combat stress are very different conditions from PTSD. The fact that DoD has been consistently evaluating the mental health concerns and symptoms of its deployed forces is

important. Military Departments have deployed mental health providers in theater to provide the prevention and treatment needed for combat stress and for mental health conditions. Resources have not driven mental health care availability. Identifying needs for mental health providers has driven the provision of mental health care capabilities.

Based on your experience, do you believe that PTSD is underreported and underdiagnosed?

I believe PTSD is underreported by the individuals who have it because of the stigma in our society about mental health. I also believe that it is therefore under diagnosed because these individuals are not seen by medical providers. However, I do believe that medical providers are appropriately diagnosing PTSD, perhaps even over-diagnosing PTSD, because the diagnostic criteria have not changed for over a decade.

If confirmed, how would you assess whether we currently have the resources needed to address the mental health needs of service members during deployment in Iraq and Afghanistan and after their return?

I would assess the adequacy of mental health resources by reviewing the data from assessments in theater and after deployment (PDHA and PDHRA), and by reviewing the medical care being provided in-theater and after return home in our DoD system and the VA system. Additionally, I would survey the Service members and their families for their evaluation of the adequacy of our programs to meet their mental health needs.

Do you believe that the DOD disability ratings fairly address the disabilities that result from PTSD?

The DoD disability rating system is designed to evaluate an individual's functional capability. A diagnosis of PTSD requires that the individual have some impairment, along with other symptoms. With early diagnosis and treatment, it is believed that the impairment will resolve, while other symptoms may persist or become intermittent. Therefore it is difficult to definitively respond if the system "fairly" addresses disabilities that may no longer be present.

Research on Gulf War Illness

Both the DOD and the Department of Veterans Affairs have conducted research on Gulf War Illness stemming from health concerns of veterans.

What is your assessment of the evolution of research in this field to date?

More research has been done to understand the health concerns of veterans of the Gulf War than on any other war. The recent Institute of Medicine review of the medical literature from this research has stated that while there is no unique syndrome that has been identified, the Gulf War veterans experience a wide spectrum of symptoms at a rate nearly double that of military personnel who were on active duty at that time but did not deploy. The medical challenge is to better understand the causes of symptoms in our patients, particularly for the subjective symptoms.

What, in your view, are the promising areas for further research, especially for the treatment of symptoms resulting from neurological damage due to chemical exposures?

Medical science is developing a better understanding of brain function and brain physiology due to better tools and better understanding from research that has been ongoing in the fields of mental health, traumatic brain injury and the spectrum of neurological diseases like Alzheimer's, Parkinson's disease, amyotrophic lateral sclerosis and others. Research focused on relating symptoms to specific brain functions, insults, or neurotransmitter changes would have major importance, not only to Gulf War veterans, but to humanity.

If confirmed, what approach would you take to assess the core biomedical research programs of the DOD to ensure that the objectives and resourcing of such research is consistent with future potential threats to U.S. Forces?

The core biomedical research programs in the DoD are requirements driven, and those requirements are based on military unique issues. The governance of the biomedical research is through the Armed Services Biomedical Research Evaluation and Management committee which the ASD(HA) co-chairs.

Quality of DOD Medical Care

Please describe your knowledge of quality improvement programs in the civilian sector, and comment on how they would compare to military health care quality programs.

From 30 years of experience with quality improvement processes at university, community, and government hospitals, and HMO's, I have seen these processes improve. They work best where there are electronic medical records, and committed leadership that fosters a sense of teamwork and energy, not intimidation. From my limited (2 years) experience in Army Medicine I believe the process is taken very seriously. From my service on GE Healthcare's Advisory Board, I am keen to assist the Lean/Six Sigma initiative and process now underway at DoD.

If confirmed, what role would you take in the monitoring of quality and patient safety throughout the military health care system?

There has been an increasing awareness of the need to improve the quality of care and patient safety in our medical facilities across the nation. The Institute of Medicine's reports "To Err is Human" in 1999 and "Crossing the Quality Chasm" in 2001 sounded the alarm regarding the scope of the problem and the opportunities for improvement. Improving Quality and Patient Safety have been high priorities for the health systems with which I have worked, and finding solutions to the problems we confront requires a multifaceted, team approach: Quality care begins with well trained and qualified professionals who work together as a team. These professionals must be provided appropriate ancillary support services and facilities to create a

safe "environment of care" focused upon the needs of patients and their families. We must have automated systems for documentation of care, surveillance, supply support, and to meet the information needs of the health care team. Periodic assessment of organizational programs and procedures by the Joint Commission and other certifying organizations is important. Finally, Senior Leaders must be committed to supporting health care quality and safety by establishing strategic objectives and providing the resources necessary to achieve them.

I am aware that the military health system has been engaged in addressing quality and safety along with its civilian counterparts. Military professionals, graduate medical education programs and facilities also meet the same standards as those established for civilian sector professionals and organizations. If confirmed, I can assure you that providing high quality, safe health care for the men and women who serve, their families and all other beneficiaries of the Military Health System will be one of my highest priorities.

Dental Benefits

The Committee has increasingly heard complaints that DOD dental benefits are less attractive than those offered by other employers. Also, DOD beneficiaries, especially members of the Reserve Components, have shown a reluctance to use their dental benefits.

If confirmed, what action would you take to evaluate the effectiveness of dental programs for the active duty, reservists and retirees and their dependents?

I would expect my staff to evaluate the benefit on an ongoing basis, including analysis of enrollment and utilization, and surveys of members to determine their satisfaction. I would expect to work with the Congress to make any necessary changes to the program.

Role of Physicians in Interrogations

Under current DOD policies, a physician is authorized to participate in the interrogation of a detainee with the approval of the Assistant Secretary of Defense for Health Affairs.

If confirmed, what criteria would you use for deciding to allow a member of the medical profession to participate in interrogations?

I have not yet been briefed on this issue. In the civilian sector, I am aware that law enforcement agencies often use medical professionals to assist them with their investigations. Medical professionals also assist the courts in assessing the mental health of those accused or convicted of crimes. However, I am not familiar with the current role of military medical professionals in interrogations. If confirmed, I will review the use of military medical professionals in interrogations.

National and international medical organizations have taken positions in opposition to DOD policy on this matter.

Do you think that DOD should have a different ethical standard for its physicians than those adopted by recognized national and international bodies?

I believe that military physicians and other medical professionals should adhere to the same high level of ethical standards that we expect of our physicians in civilian practice. Based upon my experience as an Army Reservist, and having observed military providers first-hand in Iraq, I can tell you that military medical professionals are exceptionally high in both clinical quality and ethical standards. I am also aware that even national and international professional bodies may disagree about what constitutes the ethical course of action for some of the more controversial ethical issues facing healthcare professionals, such as support for individuals at the end of life, certain types of medical research, or involuntary treatment of the mentally ill or others trying to harm themselves.

If so, why?

Do you think that DOD's current policy needs to be re-evaluated?

If confirmed, I will review DoD's policy on use of medical professionals in interrogations.

Congressional Oversight

In order to exercise its legislative and oversight responsibilities, it is important that this Committee and other appropriate committees of the Congress are able to receive testimony, briefings, and other communications of information.

Do you agree, if confirmed for this high position, to appear before this Committee and other appropriate committees of the Congress?

Yes

Do you agree, if confirmed, to appear before this Committee, or designated members of this Committee, and provide information, subject to appropriate and necessary security protection, with respect to your responsibilities as the Assistant Secretary of Defense for Health Affairs?

Yes

Do you agree to ensure that testimony, briefings and other communications of information are provided to this Committee and its staff and other appropriate Committees?

Yes

Do you agree to provide documents, including copies of electronic forms of communication, in a timely manner when requested by a duly constituted

Committee, or to consult with the Committee regarding the basis for any good faith delay or denial in providing such documents?

Yes