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STATEMENT BY

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&
CHIEF, ARMY NURSE CORPS

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Acting The Surgeon General of The United States Army

Mr. Chairman, Congressman McHugh, and distinguished members of the subcommittee, thank you for the opportunity to discuss the current posture of the Army Medical Department (AMEDD). America is well aware of our medical capabilities and the challenges we face as your Army remains engaged in combat operations in Afghanistan and Iraq. During these operations, we have recorded the highest casualty survivability rate in modern history. More than 90 percent of those wounded survive and many return to the Army fully fit for continued service. Our investments in medical training, equipment, facilities, and research, which you have strongly supported, have paid tremendous dividends in terms of safeguarding Soldiers from the medical threats of the modern battlefield, restoring their health and functionality to the maximum extent possible, and reassuring them that the health of their families is also secure.

Army Medicine is an integral part of Army readiness and, like the Army, is fully engaged in combat operations around the world. On any given day more than 12,000 Army medics – physicians, dentists, veterinarians, nurses, allied health professionals, administrators, and combat medics – are deployed around the world supporting our Army in combat, participating in humanitarian assistance missions, and training throughout the world. These medics are recruited, trained, and retained through a integrated healthcare training and delivery system that includes the Army Medical Department (AMEDD) Center and School at Fort Sam Houston, Texas; 36 medical centers, community hospitals, and clinics around the world; and, combat training centers and 18 Medical Simulation Training Centers wherever our combat formations are located. It is the synergistic effect of this system that enables us to place in our combat formations the Nation's best trained medical professionals while always ensuring the Soldier is medically and dentally ready to withstand the rigors of the modern battlefield.

The modern battlefield is an incredibly complex environment and Army Medicine is engaged in every phase of deployment. Every Soldier who deploys must meet individual medical readiness standards. These standards are designed to ensure Soldiers are medically and dentally prepared to withstand the rigors of modern combat. Army Medicine ensures each Soldier is medically fit, has appropriate immunizations, and has no active dental disease before they leave the United States or Europe.

Once deployed, our healthcare professionals not only care for those wounded but sustain medical readiness to ensure the combat effectiveness of deployed units. More than 50 percent of the Army Medical Department has deployed to the Central Command area of responsibility in support of combat operations. Twenty-six combat support hospitals have deployed (4 more than once); 41 forward surgical teams have deployed (11 more than once); 11 medical brigade/medical command headquarters have deployed (3 more than once); 21 aeromedical evacuation units have deployed (11 more than once); and 13 Combat Stress Control units have deployed (6 more than once). Like the rest of the Army, this operations tempo is beginning to take its toll on the equipment and people who are vital to its success.

The superb performance of our healthcare professionals during the Global War on Terrorism cannot be understated but it is not our only area of focus. AMEDD personnel supported nation building engagements not only in Iraq and Afghanistan but in 15 countries during 25 medical readiness training exercises during Fiscal Year 2006. Our medical logistics system has moved more than 17,000 short tons of medical supplies into Iraq and Afghanistan. More than 70 percent of the workload in our deployed combat support hospitals is emergency care provided to Iraqi forces and Iraqi citizens injured in fighting. Today, we maintain one combat support hospital split between two detainee facilities in Iraq – providing the same care available to American Soldiers in Iraq and in compliance with all internationally-recognized laws and standards for care of detained persons.

The toll has been high in terms of cost and human sacrifice. Army Medics have earned 220 awards for valor and more than 400 purple hearts. One hundred and two AMEDD personnel have given their lives in Iraq and Afghanistan. These heroes represent many aspects of Army Medicine including Combat and Special Forces

medics, Army Medical Service Corps, Army Medical Corps, and Army Veterinary Corps. These men and women are truly the best our Nation has to offer and will make any sacrifice in defense of their Nation and, most importantly, for the care of their patients.

Despite these sacrifices, the morale of our healthcare professionals remains strong. Some data indicates that a deployment leads to increased retention for our physicians and we are looking carefully at the impact of deployments on nurses and other health professionals. We recently hosted a Human Capital Strategy Symposium to address growing concerns within Army Medicine about accessions/retention, including well-being issues which have a direct impact on morale. In an effort to maintain and improve the morale of the Army's Medical force, our staff has been working to make improvements to the monetary incentives offered as accessions and retention tools. We have established a 180-day deployment policy for select specialties, established a Physician's Assistant Critical Skills Retention Bonus to increase the retention of physician's assistants, increased the Incentive Special Pay (ISP) Certified Registered Nurse Anesthetist, and expanded used of the Health Professions Loan Repayment Program (HPLRP). The Physician's Assistant and Nurse Anesthetist bonuses have been very successful in retaining these providers who are critically important to our mission on the battlefield.

However, we are concerned about the long-term morale of our serving Army medical force as well as our ability to recruit our future force. Fiscal Year 2006 presented Army Medicine with challenges in recruiting healthcare providers. For the second consecutive year, the Army fell short of its goals for awarding Health Professions Scholarships in both the Medical Corps (83% of available scholarships awarded) and Dental Corps (70% of scholarships awarded). These scholarships are by far the major source of accessions for physicians and dentists. This presents a long-term manning challenge beginning in Fiscal Year 2009. As part of the 2007 National Defense Authorization Act, the Congress provided important authorities to allow the Secretary of Defense to increase the monthly stipend paid to scholarship recipients. These increases will make this program more attractive to prospective students and ease the financial burden they face as students. Thank you for taking this important step to improve this critically important program. We are working hard to ensure every

available scholarship is awarded this year. In conjunction with United States Army Recruiting Command (USAREC) we have initiated several new outreach programs to improve awareness of these programs and to increase interest in a career in Army Medicine.

The Reserve Officer Training Corps (ROTC) is a primary source for our Nurse Corps Force. In recent years, ROTC has had challenges in meeting the required number of Nurse Corps accessions and as a consequence, USAREC has been asked to recruit a larger number of direct accession nurses to fill the gap. This has been difficult in an extremely competitive market. In Fiscal Year 2006, USAREC achieved 84% of its Nurse Corps mission (goal of 430 with 362 achieved). To assist USAREC we have instituted an Accession Bonus for 3-year obligation and have increased the bonus amount for those who obligate for four years. Additionally, we raised the dollar amount that we offer individuals who enter our Army Nurse Candidate Program to $5000 per year for max of two years with a $1000 per month stipend. In 2004, we increased the multi-year bonuses we offer to Certified Registered Nurse Anesthetists with emphasis on incentives for multi-year agreements. A year's worth of experience indicates that this increased bonus, 180-day deployments, and a revamped Professional Filler system to improve deployment equity is helping to retain CRNAs.

The Reserve Components provide over 60 percent of Army Medicine's force structure and we have relied heavily on these citizen Soldiers during the last three years. They have performed superbly. But accessions and retention in the Army National Guard and Army Reserve continue to be a challenge. In Fiscal Year 2005, we expanded accessions bonuses to field surgeons, social workers, clinical psychologists, all company grade nurses and veterinarians in the Army National Guard and Army Reserve. We also expanded the Health Professions Loan Repayment Program and the Specialized Training Assistance Program for these specialties. In February 2006, we introduced a Baccalaureate of Science in Nursing (BSN) stipend program to assist non-BSN nurses complete their 4-year degree in nursing. This is an effective accessions and retention tool for Reserve Component Nurses who have only completed a two-year associate's degree in nursing. Working with the Chief of the Army Reserve and the

Director of the Army National Guard, we continue to explore ways to improve Reserve Component accessions and retention for this important group.

The high operations tempo has also placed strain on our equipment. The Fiscal Year 2007 Emergency Supplemental Appropriation request and the Fiscal Year 2008 Budget Request adequately funds the replacement and reset medical equipment in Iraq and Afghanistan as well as equipment organic to units deploying to and redeploying from the Middle East. One area that requires our focused attention is the need for an armored ground ambulance. Because our current ground (wheeled) ambulances are not armored they are not employed outside the Forward Operating Bases (FOB) on a regular basis. This reduces a maneuver commander's ability to employ ground ambulances in support of combat operations. When the ground ambulances have operated outside the FOB perimeter, it led to the death of some medical personnel. The Army's modernization plan addresses this issue and your continued support of the Joint Light Tactical Vehicle (JLTV), which includes an armored ground ambulance, will help alleviate this problem. The Army has tested several methods of providing armored ambulances to the force until production of the JLTV commences. Product Manager for Light Tactical Vehicles (PM LTV) has indicated that armoring a four-litter M997 ambulance, to include the patient care area, would cause a significant overload condition resulting in an unsafe, top-heavy vehicle. Studies to armor the current ambulance shelter and placing it on the M1152A1 also indicate a significantly overloaded vehicle. Currently, PM LTV has awarded a work directive to AM General Corporation to complete a feasibility study for a two-litter armored ambulance based upon the M1151/52/65 vehicle chassis.

PM LTV is also working with AMEDD to address immediate armored ambulance needs through development of an improved Casualty Evacuation (CASEVAC) kit for the M1114 and eventually the M1151A1 vehicles. The US Army Medical Research and Materiel Command (MRMC) has developed a temporarily installed one-litter CASEVAC kit in which the casualty is suspended on litter mounted crossways over the rear seats that can be fitted on either the M1114 or M1151A1. Once the CASEVAC mission is complete, the kit is stowed and the vehicle is ready for normal operations.

The Army Medical Department is a learning organization that seeks to quickly integrate lessons learned from the battlefield into healthcare training and doctrine not only in military medicine but throughout the United States as well. Most of the emergency medical response doctrine in practice in the United States today evolved from medical experiences in the jungles of Southeast Asia in the late 1960's. Today, Army Medicine continues to lead the Nation in adopting new trauma casualty management techniques. Since 2003 we have provided rapid fielding of improved tourniquets, new pressure dressings, and the use of hemostatic bandages that promote clotting. Training for all Soldiers in initial entry training has been revised and we continually revise Combat Lifesaver and Combat Medic training based on lessons learned on the battlefield.

These lessons learned are incorporated in our doctrine taught at the Army Medical Department Center and School and in 18 new Medical Simulation Training Centers across the Army designed to ensure all Combat Medics are trained on the most current combat casualty care techniques under fire, in a tactical environment, and during evacuation. To date, more than 17,800 Combat Medics have received training in these Medical Simulation Training Centers which use computerized mannequins that simulate human response to trauma. Medics can practice their skills in combat scenarios at their duty station. Live tissue training is an integral part of Brigade Combat Team Trauma Training, building the confidence of 68W combat medics and providers in extremity hemorrhage control with use of various hemostatic agents. Use of live tissue best simulates the challenges and stress inherent in stopping actual bleeding.

The Improved First Aid Kit (IFAK) is the first major improvement in individual Soldier care in the past 50 years. Today every Soldier carries a first aid kit that provides intervention for the leading causes of death on the battlefield. The vehicle Warrior Aid Litter Kit (WALK) has enhanced the capability of Soldiers to save lives when vehicles are attacked in theater. This is an expanded version of the IFAK with the addition of a collapsible litter to facilitate ground / air medical evacuation.

Hypothermia was leading to poor casualty outcomes and, as a result, the Army added new equipment for patient warming and fluid warming to medical equipment sets

including the Combat Medic's aid bag, ground and air ambulances, the battalion aid station, the Forward Surgical Team, and the Combat Support Hospital.

The Joint Theater Trauma Registry is proving invaluable; rapidly collecting the lessons learned and guiding decisions about training, equipment and medical supplies based on near real-time data. An organized, systematic method to collect information and use it to drive improvements is a key component of future military medical operations. As knowledge of the actual experience of US medical units in Iraq and Afghanistan has grown, Army Medicine has developed a Theater Combat Casualty Care Initial Capabilities Document under the Joint Capabilities Integration and Development System that captures the required capabilities and capability gaps in combat casualty care to guide research and development efforts and effect changes in doctrine, organizations, training, materiel, leadership, personnel and facilities.

At the same time we are rapidly introducing new medical products and practices on the battlefield, we are transforming our deployable units to better support the Army in combat. Last year, we completed a reengineering of our aero-medical evacuation units, placing them under the command of the Army's General Support Aviation units to improve maintenance and training for our Dustoff units. We reviewed the doctrinal employment of forward surgical teams to ensure we are making the best use of this light, very mobile, far forward surgical capability. We also redesigned our Professional Officer Filler System (PROFIS) to improve the equity of deployments across regions and medical specialties.

But our successes are evident in other aspects of medical care as well. America does not know that US Army Medical Command is a $7 billion a year business that provides care for more than 3 million beneficiaries world-wide. Civilian healthcare executives are frequently surprised to find that all of our hospitals and clinics are accredited by the Joint Commission on Accreditation of Healthcare Organizations. Our civilian peers are further surprised when they learn of the quality of our graduate medical education programs and the superb quality of Army healthcare professionals as evidenced by medical board scores, board certification rates for physicians, nurses, administrators and other allied professionals, and graduate and post-graduate education levels.

This healthcare delivery system is essential to our success on the battlefield. It is within this system that our healthcare professionals train and maintain their clinical skills in hospitals and clinics at Army installations around the world everyday. These facilities provide day-to-day healthcare for Soldiers to ensure they are ready to deploy; allow providers to train and maintain clinical competency with a diverse patient population that includes Soldiers, retirees, and families; serve as medical force projection platforms, and provide resuscitative and recuperative healthcare for ill or injured Soldiers. To accomplish this ambitious mission, we constantly strive to sustain appropriate staffing ratios, facility workspace, workload productivity, and patient case-mix in our direct-care facilities while maintaining the right balance with an appropriately-sized and supportive network of civilian providers for healthcare services we cannot effectively or efficiently provide on a day-to-day basis. In order to remain successful, however, we must transform the Medical Command along with our battlefield system of care.

The combination of Base Realignment and Closure (BRAC) decisions, Army Modular Force (AMF) redesign and stationing, and the transformation of the Global Defense Posture (GDP) have presented us with a significant challenge to adapt in support of rapid change. But more importantly, these initiatives offer an unprecedented opportunity to improve the way we care for patients at affected installations. We are working with the Army Corps of Engineers to improve the historically long-lead time necessary to plan and execute military medical construction projects, especially given limited funding and low fiscal thresholds that we must work within. Although it will be a significant challenge, the Army Medical Department approaches this epoch as an opportunity to make significant strides not only to transform, realign and improve our vast and aging infrastructure, but also to integrate exciting new acquisition methodologies, cutting-edge medical technologies, our robust information management system and emerging concepts of patient treatment and care, such as Evidence Based Design. I am confident that with the help of Congress, we will be able to leverage this once-in-a-lifetime opportunity to further advance healthcare, by properly aligning and improving the enabling facility infrastructure.

Despite our operations tempo, we have maintained quality of care for Soldiers, their families, and our retirees. Private sector care enrollment and workload are

increasing as we continuously evaluate and optimize our facilities' enrollment to ensure appropriate personnel and facilities are available to meet healthcare demand. We have prioritized workload to support casualty care and deployment medical screening, shifting a portion of our family member and retiree care to the private sector to ensure they will continue to receive continuous high-quality care during ongoing deployment of our medical personnel. Additionally, families of mobilized Reserve Component Soldiers now have TRICARE available to them as their health insurance in many areas where military facilities do not exist or do not have the capacity to absorb additional enrollees.

Going to war affects all Soldiers. The number of Soldiers with Post Traumatic Stress Disorder (PTSD) and other stress-related symptoms has gradually risen. The AMEDD has been supporting our Soldiers at war for 5 years, during 9/11 at the Pentagon, in Afghanistan, in Iraq and around the globe. But America does not know about the extensive array of mental health services that has long been available for Soldiers and their families. Since 9/11, the Army has augmented behavioral health services and post-traumatic stress disorder counseling throughout the world, but especially at Walter Reed Army Medical Center and at the major Army installations where we mobilize, train, deploy, and demobilize Army forces. Demand for these services will not decrease in 2007 and we are committed to providing the long-term resources necessary to effectively care for Soldiers and families dealing with a wide variety of stress-related disorders.

Soldiers are also now receiving a global health assessment, with a focus on behavioral health, 90 to 180 days after redeployment. This assessment, the Post-Deployment Health Reassessment (PDHRA), includes an interview with a healthcare provider. The PDHRA provides Soldiers an opportunity to identify any new physical or behavioral health concerns they may be experiencing that may not have been present immediately after their redeployment. This new program has been very effective in identifying Soldiers who are experiencing some of the symptoms of stress-related disorders and getting them the care they need before their symptoms manifest into more serious problems.

The AMEDD is also performing behavioral health surveillance and research in an unprecedented manner. There have been four Mental Health Advisory Teams (MHATs)

performing real time surveillance in the theater of operations, three in Iraq and one in Afghanistan. COL Charles Hoge has led a team from the Walter Reed Army Institute of Research in a wide variety of behavioral health research activities. His research shows that generally the most seriously affected by PTSD are those most exposed to frequent direct combat.

Since the beginning of Operation Iraqi Freedom (OIF) in 2003, there has been a robust Combat and Operational Stress Control presence in theater. Today, more than 170 Army behavioral health providers are deployed in Iraq and another 25 are deployed in Afghanistan. Air Force and Navy mental health teams are also deployed and supporting Soldiers, Sailors, Airmen, and Marines in Iraq and Kuwait. The MHAT reports demonstrate both the successes and some of the limitations of these combat stress control teams. Based on MHAT recommendations, we have improved the distribution of behavioral health providers and expertise throughout the theater. Access to care and quality of care have improved as a result.

There is a perceived stigma associated with seeking mental healthcare, both in the military and civilian world and we must take action to address this problem. Therefore, we are moving to integrate behavioral healthcare into primary care, wherever feasible. Our pilot program at Fort Bragg, Respect.Mil, which provides education, screening tools, and treatment guidelines to primary care providers, was very successful. We are in the process of implementing this program at thirteen other sites across the Army.

Training in behavioral health issues is ongoing in numerous forums. The Walter Reed Army Institute of Research has developed a training program called "BATTLEMIND". Prior to this war, there were no empirically-validated training strategies to mitigate combat-related mental health problems, and we have been evaluating this post-deployment training using scientifically rigorous methods with good initial results. This new risk communication strategy was developed based on lessons learned from COL Hoge's Land Combat Study and other efforts. It is a strengths-based approach that highlights the skills that helped Soldiers survive in combat instead of focusing on the negative effects of combat. Two post-deployment training modules have been developed, including one version that involves video vignettes that emphasize safety

and personal relationships, normalizing combat-related mental health symptoms, and teaching Soldiers to look out for each other's mental health.

The acronym "BATTLEMIND" identifies 10 combat skills that, if adapted, will facilitate the transition home. An example is the concept of how Soldiers who have high tactical and situational awareness in the operational environment may experience hypervigilence when they get home. The post-deployment BATTLEMIND training has been incorporated into the Army Deployment Cycle Support Program, and is being utilized at Department of Veterans' Affairs Vet Centers and other settings. We have also been developing pre-deployment resiliency training for leaders and Soldiers preparing to deploy to combat using the same BATTLEMIND training principals, as well as training for spouses of Soldiers involved in combat deployments.

Traumatic brain injury (TBI) is emerging as a common blast-related injury. TBI is a broad grouping of injuries that range from mild concussions to penetrating head wounds. An overwhelming majority of TBI patients have mild and moderate concussion syndromes with symptoms not different from those experienced by athletes with a history of concussions. Many of these symptoms are similar to post-traumatic stress symptoms, especially the symptoms of difficulty concentrating and irritability. It is important for all providers to be able to recognize these similarities and consider the effects of blast exposures in their diagnoses. Through the Defense and Veterans Brain Injury Center (DVBIC), headquartered at Walter Reed, we understand a lot about moderate to severe TBI, including severe closed head trauma, stroke, and penetrating head wounds. What we do not fully understand is the long-term effects of mild concussion or multiple mild concussions on Soldier performance. Though Congress' support of the DVBIC has been instrumental in providing the DoD with a firm foundation to quickly improve our understanding of mild TBI, we must move quickly to fill this knowledge gap.

In December 2006, The Surgeon General chartered an Army Task Force on TBI to review our policies and resources dedicated to TBI from scientific research, acute diagnosis and treatment, to long-term rehabilitation. This Task Force, led by Brigadier General Don Bradshaw, includes subject matter experts from across Army Medicine. We also invited the Navy, the Air Force, and the Department of Veterans Affairs to have

representatives participate in the Task Force. I expect General Bradshaw to provide me a report and recommendations by late spring 2007.

The rapid growth in national healthcare costs threaten our medical system and, ultimately, Army readiness. The Army requires a robust military medical system to meet the medical readiness needs of active duty service members in both war and peace, and to train and sustain the skills of our uniformed physicians, nurses, and combat medics as they care for family members, retirees, and retiree family members. Therefore, we share the DoD's concern that the explosive growth in our healthcare costs jeopardizes our resources, not only to the military health system but in other operational areas as well.

DoD continues to explore opportunities to help control costs within the DHP and in many of these initiatives the Army leads the way in implementation and innovation. In 2006, we implemented a performance-based budget adjustment model throughout the Army Medical Command. This model accounts for provider availability, workload intensity, proper coding of medical records, and the use of outcome measures as quality indicators to adjust hospital and clinic funding levels to reflect the actual cost of delivering healthcare. The Southeast Regional Medical Command implemented an early version of this system in 2005 where it showed great promise. This enterprise-wide model focuses command attention on the business of delivering quality healthcare. It is a data-driven methodology that enables commanders at all levels to receive fast feedback on their organization's performance. Finally, the use of Clinical Practice Guidelines encourages efficiency by using nationally accepted models for disease management. These adjustments provide my commanders the ability to reward high-performing activities, encourage best-business opportunities, and exceed industry-standard wellness practices.

Fiscal Year 2007 and Fiscal Year 2008 will be challenging years for the Defense Health Program (DHP) and Army Medicine. Our estimates for cost growth through 2013 are not complete, but we are still witnessing sizable growth in the number of TRICARE-reliant beneficiaries in our system, and the pressures on the defense budget continue to grow while military healthcare costs continue to substantially increase. The FY 2008 President's budget request includes a legislative proposal that aligns TRICARE

premiums and co-payments for working-age retirees (under age 65) with general health insurance plans. The Department may modify or supplement this request after it considers recommendations from the DoD Task Force on the Future of Military Healthcare that has been recently established with distinguished membership from within the Department, other federal agencies and the civilian sector. A key area the Task Force will study is "beneficiary and government cost-sharing structure." We believe this and the other recommendations they make will markedly benefit the MHS in the future.

The DHP is a critical element of Army medical readiness. Healthy Soldiers capable of withstanding the rigors of modern combat; who know their families have access to quality, affordable healthcare, whether the Soldier is home with them or deployed to a combat theater; and who are confident when they retire they will have access to that same quality healthcare is an incredibly powerful weapon system. Every dollar invested in the DHP does much more than just provide health insurance to the Department's beneficiaries. Each dollar is truly an investment in military readiness. In OIF and OEF that investment has paid enormous dividends.

We continue to aggressively work to improve the transition from inpatient care to outpatient care for our Wounded Warriors at Walter Reed Army Medical Center and across Army Medicine. Under the leadership of General Cody, the Army's Vice Chief of Staff, we have taken the lessons learned at Walter Reed and implemented an Army-wide action plan. This plan includes operation of a Wounded Soldier and Family Hotline, an "800-number" call center and operation center located at the US Army Human Resources Command. If there are issues, they'll get elevated to the Army leadership quickly and not be allowed to percolate at a low level without being addressed. We are also implementing a One Stop Soldier and Family Assistance Center at Walter Reed. This center brings together case managers; family coordinators; personnel and finance experts; and representatives from key support and advocacy organizations such as the Army Wounded Warrior Program, Red Cross, Army Community Services, Army Emergency Relief, and the Department of Veterans Affairs. We are also creating a formal Patient Advocate Program (an ombudsman program

established initially at Walter Reed) to be established at other major installations across the force.

We are also revamping the administrative process of evaluating and adjudicating our Soldiers' disabilities. Our goal is to streamline the process to eliminate confusion among Soldiers and families. As we revamp this system we must be careful that we do not compromise the quality of medical care received or the Soldier's right to a full and thorough medical evaluation.

The Army will ensure that Soldiers will no longer leave the resources and attention of its medical system behind when they walk out the hospital doors. The Army will ensure that Wounded Warriors and their families are treated the way they so richly deserve and the way the Nation rightfully expects. We are grateful to the Congress for the concern and attention paid to Soldiers - and will continue to keep the Congress informed as we improve these identified challenges.

In closing, let me emphasize that the service and sacrifice of our Soldiers – and their families – cannot be measured with dollars and cents. The truth is that we owe far more than we can ever pay to those who have been wounded and to those who have suffered loss. Thanks to your support, we have been very successful in developing and sustaining a healthcare delivery system that honors the commitment our Soldiers, retirees, and their families make to our Nation.

Thank you again for inviting me to participate in this discussion today. I look forward to answering your questions.