DEPARTMENT OF DEFENSE APPROPRIATIONS FOR FISCAL YEAR 2010

WEDNESDAY, MARCH 18, 2009

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 10:30 a.m., in room SD–192, Dirksen Senate Office Building, Hon. Daniel K. Inouye (chairman) presiding.

Present: Senators Inouye, Murray, Cochran, and Bennett.

DEPARTMENT OF DEFENSE

MEDICAL HEALTH PROGRAMS

STATEMENT OF LIEUTENANT GENERAL ERIC B. SCHOOMAKER, M.D., Ph.D., SURGEON GENERAL, U.S. ARMY MEDICAL COMMAND

OPENING STATEMENT OF SENATOR DANIEL K. INOUYE

Chairman INOUYE. I'd like to welcome all of the witnesses today as we review the Department of Defense (DOD) medical programs. There'll be two panels this morning. First we'll hear from the service surgeon generals: General Eric Schoomaker, Vice Admiral Adam Robinson, Jr., General James Roudebush. Then we'll hear from our chiefs of the Nurse Corps: General Patricia Horoho, Rear Admiral Christine M. Bruzek-Kohler, and General Kimberly Siniscalchi. Did I get it correct?

I'd like to welcome back all of the three surgeon generals to our subcommittee once again. I look forward to continuing our work together to ensure the future of our military medical programs and personnel.

As you may have noted, this is the first defense hearing that the subcommittee will be holding this year. We deliberately selected the medical programs as our inaugural topic to underscore the importance that this issue has to our subcommittee. Our surgeon generals and the chiefs of the Nurse Corps have been called upon to share their insight on what is working and what is not working.

Military medicine is a critical element in our defense strength. Our ability to care for our wounded soldiers on the modern battlefield is a testament both to the hard work and dedication of our men and women in uniform and to the application of the new technology which is a hallmark of the U.S. armed forces, and so to our medical programs' demonstrated commitment to provide for our servicemembers and their families, which is unsurpassed in any

other military. It is a vital component in our military compensation package, one that is necessary to sustain the all-volunteer force, a force, I might add, which by all measurement is the finest in the world.

This is a unique medical hearing because we have not received the details of the fiscal year 2010 DOD budget, nor have we received the remaining fiscal year 2009 supplemental request. While we may not be able to discuss detailed budget issues, we'll focus on various medical personnel and medical technology issues facing the Department, our servicemembers and their families.

On a personal note, when I was in the Army some time ago 4 percent of the men in my regiment were married, just 4 percent. I think that was about the average in the United States Army. Now 56 percent of the Army, 54 percent of the Navy, and 45 percent of the Marine Corps, and 59 percent of the Air Force are married. This completely alters the dynamic of the service I remember to the one you see today.

Not only that, but the demographics of our servicemembers have drastically changed. We also have more than a few dual-service parents and couples, both of which deploy to theater.

We've all read about the rising rates of suicide, divorce, substance abuse in our military. This is not something that can only be addressed with the service member. This must be approached with the service member, their family, their fellow soldiers, sailors, marines, and airmen. The solutions are not one size fits all or one service fits all. Instead, all ideas must be on the table for everyone to consider. What works for the Army may not necessarily work for the Navy.

In addition, we need to take a unified approach to medical research in areas directly tied to the warfighter that we are currently tackling and those that could be right around the corner. This coordinated approach should cross the entire Federal Government, utilizing the resources and expertise of the Department of Veterans Affairs, the National Institutes of Health, Department of Homeland Security, and the Substance Abuse and Mental Health Services Administration, just to name a few.

The Department stands at a very pivotal juncture in its efforts to modernize the medical technology enterprise architecture. I'm certain each one of you can share a story or two about the various versions of the Department's medical health records and how challenging it can be, at the least. Now you are tasked to both modernize the system and make it interoperable with the Veterans Administration (VA) to facilitate seamless transitions for our servicemembers and to enable joint DOD–VA locations to care for both veterans and servicemembers.

These are not simple tasks and I know that there are many challenges ahead. These are some of the issues we'll face in the years ahead. We continue to hold this valuable hearing with the service surgeon generals and the chiefs of the Nurse Corps as an opportunity to raise and address these and many other issues.

I look forward to your statements and note that your full statements will be made part of the record.

Before we proceed with witnesses, may I call upon the vice chairman of the subcommittee, Senator Cochran.

STATEMENT OF SENATOR THAD COCHRAN

Senator COCHRAN. Mr. Chairman, thank you very much. I'm pleased to join you in welcoming our two panels of witnesses today, the service surgeon generals and the chiefs of the Nurse Corps. We have an important duty to provide for the medical needs of our active, Guard, and Reserve personnel. The joint approach in managing the military medical programs has been very important in supporting our soldiers, sailors, airmen, and marines, especially during wartime.

The men and women of the medical service corps deserve our thanks for their services they've provided and continue to provide. I'm pleased to join the chairman in being here to receive your testimony and working with you as we try to identify the priorities that need special attention in the funding cycle that we are approaching.

Thank you very much.

Chairman INOUYE. Thank you very much.

I am especially pleased to have with us in the subcommittee this morning Senator Bennett of Utah. He's our newest member. Welcome, sir. Would you like to make a statement?

Senator BENNETT. Your being pleased is only exceeded by my being pleased at the opportunity to be here. Thank you for your welcome.

Chairman INOUYE. Thank you very much.

May I call upon the first witness, Lieutenant General Eric B. Schoomaker. He's a doctor, a Ph.D. He's also the Surgeon General of the U.S. Army.

General SCHOOMAKER. Thank you, sir. Chairman Inouye, Vice Chairman Cochran, Senator Bennett: Thank you for providing all of us here a forum for discussing our service medical programs and to allow me to discuss Army medicine and the defense health program (DHP).

As you mentioned earlier, sir, I'm joined by our Chief of the Army Nurse Corps, Major General Patty Horoho, and the Commander of the Western Regional Medical Command at Madigan Army Medical Center at Fort Lewis, Washington.

Also, in recognition of the Army's having declared 2009 as the year of the NCO, the noncommissioned officer, I'm joined today by my senior—the senior enlisted medic in the Army, who is my command sergeant major, Althea Dixon. She is one of the finest soldiers and leaders with whom I have had the pleasure to serve and is an invaluable member of my command team. Command Sergeant Major Dixon has been my battle buddy and my conscience and my unwavering standardbearer throughout these last three commands and through some of the most difficult challenges that Army medicine has faced. We've traveled together throughout the United States, especially throughout the southeast United States when we worked together in the Southeast Regional Medical Command, but also in Europe and in Kenya, Thailand, Korea, and most recently in Afghanistan and in Iraq.

She embodies really the ethos of the noncommissioned officer. She's the person to whom I turn for unvarnished truth about my command and my effectiveness as a commander. She's my constant

reminder of what is one of the most distinguishing and powerful features of our Army, which is our noncommissioned officer corps.

For my oral statement today I'd like to highlight just a handful of key points that I raise in my written testimony. First I'd like to thank the Congress and this subcommittee in particular for the very generous and much appreciated funding support that you provided for the military health system and for Army medicine over the last year. Congress has been attentive to the needs we have in military medicine, particularly in our sustainment, restoration, and modernization (SRM) funding, SRM funding for facilities, and our research and development funds for research.

Our sustainment, restoration, and modernization funding really gets put to great use by our facilities managers who keep our facilities operating safely and reliable. Some of our older hospitals are not ideal for practicing a 21st century form of medicine, but our SRM funding has really allowed us to keep them in good shape and running safely and smoothly.

Our research and development dollars are going toward some very promising research. I think the chairman alluded to that earlier. It's aimed at saving and improving the lives of soldiers on future battlefields. Frankly, although I use the term "soldiers" to describe the recipients of these efforts, increasingly we conduct our research programs really as a joint effort among my three colleagues here, so that all warriors—soldiers, sailors, airmen, marines, coast guardsmen, and other Federal agency partners—as well as the public at large are beneficiaries of our work.

Examples are biomarkers for traumatic brain injury, tissue reengineering, interventions to build resilience and prevent psychiatric hazards—just a few examples of where innovative research initiatives that were funded through our fiscal year 2009 core medical research budget are working. I eagerly await the outcomes of these and other research efforts that can better the lives of our soldiers and other warriors.

Next I'd like to briefly mention the latest developments in our warrior care and transition program. This is probably one of the most important advances that we've made over the last several years. In our first year of standing up the warrior care and transition program through the Army medical action plan, we heavily invested in the structure of our units. We focused on proper ratios of care providers and cadre that oversee our warriors in transition. That's what we call our soldiers who are in these programs. They are transitioning into uniform, back into uniform, or into civilian life, or into continued care in the private sector or in the VA.

Now in our second year, we're directing our efforts at optimizing the transition for our soldiers and families. In March 2008 we launched a comprehensive transition plan initiative for our warriors in transition. Instead of focusing solely on their injury or illness, the comprehensive transition plan fosters an holistic approach to a warrior's rehabilitation and transition. These are the lessons which wounded, ill, and injured soldiers from former wars, such as the chairman himself and Senator Dole, general retired, now Secretary, Shinseki, and general retired Fred Franks, have told us were the most important lessons to be gained from their own experiences in recovery and rehabilitation.

This is accomplished through a collaboration of a multidisciplinary team of physicians, of case managers, specialty care providers, occupational therapists, and others. Together with a soldier and the family, we develop an individually tailored set of goals, emphasize the transition phase to civilian life or return to duty. I'm confident that this is really where we need to be doing that and it's going to come up with the right outcomes for our folks.

An even newer Army program that I have high expectations for is our comprehensive soldier fitness program. The Army Chief of Staff, General George Casey, has established a vision of an Army comprised of balanced, healthy, self-confident soldiers and families and Army civilians whose resilience and total fitness enable them to thrive even in this area of high operational tempo and persistent conflict and engagement.

To achieve this ambitious vision, he's instituting a comprehensive soldier fitness program. The intent of this program is to increase the resilience of soldiers and families by developing the five dimensions of strength: physical, emotional, social, spiritual, and family.

It's currently in development. It's under the leadership of Brigadier General Rhonda Cornum, an Army Medical Department physician. I expect this program to have a positive effect and a profound effect upon our soldiers, their families, and our Army civilians.

Last, I wanted to share with you a copy of our new combat medic handbook. Our combat medics, which we call 68-Whiskeys, 68-Ws, are the best trained battlefield medics in the world, alongside our Navy and Air Force colleagues of course. As the Army and the joint force have labored to provide better body armor and protection from ballistic and burn and blast injury and have altered the tactics, techniques, and procedures in a complex urban terrain to reduce combat casualties and improve on our killed in action rates, that is survival from the initial wounding incident, our medics have enhanced these improvements and have further contributed to a historically low died of wound rates despite more destructive weapons that are wielded by our enemies.

The medics of this 68-Whiskey generation are trained to perform advanced airway skills, hemorrhage control techniques, shock management, and evacuation. Examples are: Sergeant First Class Nadine Kahla and Sergeant First Class Jason Reisler, who are 68-Whiskey NCOs assigned to the Army Medical Department Center and School in San Antonio, Texas. They are representatives of the other 17 68-Whiskey NCO authors that contributed to this new advanced fieldcraft combat skills textbook, a state-of-the-art manual for combat medics. This delineation of combat medic skills is newly published. It'll be issued to every graduating new combat medic beginning this month. It's an incredible resource developed by some truly incredible NCOs.

In closing, I wanted to thank the subcommittee for the terrific support that you have given to the defense health program and to Army medicine. I greatly value the insight of this subcommittee and I look forward to working with you closely over the next year.

I also want to salute our noncommissioned officers for their professionalism, competence, and leadership. They're truly the backbone of the Army and of Army medicine.

PREPARED STATEMENT

Thank you for holding this hearing. Thank you for your continued support of Army medicine and the warriors and families that we're most honored to serve. Thank you, sir.

Chairman INOUYE. Thank you very much, General Schoomaker.

[The statement follows:]

PREPARED STATEMENT OF LIEUTENANT GENERAL ERIC B. SCHOOMAKER, M.D., PH.D.

Chairman Inouye, Vice Chairman Cochran, and distinguished members of the Subcommittee, thank you for providing me this forum to discuss Army Medicine and the Defense Health Program. I appreciate 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 personify the AMEDD value "selfless service." In recognition of 2009 being "The Year of the NCO", throughout my testimony I will highlight the contributions of the AMEDD's Non-Commissioned Officer Corps, the backbone of Army Medicine. Non-Commissioned Officers comprise 18 percent of the Army Medical Department and play critical roles in every aspect of the organization. I am joined today by the senior enlisted medic in the Army, my Command Sergeant Major Althea Dixon, one of the finest Soldiers and leaders with whom I have had the privilege to serve and an invaluable member of my command team.

As the Commander of the U.S. Army Medical Command (MEDCOM), I oversee with the assistance of Command Sergeant Major Dixon a $10 billion international healthcare organization staffed by 70,000 dedicated Soldiers, civilians, and contractors. We are experts in medical research and development, medical logistics, training and doctrine, the critical elements of public health—health promotion and preventive medicine, dental care, and veterinary care—in addition to delivering industry-leading healthcare services to 3.5 million beneficiaries around the world. But central to everything we do in Army Medicine is the warfighter—we exist as a military medical department to support the warfighter. I am happy to report that we are accomplishing that mission phenomenally well. I can say this with great confidence after spending the first week of this month with the U.S. Central Command (CENTCOM) Surgeon at the Multi-National Force/Multi-National Corps—Iraq Surgeon's Conference in Iraq. Seeing first hand the care and civil-military medical outreach from Brigade and Division to Corps and Theater was a clear demonstration of the Joint Medical Force providing top-notch medical support across the full-continuum of care and nation building.

To determine how successful we are at executing our mission, Army Medicine uses the Balance Scorecard (BSC) approach developed in the 1990s by Harvard's Doctors Robert Kaplan and David Norton. Simply put, the BSC serves as an organizational strategic management system which can help improve organizational performance while remaining aligned to our strategy. The MEDCOM began BSC implementation in 2001 under LTG (Ret) James Peake's leadership. Since then, we have continued to refine the BSC to grow and direct our dynamic organization. I use the enclosed Army Medicine Strategy Map (published in April 2008 and revised in January 2009) and Scorecard as the principal tool by which to guide and track the Command to improve operational and fiscal effectiveness, and better meet the needs of our patients, customers, and stakeholders. The BSC communicates to our MEDCOM workforce and drives top-to-bottom organizational understanding and alignment, focusing our day-to-day efforts to ensure we execute our Mission successfully.

ARMY MEDICINE BALANCED SCORECARD (BSC) OVERVIEW

Purpose

The Balanced Scorecard strategic management framework has been and continues to serve as the centerpiece of the Army Medicine's enterprise-wide Strategic Management System. The first AMEDD strategy map was approved by LTG James B. Peake on April 2001 and the framework has continued through today with LTG Eric B. Schoomaker's January 2009 strategy map. The BSC is used to drive top-to-bottom organizational understanding and alignment, focus day-to-day efforts, and ensure that we are executing our Mission.

Overview

The BSC is a concept introduced by Doctors Robert Kaplan and David Norton in 1992. The BSC is a framework to translate the organization's strategy into terms that can be easily understood, communicated, and acted upon (measurable action).

The foundation and main driver of a BSC is the organization's Mission and Vision. Four perspectives then define the organization: Patient/Customer/Stakeholder (Ends), Internal Processes (Ways), Learning and Growth (Means), and Resource (Means). The April 2008 strategy map (one page schematic) describes Army Medicine's strategy via the strategic objectives (located in the bubbles on the strategy map) in each perspective. Behind each strategic objective is a detailed objective statement that clearly defines the meaning of the strategic objective and measure, which will drive behavior to accomplish each objective. Each measure will have a target and supporting initiatives that will drive the change required to allow the organization to move closer to its intended outcomes (ends).

The BSC is a dynamic, living document that will be refined due to mission and priority changes, organizational learning, as well as when targets are met. Periodic reviews are conducted to ensure proactive change.

Organizational Cascading and Alignment

To ensure enterprise-wide alignment to the Army Medicine BSC, Major Subordinate Command Commanders and Corps Chiefs are required to build a supporting BSC and conduct an alignment brief with TSG.

Additional Information

Detailed information, to include the Army Medicine BSC, is located at https://ke2.army.mil/bsc.

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Army Medicine Strategy Map
January 2009
Mission
- Promote, Sustain and Enhance Soldier Health
- Train, Develop and Equip a Medical Force that Supports Full Spectrum Operations
- Deliver Leading Edge Health Services to Our Warriors and Military Family to Optimize Outcomes
Vision
America's Premier Medical Team Saving Lives and Fostering Healthy and Resilient People
Army Medicine...Army Strong!
Strategic Themes
Maximize Value in Health Services
Provide Global Operational Forces
Build the Team
Balance Innovation with Standardization
Optimize Communication and Knowledge Management
SUSTAIN PREPARE RESET TRANSFORM
ENDS
WAYS
MEANS
Patient/Customer/ Stakeholder
Internal Process
Learning and Growth
Resource
In Support of
The Army Family Covenant
CS 1.0 Improved Healthy and Protected Families, Beneficiaries and Army Civilians
CS 2.0 Optimized Care and Transition of Wounded, Ill, and Injured Warriors
CS 3.0 Improved Healthy and Protected Warriors
CS 4.0 Responsive Battlefield Medical Force
CS 5.0 Improved Patient and Customer Satisfaction
CS 6.0 Inspire Trust in Army Medicine
IP 10.0 Optimize Medical Readiness
IP 11.0 Improve Information Systems
IP 12.0 Implement Best Practices
IP 7.0 Maximize Physical and Psychological Health Promotion and Prevention
IP 8.0 Improve Quality, Outcome-Focused Care and Services
IP 9.0 Improve Access and Continuity of Care
IP 13.0 Build Relationships and Enhance Partnerships
IP 14.0 Improve Internal and External Communication
IP 15.0 Leverage Research, Development and Acquisition
IP 16.0 Synchronize Army Medicine to Support Army Stationing & BRAC
LG 17.0 Improve Recruiting and Retention of AMEDD Personnel
LG 18.0 Improve Training and Development
LG 19.0 Promote and Foster a Culture of Innovation
LG 20.0 Improve Knowledge Management
R 21.0 Optimize Resources and Value
R 22.0 Optimize Lifecycle Management of Facilities and IT Infrastructure
R 23.0 Maximize Human Capital
Feedback Adjusts Resourcing Decisions
This is a dynamic, living document
UNCLASSIFIED FOUO Slide 1 of 18
For more information go to: https://ke2.army.mil/hsc

The Army Medicine BSC measures and improves organizational performance in four "balanced" Strategic Perspectives: "Resources" and "Learning and Growth" which are the "Means"; "Internal Processes" which is the "Ways"; and "Patients, Customers and Stakeholders" which is the "Ends" by which we show best value in products and services. These "Ends" are how I've organized my statement in order to best communicate the significant and varied accomplishments of Army Medicine over the last year.

The Six Army Medicine "Ends": Improved Healthy and Protected Families, Beneficiaries, and Army Civilians; Optimized Care & Transition of Wounded, Ill, and Injured Warriors; Improved Healthy and Protected Warriors; Responsive Battlefield Medical Force; Improved Patient and Customer Satisfaction; and Inspire Trust in Army Medicine.

IMPROVED HEALTHY AND PROTECTED FAMILIES, BENEFICIARIES, AND ARMY CIVILIANS

Improve the health of beneficiaries thru cost-effective evidence-based care, proactive disease management, demand management, and public health programs.

*Use of HEDIS*R *Measures*.—The Healthcare Effectiveness and Data Information Set (HEDISR) is a tool used by more than 90 percent of America's health plans (> 400 plans) to measure performance on important dimensions of care. The measures are very specifically defined, thus permitting comparison across health plans. The DOD is not a member of the HEDIS program, but uses the HEDIS methodology to measure and compare its performance to the HEDIS benchmarks. The Military Health System (MHS) Population Health Portal takes administrative data and electronic health record data and provides reports on the status of our beneficiaries on each measure. Currently, we track 9 measures and compare our performance to HEDIS benchmarks. In October 2008, the Army was in the 90th percentile compared to HEDIS health plans for 2 of 9 measures. We are in the 50th to 90th percentile for 6 measures and below the HEDIS 50th percentile for one measure. Marked improvement is seen in colorectal cancer screening which improved 8.9 percent (October 2005 to October 2008) and approaches the HEDIS 90th percentile. In addition, the Army has very high compliance with Pneumovax, the vaccine against pneumococcal pneumonia, for our enrolled patients over age 65. Since 2007, we've been providing financial incentives to our hospitals for superior compliance in key HEDIS measures. The Army was the pioneer for what the Assistant Secretary of Defense for Health Affairs is now terming Pay-for-Performance. We have shown that these incentives work to change behavior and achieve desired outcomes in our system.

MEDCOM Reorganization.—The MEDCOM is engaged in a phased reorganization designed to optimize the delivery of healthcare to our Army and to support a deploying force. With the support of senior Army leadership, I approved phase one of this reorganization which aligns CONUS Regional Medical Commands (RMCs) with their supporting TRICARE regions. MEDCOM is restructuring in order to be better aligned and positioned to support our transforming Army. Command Sergeant Major Matthew T. Brady was instrumental in developing the structure and functions for the newly designed Western RMC headquarters—his contributions are emblematic of the significant role played by NCOs across the MEDCOM in our restructuring efforts.

Healthcare support today is outstanding and it must remain so for our Army to succeed during an era of persistent conflict. As the Army changes its structures, relationships and organizational designs through transformation and other initiatives to better support our Nation in the 21st Century, the AMEDD must adapt to ensure it remains reliable and relevant for our Army. The main restructuring is from 4 CONUS RMCs to 3 CONUS RMCs. While reorganizing RMCs, we intend to further integrate healthcare resources, capabilities and assets to foster greater unity of effort and synergy of our healthcare mission. The restructuring will posture us to better provide the best support for Army Force Generation (ARFORGEN) and improve readiness through enhanced health care services for our Soldiers, their Families, and Army units.

Clinical Information Systems.—The AMEDD has long recognized a need for an information system to help us grow as a knowledge-driven organization. The AMEDD energetically assumed lead for the DOD during the implementation of the Composite Health Care System I (CHCS I), now known as AHLTA. Unfortunately, AHLTA has not always kept pace with expectations at the user-level or at the corporate level for data mining and other uses. The Army has taken significant steps to leverage the data from AHLTA and other clinical information systems to improve clinical quality and outcomes as well as patient safety. To address identified shortcomings with AHLTA at the provider level, the AMEDD has invested in the

MEDCOM AHLTA Provider Satisfaction (MAPS) initiative. This includes investment in tools like Dragon Medical™ and As-U-Type®, individualized training and business process re-engineering led by clinical champions, and use of wireless and desktop virtualization. At the Heidelberg Health Center in Germany, Staff Sergeant Kenneth M. Melick is the workhorse who took the physician vision for business process reengineering from construction to final implementation and ensured success. MAPS is beginning to show significant improvements in provider usability and satisfaction. Direct interviews with providers and staff reveal that MAPS implementation has generated a dramatic change in attitude among our staff.

The most recent version of AHLTA has presented us with challenges, but it is showing improvements and gaining provider acceptance. AHLTA provides significant benefit to beneficiaries, especially in the areas of patient safety, security, improved clinical and readiness outcomes, and global availability of records. In addition, a new enterprise architecture for the MHS will likely result in a significant improvement in managing our information systems. The next update to AHLTA (3.3) is being deployed and its additional functionality and improved speed is well-liked by the providers who have tested it.

Force Health Protection and Public Health Programs.—The U.S. Army's Center for Health Promotion and Preventive Medicine (CHPPM) is a subordinate command of the MEDCOM that affects the lives of Soldiers and Families everyday. Its mission is to provide worldwide technical support for implementing preventive medicine, public health, and health promotion/wellness services into all aspects of America's Army and the Army community. The CHPPM team supports readiness by keeping Soldiers fit to fight, while also promoting wellness among their Families and the Federal civilian workforce. CHPPM integrates public health efforts to develop and export primary prevention based products by using epidemiologic data of disease and injury to identify the best prevention programs to implement for overall population health improvement. One member of the CHPPM team—Sergeant Kerri Washington—made a notable impact on the health and safety of our U.S. Army and Iraqi Forces in the Multi National Division—Baghdad area of responsibility. Sergeant Washington deployed as a Preventive Medicine (PM) Specialist with the 61st Medical Detachment (PM) and applied his preventive medicine skills, leadership ability, and unique health surveillance training to enhance Soldier health and disease prevention.

CHPPM is establishing a Public Health Management System to evaluate the programs and policies developed to promote optimal health in the Army community which will use the public health process to provide metrics indicating the success or lack of success in these endeavors. This will allow leaders to make informed decisions on effective or ineffective public health issues in the Army. Army veterinarians play a key role in public health as well, ensuring the safety of food and water and the prevention of animal-borne diseases. As part of the MEDCOM Reorganization addressed earlier, I have directed my staff to assess the feasibility and benefits of establishing a Public Health Command which better synchronizes and integrates the efforts of all AMEDD members who contribute to public health programs. This will enhance comprehensive health and wellness and optimize delivery of public health support to the Army.

OPTIMIZED CARE AND TRANSITION OF WOUNDED, ILL, AND INJURED WARRIORS

Warrior Care and Transition Program.—The transformation of U.S. Army Warrior Care began in April 2007 with the development of the Army Medical Action Plan (AMAP), which outlined an organizational and cultural shift in how the Army cares for its wounded, ill, and injured Soldiers. Over the past 22 months, the AMAP has evolved into the Army Warrior Care and Transition Program (WCTP), fully integrating Warrior Care into institutional processes across the Army, and is achieving many of the Army's goals for enhancing care and improving the transition of wounded warriors back to duty or into civilian life as productive veterans. At the heart of the Warrior Care and Transition Program is the successful establishment of 36 Warrior Transition Units (WTUs) at major Army installations worldwide, and nine Community Based Warrior Transition Units (CBWTUs) located regionally around the United States. These units replace the Medical Holdover (MHO) system of the past and provide holistic care and leadership to Soldiers who are expected to require 6 months of rehabilitative treatment, and/or need complex medical case management.

Comprehensive Transition Plan.—In our first year of Warrior Care and Transition, we heavily invested in the structure of our units and support systems. Now in our second year, we recognize that our focus needs to be on optimizing the transition for our Soldiers. In March 2008, MEDCOM launched the Comprehensive Tran-

sition Plan initiative for Warriors in Transition. Instead of focusing solely on the injury or illness, the Comprehensive Transition Plan fosters a holistic approach to a Warrior's rehabilitation and transition. This is accomplished through the collaboration of a multidisciplinary team of physicians, case managers, specialty care providers, and occupational therapists. Together with the Soldier, they develop individually tailored goals that emphasize the transition phase to civilian life or return to duty. Goals are set and the transition plan developed within one month of the Soldier's arrival at the WTU.

Physical Disability Evaluation System.—The Medical Evaluation Board (MEB) and Physical Evaluation Board (PEB) processes have been streamlined and paperwork requirements reduced to more efficiently move a Soldier's disability package through the adjudication process. Additionally, collaboration between the DOD and the Department of Veterans Affairs (VA) ensures that Warriors in Transition have priority processing by the Veterans Health Administration (VHA) and Veterans Benefits Administration (VBA) 60 to 180 days prior to separating so that they can receive their VA benefits and health care immediately upon discharge. General Frederick M. Franks, Jr., USA Ret. has been leading an Army task force to research and recommend improvements to the MEB/PEB process. His findings, recently delivered to the Secretary of the Army, recommended that DOD and VA eliminate dual adjudication from the current system and "transition to a comprehensive process focusing on rehabilitation and transition back to either uniformed service or civilian life that promotes resilience, self-reliance, re-education, and employment, while ensuring enduring benefits for the Soldier and Family." This finding reaffirms the importance of the Comprehensive Transition Plan.

Warrior Satisfaction.—Over the past 2 years, the Army has made tremendous progress in transforming how it provides healthcare to its Soldiers, with improvements impacting every aspect of the continuum of care. Over this period, overall Soldier and Family satisfaction with the care and support they have received as a result of the efforts of the Warrior Care and Transition Program has increased significantly. Two years ago, only 60 percent of those in the legacy medical hold units were satisfied with the care they received. Today, that number has increased to 80 percent of Soldiers and Families who now receive the focused and comprehensive care and support provided by WTUs. Considering that over 20,000 Soldiers, along with their Families, have transitioned through the Warrior Care and Transition Program over that time, this represents a significant number of "satisfied" customers. A key element of increased satisfaction has been the availability of a robust ombudsman program staffed primarily with retired NCOs. An ombudsman works at each of our WTUs on behalf of the Warriors in Transition and their Families to fix problems and cut through bureaucratic entanglements. It is a great example of our dedicated senior NCOs continuing to serve Soldiers even after they've taken off the uniform.

IMPROVED HEALTHY AND PROTECTED WARRIORS

Improve the health of service members through full spectrum health services to optimize mission readiness, health and fitness, and resiliency before, during, and after deployment.

Evidence Based Practices.—The theme of evidence based practices runs through everything we do in Army Medicine and is highlighted throughout our Balanced Scorecard. Evidence based practices mean integrating individual clinical expertise with the best available external clinical evidence from systematic research. Typical examples of evidence based practice include implementation of clinical practice guidelines and dissemination of best practices. I encourage my commanders and subordinate leaders to be innovative, but across Army Medicine we must balance that innovation with standardization so that all of our patients are receiving the best care and treatment available.

Comprehensive Soldier Fitness.—The Army Chief of Staff has established a vision of an Army comprised of balanced, healthy, self-confident Soldiers, Families and Army Civilians whose resilience and total fitness enable them to thrive in an era of high operational tempo and persistent conflict. To achieve this ambitious vision, he is instituting the Comprehensive Soldier Fitness Program. General Casey identified several shortcomings in his own Army experience. For example, the Army does not routinely assess all the elements of wellness, fitness, and optimal human performance, other than physical. Resilience, life skills, and mental coping techniques are not fully trained across the Army. The Army does not always link available life skills and performance programs and interventions with Soldiers and Families until the need has been demonstrated by a negative behavior. And the Army does not teach Soldiers about the potential for Post Traumatic Growth (PTG), nor give Soldiers the opportunity to validate their post traumatic growth during Post Deploy-

ment assessments. The intent of the Comprehensive Soldier Fitness Program is to increase the resiliency of Soldiers and Families by developing the five dimensions of strength—physical, emotional, social, spiritual, and family. This program is in early development, but under the leadership of Brigadier General Rhonda Cornum, an AMEDD physician, and with the commitment of passionate non-commissioned officers like her Non-Commissioned Officer in Charge, Master Sergeant Richard Gonzales, I expect this program to have a profound positive effect on the lives of Soldiers, Families, and Army Civilians.

Brain Health.—Commanders and leaders are responsible for the mental and physical well-being and care of Soldiers. They play a critical role in encouraging Soldiers to seek prompt medical care for traumatic brain injuries (TBI). This responsibility begins on the battlefield, as close as possible in time and space to the injury. The AMEDD is developing the best process to evaluate and treat every Service member involved in an event that may result in TBI. Commanders and medics throughout theater are emphasizing early recognition of brain injuries followed by examinations and care rendered in accordance with clinical practice guidelines developed by the AMEDD in conjunction with the CENTCOM Surgeon. The Army is also working closely with the National Guard to implement a personnel tracking instrument that provides identification of individuals who may have been involved in a blast and require screening.

In coordination with the VA and the Defense Center of Excellence for Psychological Health and Traumatic Brain Injury, the Army continues to expand resources dedicated to TBI research and treatment. The Defense Centers of Excellence (DCoE), directed by Army Brigadier General Loree Sutton, lead a collaborative effort toward optimizing psychological health and TBI treatment for all Service members. The DCoE establishes quality standards for: clinical care; education and training; prevention; patient, family and community outreach; and program excellence. The DCoE mission is to maximize opportunities for warriors and families to thrive through a collaborative global network promoting resilience, recovery, and reintegration for psychological health and TBI.

Fort Campbell's Warrior Resiliency and Recovery Center for mild TBI is showing very promising results in the identification and treatment of mild TBI. The post concussive syndrome appears to exist in these Soldiers with a natural clinical history separate from that of Post Traumatic Stress Disorder (PTSD) or other psychiatric conditions. The syndrome is effectively treated with an intensive and comprehensive interdisciplinary approach. Early data indicate significant improvement in all treated cases and complete return to duty recovery in over 77 percent of treated Soldiers.

Battlemind Training.—One validated evidence-based practice that reduces the impact of post traumatic stress is the Battlemind Training System (BTS). The Battlemind Training System (BTS) reflects a strength-based approach, using buddy aid and focusing on the leader's role in maintaining our Warriors' mental health. The BTS targets all phases of the deployment cycle as well as the Warrior life cycle and medical education system. BTS includes training modules designed for Warriors, Leaders, and military spouses. Key teaching points about PTSD and concussion were recently incorporated into the deployment cycle and life cycle Battlemind modules.

RC Dental Readiness.—Maintaining dental readiness in the Reserve Components (RC) has been challenging. During the past year, new program developments have provided an integrated Army solution for RC dental readiness throughout the ARFORGEN cycle. The Army Dental Command (DENCOM) executes First Term Dental Readiness (FTDR) at Initial Entry Training (IET) installations, and focuses on examining and treating dental conditions in recruits that could otherwise render a Soldier non-deployable. Upon graduation from IET, RC Soldiers return to their units where the Army Selected Reserve Dental Readiness System (ASDRS), initiated in September of 2008, maintains RC Soldier dental readiness throughout the three ARFORGEN phases. If the RC Soldier is mobilized, they are validated for their deployment dental readiness by DENCOM-operated facilities and if found to be deficient, are examined and treated to a deployable status by dedicated AC and RC dental personnel such as Sergeant First Class Dexter Leverett, a USAR NCO mobilized since 2004, who has managed RC mobilization and demobilization dental operations at both Fort Hood and Camp Shelby, MS—two sites which have processed over 26,000 RC Soldiers in the past 5 months alone. Upon return from deployment, DENCOM resets RC Soldier dental readiness by conducting a Demobilization Dental Reset (DDR) which provides a dental exam and readiness care that can prudently be completed during the abbreviated demobilization process. Since July 2008 we have dentally reset 88 percent of RC Soldiers demobilizing from overseas. I expect this integrated approach to generate improved RC dental readiness.

Armed Forces Health Surveillance Center.—The new Armed Forces Health Surveillance Center (AFHSC), a DOD Executive Agency supported by CHPPM, performs comprehensive medical surveillance and reporting of rates of diseases and injuries among DOD service members. AFHSC's main functions are to analyze, interpret, and disseminate information regarding the status, trends, and determinants of the health and fitness of U.S. military (and military-associated) populations and to identify and evaluate obstacles to medical readiness. AFHSC is the central epidemiological resource for the U.S. Armed Forces providing regularly scheduled and customer-requested analyses and reports to policy makers, medical planners, and researchers. It identifies and evaluates obstacles to medical readiness by linking various databases that communicate information relevant to service members' experience that has the potential to affect their health.

RESPONSIVE BATTLEFIELD MEDICAL FORCE

Ensure health service assets of all three components are trained, modular, strategically deployable, and can support full spectrum operations and joint force requirements.

Pre-deployment Trauma Training.—Adhering to the policy that no one should be initially exposed to a medical challenge while on deployment or on the battlefield, pre-deployment trauma training is now mandatory for individual providers and medical units to improve survival rates. It is a critical link between standard medical care and the intense battlefield environment Soldiers face in the current conflicts. By recreating the high-stress situations medics will face in Iraq and Afghanistan, this training allows for the refinement of advanced trauma treatment skills and sensitization to hazardous conditions which allow medics to increase their confidence and proficiency in treatment. This training includes a surgical skills laboratory, the principles of International Humanitarian Law, and mild TBI and Combat Stress identification. Returning Soldiers cite this as the best training they have ever received.

Medical Simulation Training Centers.—The Medical Simulation Training Center (MSTC) grew from an Army Chief of Staff directive to create and quickly implement medical simulation training to prepare combat medics for the battlefield. Command Sergeant Major David Litteral and Sergeant First Class William Pilgrim were active in the early development of the MSTC program, and are two of the many NCOs instrumental in the program's success. In fiscal year 2008 the 14 stateside MSTCs provided training to 27,136 Combat Medics and non-medical Soldiers in the Tactical Combat Casualty Care (TC^3) and Medic sustainment courses. Also in fiscal year 2008, at four locations within the CENTCOM Area of Responsibility (AOR), 26,132 Medics and Soldiers validated their TC^3 skills and received just in time training. This success has carried into fiscal year 2009 as 20,235 Medics and Soldiers have passed through the now 16 stateside MSTCs and four CENTCOM locations for training and or validation of critical battlefield lifesaving skills.

Joint Forces Combat Trauma Medical Course (JFCTMC).—This is a 5-day trauma training course developed by the AMEDD Center and School and designed for providers deploying to Level III (Combat Support Hospital) medical missions. The course is a series of lectures with breakout sessions by specialty, which include laboratory sessions. JFCTMC prepares deploying providers to care for patients with acute war-related wounds and incorporates lessons learned from Operation Iraqi Freedom and Operation Enduring Freedom. Sergeant First Class Theresa Smith, Sergeant First Class Pearell Tyler, Sergeant First Class David Estrada, Sergeant First Class Robert Lopez, and Staff Sergeant Cedric Griggs conduct the much-praised Emergency Surgical Procedures portion of this course and provide Point of Wounding training. That's right—non-commissioned officers training physicians and other health care providers.

Combat Development.—AMEDD NCO Combat Developers, like Master Sergeant (MSG) Christian Reid and Sergeant First Class Raymond Arnold, have been front and center in product improvements of the Mine Resistant Ambush Protected (MRAP) ambulance, Army Combat Helmet, Combat Arms Ear Plugs, Improved Outer Tactical Vest, and Fire Retardant Army Combat Uniform. Additionally, MSG Reid has been pivotal in the development of the Improved First Aid Kit (IFAK) from concept to fielding in 6 months and the Warrior Aid and Litter Kit (WALK) of which more than 25,000 have been procured to support current combat operations. The MRAP-Ambulance provides increased protection to our crews and patients. To make the MRAP-Ambulance the most capable ground ambulance in the Army today, we integrated "spin-out" technology from the Future Combat System (FCS) Medical Vehicles. The combat medic is now able to leave the Forward Operating Bases to conduct medical evacuation missions and can provide world class en-route care to

wounded soldiers. The AMEDD also developed Casualty Evacuation Kits (CASEVAC) for both the MRAP and HMMV ambulances to increase capability. These efforts provided the combat medic with field ambulances built for survivability in the challenging environment of asymmetric warfare.

Fresh Blood Distribution.—Recognizing that fresher blood has been associated with increased survival on massively transfused patients, the Armed Services Blood Program Office (for which Army maintains oversight as Executive Agent) has been working with the Services to decrease the time it takes for blood to arrive in theater with the overall goal of getting 80 percent of the units in theater by day seven. The average age of red blood cells arriving in theater prior to November 2008 was 13.3 days. Sergeant First Class Peter Maas and others in the Blood Program Office identified 13 action items necessary to improve blood collection, manufacture, and distribution to the CENTCOM AOR. Since implementing these action items in November, 2008, the average age of red blood cells arriving in theater has dropped to 9.2 days. The most recent shipment had an average age of 5.6 days. In the last month, we have managed to bypass blood delivery to Bagram and are shipping blood directly to Kandahar from Qatar. This has resulted in blood reaching Kandahar that is 2–3 days fresher than before. In addition to delivering fresher blood to theater, we are actively and aggressively pursuing new blood technologies that should lead to improved warrior care on the battlefield in the near future.

Armed Forces Institute of Regenerative Medicine.—The U.S. Army Medical Research and Materiel Command (USAMRMC) in partnership with the Office of Naval Research, the U.S. Air Force, the National Institutes of Health, and the VA established the Armed Forces Institute of Regenerative Medicine (AFIRM) in March 2008. The AFIRM is a multi-institutional, interdisciplinary network working to develop advanced treatment options for our severely wounded servicemen and women. The AFIRM is made up of two civilian research consortia working with the U.S. Army Institute of Surgical Research (USAISR) in Fort Sam Houston, Texas. One consortium is led by Wake Forest University Baptist Medical Center and the McGowan Institute for Regenerative Medicine in Pittsburgh and one is led by Rutgers, the State University of New Jersey, and the Cleveland Clinic. Each of these civilian consortia is itself a multi-institutional network.

Regenerative medicine, which has achieved success in the regeneration of human tissues and organs for repair or replacement, represents great potential for treating military personnel with debilitating, disfiguring, and disabling injuries. Regenerative medicine uses bioengineering techniques to prompt the body to regenerate cells and tissues, often using the patient's own cells combined with degradable biomaterials. Technologies for engineering tissues are developing rapidly, with the ultimate goal of delivering advanced therapies, such as whole organs and engineered fingers and limbs.

Joint Theater Trauma System and Joint Trauma Analysis and Prevention of Injury in Combat.—The Joint Medical Force continues to show great improvements in battlefield care as a consequence of linking all information from Level 2 and 3 care thru the entire continuum of care via the Joint Theater Trauma System (JTTS). The JTTS, coordinated by the Institute for Surgical Research of the USAMRMC, provides a systematic approach to coordinate trauma care to minimize morbidity and mortality for theater injuries. JTTS integrates processes to record trauma data at all levels of care, which are then analyzed to improve processes, conduct research and development related to trauma care, and to track and analyze data to determine the long term effects of the treatment that we provide. The JTTS also plays an active role as a partner in the Joint Trauma Analysis and Prevention of Injury in Combat (JTAPIC) program, another MRMC asset under the DOD Executive Agency for Blast Injury Research.

The JTAPIC Program links the DOD medical, intelligence, operational, and materiel development communities with a common goal to collect, integrate, and analyze injury and operational data in order to improve our understanding of our vulnerabilities to threats and enable the development of improved tactics, techniques, and procedures (TTPs), and materiel solutions that will prevent or mitigate traumatic injuries. The JTAPIC Program has already made a difference in the way we protect our Warfighters from combat injuries as illustrated in the following key accomplishments:

—Provided actionable information which has led to modifications and upgrades to vehicle equipment and protection systems, such as seat design, blast mitigating armor, and fire suppression systems;

—Established a near-real time process for collecting and analyzing combat incident data that confirmed the presence of threat weapons of interest;

—Analyzed combat incident data to identify vulnerabilities in operational procedures, and rapidly conveyed those vulnerabilities to commanders in theater;

—Established a process for collecting and analyzing damaged personal protective equipment (PPE), such as body armor and combat helmets, to provide PPE developers with the information they need to develop enhanced protection systems.

The JTAPIC Program received the 2008 Department of the Army Research and Development Laboratory of the Year Award for Collaboration Team of the Year in recognition of its accomplishments.

Combat Medic Skills Textbook.—Our combat medics (68W) are the best trained battlefield medics in the world. The historically low "died of wounds" rate is evidence of their enhanced skills. The medics of the 68W generation are trained to perform advance airway skills, hemorrhage control techniques, shock management, and evacuation. Sergeant First Class Nadine Kahla and Sergeant First Class Jason Reisler are 68W NCOs assigned to the AMEDD Center & School. They are representative of the 17 other 68W NCO authors that contributed to the new 68W Advanced Field Craft Combat Medic Skills Textbook, a state of the art training manual for the combat medic. This delineation of combat medic skills is newly published and will be issued to every graduating combat medic beginning this month. We are currently looking at ways to distribute this textbook to every medic in the force—Active, National Guard, and Army Reserve.

IMPROVED PATIENT AND CUSTOMER SATISFACTION

Improve stakeholder satisfaction by understanding, managing, and exceeding their expectations.

Improved Infrastructure.—On behalf of the Army Medical Department team, I want to thank the Congress for listening to our concerns about military medical infrastructure and taking significant action to help us make needed improvements to our facilities. Funding provided for military hospitals in the fiscal year 2008 supplemental bill and in the American Recovery and Reinvestment Act of 2009 will positively impact the quality of life of thousands of Service Members, Family Members, and Retirees as we build new state of the art facilities in places like Fort Benning, Georgia, Fort Riley, Kansas, and San Antonio, Texas. Additional funding provided by Congress for Sustainment, Restoration, and Modernization of our facilities has been put to great use and allowed us to make some valuable improvements that have been noted by our staff and patients.

The Army requires a medical facility infrastructure that provides consistent, world class healing environments that improve clinical outcomes, patient and staff safety, staff recruitment and retention, and operational efficiencies. The quality of our facilities—whether medical treatment, research and development, or support functions—is a tangible demonstration of our commitment to our most valuable assets—our military family and our MHS staff. The environment in which we work is critical to staff recruitment and retention in support of our All Volunteer Force. Not only are these facilities the bedrock of our direct care mission, they are also the source of our Generating Force that we deploy to perform our operational mission. To support mission success, our current operating environment needs appropriate platforms that support continued delivery of the best healthcare, both preventive and acute care, to our Warfighters, their Families and to all other authorized beneficiaries. I am currently working closely with the Assistant Secretary of Defense for Health Affairs, Dr. S. Ward Casscells, and the leadership of the DOD to determine the level of investment our medical facilities will need. I respectfully request the continued support of DOD medical construction requirements that will deliver treatment and research facilities that are the pride of the Department.

Access to Care.—Army leadership and MEDCOM are decisively engaged in improving access to care for our Soldiers and their Families. These efforts will result in markedly improved access and continuous situational awareness at each medical treatment facility. Access means that patients are seen by the right provider, at the right time, in the right venue; and this applies equally to the Direct Care System & Purchased Care System (TRICARE). Key elements identified for improving access to care include: Aligning treatment facility capacity with the number of beneficiaries; enhancing provider availability; reducing friction at key points of access; managing clinic schedules; and leveraging technology.

We have developed a campaign plan to improve access by giving hospital commanders the tools they need along with the responsibility and accountability to generate results.

Sustainable Cost of Operations.—While focusing on quality outcomes, the MEDCOM is also concerned with ensuring that we maintain a sustainable cost of operation for the AMEDD. Our efforts to improve access are coupled with initiatives to improve efficiency. Our Performance Based Adjustment Model (PBAM) provides

financial incentives for improving efficiency, patient satisfaction, and quality. PBAM and other incentive programs have resulted in the Army being the only Service to achieve planned workload gains every year since 2003. A key author of PBAM is Master Sergeant (now retired) Richard Meyer.

Disseminating Best Practices.—The MEDCOM has embraced the Lean Six Sigma approach to sustaining improved performance. As an example, a Lean Six Sigma project to improve the telephone appointing process was initiated at Carl R. Darnall Army Medical Center (CRDAMC), the largest telephone appointing call center in the MEDCOM. The call center was plagued with high call volume, low patient satisfaction, long process cycle time, and high variation. The project sought to decrease process cycle time and the call abandon rate to improve patient satisfaction. By the conclusion of the project, the overall average hold time was reduced to 33 seconds (a 6-fold improvement); the call abandon rate was reduced to 3 percent (a 10-fold improvement); calls handled increased from 4,700 to 7,300 per week; and call agent turnover was reduced. Today the mean hold time at CRDAMC is 3 seconds. This project's successful action plan and metrics have been disseminated across the command as a best practice.

INSPIRE TRUST IN ARMY MEDICINE

Increase stakeholder support of Army Medicine by inspiring trust, building confidence, and instilling pride.

Improving civilian medical practices.—The implementation of tactical combat casualty care (TC^3) principals for point of injury treatment on the battlefield has changed long-standing hemorrhage control protocols in the civilian Emergency Medical Services (EMS) community. The nation's EMS community has altered long-standing treatment protocols that formerly considered tourniquet use a last resort. The use of tourniquets, based on the success of their application by military medics in theater, is now not only seen as safe by our nation's healthcare providers, but as the intervention of choice for control of severe hemorrhage. Hemorrhage control is the leading cause of death in trauma. The change in philosophy regarding tourniquet use will result in more lives saved in both urban and rural areas of our country.

Establishing Successful Interservice Partnerships (San Antonio Military Medical Center).—Wilford Hall Medical Center (WHMC) and Brooke Army Medical Center (BAMC) are quickly evolving towards the San Antonio Military Medical Center (SAMMC) which is an integrated healthcare platform in which patient care is delivered in two facilities operating under one organizational structure. The SAMMC organizational structure has been operational for over 1 year. The organizational structures of BAMC and WHMC were both realigned to form a functional organization for delivery of healthcare, maintenance of our readiness and deployment platforms, sustainment of training of all levels of healthcare providers, and promotion of research. Many physical moves of medical services have already occurred across the SAMMC platform. SAMMC is planning for the migration of the two military level one trauma centers in San Antonio to one military level one trauma center, capable of handling the same patient care volume that is being delivered today in the two centers. Planning and coordination with the City of San Antonio have been an integral part of this process to ensure continued trauma support in the city. SAMMC enjoys strong collaborations with both the University of Texas Health Science Center, local government leaders, and the Audie Murphy Veterans Memorial Hospital in support of the large tri-service beneficiary population in the San Antonio community.

Establishing Successful Interagency Partnerships (Behavioral and Social Health Outcomes).—CHPPM resources are partnered with civilian academia, the VA and HHS (including the Centers for Disease Control and Prevention, and the National Institute of Mental Health) to work in the mitigation of rising rates of suicide, depression, PTSD and other adverse behavioral and social health outcomes in our Families, Retirees, Active Duty, Reserve and National Guard Soldiers. MEDCOM is working with other key organizations to build a robust public health capability in the area of Behavioral and Social Health outcomes (to include suicides and homicides). This effort includes the construction of an Army-level relational database that draws critical information from numerous sources to enable comprehensive analysis of adverse outcomes in Army organizations and communities.

Establishing Successful Interagency Partnerships (National Interagency Biodefense Campus).—Fort Detrick, Maryland hosts and is intimately involved in the development of the National Interagency Biodefense Campus (NIBC) to fill gaps in national biodefense and integrate agencies for a whole of government approach to national security. As a charter member of the National Interagency Confederation for Bio-

logical Research (NICBR), a collaboration of the National Cancer Institute along with the NIBC partners, the Army is breaking ground in building on a model for interagency cooperation at Fort Detrick. During 2008, members of the NICBR/NIBC were involved in developing national policy on biodefense and biotechnology as well as collaborating on research. Research includes work on developing vaccines, diagnostics, forensics, and therapeutics. While focusing on protecting people from disease and bioterrorism, members of the NICBR/NIBC participated in multiple national assessments to prioritize and focus biodefense missions, all while continuing united scientific discovery. During 2009, the NICBR/NIBC will continue to work with Congress and others to define and scope gaps and seams in our Nation's biodefense posture.

In closing, I want to thank this Committee for their terrific support of the Defense Health Program and Army Medicine. I greatly value the insight of this Committee and look forward to working with you closely over the next year. I also want to salute our non-commissioned officers for their professionalism, competence, and leadership—they are truly the backbone of Army Medicine. Thank you for holding this hearing and thank you for your continued support of the Army Medical Department and the Warriors and Families that we are most honored to serve.

Chairman INOUYE. May I now call upon Vice Admiral Robinson.

STATEMENT OF VICE ADMIRAL ADAM M. ROBINSON, JR., SURGEON GENERAL OF THE NAVY, UNITED STATES NAVY

Admiral ROBINSON. Thank you very much, Chairman Inouye, also Vice Chairman Cochran, Senator Murray, and Senator Bennett, and other distinguished members of the subcommittee.

Since I last testified, we have seen the emergence of impressive changes and unique challenges to this Nation and the global community. A historic presidential election has made significant national and international political impact, a war effort sustained with military troops deploying into hostile areas, and an increasing military medicine presence playing a key role to support the humanitarian civil assistance mission.

We are seeing uncertainty, change, and fluctuation in our economy that will impact all of us, including military medicine. Navy medicine continues on course because our focus has been and will always be providing the best healthcare to our sailors, marines, and their families, all while supporting our Nation's maritime strategy.

In response to our most critical demand to support the Marine Corps, we are realigning medical capabilities to emerging theaters of operation. As the Marine Corps forces shift their efforts to Afghanistan, Navy medicine will support them and sustain our efforts in medicine, in trauma medicine, and surgery capabilities.

The Navy's maritime strategy calls for proactive humanitarian assistance and disaster response efforts, and these are now preplanned engagements. These missions deploy from sea-based, land-based, or expeditionary platforms and aim to meet a great spectrum of medical needs. Our Nation's humanitarian efforts serve as a unique opportunity for medical diplomacy to positively impact the perception of the United States by other nations.

In addition, these missions have become another avenue for improved recruiting and retention of Navy medicine healthcare providers. Filling vacancies in our medical department corps is critical to meeting our mission of maintaining medical readiness of the warfighter and providing healthcare to all eligible beneficiaries. The Chief of Naval Personnel and I have worked together on this issue, making medical recruiting a continued priority for fiscal year 2009.

In spite of successes in the health professions scholarship program (HPSP), medical and dental corps recruitment, meeting our direct accession mission still remains a challenge. I anticipate increased demand for medical service corps personnel, in particular to better meet our increasing requirements. From individual augmentation requirements to planned humanitarian assistance missions and unexpected disaster relief missions, as well as to meet the growing needs of a Marine Corps that is, in fact, growing, these demands will impact medical service corps specialties linked to mental, behavioral, and rehabilitative health and operational support.

Consistent with increased operational demand signals, as well as to compensate for prior shortfalls in recruiting, the overall recruiting goals for uniformed medical service corps officers have nearly doubled since fiscal year 2007. The Navy has been successful during the past year recruiting and retaining Nurse Corps officers using a combination of accession, retention, and loan repayment incentives. For the first time in over 5 years, Navy Nurse Corps officers gains in 2008 outpaced losses. The Chief of the Navy Nurse Corps, Rear Admiral Chris Bruzek-Kohler, is here and will follow up in her statement and testimony.

Our graduate medical education is a critical part of the foundation for Navy medicine's ongoing success. Despite the demands on faculty and staff for operational support, our Navy GME programs continue to be highly rated by the Accreditation Council for Graduate Medical Education, and our program graduates continue to pass their board certification examinations at rates significantly higher than the national average in almost every specialty.

More importantly, Navy-trained physicians continue to prove themselves to be exceptionally well prepared to provide care in austere settings ranging from the battlefield to humanitarian assistance and disaster relief efforts.

Over the last year Navy medicine expanded services so that wounded warriors would have access to timely, high quality medical care. In 2008, we consolidated all wounded, ill, and injured warrior healthcare support, with the goal of establishing global policy implementation guidance and oversight in order to deliver the highest quality customer-focused, comprehensive and compassionate care to servicemembers and their families.

As of March 2009, 161 medical care case managers were assigned to 45 medical treatment facilities and ambulatory care clinics, caring for approximately 1,500 Operation Iraqi Freedom/Operation Enduring Freedom (OIF–OEF) casualties. The medical care case managers collaborate with Navy Safe Harbor and Marine Corps Wounded Warrior Regiment, both line programs, in working directly with wounded warriors, their families, caregivers, and multidisciplinary medical teams.

We work diligently to coordinate the complex services needed for improved healthcare outcomes and to ensure that servicemembers return closer to home as soon as possible.

Navy and Marine Corps liaisons at medical treatment facilities aggressively ensure that orders and other administrative details, such as extending reservists, are completed. Last year, we established a centralized operational stress control program and coordi-

nator who is working in conjunction with our line leadership to indoctrinate mental health stigma reduction into the broader Navy-Marine Corps culture. Over 11,000 sailors have received operational stress control training to date, and formal curriculum will be introduced in the fall 2009 at key points throughout the careers of sailors—from accession to flag officer.

Also, to anticipate emerging mental health threats, Navy medicine actively conducts real-time in-country surveillance and assessment of the mental health of our troops.

PREPARED STATEMENT

Chairman Inouye, Vice Chairman Cochran, I want to express my gratitude on behalf of all who work for Navy medicine, uniformed, civilian, contractor, and volunteer personnel, who are committed to meeting and exceeding the healthcare needs of our beneficiaries. I would also like to thank you and the members for your continued support of Navy medicine and of the military health system.

Thank you.

Chairman INOUYE. Thank you very much, Admiral Robinson.

[The statement follows:]

PREPARED STATEMENT OF VICE ADMIRAL ADAM M. ROBINSON

Chairman Inouye, Senator Cochran, distinguished members of the committee, since I testified last spring we have seen the emergence of impressive changes and unique challenges to this nation and the global community. A historic Presidential election which has made significant national and international political impact, a war effort sustained with military troops deploying into hostile areas; and an increasing military medicine presence playing a key role to support the humanitarian civil assistance mission. We are seeing uncertainty, change and fluctuation in our economy that will impact all of us, including military medicine.

Navy Medicine continues on course, because our focus has been, and will always be providing the best healthcare for our Sailors, Marines, and their family members while supporting the CNO's Maritime Strategy. We are focused on strengthening Navy Medicine today, and are proactively planning to meet future healthcare requirements.

Navy Medicine is built on a solid foundation of proud traditions and a remarkable legacy of Force Health Protection. Our focus has not changed and every day in Navy Medicine we are preparing healthy and fit Sailors and Marines to protect our nation and be ready to deploy.

Navy Medicine is playing a major part in supporting the Maritime Strategy. You will find us at home and around the world providing preventive medical care; health maintenance training and education; direct combat medical support; medical intelligence; and operational planning mission support. Our Navy Medicine teams are flexible enough to perform a Global War on Terror mission, a homeland security mission, a humanitarian assistance mission, and a disaster relief mission; while at the same time provide direct healthcare to our nation's heroes and their family members at home and overseas.

In spite of all of the missions we are currently prepared to participate in, we are continuously making the necessary changes and improvements to meet the requirements of the biggest consumer of our operational support efforts—the Marine Corps. Currently, we are realigning medical capabilities to support operational forces in emerging theaters of operation. We are working on enhancing our strategic ability, operational reach, and tactical flexibility. As Marine Corps forces shift their efforts to Afghanistan, Navy Medicine stands prepared to make the necessary adjustments to provide the highest quality combat medical support. Since the global operations to combat terrorism began, Navy Medicine's combat medical support has proven exceptionally successful at bringing wounded service member's home. We hope, through our ability to remain agile and flexible, to sustain those efforts—like the record-high survivability rates—and improve them wherever possible.

The Navy's Maritime Strategy calls for proactive humanitarian assistance and disaster response efforts. These missions have been taking place since 1847, and have come a long way since then. The Navy's Humanitarian Civil Assistance mis-

sions are now pre-planned engagements deployed from sea-based, land-based or expeditionary platforms to meet a great spectrum of medical needs. From basic medical evaluation and treatment, to optometry, to general surgery, and immunizations, our physicians, nurses, dentists, ancillary healthcare professionals, and hospital corpsmen are ready.

Our efforts have continued to grow and this year, the U.S. Southern Command will sponsor four multi-service Medical Readiness Training Exercises (MEDRETEs). These missions will visit Jamaica, Honduras, the Dominican Republic and Guyana and will include a Navy Medicine Reserve Component. These two-week deployments will provide primary care in remote locations in conjunction with the Ministry of Health of each host nation. The medical services provided will include preventive medicine education, pediatrics, primary medical care, immunizations, pharmacy services, and dental care.

Over 400 Navy Medicine personnel are ready to provide humanitarian civil assistance later this year in two ship-based missions. In April, the USNS COMFORT (TAH 20) will deploy for a 120-day mission to South and Central America as part of Continuing Promise 09. Later in 2009, the USS DUBUQUE (LPD 8) will deploy for a 125-day mission as part of Pacific Partnership 09.

Our nation's humanitarian efforts serve as a unique opportunity to positively impact the perception of the United States by other nations. These often joint missions serve as examples of how increased collaboration between the other services, other government agencies, and non-governmental organizations can maximize available resources in order to improve worldwide response capability. From our experience, we have developed a successful model of healthcare education and training for host country providers. This will lead to local sustainable activities that will provide long-lasting benefits to help overcome healthcare barriers in resource poor countries. Furthermore, these missions have become another avenue for improved recruiting and retention of Navy Medicine healthcare providers.

While our humanitarian civil assistance missions provide us with some amazing opportunities as providers of medical care, Navy Medicine is acutely aware and incredibly proud of our operational commitment to the United States Marine Corps. We continue to fine tune our deployable medical capabilities to support every Marine who deploys to emerging theaters of operation. We never stop improving our strategic ability, operational reach, and tactical flexibility. As the Marine Corps forces shifts their efforts to Afghanistan, Navy Medicine will be there providing the highest quality combat medical support from the corpsmen who stand by their Marines on the battlefield, to fleet hospitals, to the care provided at a military hospital and world-class restorative and rehabilitative care facilities in the continental United States.

We continue to make improvements to meet the needs of Sailors and Marines who may become injured—while serving in theater or training at home. Over the last year, Navy Medicine significantly expanded services so that wounded warriors would have access to timely, high-quality medical care. Our response is two-tiered, first to uncompromisingly increase specialized multidisciplinary teams, and second, to expand sharing with other government agencies and the private sector of clinical resources, research and expertise.

In addition, Navy Medicine's Concept of Care is always patient and family focused. We never lose our perspective in caring for all our beneficiaries—everyone is a unique human being in need of individualized, compassionate, and professionally superior healthcare. At our military treatment facilities (MTFs), we recognize and embrace the military culture and incorporate that into the healing process. Based on the progress in a patient's care and healing, from initial care to rehabilitation and life long medical needs, we determine the best clinical location and treatment plan for that patient. Families are a critical part of the healthcare delivery team, and we integrate the family's needs into the healing process as well.

In 2008, the Bureau of Medicine and Surgery (BUMED), Headquarters for Navy Medicine, consolidated all wounded, ill and injured warrior healthcare support, with the goal of establishing global policy, implementation guidance, and oversight in order to deliver the highest quality customer-focused, comprehensive and compassionate care to service members and their families.

As of March 2009, 161 Medical Care Case Managers were assigned to 45 MTFs and ambulatory care clinics caring for approximately 1,500 OIF/OEF casualties. The Medical Care Case Managers collaborate with Navy Safe Harbor and Marine Corps Wounded Warrior Regiment in working directly with wounded warrior, family, caregivers and the multi-disciplinary medical team to coordinate the complex services needed for improved health outcomes.

The BUMED Wounded Warrior Regiment Medical Review team and the Returning Warrior Workshop support Marines and Navy Reservists, and their families by

focusing on key issues faced by reservists during their transition from deployment to home. Navy and Marine Corps Liaisons at MTFs aggressively ensure that orders and other administrative details, such as extending reservists, are completed.

Traumatic Brain Injury (TBI) is considered the signature wound of OIF/OEF, due to the proliferation of improvised explosive devices (IED). Navy Medicine continues to improve ways to identify and treat TBI. The traumatic stress and brain injury programs at National Naval Medical Center (NNMC) Bethesda, Naval Medical Center San Diego (NMCSD), Naval Hospital Camp Pendleton (NHCP), and Naval Hospital Camp Lejeune (NHCL) are collaborating to identify and treat service members who have suffered blast exposure. Navy Medicine has partnered with the Navy and Marine Corps community to identify specific populations at risk for brain injury such as front line units, SEALS, and Navy Explosive Ordinance disposal units. Navy Medicine also expanded social work assets to provide clinical mental health support in theater, at Navy MTFs and regional treatment centers.

Much attention has been focused on ensuring service members' medical conditions are appropriately addressed on return from deployment. The Pre-Deployment Health Assessment (Pre-DHA) is one mechanism that is used to identify physical and psychological health issues prior to deployment. The Post Deployment Health Assessment (PDHA) and the Post Deployment Health Re-Assessment (PDHRA) identify deployment related healthcare concerns on return to home station and 90–180 days post deployment.

Navy Medicine's innovative Deployment Health Centers—currently 17 in high Fleet and Marine Corps concentration areas—support the deployment health assessment process and serve as easily accessible non-stigmatizing portals for mental healthcare. The centers are staffed with primary care and mental health providers to address deployment-related health issues such as TBI, Post Traumatic Stress Disorder (PTSD), and substance misuse. Approximately 15 percent of Navy and Marine Corps Post Deployment Health Assessments result in a medical referral, while the PDHRA medical referral rate is approximately 22 percent for both Active and Reserve Component service members.

Navy Medicine's partnership with the Department of Veterans Affairs (VA) medical facilities is evolving into a mutually beneficial partnership. This coordinated care for our warriors who transfer to or are receiving care from a VA facility ensures their needs are met and their families concerns are addressed. Full-time VA staff members are located at several Navy MTFs where they focus on the healthcare needs of service members and their families.

Filling vacancies in the Medical, Dental, Nurse and Medical Service Corps of the Active and Reserve Components is critical in meeting our mission of maintaining medical readiness of the warfighter and providing healthcare to all eligible beneficiaries. My goal is to maintain the right workforce to deliver medical capabilities across the full range of military operations through the appropriate mix of accession, retention, education and training incentives. As a result, the Chief of Naval Personnel and I have worked together on this issue making medical recruiting a continued priority for fiscal year 2009.

Navy Medicine not only equips and trains our current healthcare professionals; we also prepare our future reliefs for the challenges ahead. To build the future force for Navy Medicine we must reach out to America's students and young professionals. We must invite them to our hospitals, our classrooms, and our research facilities so they can see what we do and they can ask career-making questions.

Congress has been very generous and attentive to the Special Pay and Bonus authorities. The Services are implementing those new programs—in some cases with limited success. An example of this is that the Critical Wartime Skills Accession Bonus offered to physicians and dentists as an incentive to directly access trained specialists was not effective in fiscal year 2008. Multi-Year Retention pays and Bonuses have historically provided the highest return for obligated service, but we thought it was important to try new authorities provided by Congress.

Navy Medicine offers one of the most generous and comprehensive scholarships in the healthcare field. The Armed Forces Health Professions Scholarship Program (HPSP) provides tuition assistance for up to 4 years of school. In addition all professional school required fees and expenses, books and equipment are paid for by the Navy. The value of this program could be well over $200,000 during the course of a 4 year professional school program. Graduates join the Navy's active duty healthcare team as commissioned officers. During fiscal year 2008, the Navy Medical and Dental Corps met its HPSP goal for the first time in several years.

In spite of the successes in HPSP Medical and Dental Corps recruitment, meeting our direct accession mission may remain a challenge. The Medical Services Corps is our most diverse Corps with 31 specialties under three general groupings consisting of clinicians, healthcare administrators, and research scientists.

I anticipate increased demand for Medical Service Corps personnel with respect to Individual Augmentation missions supporting the present course in Iraq and the anticipated role the military in Afghanistan, planned Humanitarian Assistance and unexpected disaster relief missions, as well as to meet the needs of Marine Corps manning increases and the many wounded warrior programs they support. These demands will impact Medical Service Corps specialties linked to mental, behavioral and rehabilitative health and operational support; Clinical Psychologists, Social Workers, Occupational Therapists, Physician Assistants and Physical Therapists to name a few.

While it is anticipated that the Assistant Secretary of Defense, Health Affairs guidance for recruiting and retention incentives for Clinical Psychologists, Social Workers, and Physician Assistants will be released this fiscal year, similar incentives may need to be expanded to other specialties where limited incentives currently exist. Consistent with increased operational demand signals, as well as to compensate for prior shortfalls in recruiting, the overall recruiting goals for uniformed Medical Services Corps officers have nearly doubled since fiscal year 2007.

The Navy has been successful during the past year recruiting and retaining Nurse Corps officers using a combination of accession, retention, and loan repayment incentives. Over 4,000 active duty and reserve Navy nurses are serving in operational, humanitarian, and traditional missions at home and overseas. These men and women are essential to Navy Medicine's Force Health Protection mission. Navy nurses, in particular the wartime nursing specialties of mental health, nurse anesthesia, critical care, family nurse practitioners, emergency medicine, preoperative and surgical care, have been exemplary in all theaters of operations and healthcare settings.

For the first time in over 5 years, Navy Nurse Corps officer gains in 2008 outpaced losses. Despite the growing national nursing shortage and the civilian nursing community proving to be recession resistant, the recruitment and retention of nurses continues to improve. Additional requirements will be placed on the recruiting and retention efforts of the Nurse Corps in the near future as nursing billets are restored due to changes in the Military to Civilian Conversion program. Future success in the recruitment and retention of nurses will continue to be dependent on incentive packages that are competitive with the civilian sector.

Like recruiting and retention, our Graduate Medical Education (GME) is a critical part of the foundation for Navy Medicine's ongoing success. Navy Medicine provides world-class graduate medical education at nine sites with 60 programs involving over 1,000 trainees. Despite the demands on faculty and staff for operational support, our Navy GME programs continue to be highly rated by the Accreditation Council for Graduate Medical Education. Navy program graduates continue to pass their board certification examinations at rates significantly higher than the national average in almost every specialty. More importantly, Navy-trained physicians continue to prove themselves to be exceptionally well prepared to provide care in austere settings ranging from the battle field to humanitarian assistance and disaster relief efforts.

Along with our successes, Navy GME is facing challenges. Advances in medicine and technology are resulting in longer and in some case completely new types of training which stress the fixed number of funded positions available. Additionally, we did not meet medical student accession goals 3 and 4 years ago, and this is beginning to impact our current GME programs. The lower number of uniformed graduates will challenge our ability to support our operational healthcare mission while placing an adequate number of graduates into training to meet our need for specialists in the future.

Navy Medicine scientists conduct basic, clinical, and field research directly related to current and future military requirements and operational needs. In today's unsettled world, we face not only the medical threats associated with conventional warfare, but also the potential use of weapons of mass destruction and terrorism against our military forces and our citizens at home and overseas and our allies. Navy Medicine's research efforts focus on finding solutions to traditional battlefield medical problems such as bleeding, Traumatic Brain Injury, combat stress, and naturally occurring infectious diseases; as well as the health problems associated with non-conventional weapons including thermobaric blast, biological agents, and radiation.

The DOD Center for Deployment Health Research at the Naval Health Research Center reported that 8.7 percent of U.S. troops who were deployed and exposed to combat duty in Iraq or Afghanistan reported symptoms of PTSD on a screening survey. We anticipate that this ongoing research will prove helpful in identifying populations at especially increased risk of PTSD from combat, and lead to improved diagnosis and prevention strategies.

The Naval Institute for Dental and Biomedical Research helped to prove the military utility of a new product "Dent Stat," a temporary dental filling material used in treating dental emergencies in all forward deployed settings. This user-friendly temporary restorative material helps stabilize and reduce pain from fractured teeth and lost or broken fillings so warfighters can quickly return to their units.

The Navy Medical Research Center developed an updated vaccine against Japanese encephalitis (JE) allowing for U.S. Food and Drug Administration licensure. The JE vaccine should prevent this mosquito-borne potentially fatal brain infection, and will save lives of military personnel who deploy to the Asia-Pacific region, and also civilian travelers to JE-endemic regions.

These are just a few examples of how Navy Medicine's biomedical and dental research, development, testing and evaluation, including clinical investigations, will protect and improve the health of those under our care.

It is important to recognize the unique challenges before Navy Medicine at this particularly critical time for our nation. Growing resource constraints for Navy Medicine are real, as is the increasing pressure to operate more efficiently without compromising healthcare quality and workload goals. The Military Healthcare System (HMS) continues to evolve, and we are taking advantage of opportunities to modernize management processes that will allow us to operate as a stronger innovative partner within the MHS.

Integration of care between the military direct care and our civilian network, and across the services, has implications related to both the quality and cost of care. The National Capital Area and the San Antonio military markets have become pilots for a "joint" healthcare system. While the models are different, the end goal is the same: a single approach to healthcare. With the current economic situation driving the need for cost effectiveness, movement toward a Unified Medical Command construct will likely accelerate. Identifying those functions that can be joint—along with those that need to remain service specific—is a critical component of the success of the project. Bringing the direct care system and the TRICARE Management Activity under a single command structure offers significant advantages and might be the next best step as military healthcare evolves. Navy Medicine supports and is actively engaged in these efforts.

Chairman Inouye, Ranking Member Cochran, I want to express my gratitude on behalf of all who work for Navy Medicine—uniformed, civilian, contractor, volunteer personnel—who are committed to meeting and exceeding the healthcare needs of our beneficiaries. Thank you again for providing me this opportunity to share with you Navy Medicine's mission, what we are doing today, and our plans for the future. It has been my pleasure to testify before you today and I look forward to answering any of your questions.

Chairman INOUYE. May I now call upon Lieutenant General Roudebush.

STATEMENT OF LIEUTENANT GENERAL JAMES G. ROUDEBUSH, AIR FORCE SURGEON GENERAL, UNITED STATES AIR FORCE

General ROUDEBUSH. Mr. Chairman, Mr. Vice Chairman, Senator Murray, Senator Bennett: Thank you for this opportunity to share our issues, our concerns, but also our accomplishments with you this morning.

I believe your comments frame it very appropriately and very correctly in terms of the importance of what we bring both individually and collaboratively to the care of the men and women who have raised their right hand and sworn to support and defend and go into harm's way for our Nation. It's important that we do care for them, and it's important that we work with each one, one by one, as they transition perhaps to care within the Department of Veterans Affairs, to assure that that transition is as smooth, effortless, and user-friendly as it can be.

So I think your comments set this up very, very well. Thank you, sir. And thank you and the subcommittee for your unwavering support in our endeavors in this regard. We simply could not do it without you, and we truly appreciate that.

This morning, sir, I'd like to talk a bit about Air Force medicine, understanding that Air Force medicine is part of a joint capability, and we keep that issue very clearly in mind. Air Force medicine contributes significant capability to the joint warfight in combat casualty care, wartime surgery, and aeromedical evacuation.

AIR FORCE THEATER HOSPITAL

On the ground, at both the Air Force theater hospital at Balad and Craig Joint Theater Hospital in Bagram we are leading numerous combat casualty care initiatives that will positively impact combat and peacetime medicine for years to come. Air Force surgeons laid the foundation for the state-of-the-art intervascular operating room at Balad, the only DOD facility of its kind, and their use of innovative technology and surgical techniques has greatly advanced the care of our joint warfighter and coalition casualties, and their work within the joint theater trauma system, collaborative joint work, their work within this joint system, has literally rewritten the book on the use of blood in trauma resuscitation.

To bring our wounded warriors safely and rapidly home, our critical care aeromedical transport teams, or CCATs, provide unique intensive care unit (ICU) care in the air within DOD's joint en route medical care system. We continue to improve the outcomes of CCAT wounded warrior care by incorporating lessons learned into clinical practice guidelines and modernizing the equipment we use to support this important mission.

MEDICAL LIFESAVING OPERATIONS—HURRICANES KATRINA AND RITA

But it's important to note that this Air Force-unique expertise also pays huge dividends back home. When Hurricanes Katrina and Rita struck in 2005, Air Force active duty, Guard, and Reserve medical personnel were in place conducting lifesaving operations. Similarly, hundreds of members of this total force team were in place September 1, 2008, when Hurricane Gustav struck the Louisiana coast and when Hurricane Ike battered Galveston, Texas, less than 2 weeks later.

During Hurricane Gustav, Air Mobility Command coordinated the movement of more than 8,000 evacuees, including 600 patients. Air crews transported post-surgical and intensive care unit patients from Texas-area hospitals to Dallas principally. I'm extremely proud of this incredible team effort.

The success of our Air Force mission, however, directly correlates with our ability to build and maintain a healthy and fit force at home station and in theater. Always working to improve our care, our family health initiative establishes an Air Force medical home. This medical home optimizes healthcare practice within our family healthcare clinics, positioning a primary care team to better accommodate the enrolled population and streamline the processes for care and disease management. The result is better access, better care, and better health.

PSYCHOLOGICAL HEALTH OF OUR AIRMEN

The psychological health of our airmen is critically important. To mitigate their risk for combat stress symptoms and possible mental

health problems, our program known as Landing Gear takes a proactive approach, with education and symptom recognition both pre- and post-deployment. We educate our airmen that recognizing risk factors in themselves and others, along with a willingness to seek help, is the key to effectively functioning across the deploying cycle and reuniting with their families. Likewise, we screen carefully for traumatic brain injury at home and at our forward deployed medical facilities.

To respond to our airmen's needs, we have over 600 active duty and 200 civilian and contract mental health providers. This mental health workforce has been sufficient to meet the demand signal that we have experienced to date, but, that said, we do have challenges with respect to active duty psychologists and psychiatrists recruiting and retention and we're pursuing special pays and other initiatives to try to bring us closer to 100 percent staffing in these two very important specialties.

For your awareness, over time we are seeing an increasing number of airmen with post-traumatic stress disorder (PTSD). 1,759 airmen have been diagnosed with PTSD within 12 months of returning from deployment from 2002 to 2008. As a result of our efforts at early post-traumatic stress identification and treatment, the majority of these airmen continue to serve with the benefit of treatment and support.

Also, understanding that suicide prevention lies within and is integrated into the broader construct of psychological health and fitness, our suicide prevention program, a community-based program, provides the foundation for our efforts. Rapid recognition, active engagement at all levels, and reducing any stigma associated with help-seeking behaviors are hallmarks of our program. One suicide is too many and we're working hard to prevent the next.

SUSTAINING THE AIR FORCE MEDICAL SERVICE

Sustaining the Air Force medical service requires the very best in education and training for our professionals. In today's military that means providing high-quality programs within our system as well as strategically partnering with academia, private sector medicine, and the Department of Veterans Affairs to ensure that our students, residents, and fellows have the best training opportunities possible.

While the Air Force continues to attract many of the finest health professionals in the world, we still have significant challenges in recruiting and retention. We're working closely with our personnel and recruiting communities using accession and retention bonus plans to ensure full and effective staffing with the right specialty mix to perform our mission. At the center of our strategy is the health professions scholarship program. HPSP is our most successful recruiting tool. But we're also seeing positive trends in retention from our other financial assistance programs and pay plans. Thank you for your unwavering support in this critical endeavor.

In summary, Air Force medicine is making a difference in the lives of airmen, soldiers, sailors, marines, family members, coalition partners, and our Nation's citizens. We are earning their trust every day. As we look forward to the way ahead, I see a great fu-

ture for the Air Force medical service built on a solid foundation of absolutely top-notch people, outstanding training programs, and strong partnerships. It's an exciting, challenging, and rewarding time to be in Air Force and military medicine. I couldn't be more proud of this joint team.

PREPARED STATEMENT

We join our sister services in thanking you for your enduring support, and I look forward to your questions.

Chairman INOUYE. I thank you very much, General Roudebush.

[The statement follows:]

PREPARED STATEMENT OF LIEUTENANT GENERAL (DR.) JAMES G. ROUDEBUSH

Mr. Chairman and esteemed members of the Committee, it is my honor and privilege to be here today to talk with you about the Air Force Medical Service. Our Air Force medics work directly for the Line. To that end, we too are focused on reinvigorating the Air Force nuclear enterprise; partnering with the joint and coalition team to win today's fight; developing and caring for Airmen and their families; modernizing our Air and Space inventories, organizations, and training, and recapturing acquisition excellence.

In support of our Air Force priorities, our Air Force Medical Service (AFMS) is on the cutting edge of protecting the health and well-being of our Service men and women everywhere. Our experience in battlefield medicine is shaping America's healthcare for the 21st century and beyond. We are actively enhancing readiness; ensuring a fit, healthy force, and building/sustaining the model health system for DOD. In short, it's a great time to be in Air Force medicine!

ADVANCEMENTS IN READINESS

Air Force medics contribute significant capability to the joint warfight in aeromedical evacuation, combat casualty care and wartime surgery. Our advancements in these areas are unparalleled in previous combat experience.

Our Critical Care Air Transport Teams (CCATTs) provide unique "ICU care in the air" within DOD's joint enroute medical care system. We continue to improve the outcomes of CCATT wounded warrior care by incorporating lessons learned into clinical practice guidelines and modernizing equipment to support the mission. For example, we are developing a joint electronic in-flight patient medical record to ensure effective patient care documentation and record availability. We are working to improve CCATT equipment, such as mobile oxygen storage tanks and airborne wireless communication systems, and continuing to evaluate existing equipment to ensure safety for our patients.

On the ground, at both the Air Force Theater Hospital at Balad, Iraq and Craig Joint Theater Hospital at Bagram, Afghanistan, Air Force medics lead numerous combat casualty care initiatives that will positively impact combat and peacetime medicine for years to come. The Air Force surgeons garnered invaluable experience in the field of vascular surgery that laid the foundation for a state-of-the-art endovascular operating room at Balad—the only DOD facility of its kind. The inaugural use of diagnostic angiography and vena caval filters, along with coil embolization and stent grafts in select vascular surgeries in-theater have truly modernized care of our joint warfighter and coalition casualties. Colonel (Dr.) Jay Johannigman, the 332nd Expeditionary Medical Operations Squadron lead trauma surgeon, said, "Our Joint combat hospitals, be they Army, Navy, or Air Force, are all beginning to think alike and do things similarly. These efforts help us improve and speed the care to the patient."

Working with the Armed Services Blood Program Office, Air Force medics have improved the supply of crucial life-saving blood products in-theater, supplementing fresh blood with a new frozen red blood cell product with an extended shelf life. An in-theater apheresis center was established to collect fresh platelets needed to support aggressive treatment of trauma patients requiring massive transfusions.

The ability to collect and analyze data is critical to our success in combat casualty care. The Joint Theater Trauma Registry (JTTR), established in 2004, has made significant strides in these efforts. Their work led to major changes in battlefield care, including management of extremity compartment syndromes, burn care resuscitation, and blood transfusion practices. Their results are setting military-civilian benchmarking standards. The JTTR is truly a joint effort, with full participation of

the Air Force. An Air Force physician is the JTTR system deputy director, and our critical care nurses are key players in the in-theater JTTR team. Through the JTTR we're capturing and implementing best practices for management of the extensive trauma cases seen.

Air Force-unique expertise pays dividends back home, as well as in theater, and is saving lives. Many Americans who have become victims of natural disasters benefited from our humanitarian support. When Hurricanes Katrina and Rita struck in 2005, Air Force Active Duty, Guard, and Reserve medics were in place conducting lifesaving operations. Similarly, hundreds of members of this Total Force team were in place September 1, 2008 when Hurricane Gustav struck the Louisiana coast and when Hurricane Ike battered Galveston, Texas, less than 2 weeks later. During Hurricane Gustav, Air Mobility Command coordinated the movement of more than 8,000 evacuees, including 600 patients. Aircrews transported post-surgery/post-intensive care unit patients from Galveston area hospitals to Dallas medical facilities. I am extremely proud of this incredible team effort.

ENSURING A FIT AND HEALTHY FORCE

The success of our medical readiness mission directly correlates with our ability to build and maintain a fit and healthy force at home station and in-theater. One way we do this is through optimization of health care delivery. Our Family Health Initiative, our Air Force "medical home," optimizes health care practice within our family health clinics, increasing the number of medical technicians on the family health teams to better accommodate the enrolled population and streamlining the processes for care and disease management.

We achieve a fit and healthy force by measuring our health care outcomes. The AFMS has used the Healthcare Effectiveness Data and Information Set measures for more than 8 years to assess the care we deliver. Our outcome measures for childhood immunization delivery, asthma medication management, LDL cholesterol control in diabetics, and screening for Chlamydia all exceed the 90th percentile in comparison to civilian benchmarks. We also compare very highly with civilian hospital care for all 40 of our measures developed by the Agency for Healthcare Research and Quality, which evaluates patient safety, inpatient quality, pediatric care quality, and prevention-related quality for our hospital services. We recently began measuring 30-day mortality rates for myocardial infarction, pneumonia and congestive heart failure, and found that the AFMS is well below the national benchmark in all three measures. In 2009, we will implement measurement of well-child visits and follow-up after mental health hospitalization. While this is all good news, we must remain vigilant in analyzing and evaluating the effectiveness of our healthcare delivery—our patients deserve the very best.

The exposure of our Airmen to battlefield trauma puts psychological health at the forefront of our health and fitness mission. To mitigate their risk for combat stress symptoms and possible mental health problems, our Landing Gear program takes a proactive approach with education and symptom recognition, both pre- and post-deployment. We educate our Airmen that recognizing risk factors in themselves and others, along with a willingness to seek help, is the key to effectively functioning across the deployment cycle and reuniting with their families.

We have over 600 Active Duty and over 200 civilian and contract mental health providers. This includes 97 additional contract Mental Health providers we added in 2007 to manage increased workload. This mental health workforce has been sufficient to meet the demand signal that we have experienced to date. That said, we do have challenges with respect to Active Duty psychologist and psychiatrist recruiting and retention, and we are pursuing special pays and other initiatives to try to bring us closer to 100 percent staffing in those two specialties. We continually assess and reassess the demand based on mission requirements as well as the need for clinical services. We are seeing a gradual increase in the incidence of post-traumatic stress disorder (PTSD) in our Airmen and we are also seeing a persistent demand at the 1:2 dwell rate for mental health providers in the deployed environment. This demand is not likely to decrease, and could well increase over time. We are tracking this demand closely to ensure that we have the resources to meet tomorrow's demand.

With regard to what we are doing about PTSD, we address post-traumatic stress (PTS) in our Airmen by combining resilience training with frequent screening and ready access to mental healthcare. Resilience training is conducted via an Air Force developed program Landing Gear, where Airmen learn what to expect while deployed, and when and how to get help for stress symptoms. Screening occurs before deployment, at the end of deployment, 90–180 days post-deployment and annually via the Physical Health Assessment. Each screening asks about PTS and other psy-

chological symptoms. Healthcare providers fully assess all symptoms noted on the screening, and refer to mental health providers for further care as needed. We also train frontline supervisors and have positioned mental health personnel in our primary care clinics in order to increase access and reduce stigma. Quality healthcare for our Airmen requires our mental health providers to have the best tools available to treat PTS. To that end, we have sent 490 of our mental health providers to 2 and 3-day workshops conducted by civilian subject matter experts on the two widely recognized methods of PTSD treatment. All our providers, mental health and primary care, are trained and follow nationally/Veterans Affairs (VA) approved clinical practice guidelines to assure that all treatment for PTSD is state of the art and meets the highest standards.

For your awareness, 1,758 Airmen have been diagnosed with PTSD within 12 months of return from deployment (fiscal year 2002-fiscal year 2008). The vast majority of these Airmen continued to serve with the benefit of treatment and support. Of these Airmen, 255 have been enrolled in our Wounded Warrior program secondary to PTSD, and are not expected to be returned to duty. Our efforts at early PTS identification and treatment strive to maximize the number of Airmen we are able to return to full duty and health. As noted, however, we are seeing an increase over time in the number of our Airmen with diagnosed PTSD.

Understanding that suicide prevention lies within and is integrated into the broader construct of psychological health and fitness, we continue to aggressively work our eleven suicide prevention initiatives, which include frontline supervisor training and suicide risk assessment training for mental health providers. We have mental health providers in our family health units to provide the full spectrum of care for both our active duty and family members. This allows us to approach issues in a way conducive to quick recognition and resolution, while reducing any perceived stigma associated with visits to mental health clinics. Suicide prevention requires a total Air Force community effort, using all tools available. We are expanding our ability to identify, track and treat Airmen dealing with PTSD, Traumatic Brain Injury (TBI), or other mental health problems to ensure no one is left behind who needs help. We have the resources, the opportunity, and clearly the need to better understand, and care for these injuries.

Current treatment/management for TBI is based on Defense and Veterans Brain Injury Center (DVBIC) TBI Clinical Guidance. The Air Force TBI treatment is done by a multidisciplinary team guided by comprehensive brain injury and mental health assessment tools. All TBI patients receive education on TBI symptoms and management as well as appropriate referrals for occupational therapy, physical therapy, speech and language, pharmacy, audiology and optometry. Cognitive rehabilitation is initiated after medical issues have subsided and the patient's pain is managed. In fiscal year 2009, video teleconferencing equipment will be installed in all mental health clinics to allow direct consult with the DVBIC.

We have also taken the lead in DOD with diabetes research and community outreach. We have a very productive partnership with the University of Pittsburgh Medical Center (UPMC) and the Army. Wilford Hall Medical Center (WHMC), Lackland AFB, Texas, is designated as the initial DOD roll-out site for diabetes initiatives developed at UPMC. Major Mark True, an endocrinologist, is the WHMC project lead and director for the Air Force diabetes program. He established a Diabetes Center of Excellence (DCOE) program and, in August 2007, introduced several inpatient diabetes protocols and initiatives in the hospital, including an intravenous insulin protocol that substantially improved glucose control in critical care units. We are working to open an outpatient regional DCOE that will impact clinical outcomes across a regional population. This will be supported by the Mobile Diabetes Management with Automated Clinical Support Tools project beginning this year, which will demonstrate improved diabetic management through cell phones and web-based technology use.

BUILDING AND SUSTAINING A PRE-EMINENT AFMS

Sustaining the AFMS as a premiere organization requires the very best in education and training for our professionals. In today's military, that means providing high quality programs within our system, as well as strategically partnering with academia, private sector medicine and the VA to assure that our students, residents and fellows have the best training opportunities possible.

With the ongoing demand for well trained surgeons in our trauma care mission, we have focused on Surgical Care Optimization. This initiative identified eleven medical treatment facility (MTF) platforms to provide the capacity necessary to keep critical wartime medics proficient in battlefield trauma care. It also seeks to in-

crease MTF recapture of DOD beneficiary specialty care by optimizing operating room access and efficiency.

Our Graduate Medical Education programs consistently graduate residents fully prepared to provide excellent clinical care in the inpatient, outpatient and deployed settings. The outstanding performance of our residents on board certification exams is just one marker of the success of our numerous training programs, many of which are partnered with leading civilian institutions throughout the country, including Wright State and Cincinnati University in Ohio; Saint Louis University in Missouri, and the Universities of Mississippi, Texas, Nevada and California.

We partner with local civilian medical facilities to support the Sustainment of Trauma and Resuscitation Skills Program, enabling home-station clinical currency rotations in private sector level one trauma centers. Our Centers for Sustainment of Trauma and Resuscitation Skills is an immensely successful partnering endeavor that provides immersion trauma skills training with some of the great trauma centers in the Nation—R. Adams Cowley Shock Trauma Center in Baltimore, Maryland; University Hospital in Cincinnati, Ohio; and St. Louis University Medical Center, Missouri. Nearly 800 physicians, nurses and technicians completed this training in 2008; many of them deployed soon after and reported being very well prepared for their roles in combat medicine.

Working closely with our Department of Veterans Affairs partners, we continuously strive to streamline the system for all our personnel to include our wounded, ill and injured Airmen. A major success in this partnership is our joint ventures. The Air Force has four of the eight existing DOD/VA joint venture sites—Elmendorf AFB, Alaska; Kirtland AFB, New Mexico; Nellis AFB, Nevada; and Travis AFB, California. Three additional sites are under consideration or in development at Keesler AFB, Mississippi; Buckley AFB, Colorado; and Eglin AFB, Florida. These joint ventures offer optimal healthcare delivery capabilities for both our patient populations, while also serving to make the most of taxpayer dollars.

The Disability Evaluation System pilot program is a joint effort that resulted from the Commission on Care for America's Returning Wounded Warriors. The goal is to simplify healthcare and treatment for injured Service members and veterans and to deliver benefits as quickly as possible. Malcolm Grow Medical Center at Andrews AFB, Maryland was one of the initial three military medical treatment facilities in the National Capital Region to participate. The pilot streamlined and increased transparency of both the medical examination board process and the VA disability and compensation processes. In the pilot, both processes now occur concurrently, provide more information for the member during the process, and supply comprehensive information regarding entitlements from both agencies at the time of the separation. Continued evaluation of the study is slated to occur at 19 more military installations, to include Elmendorf AFB, Alaska.

Cutting-edge research and development initiatives are critical to building the future AFMS. The Virtual Medical Trainer is a continuation of existing efforts to develop advanced distributed learning. This project focuses on the development of training for disaster preparedness and medical care contingencies, addressing such areas as equipment, logistics, and war readiness skills training. Extensive work has been done to increase simulation in all of our hospitals and trauma training centers. Shared simulation with our university partners improves care and patient safety for both civilian and military patients. Virtual or simulation capabilities are a very cost-effective way to train and prepare our medics to do a variety of missions.

Keesler AFB, Mississippi is studying advanced technologies to include robotic microscopy and virtual (whole slide) imaging. Eight MTFs have the robotic microscopes, and efforts are underway to obtain connectivity between MTFs and the VA Medical Center at Omaha, Nebraska. Once fully operational, this system allows general clinicians remote access to expert advice, diagnosis, and mentoring, and provides high quality standard of care independent of location.

Similarly, telemedicine is vastly expanding the capabilities of our existing resources. Wright-Patterson AFB, Ohio radiologists and clinicians are successfully providing consultation services across the Air Force, and this year the project is slated to extend to Landstuhl Army Medical Center, Germany, and RAF Lakenheath, England. Automated Identification and Data Collection, a new business process study at Keesler AFB, Mississippi will identify opportunities for radiofrequency identification and barcode technologies in military medicine. We are exploring how to improve clinical and administrative processes in medical equipment management and repair, patient flow analysis and management, bedside services, medication administration, and surgical tray management.

Successfully building and sustaining the AFMS requires continued focus on the physical plants we occupy to perform our mission. We greatly appreciate the tremendous support you have provided to recapitalize Air Force aging medical infra-

structure. We're excited about our plans to improve facility restoration and sustainment and to move forward with sorely needed medical military construction (MILCON) projects.

Green design initiatives and energy conservation continue to be high priorities for the Air Force. We are incorporating these into AFMS MILCON and restoration projects for our MTFs. We use the nationally accepted benchmark—Leadership in Energy and Environmental Design—to design and construct buildings with sustainable design elements. I'm pleased to share some recent examples, such as exterior solar shading panels used in Keesler AFB's Base Realignment and Closure (BRAC) Tower and Diagnostic Imaging Center projects. A grey water system incorporated into Tinker AFB, Oklahoma MILCON recycles treated wastewater generated from MTF hand-washing for use in toilets or irrigation systems, decreasing or eliminating the amount of fresh water used for those purposes. Our projected fiscal year 2010 Air Force MILCON projects will incorporate enhanced day lighting concepts allowing more natural light into buildings and office spaces. Our energy optimization efforts are both environmentally and fiscally beneficial and enable us to better serve military members and their families.

Our most critical building block for the future is our people. With these unprecedented advances in training and research, it is understandable that the Air Force continues to attract many of the finest health professionals in the world. In fiscal year 2008, the Air Force Medical and Dental Corps exceeded their Health Professions Scholarship Program (HPSP) recruiting goals. HPSP is our most successful recruiting tool, and we are seeing positive early trends in retention from our other financial assistance programs and pay plans. We are working closely with our personnel and recruiting communities at targeting accession and retention bonus plans to ensure full and effective staffing with the right specialty mix to perform our mission.

BUILDING A JOINT AND EFFECTIVE MILITARY HEALTH SYSTEM

The AFMS is committed to working with our Sister Services to support joint medical capabilities and leverage common operating platforms such as logistics, research and development and information management/information technology. We are well on the way to bringing BRAC plans to fruition. The Joint Task Force National Capital Region Medical, or JTF CapMed, is moving forward with plans to combine the Army, Navy, and Air Force assets into the new Walter Reed National Military Medical Center. Malcolm Grow Medical Center at Andrews AFB, Maryland is our component to JTF CapMed and serves as an important care delivery platform in the NCR as the east coast hub for aeromedical evacuation. Since late 2001, Andrews AFB has welcomed home and cared for more than 33,000 patients arriving from Operations Enduring Freedom and Iraqi Freedom, U.S. Central Command, U.S. European Command and U.S. African Command.

The BRAC plans are also moving forward in San Antonio, Texas, to integrate Army and Air Force MTFs into the new San Antonio Military Medical Center (SAMMC), creating the largest inpatient facility in DOD. SAMMC has integrated nearly all clinical activities and has led the way in bringing the Air Force and Army together in an integrated platform that meets the Air Force, Army, and joint mission requirements all the while maximizing the use of existing resources.

Also in San Antonio is the Medical Education and Training Campus (METC). This is an important step toward what leaders are calling the largest consolidation of training in the history of the Department of Defense. Upon completion in 2011, the joint campus, led by tri-Service leadership, will centralize all Army, Navy and Air Force basic and specialty enlisted medical training at Fort Sam Houston, Texas. At Wright-Patterson AFB, Ohio, the 711th Human Performance Wing has been activated and will serve as a cutting-edge joint center of excellence for human performance and aerospace medicine.

These are but some of the ways and places we are working toward joint solutions that enhance mission support and benefit the quality of medical care for our warfighters and their families.

BRIGHT FUTURE AND GOOD TIME TO BE IN THE AIR FORCE MEDICAL SERVICE

Air Force medics make a difference in the lives of Airmen, Soldiers, Sailors, Marines, family members, coalition partners and civilians. They take pride in every patient encounter and earn our Nation's trust—everyday!

As we look to the way ahead, I see a great future for the AFMS, built on a solid foundation of top-notch people, outstanding training programs and strong partnerships. It is indeed an exciting, challenging and rewarding time to be in Air Force medicine! I couldn't be more proud.

We join our Sister Services in thanking you for your enduring support.

FEDERAL HEALTH CARE CENTER AT GREAT LAKES

Chairman INOUYE. I'd like to begin questioning now. Admiral Robinson, on October 1 of this year the Great Lakes Naval Health Center and the North Chicago Veterans Center will be merging. It's not the first DOD–VA activity, but it is without question the largest. I'm certain you have, as we have learned, legislative and other problems, problems with labor unions, problems on the commingling of funds and such.

Can you tell this subcommittee what is being done at this moment?

Admiral ROBINSON. The Department of the Navy, working in conjunction with the Department of Veterans Affairs, are coming together to establish the Federal Health Care Center (FHCC) at Great Lakes. We are working to make sure we have a seamless healthcare operation in north Chicago that will take care of the healthcare needs of the uniformed servicemembers in the Great Lakes area, as well as the beneficiaries of the VA system.

There are a number of significant obstacles that I think will be overcome, but that is not to say they are not there. The first and most notable among them is the IM/IT system. That revolves around using VISTA and using ALTA, which system is the best. They are incompatible in the sense that we can't use both of them together. They do different things for both systems. Yet, we need to have one IT system that we can utilize in the facility.

There have been a number of work-arounds. This is not an insoluble issue, but it is a major issue that we have to get resolution with, and in fact Navy medicine is pledged, along with VA, to make sure that we can come to some understanding of how we can use the best parts from both systems so that we don't destroy either VISTA or ALTA, but at the same time we can have one system at the VA.

There are also issues around recruitment and employee relationships at Great Lakes. There are also issues that from my perspective as Surgeon General are very large issues in terms of credentialing, particularly of our ancillary healthcare providers. The VA and how they credential is different than what we do in DOD because very few VA providers, perhaps none, but very few VA providers are operationally oriented or deploy. But I have to make sure my providers maintain their operational medical skills so that when I tap them to deploy to an operational area they are full up. So I have to make sure that we have the credentialing issues that are taken care of and that we are going to solve problems that I may have in the Navy.

Then there are the funding streams for both DOD and DVA, how those funds matriculate through our services, and the oversight of those funds. All of those issues, and this is just a very small example, have to be dealt with and we have to maintain the equities and missions of both DVA and DOD.

Again, these are a few examples of the issues that are involved. Mr. Chairman, I think that we are going to solve all of these issues, but I will also say, with openness, that these are very difficult issues, and we're working them hard. So there are not easy

solutions, but I do think that we can get to a place where we can have an excellent healthcare facility at FHCC.

Chairman INOUYE. So you're telling us that on October 1 all of the issues will not be fully addressed?

Admiral ROBINSON. All the issues are not going to be fully addressed on October 1. But I think that if we take an iterative approach to the issues of how we serve our beneficiary population, how we serve our patients, can the doors open and can we, in fact, be an effective healthcare institution for DVA and DOD patients, I think the answer is yes.

I do not think that all of the issues that I have talked about will be fully resolved, and in fact I think that that is absolutely essential in order to get to the quality care and the quality of service that we in DOD and DVA have to have in order to take care of patients.

Chairman INOUYE. There is a problem that is not in your jurisdiction, but as a result of these joint facilities we have a Veterans Committee, we have an Armed Services Committee, and so the matter of who has control is becoming a bit sensitive now. But that's not your problem.

Admiral ROBINSON. Yes, sir.

CENTER FOR EXCELLENCE

Chairman INOUYE. Can I ask a question of General Schoomaker. Everywhere you turn there seems to be a center for excellence. We have been creating one for traumatic brain injury. I support that. We have one for amputees, for hearing and vision. Do you believe that by creating centers we give the impression that only these centers are the ones that we are concerned with and other matters are not of interest to us?

General SCHOOMAKER. Well, sir, I think I understand your question and I understand the concern. I think the efforts of those that have chartered those centers, as well as the execution of the centers, the leadership of the centers, are working very hard not to focus so much on brick and mortar solutions, but to act as clearinghouses. I think increasingly, with the generosity of the American public and the innovation that occurs within the academic community, with other Federal research and treatment entities like the National Institutes of Health, we are seeing—and the use, that's already been alluded to by Admiral Robinson, the use of information technology—we have an opportunity for these centers really to be the nexus of knowledge networks and to harvest best ideas, to find potential solutions, while also monitoring where problems are arising, and to move funding, to move energy, to move focus to those physical brick and mortar sites where that can be done.

I think this is—certainly the effort that's underway in the Defense Center of Excellence for Traumatic Brain Injury and Post-Traumatic Stress Disorder and Psychological Health, I don't think anyone—certainly I do not conceive of this new center of excellence as being the sole brick and mortar site and only repository of good research and clinical activity. But certainly it is in a position to reach out to anyone who can offer solutions to the problems that are arising.

SERVICEMEMBER WELLNESS/FAMILY ADVOCACY

Chairman INOUYE. Admiral and General Roudebush, as you've indicated, there's been a rise in suicides, substance abuse, spousal abuse, children abuse. Are we making a joint effort of all services, or just each service on its own?

General ROUDEBUSH. Well, sir, in terms of approaching what are very complex problems that cross a variety of areas when you're caring for the active duty soldiers, sailors, marines, and caring for their family members, we do approach that in a service-specific way which attends to the culture that those families both exist within and operate within, whether it's an Army post or a Navy station or an Air Force base.

So we each have an approach that I think is adapted to the operational perspective of how we operate, but also attends to that culture. But we also work across services in terms of sharing both successes and issues, sharing programs, sharing insight into what we're doing, and operate I think effectively across those areas.

Now, I will tell you that as we are able to reduce stigma, as we are able to increase visibility of issues, we are seeing more. Perhaps we're seeing more because there are more, and we need to be very attentive to that. But I think we're also seeing more because we are able to see more, and give us the opportunity to engage, hopefully intervene, to assure that proper care is provided at a time when it can make a difference, and do it either within the service construct or within the joint construct, because we certainly care for Navy and Army families in our Air Force facilities, and likewise our Air Force families are very well cared for in Army and Navy facilities.

So it's incumbent upon us to work jointly, but we also need to work separately to assure that we are getting at the issues within our operational platforms.

Chairman INOUYE. Thank you very much.

Senator Cochran.

Senator COCHRAN. Mr. Chairman, thank you.

MEDICAL EVACUATIONS

Admiral Robinson, more marines will be deployed to Afghanistan in coming months, and I've been informed that the standard time required for medical evacuations in Afghanistan are considerably different from those in Iraq. Would you comment on the adequacy of the resources that will be available and the response time for medical evacuations as more marines and corpsmen are involved in that theater of operation?

Admiral ROBINSON. Yes, sir, Mr. Vice Chairman. The Afghanistan area of operation is substantially different than the area of operation in Iraq, both from a terrain and an infrastructure point of view. Afghanistan has desert terrain, which can reach upwards of 140 degrees Fahrenheit, all the way to mountains, which are very, very cold, very sub-zero weather. Additionally, infrastructure in terms of roads are almost completely lacking in Afghanistan, as opposed to other areas, which makes the necessity for how we operate there from a medical point of view a lot different in terms of mobility and in terms of air evacuation.

The golden hour which I as a surgeon and as a former chief of surgery at Portsmouth Naval Hospital, having trained many general surgeons in trauma, is an age-old edict that we've used in surgery since it was first developed at the University of Maryland Shock Trauma. It's based upon the work from the Vietnam war and also the fact that if we can utilize air evacuation of critically injured personnel and get them to immediate definitive medical facilities we can save lives, and in fact that is absolutely true.

One of the things that we in Navy, Army, and Air Force medicine also utilize is the effective resuscitative capability that the Army medic, the Navy corpsman, and the Air Force medic utilize on the ground at the time of injury, such that we can start definitive care. We can start adequate resuscitation of injured personnel, stabilize them, control their airway, until adequate evacuation capability is there.

So the 60 minutes and the air evacuation, which is more difficult in Afghanistan, is not something that is necessarily going to reduce either the capability or the success of trauma surgery or trauma capability that we've had in the past. I only emphasize that from a medical and a surgical point of view because very often the golden hour appears to be truly a 60-minute evolution. It actually includes the ability to stop bleeding, to make sure that we have ABC, airway breathing, and circulation reestablished, to make sure that we have resuscitation reestablished, to make sure that we've done those definitive measures for the injured personnel who are going to in fact survive such that we can get them to definitive care. And in fact, if we get them there 2 or 3 hours after injury, that is usually adequate as long as resuscitation has occurred.

So the long answer to the short answer: We, Navy medicine, Air Force and Army medicine, will be capable of making sure that we give the same care to our trauma victims in Afghanistan.

Senator COCHRAN. That's very impressive and I think deserves commendation for the excellent leadership you're providing in this area.

SUFFICIENT SUPPLIES AND PERSONNEL FOR AFGHANISTAN

General Schoomaker, with the increase in personnel deployed to Afghanistan, do you believe that you will have sufficient medical personnel and medical supplies to support this troop increase?

General SCHOOMAKER. Sir, I think medical supplies is probably the easier of the two to answer. I don't envision any rate-limiting element of medical supplies or equipment there. We have I think evolved the medical logistics capability of the entire CENTCOM area of operation dramatically over the last 6, 7 years, focusing on the so-called theater level medical material centers, one of which is in Europe, one of which is in Qatar, and we have distribution sites within Afghanistan.

So I don't have concerns so much about that. Medical personnel I think is a challenge to us. This is one of those areas, quite frankly, that the coordination among the three services is most important. The Army right now is very heavily engaged both in Afghanistan and in Iraq in providing medical support. As we draw down troop levels in Iraq, we're going to continue to have fairly robust

medical support because, as we all know, you have to support the areas in which troops are operating in.

So we're going to continue to see Army medics and, for that matter, Navy and Air Force as well, maintained in Iraq. So we're cooperating I think with the CENTCOM planners and with the joint medical planners within Afghanistan to provide the resources that we can and the Navy and the Air Force, I think as you heard earlier, the air base at Bagram now, and that level three or role three facility now is largely Air Force, after having been started by the Army and transitioned to the Air Force. The Navy is going to play a more important role in the south.

So yes, we're stretched. But we're working as closely as we can with our joint partners to cover those areas of responsibility.

TROOP INCREASE IN AFGHANISTAN

Senator COCHRAN. Will the increase in deployment affect rotation schedules and deployments of surgeons, as well as medical specialists? What is your expectation?

General SCHOOMAKER. Well, sir, everybody plays a role in this in Army medicine. It's not recognized by many people, but some of our most heavily deployed specialties are not surgeons at all; they're pediatricians, who serve as general field surgeons, physicians assistants. Our psychologists, psychiatrists, our mental health workers, are very heavily engaged.

Do I think it's going to change the rotation length? No, sir, it's not going to change the rotation length. In fact, we're working to come closer to what our colleagues in the Air Force and the Navy have, which are shorter rotations, even if they're more frequent. We know from talking with our families and talking with our specialists that not only can they maintain the broad range of skills that they require in their specialties if they're deployed for a shorter period of time, even if that turns into more frequent deployments, but the families are much more tolerant of shorter rotations, especially 6 month or so rotations.

So we're working very hard to do that and getting support from the line for that.

Senator COCHRAN. Thank you very much.

General Roudebush, what role will the Air Force have in supporting the troop increase in Afghanistan?

General ROUDEBUSH. Sir, the Air Force is in Afghanistan, as General Schoomaker pointed out. We have the Air Force theater hospital at Bagram, which is jointly manned with the Army, but, as General Schoomaker pointed out, primarily Air Force, as well as a number of other smaller facilities that are either Air Force or jointly manned. We will certainly sustain those and over time being increasing Air Force medical laydown to support what you initially pointed out with Admiral Robinson in terms of working the medevac support time, which I believe you know, but I will note, our line leadership has really leaned into supporting that with additional rotor capability. The Air Force is providing additional helicopter assets and other assets to assure that we can be as timely as we need to be, and I think Admiral Robinson laid that out very well.

So we will be certainly supporting the increased troop laydown. However, I think there's two other points that I would note. The Air Force and Navy and Army are also deeply involved in rebuilding the nation. We have embedded training teams working with the Afghan military and police to rebuild their medical infrastructure, to mentor the Afghanis, so that they can be ultimately self-sufficient; provincial reconstruction teams doing a great deal of work to bring that nation forward to the point where it can in fact operate on its own recognizance.

The second point I would make is that we have significant support from our North Atlantic Treaty Organization (NATO) allies on the ground in Afghanistan from a medical perspective, which we also integrate and leverage to assure that we have not only a joint approach to this, but we also have a coalition approach. So as we look at the overall military laydown in Afghanistan, there are a variety of perspectives that play into this that I think will assure that our forces are best positioned to do the mission that they are being sent there to do.

Senator COCHRAN. Thank you, Mr. Chairman.

Chairman INOUYE. Thank you.

Senator Bennett.

Senator BENNETT. Thank you very much, Mr. Chairman.

Gentlemen, let me thank you for your service and your expertise. I come to this subcommittee new, so I don't have as intelligent or well-informed questions, but the only way I'm going to learn is to ask some stupid ones. So bear with me.

MEDICAL HEALTH SCREENING

General Schoomaker, you talked about general wellness, that is physical, psychological, spiritual, et cetera, et cetera. I think that ties into this whole question of mental health. The discussion about suicides and child abuse and other things has been an interesting one to listen to. In this process of trying to make sure that the individuals who serve in the armed forces are well-rounded and balanced in every area, is there any prescreening of people who might be susceptible, more susceptible to some kind of mental trauma and preparation prior to their going into deployment, so that they might, if something happens to them, have some previous training or preparation or expectation that could help them after the fact deal with the problem more than if it just hit them for the first time?

General SCHOOMAKER. Yes, sir. I think let me talk first about the screening because I think that's fairly—that I can deal with fairly quickly. That is that, aside from the usual accession screening, to include medical and psychological screening that occurs on any inductee, we don't have any specific screens that are used or selections that are used, because, quite frankly, I don't know that we have any determinants right now for success or failure in terms of the whole fitness of an individual. We use physical fitness monitors and assessments of general health, but other than that none.

I think one of the promises of the research that is now being conducted in traumatic brain injury, and especially in psychological health potentially, is finding early markers, if you will, and determinants of psychological injury. There are emerging theories and

I think there's some empiric evidence to support that post-traumatic stress reaction, for example, which occurs in a very large number of people subjected to trauma, whether that's in combat or the trauma of natural disaster or rape or violent crime or family violence, motor vehicle accidents, might be the persistence of a dysfunctional flight or fight reaction, and that there may be markers that we can discover and alert people very early to that emergence.

In the meantime, what we're doing in the Army is, through the use of a set of tools, a suite of training tools called Battlemind training, developed by the Walter Reed Army Institute of Research, we are building resilience in deploying soldiers before they deploy, during the deployment, and then upon redeployment. This suite of tools, Battlemind, which has become sort of our branded name for that, is one of the cornerstones of resiliency training. It's been one of the only instruments that we're aware of that has actually been shown to reduce during deployment the incidence of new post-traumatic stress problems.

The chief of staff's initiative in comprehensive soldier fitness is that attempt writ large. The idea here is that we have spent a lot of our time as a corporation, as an institution, looking only at the negative events—suicides, family violence, driving while intoxicated or drug-associated crimes or misconduct, and emergence of post-traumatic stress reactions and post-traumatic stress disorder if not addressed early enough and reversed. What the Army is trying to do is to find those determinants of resilience and growth and post-traumatic growth, rather than to turn adversity into a trauma and into an irreversible psychological injury, is to build the capacity of individuals through a multidisciplinary approach which works on the positive.

So we're working with some of the leaders in positive psychology and other tools to promote that aspect, rather than only measure in terms of what negative events occur. In so doing we hope to move the whole population of soldiers and families away from the threshold where they become dysfunctional.

Senator BENNETT. Thank you. That's really helpful.

Now, I was interested in the comment that you get significant increases, to use the business language, significant increases in productivity out of the troops if you alter the length of their deployment. I'm guessing here, but are there any studies going toward the question of frequency of patrols, for example, during the deployment, where you send marines into a nasty neighborhood in Fallujah day after day after day, as opposed to every other day or every third day or something of that kind?

Is there any research in this regard or any attempt to find research in this regard that might have the same impact that you have found with respect to the overall length of deployment, 6 months gives you better soldiers even if there are more deployments than if you put them there, say, for 18 months and kind of leave them alone. Is there any further research in the area I've talked about, about their exposure to traumatic situations on deployment?

IMPACT OF DEPLOYMENT LENGTH

General SCHOOMAKER. Well, sir, first of all, you may have inferred something that I did not intend to imply, that is that productivity of a soldier in general is somehow linked to the length of deployment. The chairman I think or the vice chairman earlier asked about the tolerance of recurrent deployments of medical specialists or surgical specialists as a function of the length of the deployment. My comment there is that we observe that the skills of, for example, a general surgeon begin to deteriorate after a certain amount of time in theater because they're not exploring and not using the full spectrum of what a general surgeon would use.

Senator BENNETT. I did misunderstand you, then. I got the impression that there were data that suggested the front line troops would benefit from more frequent, but shorter, deployments. You're saying that that's not the case, and I misunderstood you.

General SCHOOMAKER. Yes, sir. I think we have ample evidence through a series of annual iterative surveys called the mental health advisory teams, MHAT. We're in our sixth iteration of this, the sixth year. That team is right now in Iraq gathering data. We do have ample evidence that the length of deployment is associated with increased problems of the development of post-traumatic stress and other problems of soldiers in theater.

So I think you got that exactly right, sir. As we were in that period of the surge when we had 15 month long deployments, there was no question that the longer that deployment went the more problems soldiers had.

We do find, as I mentioned earlier, that if those soldiers pre-deployment and during deployment are exposed to Battlemind training and sort of re-inoculation with this, it reduces the incidence of that. So as I said before, it has been shown to be effective.

But as far as, so to speak, the productivity of the soldier or the effectiveness of a soldier, I would not ask you to infer from what I've been describing here that a soldier's effectiveness is improved by shortening the length of deployment. In fact, operational commanders would probably take me—take exception with some of that as a grand statement.

Senator BENNETT. Thank you. I appreciate that clarification because as I've studied the Vietnam war one of the things that was said was that you just got your unit cohesion going and then you'd pull them out and put in a bunch of green troops in, and that was one of the problems. So I'm glad to get that resolved.

Thank you, Mr. Chairman.

Chairman INOUYE. Senator Murray.

Senator MURRAY. Thank you very much, Mr. Chairman.

Thank you all for your testimony today.

DISABILITY EVALUATIONS

General Schoomaker, let me start with you. How are things going with the DOD and the Department of Veterans Affairs expansion of the pilot programs to expedite the processing of injured troops through the disability evaluation system?

General SCHOOMAKER. Ma'am, I think that's going very well. As you know, or at least I've gone on record to say that the pilot, al-

though a very, very good effort and one that we support very, very vigorously—in fact, once the pilot was established in those few sites like Walter Reed, I've done everything in my power to implement it as widely as we can. Once we learned that we can simplify bureaucratic morass and we can make it more user-friendly for families and soldiers, I think we ought to be doing it as quickly as we can.

But I've also said that I'm concerned that it doesn't get at one of the most important and most disaffecting parts of our system of physical disability and evaluation, which is the dual adjudication of disability, one by the Department of Defense for the unfitting condition, for which the soldier, sailor, airman, marine, coast guardsman is awarded a specific disability rating linked to benefits, not the least of which is benefits for TRICARE for him or herself and their families; and then the Veterans Administration adjudicates a second, comprehensive level of disability based upon the whole person.

Senator MURRAY. I thought we were all going to go to the same system.

General SCHOOMAKER. Ma'am, until we change the law, my understanding is that we cannot get away from the dual adjudication of disability for anyone in uniform. We still have the single unfitting condition for the service member and the whole person concept for the VA. What we need in my understanding is legislative relief to be able to bring those two together.

But every other aspect of this highly bureaucratized system I think we're working very hard with the VA in doing, and we're encouraging that and supporting that in every way we can.

Senator MURRAY. Admiral?

Admiral ROBINSON. I think that General Schoomaker has summed up well what the issues are. I think that the Federal Health Care Center in Chicago actually underscores some of the difficulties of the DVA and DOD system in terms of trying to—your question is specifically with the disability evaluation system. But we have two chains of command that work vastly different, with different sets of rules and regulations, and trying to bring them together has been the real challenge.

Additionally, the same issues that affect the FHCC, the Federal Health Care Center in Chicago, regarding IM/IT—that is, VISTA and ALTA—are the same sorts of things that affect the merger of the disability evaluation system. How does that relate? If we have one system, we're going to have to have one medical IT way of dealing with those beneficiaries and whatever their medical needs may be.

That's a very small example, but those come together. In terms of my eyes-on Surgeon General of the Navy at the Department of Defense for the oversight committees that very often General Roudebush and General Schoomaker attend with me, both DOD and DVA and all of the reps in between and the Marine Corps, and all the other people involved have been working tirelessly to make this work, looking first at our patients and their needs and not at bureaucratic or other issues.

I will say that across the board we have done that. We're looking at patients and what they need, not at the institutional obstacles.

I only bring the institutional obstacles up because at the end of the day they exist and they make a difference.

Senator MURRAY. General Roudebush.

General ROUDEBUSH. Yes, ma'am, I think you raise a very interesting question. I'd like to offer perhaps an observation on your question, but also give it perhaps a little different perspective.

The Department of Defense and the Department of Veterans Affairs have different missions. Where we come together, the interface really most directly is as we transition an individual from Department of Defense—Army, Navy, Marine Corps, Air Force—to the Department of Veterans Affairs. We do need to assure that that transition is seamless.

Now, DOD, in my instance the Air Force, needs to determine fitness for duty in terms, is that individual fit to serve in the mission for which they're trained. The VA takes a rather broader look at how that individual is going to function back in the private sector. So these are two rather different determinations, and I think to the extent that we simplify the transition to assure that these great men and women are cared for, only have to fill out paperwork once, have a smooth move from DOD activities to VA, to include benefits, all benefits, is very important.

Our pilot projects I think are helping in that regard. For us, we're going to be expanding to a variety of locations, very small, Vance in Oklahoma for example, to very large or larger, Elmendorf in Alaska. I think that will continue to be instructive.

The metrics show that we are, in fact, reducing the time, but not to the time that we would consider to be appropriate. But as we bring these two great institutions, DOD and VA, together, we also have other experiences. DOD joint ventures, for example. We've got a great example at Keesler, where we use centers of excellence, what the VA brings very well within their operation, what the Air Force brings in our operation, and we leverage each other's capabilities, maintaining mission focus for the Air Force, for the VA, but really leveraging each other's capabilities.

So I think those kinds of opportunities and experiences are important, and also help instruct such things or inform such processes as how to best transition these men and women from DOD to VA. So I think we're making progress. We are not where you want us to be. We are not where we want to be. But I think we are making progress in really identifying the issues that need to be attended to as we work this.

Senator MURRAY. No one said it was going to be easy.

General SCHOOMAKER. No, ma'am.

Senator MURRAY. But we're working, and we need to get there. Okay.

General SCHOOMAKER. Thank you.

Senator MURRAY. Can you provide me with an update on the implementation of the comprehensive TBI registry that we started, I guess it was 1 year or so ago, including a single point of responsibility to track incidence and recovery, General Schoomaker?

General SCHOOMAKER. I will take that for the record, ma'am.

Senator MURRAY. Could you?

General SCHOOMAKER. Yes, ma'am.

[The information follows:]

TBI REGISTRY

Traumatic brain injury incidence and recovery is tracked through various complementary mechanisms at the VA and the Department of Defense (DOD). The National Defense Authorization Act for Fiscal Year 2008 states that the Secretary of Veterans Affairs shall establish a registry to be known as the "Traumatic Brain Injury (TBI) Veterans Health Registry." The Act further specified that the Secretary of the VA collaborate with facilities that conduct research on rehabilitation for individuals with TBI, facilities that receive grants for such research from the National Institute on Disability and Rehabilitation Research (NIDRR), and the Defense and Veterans Brain Injury Center (DVBIC) of the DOD and other relevant programs of the Federal Government. The VA, NIDRR, and DOD have collaborated in this initiative with the VA as lead. The summary below is based upon those collaborations. Further details can be provided by the VA.

TBI operational Surveillance: TBI Veterans Health Registry

The VA has developed a mechanism to collect and consolidate all relevant medical data relating to the health status of an individual who served as a member of the Armed Forces in OIF or OEF and who exhibits symptoms associated with TBI, and who applies for care and services furnished by the VA; or files a claim for compensation on the basis of any disability associated with such service. Relevant data will be merged, and de-identified. The VA will then enlist NIDRR to assist with analysis of the data and timely production of reports.

Status: All components of this program have been designed and will be initiated very shortly.

Research Database: TBI Veterans Health Registry with Additional Information

As per the NDAA for fiscal year 2008, additional information the Secretary considered relevant and appropriate with respect to individuals will be included in the Registry if the individual grants permission to include such information, or is deceased at the time the individual is listed in the Registry. The additional information to be collected for patients providing informed consent in any of the VA PolyTrauma Centers includes a structured TBI Registry with additional data elements developed in coordination with the agencies listed in the NDAA for fiscal year 2008. These collaborations permit comparisons of Registry information with data collected on civilian TBI patients and DOD patients and returning service members. The VA TBI Registry has substantial overlapping data elements with the civilian Model Systems' TBI Registry and the existing DOD TBI Registry, which will facilitate future comparative studies.

Status: This program, involving additional information for patients providing informed consent, has been submitted as a protocol to the Institutional Review Boards at the PolyTrauma Centers.

National Archive Database

In addition to the secure database developed as a collaboration between VA and NIDRR, additional databases may facilitate the sharing of selected elements of the TBI Veterans Health Registry with Additional Information with data collected within the DOD and across other civilian agencies and centers. The pooling of shared, common data elements will facilitate understanding of the course, diagnosis, and correlates of TBI in returning service members. The National Data Archive, a recent collaboration between NIH and DVBIC will provide for secure upload and storage of all original and processed images, associated clinical and genomics data for TBI, Post Traumatic Stress Disorder (PTSD) patients, and other relevant patient populations.

Sharing of phenotypic, imaging, and genomic data from a central secure repository will include the ability for researchers to validate research results, pool standardized information to improve statistical significance, use data collected by others to explore new hypotheses all in effort to improve PH and TBI treatments, use sophisticated analysis tools to gain a better understanding of risk factors and mitigating factors in PH and TBI.

General SCHOOMAKER. That is being—the focus in Army medicine is to direct all of our energies and our talents toward the Defense Center of Excellence for Traumatic Brain Injury and Psychological Health under Brigadier General Loree Sutton.

Senator MURRAY. Could you get back to me on that? It was one of our huge questions 1 year ago; making sure that people were

registered and we were tracking them. So if you could please get back to me on that.

General SCHOOMAKER. Yes, ma'am.

RESERVE HEALTHCARE REQUIREMENTS

Senator MURRAY. Let me ask all of you: The Reserves and particularly the National Guard have some unique concerns when they're deployed. We continue to hear from our folks out in our States about this, and obviously as we transition from Iraq to Afghanistan they're going to continue to be used. So my question for each of you is: Have you budgeted properly to accommodate for the Reserve components as they are going to need DOD healthcare into the future? General Roudebush, we'll start with you.

General ROUDEBUSH. Ma'am, in the Air Force and I believe in the other services, we have separate funding streams. The Guard comes from the States, the Reserve comes from the Reserve dollars, and DOD comes from the defense health programs. Now, to the extent that we merge our interests and our activities we do cross-flow that very, very carefully.

For us, for example, we assure that our Guard members and our Reserve members and our active duty members are tracked for completion of the post deployment health assessment and the post deployment health re-assessment (PDHA–PDHRA), and, in fact, our Guard and Reserve members are kept on active duty status, man-day status, until issues are resolved. So they retain full benefits as we work them through.

But they do come from different streams of money. However, the oversight and the application of that is very coordinated and very integrated for the Air Force.

Senator MURRAY. Admiral.

Admiral ROBINSON. Your question is do we have adequate funds for the Reserve forces, and the answer is yes. Our Reserve forces have adequate funds. We have methods of making sure that our Reserve forces, once they come on active duty, are cared for just as any other active component member would be. As that Reserve component member goes off of active duty, the service member and his or her dependents are covered by TRICARE for approximately a 180-day period.

If there is some limiting mental or physical disease or condition that would make it better for them to stay on active duty, they will remain on active duty. As they transition to the Navy mobilization platforms, NMPS, to the Reserve component, to the NOSCS, which are the local Reserve units back in their home towns or their home cities, they will go back into how we fund them from the Reserve component perspective.

But the key is that we have a number of medical, mental health, and other areas that we track our Reserve forces, that we integrate our Reserve forces, and that we care for our Reserve forces, and we are funded adequately to do that.

Senator MURRAY. General.

General SCHOOMAKER. My comments would echo my colleague's here, that we're well funded. They are separate lines for the Army National Guard, Reserve, and Army Reserve, and the active component. As the Admiral just commented, we're working very hard to

ensure that any mobilized reservists or National Guardsmen while on active duty is kept healthy; if they incur an injury, a combat wound or an illness, that it';s fully treated and they're restored to health, including dental health. We made a major effort to restore dental health and hygiene before mobilized reservists and National Guardsmen are put back out into civilian life.

Our warrior transition units are roughly 8,000 in total right now across 36 units and nine States, are made up of both active—of all three elements, all three components, to include National Guard and Reserve. They have full access to those warrior transition units. In fact, about one-third of our warrior transition units warriors in transition are soldiers who are returning from deployments or mobilizations who identified a problem that they have, and they're brought in and they're retained on active duty until we can take care of the problem.

Senator MURRAY. Thank you.

I appreciate a lot of the conversation that's already gone on regarding the increase in suicides and mental health. We have to stay focused on that, and I appreciate all of your earlier comments, so I won't ask you about that.

DEPARTMENT OF DEFENSE FISCAL YEAR 2008 REPORT ON SEXUAL ASSAULT IN THE MILITARY

But I did want to ask you about another issue, because yesterday DOD made public the fiscal year 2008 report on sexual assault in the military, and it showed an 8 percent increase of reports of sexual assaults. Now, some are arguing that that increase illustrates the fact that victims are now more likely to report those crimes, but I find the trend very disturbing because these crimes are happening at all.

I was part of the Women's Military History Month. A week ago I participated in the Army's panel on sexual harassment, assault prevention and response program, and clearly we all share the goal of eliminating sexual assaults in the military. But until that goal is achieved, I am very interested to hear from all of you about how the medical community is supporting the efforts to care for these victims' physical and psychological wounds in general.

SEXUAL ASSAULT AND RESPONSE PROGRAM

General Schoomaker, I want to start with you.

General SCHOOMAKER. Yes, ma'am. First of all, I would say that the Army leadership and the Army as a whole shares your outrage with sexual assault and any increase in the incidence of these crimes. The Army has taken the approach that this is an assault, not just on the individual woman, but on the ethos of soldiers, of the warrior ethos, that this is not to be tolerated, and is taking a very active proactive role in education and prevention, which is on the shoulders of commanders.

The medical side of this is that we are the response. We provide the examination. We help the woman through the stages of forensic evaluation. We have in all of our facilities, to include, as General Horoho can tell you, in our visit there last week her review of what's taking place in the deployed setting in Iraq.

We have sexual assault response coordinators in each of these facilities, either working with the assets we have in uniform in the uniformed facility, or in a case when I was the installation commander at Fort Dietrich, Maryland, we leveraged expertise of the community of Frederick, Maryland, to assist us through Frederick Memorial Hospital.

So we do the counseling, we do the examination. We help the woman. We go—we help her through the process that she has to go through in order to gather the necessary information about the assault and to investigate the crime. But we also do the follow-on counseling and help coordinate all those services that are necessary for her.

Senator MURRAY. Admiral.

Admiral ROBINSON. Senator Murray, the Navy has the Sexual Assault Victims Intervention Program (SAVI), which was established in 1994. From that program has come an effort to not only educate people as to what is a sexual assault and to bring it to a level of visibility so that we are talking about it in our commands and it becomes a leadership issue on a daily basis, but we've also grown from that to develop a lot of the sexual assault response and prevention programs (SARP) that you've seen and participated in some of the workings with DOD.

From the medical point of view specifically, we help in the training of SAVI. The SAVI Program is also interesting because it takes the victim and puts the victim at the center of the activity. In other words, it makes sure that the victim understands, is affirmed, and actually has the counseling that he or she may need is a critical element in how we run the program.

The second one is to make sure that we then train the forensic experts that need to come along and do the investigations, which is what General Schoomaker was referring to, which is critically important. I would suggest that if those folks are not trained in the military treatment facility that we utilize our civilian forensic police and forensic facilities to make sure that that's done properly.

Then the third point is the education and the prevention, which is something that needs to be done at the beginning of training in the military. This is for men and women, and it goes through some of the very didactic, but very necessary thoughts regarding training, regarding definitions: What is a sexual assault? What does consent mean? What does "yes" mean? What does "no" mean? All of these types of things which men and women have to listen to.

Then the last part is to make sure that after we've done that, that we have a program that's sensitive to the needs of those people who fall victim the sexual assault. That includes psychological and the mental health issues. Additionally, we need to make sure that their families are cared for. Very often men and women are married or they have other family issues, and we have to make sure that that's cared for.

We in the Navy have taken this full-bore and are very sensitive to what you've talked about. We have been working this very hard for a long time.

Senator MURRAY. I appreciate that answer. Thank you.

Admiral ROBINSON. Thank you.

Senator MURRAY. General.

General ROUDEBUSH. Ma'am, I think your approach is the one that I would echo. We know there are increased numbers. Now, whether it's increased reporting or increased incidence, we can certainly discuss. The fact that there is one is too many.

SEXUAL ASSAULT

Senator MURRAY. That's correct.

General ROUDEBUSH. So beginning with that as the going-in position is precisely where the Air Force leadership is attacking this issue. It's a matter of respect. It's a matter of respecting each other. It's a matter of honoring each other's integrity and their person and treating each other as we would want to be treated.

It's an operational issue. It has direct mission impact. It's a cultural issue. It's a family issue, because we strive individually, we execute as a team, but we take care of each other as a family. So this is a family issue.

We come at it in a very structured way. We learned important lessons as we assessed the issues at our Air Force Academy, which we have implemented across the board in terms of a sexual assault program that works to prevent sexual assault, but if it occurs we respond in a very sensitive and coordinated way, to include restricted reporting if the individual prefers, to perhaps help them come forward and get the help that they will need.

We have a sexual assault response coordinator at every installation wired into the wing leadership. Medical is a key part of it. As General Schoomaker pointed out, we have important responsibilities and we are postured and do execute those responsibilities. But really, it's a matter of taking care of each other, respecting each other, and that's precisely where our program is going in terms of training, education, and sensitization, and establishing the fact that it will not be tolerated any way, any shape, any form, anywhere, any time. It's a matter of respect.

Senator MURRAY. Well, I appreciate your comprehensive answers, all three of you, and I hope that's echoed throughout the forces. I think that the worst thing we can do is to not talk about it. This is an issue I'm going to continue to follow. I encourage all of you as well, to make sure that those policies are implemented, so that no one fears coming forward; that we start at the very beginning, so that it's not tolerated; and then if it does occur, that people get services and support and it doesn't become a crime that no one talks about.

So I appreciate all of your answers on that.

Thank you, Mr. Chairman.

Chairman INOUYE. Thank you very much.

I have many questions I'd like to submit to you, but one final one if I may. When I was wounded in World War II, from the battlefield to the hospital it took me 9 hours to be evacuated, most of the evacuation carried out by stretcher bearers. Today if I were wounded with the same injury in Baghdad, I suppose I'd be in a hospital within 30 minutes because of helicopters and such.

As a result, a lot of things have happened. For example, in my regiment I don't believe we have one double amputee survivor. Today most double amputees survive. And you have many brain injuries and such, which in World War II very few ever survived.

But equally as important, I spent 22 months in a hospital. Today if I were at Walter Reed I'd be out in 6 months on the street. But when I left Percy Jones in Michigan I knew a little about carpentry, electrical work, plumbing. I knew how to play basketball and swim. I knew how to drive. I knew how to go to a restaurant and order food, dine, dance. I knew how to defend myself. I knew what sex was all about.

COMPREHENSIVE TRANSITION PLANNING

My question is, do you believe that the men and women who are being wounded in this war leave the service as I did, reassured, confident that I can tackle the world?

General SCHOOMAKER. Sir, if I might start the answer from the standpoint of the Army, I think your eloquent description of what you went through and your sharing that with me personally and with my staff in the office visits with you I think really captures the essence of what we're attempting in this comprehensive transition planning. What we observed—and quite frankly, Senator Murray's question about the physical disability evaluation system is really incomplete without addressing one aspect of this system.

We have a system that, its name alone telegraphs what it's about, "physical disability." It's a system that is rooted in the industrial age. It's 50 years old. It's highly bureaucratic and it's contentious and adversarial. We're trying to change the culture of disability and permanent dependency toward one of growth, of rehabilitation, of your experience, without leaving any soldier, family without the necessary safety nets and transition support that they may require in the case of a very severe injury or illness.

So candidly, we've turned away from—the chief of staff of the Army engaged another former wounded soldier, General retired Fred Franks, a veteran of Vietnam, where he lost part of a leg, and went on to retire as a four-star general, as the commander of the 7th Corps in Desert Storm. General Franks has looked at the physical disability evaluation system and has concluded some of the same things that, much of what I've said here today, which is that we need to move the culture away from one that's focused on disability and permanent dependency toward one that is aspirational, that's positive, that builds back a capability and potential in every individual soldier, sailor, airman, marine, coast guardsman, and their family.

We draw upon the experiences of soldiers such as yours. Today I will tell you that with your injury you very likely would remain in our hospitals the same length of time that you were there before, only because it may take that long to fully recover from the wounds that you had and to be fully rehabilitated to do what you needed to do, to include remaining on active duty.

We've turned away from looking at time as a goal or an outcome measure for this system of transition. We look at—we're beginning to look at and assess the goodness of the outcome for the individual soldier and family based upon what their comprehensive transition planning is. So have we reached that point? At this point I would have to say no, sir, we have not. Does every soldier who's wounded grievously or is injured or ill to the degree that you suffered or others have have the confidence and realize the full potential? At this

point I'd have to say no. But we won't be successful in this program of transitioning until we have all of our soldiers aspiring to what you've achieved.

Admiral ROBINSON. Mr. Chairman, I think your question and your comments are very profound, and it makes me think of a movie in 1947 or 1948, "The Best Years of Our Lives," in which a sailor is depicted, Homer, a double amputee coming out of the war, and spending approximately 24 to 30 months in a VA hospital. I think he learned all of the things that you learned. I don't think that they ever stated it as you did here, but he learned so much.

But one of the things that was lacking in that movie and in that whole scenario was the family, because he was scared to death as to how he was going to be received by his mother, his father, his sister, and his girlfriend next door.

The difference now is that we've brought families into the whole rehabilitation issue. The second part is that the length of time—I absolutely agree with General Schoomaker—it's not the time element, although it can be, but the length of time that one takes is not commensurate with the length of time that they stay in hospital. It's the length of time that they have in that rehabilitative process with their families and in that re-engagement in the community and to be a full-up member economically, socially, spiritually in each community everywhere.

The Marine Corps and the Navy take a much different view than the Army, and we think that we need to get them out of that care facility environment and into that rehabilitative environment that's more community-based and that is run by the line element and their leaders, that in fact have those men and women take care of those men and women, and place them back into those original slots that they have come from if possible, or back into their communities, so that they can learn many of the things that you learned at the VA hospital in Michigan.

So I think that what I see as different is that we're no longer hiding people away or putting you in a position where you are, I won't say warehoused, but you are at least put away, and then you reemerge into your communities and into societies wondering if in fact you are going to be fully received back into those areas. We've merged those systems now. When you're wounded, not only are you off the battlefield quicker, not only are you back to a definitive care facility faster because of the great work that we do across Army, Navy, Air Force medicine, but we also make sure that as you get into the definitive care facilities we bring your families and we include them from day one in that care. That also extends as we transition to the VA to make sure that your family and you also have an opportunity to do that.

So it's a completely different model, but I think it is trying to in fact do the same things, and that is to make sure that when you go out you are prepared to re-integrate into your communities and become productive citizens and reestablish yourself for the future.

One last comment. The only thing that you point out and underline dramatically is this: wounds of war which are incurred during battle in a time sphere become the responsibility of the military health system and Department of Veterans Affairs for the lifetime of the member and that member's family. That means that the

wounds of war of 2006, 2007, and 2008 will be the responsibility of all of us sitting here through the out-years in 2040 and 2050. So we have to prepare for that and we have to take care of those individuals.

DOD/VA COORDINATION

Chairman INOUYE. Thank you.

General ROUDEBUSH. Sir, you frame both a compelling argument and a compelling challenge. To the extent that we are meeting that today, I offer two quick observations. One, we do not even begin the disability evaluation process until we believe the individual has recuperated and recovered to the full extent, and there is time involved in that and we are willing to invest that time.

As part of that time involved, the wounds that we're seeing are not singular in many cases; they are multiple. An amputee probably has some aspects of traumatic brain injury, some aspects perhaps of post traumatic stress disorder or PTSD. So we have to approach each individual holistically and work those issues through.

Now, as we do that, my two observations: One, we have been I believe wonderfully assisted by our centers of excellence. Walter Reed has done a magnificent job of really centering the care of amputees and the Fisher Foundation in building the Center for the Intrepid in San Antonio really begins to get at a number of those issues you talked about: How do you function within a living environment, an apartment, a house? How do you ambulate? How do you interact?

They have done I think wonderful service to our men and women in assisting with that. And our centers of excellence at Bethesda in terms of head injuries. As we work through this, it really is a joint and collaborative issue.

But I would leave you with one observation. My wife's uncle, a delightful gentleman who now resides in Phoenix, was injured when a German 88 blew up in his bridging squad bridging a river in World War II. He was never the same after that injury in terms of his physical capabilities and had significant issues through life.

But he has been a tremendous force in our family, just as you have been a tremendous force in our Nation, perhaps based on some of those experiences and perhaps based on perspectives coming from a position that is different than others who might be walking down the street.

So I think we need to listen very carefully. We need to honor, we need to respect, and we need to support. I think Admiral Robinson has it just right. This is our challenge, but this is our duty.

Thank you, sir.

Chairman INOUYE. Gentlemen, I thank you.

Do you have any questions, Senator?

Senator COCHRAN. Mr. Chairman, I have no questions. This has been an excellent hearing. I thank you.

Chairman INOUYE. I thank you very much, gentlemen.

Now the second panel, the important one.

I'd like to welcome back: Rear Admiral Christine Bruzek-Kohler, Director of the Navy Nurse Corps, also Major General Patricia Horoho, Chief of the Army Nurse Corps, and Major General Kimberly Siniscalchi, Chief of the Air Force Nurse Corps.

There are many things I'd like to say at this point, but it's been my pleasure to work with all of you for many years. I'd like to extend my congratulations to Admiral Bruzek-Kohler, who has been selected to serve as the first Nurse Corps officer ever to be in command of Navy Medicine West and Navy Medical Center—San Diego, along with her continued role as Corps Chief of the Navy Nurse Corps. I look forward to listening to your testimony.

So may I call upon the Admiral first.

STATEMENT OF REAR ADMIRAL CHRISTINE M. BRUZEK-KOHLER, DIRECTOR, NAVY NURSE CORPS, UNITED STATES NAVY

Admiral BRUZEK-KOHLER. Good morning, Chairman Inouye, Vice Chairman Cochran, and distinguished members of the subcommittee. As the 21st Director of the Navy Nurse Corps, I am honored to offer my testimony to you and your esteemed colleagues. My written statement has been submitted for the record and today I would like to highlight some of the remarkable work being accomplished by Navy nurses.

The role of Navy nursing is unquestioned in today's Navy. We are at the forefront of all operations, and are accepted as mission essential within Navy medicine in support of the Navy and Marine Corps. Under my leadership, we have developed a model of professional military nursing, the essence of nursing relevance and practice in the Nurse Corps today. Built upon a solid foundation of clinical skills, Navy nursing encompasses clinical specialization via advanced education and certification, operational readiness, and leadership development.

When combined, these yield clinical nursing leaders and future executives for Navy medicine who are business-savvy, operationally experienced, and clinically adept. These nurses can and will impressively lead our people and organization into the future.

As Navy nurses, we are renowned for our steadfast commitment to our patients, and respected for our impressive ability to collaborate with a host of other healthcare disciplines. We are integral in the provision of superb care to America's fighting forces, their families, and the retired community.

While we are a corps of many specialties, I have identified eight which are the critical wartime mission essential specialties: medical/surgical, psychiatric/mental health, critical care, perioperative, emergency/trauma, maternal-child, certified registered nurse anesthetists, and nurse practitioners. Of all of these, medical surgical nursing is the bedrock of our practice. For this reason, it is my expectation that all nurses in the Navy Nurse Corps maintain their clinical relevance in medical surgical nursing, particularly if they function in purely administrative roles.

Our total Navy nursing workforce is composed of over 5,500 active, Reserve, and Federal civilian nurses. Our active component manning is at 96 percent. For the third consecutive year, I am proud to share with you that the Navy Nurse Corps has met its active duty direct accession goal and, as we heard from my Surgeon General, for the first time in over 5 years Navy Nurse Corps gains have outpaced our losses.

In speaking with Nurse Corps officers, I have found that their engagement in local recruiting initiatives from elementary schools

to colleges, opportunities to provide nursing support via disaster relief and humanitarian assistance missions, and pursuit of advanced education via our Duty Under Instruction Program have all contributed to their decision to stay Navy.

While recruiting to the active component remains robust, manning in the Reserves is of concern to me and my Reserve component deputy director, Rear Admiral Cynthia Dullea, who is here with us today. Despite meeting 107 percent of the recruiting goal in 2008, deficits from shortfalls in the 3 previous years have led to challenges in filling junior officer billets. To that end, Reserve component recruiting initiatives will be targeted toward these vacancies.

Last year we saw the release of a new retention initiative, the registered nurse incentive specialty pay (RNISP), uniquely designed to incentivize military nurses to remain at the bedside providing direct patient care. We targeted RNISP eligibility toward our critical wartime undermanned specialties with inventories of less than 90 percent.

This year we were able to expand the RNISP to include psychiatric/mental health nurses and nurse practitioners, women's health nurse practitioners, and certified nurse midwives. In the future I look forward to being able to offer an incentive such as this to all of my nurses practicing within their specialties.

In addition, targeted recruiting efforts for both active and Reserve assets will be focused not only on the acquisition of medical/surgical nurses, but also on fortifying high operational tempo communities of critical care and perioperative nurses and family nurse practitioners.

Recognizing the efforts of those who diligently serve our beneficiaries when Navy nurses deploy, we have recently implemented two innovative programs to expand the professional development of our valued Federal civilian registered nurses. One of these programs offers training in perioperative nursing, augmenting a high-deploying critical nursing specialty and providing service continuity to patients at our military treatment facilities.

The graduate program for Federal civilian registered nurses provides funding for competitively selected candidates to pursue their master of science degree in nursing, adding to our pool of clinical nurse specialists who help mentor and train our junior nurses and hospital corpsmen.

I remain an ardent supporter of the Tri-Service Nursing Research Program (TSNRP), and am duly committed to its sustainment. Navy nurses throughout our military treatment facilities are engaged in research endeavors that promote not only the health and wellness of our servicemembers, but that of their families as well.

Nurses have always been recognized for their expertise in disease prevention, health promotion, and patient education. The melding of Navy nurses' clinical proficiency in the aforementioned areas, and their keen operational focus, ensures success in Navy deployments and encounters in rural isolated villages with impoverished communities.

My nurses are agile, adaptable, capable, and ready to deploy. The Navy's newest nurses graduating from the Officer Development

School in Newport, Rhode Island, eagerly inquire how soon they might deploy after reporting to their very first command. All of my nurses from ensign to captain, because of their clinical relevance, have the potential opportunity to deploy. Today's deployment environments involve locations in harm's way and include practice settings that require the application of clinical expertise in a myriad of areas.

Line-type commanders recognize our nurses' value immediately and champion their assumption of key operational leadership roles previously held by other professional corps and services. Recently returned from deployment as the officer in charge of the combined joint task force cooperative medical assistance team in Afghanistan, a Navy pediatric nurse practitioner offered and I quote "I would be willing to redeploy to an operational setting and endure separation from my family and even sacrifice my safety because of the overwhelming sense of fulfillment that I received in helping empower the women of Afghanistan. Even the smallest changes that we made to increase their education, economic stability, and improve their health will ultimately make a profound difference in their lives and that of their children."

A Navy nurse deployed as an individual augmentee assumed the role of team leader for an embedded training team in Kabul. She served as a mentor to a senior nursing leader of the Afghan National Army and was instrumental in the development of a variety of educational programs for over 80 military nurses and 140 health aides. She shared that she and her team empowered these nurses to become not only teachers, but leaders, and in doing such they became role models to others within their organization.

The maturity, sense of personal fulfillment and confidence of having done something that their peers have not done is readily identifiable among my nurses returning from these unique deployments. From the way they act, talk, and perhaps even the swagger in their walk, one can tell that they have returned with experiences foreign to many, accomplished goals unrealized in the past, and matured in a way years could never have provided. Indeed, they are forever changed.

However, in order to remain resilient we are committed to ensuring they have access to all resources via our Care of the Caregiver Program and can continue to live in a healthy manner as members of our corps.

Last year we celebrated the 100th anniversary of the Navy Nurse Corps. Within the next century we have identified what we must do to continue to prepare our nurses to deploy in any environment to care for America's heroes. We are not the same Nurse Corps of our ancestry. We are moving into assignments and uncharted roles that were never held by Navy nurses before.

For example, within this coming year a Navy nurse will become the first nurse assigned to headquarters, Marine Corps. Are the marines in for a surprise.

We are models of interoperability as we function seamlessly in missions beside our sister services on land, sea, and air. Our skillful integration and translation between services is perhaps best exemplified in this last vignette. At the conclusion of one of my nurses' briefs in Afghanistan during a transfer of authority be-

tween incoming and outgoing personnel, a colleague turned to her and said: "While you might not have learned a lot of Dari while you were here, you can sure speak Army well. Hoo-ah."

PREPARED STATEMENT

I appreciate the opportunity to share some of these accomplishments of my wonderful nurses and I look forward to continuing our work together as I lead Navy nursing. Thank you.

Chairman INOUYE. Thank you very much, Admiral.

[The statement follows:]

PREPARED STATEMENT OF REAR ADMIRAL CHRISTINE M. BRUZEK-KOHLER

OPENING REMARKS

Good Morning, Chairman Inouye, Senator Cochran and distinguished members of the subcommittee, I am Rear Admiral Christine Bruzek-Kohler, the 21st Director of the Navy Nurse Corps. Nursing relevance and practice is the Navy Nurse Corps of today. Navy nurses are inculcated into our organization based on the development of a solid clinical skills foundation. It is my expectation that all nurses in the Navy Nurse Corps maintain clinical relevance from the day they are commissioned until the day they retire.

Today I will highlight the accomplishments of a total Navy Nurse Corps force composed of over 5,500 active, reserve and federal civilian nurses who play an invaluable role in Navy Medicine as clinicians, mentors, teachers, and leaders. We are renowned for our steadfast commitment to our patients and respected for our impressive ability to collaborate with other healthcare disciplines in the provision of superb care to America's fighting forces, their families and the retired community.

CLINICAL EXCELLENCE/READINESS AND CLINICAL PROFICIENCY

My goal is to establish a culture of clinical excellence for all nurses in all missions and support a consistent, interoperable standard of nursing practice throughout Navy Medicine, one that easily transitions to interoperability as we work more and more collaboratively with our sister services. We assessed the current state of clinical proficiency in various nursing specialties and developed and delivered standardized nursing core competencies. These competencies transition to all nursing practices throughout Navy Medicine ensuring clinical proficiency. Competencies in the nursing fields of medical/surgical, emergency/trauma, psychiatric/mental health and critical care have been deployed throughout Navy Medicine for almost a year. We are currently developing competencies in the following practice areas: neonatal intensive care, maternal infant, pediatrics, perioperative, multi-service ward, operational nursing, case management, and immunizations.

TRAINING

Today's Navy nurses face unprecedented challenges in caring for America's returning wounded warriors. They are confronted with injury and wound complexities that they have never seen or treated before. From the moment the service members reach our medical facilities until the day they are discharged home with their families, Navy nurses have served as a galvanizing force among a cadre of healthcare professionals in helping the wounded, ill and injured successfully transition to a life post combat.

Navy nursing is spearheading the development and implementation of the Combat Wound Initiative, composed of two programs: Complex Wound and Limb Salvage Clinic (CWLSC); and, Integrated Wound Care Programs at Walter Reed Army Medical Center (WRAMC) and National Naval Medical Center (NNMC). Over the past year, there were approximately 2,000 patient encounters between the two programs. The CWLSC is an advanced, multi-disciplinary wound care center which uses state-of-the-art assessment, testing, and evidence-based treatment for the care of complex wounds in the combat wounded and DOD beneficiary. The CWLSC, a portion of the Combat Wound Initiative, integrates targeted clinical and translational research incorporating advanced technology and treatment, informatics, and tissue banking.

At NNMC, a Navy nurse serves as the Medical Evacuation (MEDEVAC) team leader and expertly orchestrates staffing and equipment decisions which were essential to the safe transportation of over 220 patients on 100 inbound MEDEVAC missions from Andrews Air Force Base to NNMC over the course of the past year.

Our nurse at Fleet Forces Command facilitates a quarterly Tidewater Medical Coordination Council consisting of Type Commander (TYCOM) Medical Leadership and the local Military Treatment Facility's (MTF) executive officer, clinic directors, officers-in-charge, and Operational Forces Medical Liaison Services. The purpose of these meetings is to bring both sides together to ensure fleet Sailors are receiving the care they need in a timely manner and to address any concerns from the MTF perspective.

Navy nursing leaders partnered with the Navy Chaplain Corps to develop and implement the Combat and Operational Stress Control Training for Caregivers course to provide state of the art knowledge to a full range of caregivers in the recognition of deployment related reactions, planning of effective interventions, enhancing caregiver collaboration, and facilitating the use of mental health services for individual service members and military families. Phase one of this training included over 1,500 participants. This year's training is designed specifically to address the deployment experiences of families and is being offered to over 3,000 caregivers at 19 sites worldwide.

JOINT TRAINING AND MUTUAL SUPPORT WITH OTHER UNIFORMED SERVICES AND COUNTRIES

In highlighting perhaps some of the most publicly recognized joint initiatives in which Navy nurses have participated, one must include: the Federal Health-Care Center in North Chicago, the merger of two highly acclaimed Army and Navy medical centers into the Walter Reed National Military Medical Center in the national capital area, and missions aboard the USNS MERCY (T–AH 19) and USS KEARSARGE (LHD 3) and BOXER (LHD 4).

Navy nurses from the Naval Health Clinic Great Lakes diligently work on both local and national level committees with their colleagues from the North Chicago VA Medical Center (NCVAMC) in preparation for the merger of the two facilities to become the first Federal Health-Care Center in 2010.

Collaborating with medical department members from all three armed services and other partners, the Navy nurses at Joint Task Force National Capital Region Medical (JTF CAPMED) are actively developing the master transition plan to close Walter Reed Army Medical Center, develop the first integrated regional military medical command and expand the National Naval Medical Center into the "world-class" Walter Reed National Military Medical Center.

The nurses at NNMC and WRAMC held two nursing integration kick-off meetings in 2008 to network with their counterparts and strategize plans of actions for the new Walter Reed National Military Medical Center-Bethesda (WRNMMC). These meetings were well attended and the nurses are committed to ensuring the success of this venture.

USNS MERCY (T–AH 19) departed San Diego, California in May 2008 with a 1,000-person joint, multi-national, Military Sealift Command Civilian Mariner, U.S. Public Health Service and non-governmental organization (NGO) team to conduct Pacific Partnership 2008 (PP08). The core nursing team consisted of 40 Navy and five Air Force Nurse Corps Officers. Additional nursing augmentation was provided by 84 colleagues from the Navy Reserves. Supplemental support was available via military nurses from partner nations Australia, Canada, Indonesia, New Zealand, and the Republic of the Philippines, as well as NGO nurses from International Relief Teams, Project HOPE and Operation Smile.

USNS MERCY's Casualty Receiving (CASREC) nursing team processed over 1,900 patients, of which more than 1,500 were admitted. A total of 1,369 shipboard surgeries were performed, with Navy nurses involved in every phase of the operative process. During Pacific Partnership 08 (PP08), the ship's reduced operating status (ROS) perioperative nurse was selected as Medical Advance Team Leader in Chuuk, Federated States of Micronesia (FSM). In this role, he identified prime locations and established logistical support for medical clinics ashore, facilitating the treatment of 12,000 patients in 8 days. In addition, he worked with local and U.S. public health and government officials to contain a deadly outbreak of multi-drug resistant tuberculosis. He coordinated efforts between the FSM President's Office, Chuuk Governor's Office, U.S. Ambassador, and Centers for Disease Control, ensuring that 100 percent of suspected cases were contacted, screened and prescribed appropriate treatment.

Navy nurses also served aboard both USS KEARSARGE (LHD 3) and USS BOXER (LHD 4) as they delivered relief services and provided medical care to over 71,000 patients from eight Latin American and Caribbean nations during Operation Continuing Promise.

COLLABORATION WITH CIVILIAN MEDICAL INSTITUTIONS/COMMUNITIES/OUTREACH

We will soon mark the 1 year anniversary of the merger of the Navy Nurse Corps Anesthesia Program with the Uniformed Services University (USU) Graduate School of Nursing anesthesia program. The inaugural class of this federal nurse anesthesia program will graduate in 2010.

At the Expeditionary Medical Facility, Camp Lemonier, Djibouti City, Djibouti, Africa, our nurses are members of a small surgical team who provide teaching assistance in areas such as laparoscopic surgery, regional anesthesia, and sterilization at Africa Peltier General Hospital, Djibouti via a request the hospital made to the U.S. Embassy and the United States Agency for International Development. While the surgeons focus on teaching laparoscopic techniques, the nurses foster collegial relationships and offer classes on improved sterilization techniques, laparoscopic equipment care and use, epidural catheter placement for surgery and pain control, and caudal anesthesia in pediatrics.

In collaboration with a Chief Naval Operations (CNO) working group, Bureau of Navy Medicine and Surgery (BUMED) and Navy Medicine East (NME), a plan has been approved to redesign a building into a 28 bed long term care facility to house aging Special Category Residents (formerly Cuban Exiles) who receive assisted living or total nursing care on the wards of the Naval Hospital Guantanamo Bay, Cuba. At times, these patients can absorb 50 percent of the naval hospital bed capacity. Navy nurses are working with civilian facilities in the Portsmouth, VA area to obtain requisite training as they move forward with this one of a kind Navy facility. Staffing will consist of a combination of military, civilian and foreign national home health aides.

Senior nursing leaders from Naval Hospital Camp Lejeune join their civilian peers from Onslow County, North Carolina in monthly meetings as partners in the East Carolina Center for Nursing Leadership Robert Wood Johnson Grant for "Partners for Rural Nursing." The grant's objective is to mobilize rural nurse leaders' ability to partner, evaluate, and develop interventions to solve local nursing workforce issues and create healthier communities in eastern North Carolina. The long-term goal of this project is the creation of a permanent county nurse association that will recruit more nurses to the county and increase the overall educational level of the nurses and educators.

DEPLOYMENTS/OPERATIONAL MISSIONS

Coinciding with the advancement of their professional practice is the simultaneous development of our nurses as naval officers who are operationally ready to meet any call to deploy in any mission at a moment's notice. As such, the Navy Nurse Corps continues to be a mission critical asset in supporting Navy Medicine deployments.

From January 2008 to January 2009, 441 Navy nurses have deployed—Active (257) and Reserve (184). They served admirably in operational roles in Kuwait, Iraq, Djibouti, Afghanistan, Bahrain, Qatar, Indonesia, Thailand, Southeast Asia, Pakistan, Guantanamo Bay, Cuba, Germany, and aboard both hospital ships, USNS MERCY and USNS COMFORT, and on grey-hulls such as USS KEARSARGE and USS BOXER. They are part of Provincial Reconstruction Teams (PRTs), Expeditionary Medical Facilities (EMFs) and Flight Surgery Teams. They participate in the Sea Trial of the Expeditionary Resuscitative Surgery System (ERSS) and perform patient movement via Enroute Care at or near combat operations.

Nurses in our Reserve Component (RC) have made significant contributions to operational missions over the past year with Medical Readiness Training Exercises (MEDRETE) in Peru, Suriname, Honduras, and Trinidad and Tobago. Additionally, there are currently 101 RC nurses mobilized to Landsthul Regional Medical Center, Germany.

In Afghanistan, Navy Nurse Corps officers have assumed the role of Officer in Charge (OIC) of the Combined Joint Task Force-101/82 joint Cooperative Medical Assistance (CMA) team. Previously held by Army Medical Officers, this position was most recently held by a senior Navy Nurse Corps officer who was also a pediatric nurse practitioner. The mission of the Cooperative Medical Assistance (CMA) team is to plan, coordinate and execute medical and veterinarian humanitarian civil-military operations across the combined joint operations area of Afghanistan. Under Navy Nurse Corps leadership, the CMA team has mentored and taught over 250 Afghanistan physicians, midwives, and nurses in the past year. Additionally, the CMA team provided direct medical and veterinarian care in over 200 rural villages in hostile areas along the Pakistan border and in Southern Afghanistan. In an effort to fight the overwhelming infant and childhood mortality rates in Afghanistan, the first Navy Nurse OIC of the CMA team authored a U.S. CENTCOM's Humanitarian

Assistance, Disaster Recovery and Mine Resistance grant to fund three projects in Regional Command—East, Afghanistan. Currently in the execution phase, this $50,000 grant will provide medical intellectual capacity building to Afghan healthcare providers in some of the most remote, hostile and rural areas of Afghanistan; directly impacting the lives of Afghan infants and children.

We continue to monitor our deploying specialties within the Navy Nurse Corps. While earlier deployments were more aligned with our critical wartime specialties of certified registered nurse anesthetists, advanced practice nurses, psychiatric/mental health, medical/surgical, critical care, perioperative and emergency/trauma nurses; we have noted the communities of pediatrics and women's health are also being engaged for roles on Provincial Reconstruction Team and Humanitarian Assistance missions.

CARE OF THE CAREGIVER

Navy Medicine leaders have recognized that operational and occupational demands impact the quality of patient care and caregiver quality of life. Consequences of untreated cumulative stress can result in medical errors, physical illness, decreased job satisfaction, and emotional difficulties. The Navy Medicine Caregiver Occupational Stress Control (OSC) Program, sometimes called Care for the Caregiver, has three fundamental principles; early recognition, peer intervention, and connection with services as needed. There are many strategies and resources that are being developed to assist Navy Medicine caregivers with the operational, occupational, and compassion demands of the care we provide to Sailors, Marines, and their families. One of the main strategies for addressing the psychological health needs of our caregivers is to develop occupational stress training and intervention teams for our major treatment centers.

THE WARFIGHTER, THEIR FAMILIES AND THE CONTINUUM OF CARE

Navy nursing encompasses the care of warriors and their families in countless interactions in locations at home and abroad.

THE WARFIGHTER

A Nurse Corps officer at Naval Medical Clinic Patuxent River plays an invaluable role in their local ongoing Individual Augmentee (IA) pre-deployment program by ensuring that all medical records are pre-screened as soon as the active duty member receives IA orders. This early screening affords sufficient time to explore potential deployment medical disqualifiers and provides the squadron's time to identify an alternate in the event the augmentee is deemed non-deployable.

The Department head of the Occupational Health Clinic at Naval Hospital Camp Lejeune, a civilian nurse, along with the local military audiologist, identified that a significant number of 17–27 year old active duty members were being fitted bilaterally for hearing aids after returning from war. This led to the inception of a new initiative called "Warriors Silent Wound" hearing conservation program addressing readiness, education and hearing protection for the Camp Lejuene based Marines.

The Medical Rehabilitation Platoon (MRP) Case Manager position at Camp Geiger, Branch Medical Clinic, Naval Hospital Camp Lejeune is held by a Nurse Corps officer who coordinates the care for over 80 Marines, ensuring that every patient in MRP receives accurate and timely healthcare reducing the time spent in MRP and increasing the amount of Marines returning to training and eventually to the Fleet Marine Force.

A Navy Nurse Corps officer currently runs a Warrior Return Unit at Expeditionary Medical Facility Kuwait for injured/ill warfighters. Located on Camp Arifjan and initiated in 2005, its mission is to maximize the quality of life for coalition forces during the period of convalescence, expediting return to duty or transfer to definitive care. The Warrior Return Unit (WRU or "Roo") is a three-building complex, 136 bed capacity, dedicated solely for the purpose of providing a place for service members to live, relax, and heal from their illnesses, injuries, or surgical procedures and, ideally, return to duty. The WRU also provides an entertainment lounge, DSN lines for business or morale calls, gaming stations, and internet access, as well as 24 hour staffing, with a nurse on site and dedicated transportation to and from the hospital. Approximately 80 percent of all wounded warriors do indeed return to duty from the WRU and almost three-quarters of them return directly back to Iraq. Those who cannot return to duty are medically evacuated to Landsthul Regional Medical Center or back to Military Treatment Facilities in the continental United States (INCONUS).

At NNMC, the Casualty Affairs Office consists of a Navy nurse and a Hospital Corpsman. They meet with every combat casualty and their family in order to in-

sure all of their needs are met; allowing them to focus solely on the healing process. The Casualty Affair Office employs the ethos "their feet never hit the ground"; referring to the fact that no request goes unnoticed for the 110 patients and families they have met in the past year.

GROWING MENTAL HEALTH REQUIREMENTS/PSYCHIATRIC AND MENTAL HEALTH NURSING

The Navy Nurse Corps has met the Surgeon General's guidance for psychiatric/mental health nurse practitioners (PMHNPs). We have programmed 18 PMHNPs through the Future Years Defense Plan (FYDP) to meet currently projected growth of the Marine Corps, Blue in Support of Green (BISOG) and the development of the Operational Stress Control and Readiness (OSCAR) teams.

Our psychiatric nursing leaders are critical members of the multidisciplinary team writing the maritime doctrine for combat and operational stress control for the U.S. Marine Corps and U.S. Navy. A Nurse Corps officer has been appointed as the first Coordinator for the Line owned and led Navy Operational Stress Control (OSC) program. Secretary of the Navy and the Chief of Naval Operations have directed a Navy stress control program to specifically (1) define doctrine and organization; (2) address mental health stigma; (3) define curricula, develop training and exercise requirements for pre-deployment and post-deployment of all personnel; and (4) build resilient Sailors and families. Operational Stress Control is leader-focused actions and responsibilities to promote resilience and psychological health in Sailors, commands, and families exposed to the stress of routine or wartime military operations in all environments, whether at sea, in the air, or on the ground, and in both operational and supporting roles. The goals of OSC are to create an environment where Sailors, commands, and families can thrive in the midst of stressful operations.

EMF Kuwait mental health nurses are providing outreach training for more than 200 personnel at various units on anger/stress management and improving communication skills. One Navy mental health nurse practitioner from EMF Kuwait forward deployed for a 3 week period into Iraq, backfilling a transitioning Army psychiatrist billet providing mental health services throughout Iraq.

A newly hired civilian mental health nurse practitioner at Naval Medical Clinic Quantico's Deployment Health Center assumes the continuation of care for patients who require more than eight encounters at the center, providing continuity of care and bolstering patient/provider rapport.

The newly opened Post Deployment Health Center in Groton, CT, part of the DOD initiative to respond to mental health needs of returning veterans, provides individual and group counseling services to active-duty members from all branches of the military from throughout the Northeast. Prior to the opening of this clinic, patients would have had to travel as far as Bethesda, MD for this same type of care milieu.

The first active duty PMHNP assigned to the Deployment Health Center at Naval Hospital Twentynine Palms, closely follows 80 of the clinic's 225 active cases.

She provides initial psychological evaluations, medication screenings, and shares valuable information with colleagues, general medical providers, and commands on recommendations about service members' fitness for deployments. She also serves as the clinic spokesperson and is closely involved with the family advocacy program and substance abuse counseling center, ensuring that information is provided to dependents as well as the active duty member. This PMHNP candidly offers that this has been her "most fulfilling job in the Navy".

THE FAMILY

Last year, several Outside Continental United States (OCONUS) and geographically remote Continental United States (CONUS) military treatment facilities (MTFs) received fourteen junior Nurse Corps officers who attended our new 4 week Perinatal Pipeline training program at Naval Medical Center San Diego, Naval Medical Center Portsmouth, and National Naval Medical Center. The program was designed to train medical-surgical nurses who expect to work in labor and delivery or the newborn nursery at OCONUS or geographically isolated facilities. This program has increased the nurses' knowledge, confidence, and subsequently the quality of care and patient safety for these commands. Along this same theme, Naval Hospital Okinawa hosted the Western Pacific Perinatal Orientation Education Program/Neonatal Orientation Education Program (PEOP/NEOP) training for 40 staff from Okinawa, Yokosuka and Guam; yielding over $160,000 in training cost savings to the aforementioned facilities.

At Naval Medical Center Portsmouth, a pediatric nurse practitioner with a passion for early detection and prevention of child abuse identified an opportunity to improve communication between her facility and outside protective services. With

the help of the hospital's web designer, and 2 years of diligent dedication, she created an online algorithm and reporting system nicknamed C.A.N.A.R.E.E.S., which stands for Consolidated Abuse, Neglect, Assault, Reporting Electronic Entry System. This program, presently piloted in the facility's Emergency Department, links to the Composite Health Care System and provides consolidation of all demographic data and patient encounter information into required report formats. This new reporting mechanism alleviates illegible handwriting and streamlines reporting agency notifications. It also serves as a data repository that may be used in quality assurance and statistical analysis to target training or educational offerings as indicated by set thresholds.

THE WOUNDED WARRIOR CARE CONTINUUM

Wounded Warrior Case Management is quite different now than it was 2 years ago. Many of the more severely injured are cared for at one of Navy's large medical centers or at one of four VA Polytrauma centers closest to the service members' homes.

The Wounded Warrior Berthing, also known as the "Patriot Inn," at Naval Medical Center Portsmouth continues to provide temporary lodging, monitoring, and close proximity to necessary recovery resources for active duty ambulatory patients in varying stages of their health continuum.

At Naval Hospital Camp Pendleton, active duty Nurse Corps officers work directly with the Wounded Warrior Battalion to manage the wounded warrior cases, providing a comprehensive plan of care throughout the healthcare system. The patients assigned to this battalion are primarily ambulatory patients who are receiving continuing care for orthopedic or mental health issues.

The Naval Medical Center San Diego's (NMCSD) Comprehensive Combat and Complex Casualty Care (C^5) Program (recipient of the 2008 Military Health System Healing Environment Award) recently expanded its Primary Care division to include two government service nurse practitioners (one former Army veteran), one physician assistant, two civilian health technicians (one former Independent Duty Corpsman) and two Hospital Corpsmen. This group provides continuity in medical management of these service members; ensuring primary health care needs are addressed during their rehabilitation. Recently, the C^5 lead nurse case manager received the prestigious San Diego Regional Chamber of Commerce Military Honoree Award for 2008.

NMCSD is also home to an Army Warrior Transition Unit (WTU), the only one of its kind in a non-Army treatment facility. This staff is comprised of a provider, nurse case managers, licensed clinical social worker and administrative support staff who oversee the medical and non-medical case management of soldiers transferred here for rehabilitation services.

GRADUATE EDUCATION

Continuation of a Navy nurse's professional development via advanced educational preparation, specialization, and pursuit of national certification is necessary to better serve our beneficiary population, as well as strengthen their respective communities of practice and prepare the officer for promotion. Our training plan this year included the opportunity for 70 officers to seek advanced degrees. We focused on fortifying our critical wartime inventories of certified registered nurse anesthetist, psychiatric/mental health clinical nurse specialist and nurse practitioner, and critical care and medical/surgical nursing.

NURSING RESEARCH

I remain an ardent supporter of the Tri-Service Nursing Research Program (TSNRP) and am duly committed to its sustainment. Navy nurses assigned throughout our MTFs are engaged in research endeavors that promote not only the health and wellness of our warriors, but that of their families too. My senior nurse executives have identified creative ways to pique junior officer's interest in research activities.

At Naval Hospital Oak Harbor, a Navy nurse has a research study entitled, "Breastfeeding Rates among Active Duty Military Women across the First Year Postpartum" with Independence University. A novice researcher, she is being mentored in her first endeavor by the Senior Nurse Executive at her command and a nurse researcher assigned to Naval Medical Center San Diego.

The Senior Nurse Executive at NMCSD has implemented the Senior Nurse Executive Nursing Fellowship Awards. This competitive award recognizes two junior nurses/Clinical Nurse Specialist (CNS)/Nurse Researcher team dyads and provides them the resources and man-hours to conduct a year long research proposal. Both

junior nurse/CNS dyads attend research methods or evidence based nursing courses to assist them in the development and implementation of their studies. The results have been quite impressive.

One dyad completed a pilot study to determine whether an educational intervention could be designed to reduce Compassion Fatigue in the healthcare providers caring for C^5 (Comprehensive Combat and Complex Casualty Care) patients. The findings demonstrated that the study participants' scores in compassion satisfaction increased and burnout scores decreased after viewing the Compassion Fatigue intervention. The dyad presented a poster at the Karen Rieder Federal Nursing Poster Presentation titled Compassion Fatigue in C^5 Staff Caring for Wounded Warriors. A study-designed educational intervention was developed from this study and was implemented to 43 staff caring for Wounded Warriors, awarding 172 contact hours.

The second dyad was awarded the Research Award for Best Evidence Based Practice from the Zeta Mu Chapter of the Sigma Theta Tau organization. The proposed project was titled "Implementation of An Open Crib Phototherapy Policy: Adaptation of an Evidence Based Guideline Project". The dyad's work has resulted in the local implementation of the guideline to include standardizing physician order sets and staff education. One member of the dyad has been invited as a presenter to the annual National Association of Neonatal Nurses (NANN) Research Summit.

EDUCATIONAL PARTNERSHIPS

Navy nurses, at our hospitals in the United States and abroad, passionately support the professional development of America's future nursing workforce by serving as preceptors and mentors for a myriad of colleges and universities.

Because of the vast array of clinical specialties available at our medical centers at Bethesda, Portsmouth and San Diego, they have multiple Memoranda of Understandings (MOUs) with surrounding colleges and universities to provide clinical rotations for nurses in various programs from licensed practical/vocational nursing, baccalaureate, and graduate degrees which include nurse practitioner and certified nurse anesthetist tracks.

Not to be outdone, nurses at our smaller facilities such as Naval Hospital Twentynine Palms, Beaufort, Bremerton, Charleston, Cherry Point, and Guam coordinate training opportunities with local hospitals in resuscitative medicine, medical/surgical and obstetrical nursing and serves as clinical rotation sites for local colleges.

During Pacific Partnership 2008, Navy nurses from USNS Mercy (T–AH 19) served as subject matter experts to nurses in five host nation hospitals on topics such as basic and advanced life support, critical care and pediatric nursing, isolation techniques, and blood transfusion therapy. In total, at least 200 hours of classroom instruction were presented to over 1,000 students.

Navy nurses deployed to the Expeditionary Medical Facility, Camp Lemonier, Djibouti City, Djibouti, collaborated with the Djibouti School of Nursing to review nursing fundamentals and discuss nursing issues important to Djibouti nurses as part of an English language skills enhancement class.

NURSING PUBLICATIONS

Navy nurses are accomplished authors whose works encompass all specialty areas of nursing and have appeared in nationally recognized publications as follows: Advances in Neonatal Care, AORN Journal, Critical Care Nursing Clinics of North America, Journal of Advanced Nursing, Journal of Forensic Nursing, Journal of Pediatric Healthcare, Journal of Psychosocial Nursing, Journal of Trauma Nursing, Nursing Administration Quarterly, Military Medicine and Viewpoint.

PRODUCTIVITY INITIATIVES

At Naval Hospital Lemoore, Nurse Corps officers in the Primary Care Clinics spearhead various clinical functions such as telephone triage, dysuria protocol, and newborn infant well-baby visits saving approximately 80 appointments per month for higher level providers and yielding improved access to care for patients.

A Navy nurse midwife who serves as both the Director of Health Services and the Department Head of Obstetrics and Gynecology at Naval Hospital Charleston was also the second highest provider in patient care encounters compared to peers who practice at the same facility.

A women's health nurse practitioner at Naval Hospital Beaufort is solely responsible for the women's health visits of 4,000 female recruits. Other nurse-run clinics at this facility medically in-processed 22,234 Marine recruits and administered over 154,000 immunizations.

FORCE SHAPING/RECRUITMENT AND RETENTION

Recruitment

Today's Navy Nurse Corps (AC) is 95.7 percent manned with 2,780 nurses serving around the globe. We expect to make Navy Nursing's recruiting goal for 2009 within the next few months and this will be the third year in a row that we have achieved this important milestone. Our recruiting efforts this year have outpaced those of 1 year ago. Our nurses' diligent work and engagement with local recruiting initiatives have certainly contributed to these positive results.

The top three programs that we should credit to this accomplishment include the increases in Nurse Accession Bonus (NAB) now at $20,000 for a 3 year commitment and $30,000 for a 4 year commitment; the Health Professions Loan Repayment Program (HPLRP) amounts up to $40,000 for a 2 year consecutive obligated service and the Nurse Candidate Program (NCP), offered only at non-Reserve Officer Training Corps (ROTC) Colleges and Universities, which is tailored for students who need financial assistance while in school. NCP students receive a $10,000 sign on bonus and $1,000 monthly stipend. Other factors contributing to our recruiting success include the location of our duty stations and the opportunity to participate in humanitarian missions.

Last year we created a Recruiting and Retention cell at the Bureau of Medicine and Surgery (BUMED) with a representative identified from each professional corps. These officers serve as liaisons between Navy Recruiting Command (NRC), Naval Recruiting Districts (NRD), Recruiters and the MTFs and travel to and or provide corps/demographic specific personnel to attend local/national nursing conferences, or collegiate recruiting events. In collaboration with the Office of Diversity, our Nurse Corps recruitment liaison officer coordinates with MTFs to have ethnically diverse Navy personnel attend national conferences and recruiting events targeting ethnic minorities. This has allowed us to broaden our reach and recruit at national nursing conferences that we never before attended.

The Nurse Corps Recruitment liaison officer works with a speaker's bureau comprised of junior and mid-grade Nurse Corps officers throughout the country who reach out to students at colleges, high schools, middle and elementary schools. We recognize that the youth of America are contemplating career choices at a much younger age than ever before. Over the course of the past year, we have tailored more of our recruiting initiatives to engage this younger population. Our nurses realize that each time they speak of the Navy Nurse Corps they serve as an ambassador for our corps and the nursing profession too.

Since returning from Pacific Partnership 08, USNS MERCY (T–AH 19) has collaborated with the Navy Recruiting Region WEST Medical Programs Officer to host two recruiting tours. In total, 40 potential Navy Medicine candidates visited the ship. Both the USNS MERCY and USNS COMFORT are invaluable tools in the Nurse Corps recruiting arsenal. Shipboard tours are frequently requested by faculty and students alike.

Naval Hospital Camp Lejeune, in conjunction with Navy Recruiting District Raleigh, NC, has initiated a joint effort to recruit Nurse Corps officers from the Eastern North Carolina area. In supporting the Nurse Corps recruiting and retention initiatives, Naval Hospital Camp Lejeune has created the Nurse Recruiting and Retention team. The team, co-chaired by two senior Nurse Corps officers works closely with the medical department recruiter to coordinate visits to area universities to speak with students regarding benefits of joining the Navy Nurse Corps. The team members also provide real life testimony to the students and provide insight into the personal experiences of team members. The team also serves as points of contact for interested students and is available to entertain questions or concerns via email or telephone. This mentoring provides yet another example of why the Navy Nurse Corps is so attractive to the students. The team encourages and sponsors visits to the Naval Hospital and gives them the opportunity to see Navy nurses, civilian nurses and hospital corpsmen working together to provide world class care. The team also supports the Recruiting District by coordinating and conducting the personal interviews required as a portion of the Nurse Corps application process. Since its inception in September 2008, this effort has led to 25 potential Navy Nurse Corps officers accessioned into the recruiting pipeline for NRD Raleigh, North Carolina.

A senior Nurse Corps officer at Fleet Forces Command serves as a liaison between the fleet shore-based Sailors and the MTF. She and other officers around the world have become mentors to the Medical Enlisted Commissioning Program (MECP) applicants. The MECP program is a robust enlisted commissioning track that selects and educates 55 Sailors and Marines to become Navy nurses each year.

Last year the Navy Nurse Corps reserve component (RC) met 107 percent of their recruiting goal. Over 56 percent of the goal was comprised of NAVETS (nurses coming to the RC from active duty) and the remainder were direct accessions to the Navy Reserve. Success in recruiting NAVETS is related to the initiation of an affiliation bonus of $10,000 and the policy that guarantees NAVETS coming into the RC will be granted a 2 year deferral from deployment. Recruiting initiatives targeting direct accessions offer entry grade credit for advanced education and work experience among the critical wartime specialties of psychiatric/mental health, emergency room, and perioperative nursing. The RC recruiting shortfall in fiscal year 2005, 2006, and 2007, coupled with the national nursing shortage and increased competition with both the civilian and federal employment healthcare sectors, had a detrimental impact on filling RC Nurse Corps billets with junior officers.

Today, the Reserve Component is 1,189 nurses strong and manned at 89.1 percent. The last 4 years of missed reserve nurse recruiting goal has impacted critical wartime specialties in nurse anesthesia (59 percent), perioperative (73 percent), and critical care nursing (80 percent) and subsequently contributed to their 145 unfilled billets.

Retention

Recruiting is just one-half of the story for Navy nursing. Retention tells the other important half. Last year was the first time in the past 5 years that the Navy Nurse Corps' losses nearly matched our gains. In talking to Nurse Corps officers around the globe, I have found that we are implementing creative mentoring and leadership programs designed to get the information to the officers before they make a career decision to leave the Navy.

Naval Hospital Bremerton's senior Nurse Corps officers conduct quarterly Career Development Boards for officers at various decision points in their career (first tour, promotion eligible, considering Duty under Instruction, considering release from active duty). Nurse Corps officers also participate with medical programs recruiters in Seattle and Denver to provide tours, interview candidates, answer questions, join them for local college career days and attend conferences.

Naval Medical Center San Diego established a Nursing Retention and Recruitment Committee. There was an exceptional response to the request for volunteers. Members of the committee include a wide cross-section of nurses throughout the command, to include active duty (all ranks), government service, contract, reservists and recruiters. The committee meets monthly and reports to the Senior Nurse Executive.

The Registered Nurse Incentive Special Pay (RNISP) program was a new retention initiative begun in February 2008 and included critical care and perioperative nursing, pediatric nurse practitioners, and family nurse practitioners. We have noted improvements in overall manning percentages for the aforementioned nursing communities. The RNISP program is designed to encourage military nurses to continue their education, acquire national specialty certification and remain at the bedside providing direct care to wounded Sailors, Marines, Soldiers, Airmen and Coastguardsmen. This year the RNISP program was expanded to include four additional communities: psychiatric/mental health nurses, psychiatric/mental health nurse practitioners, women's health nurse practitioners, and certified nurse midwives. Certified Registered Nurse Anesthetists (CRNAs) have been long standing recipients of the ISP, and they are currently manned at 99 percent.

Continuing deployment cycles and Individual Augmentee roles continue to pose a challenge to retaining nurses in our service, yet our fiscal year 2008 Nurse Corps continuation rate after 5 years is 68 percent, up slightly from last year. We continue to work issues to retain mid-grade officers at the 4 to 9 year point of commissioned service.

The Operational Stress Control program has an indirect impact on the shape of the force, military retention, and Navy nurses. By developing and providing education and training opportunities throughout the career of the nurse, "from Accessions through Flag Officer", OSC will build resilience and increase effective responses to stress and stress-related injuries and illnesses. The art of nursing service members and their families through illness to wellness is frequently stressful. Strengthening the resilience of Navy nurses will assure they are better equipped to meet the day-to-day challenges of both naval service and their profession.

Our total Navy nursing workforce, active and reserve components plus federal civilian registered nurses, is over 5,500 strong. Recognizing the invaluable contribution that our civilian nursing workforce provides in regards to continuity of care and access to services for our patients, especially during our deployments, we have established two new education programs exclusively for them.

The Perioperative Nurse Training Program is a competitive program in which federal civilian registered nurses may apply to attend the fully funded 12 week Navy perioperative nurse training program. Upon completion of the training, the federal civilian nurse incurs a 1 year continued service agreement and works in the perioperative setting.

The Graduate Program for Federal Civilian Registered Nurses provides funding for competitively selected federal civilian registered nurses to pursue their Master of Science in Nursing. Selected candidates agree to work a compressed work schedule during the time they are in graduate school and incur a 2 year continued service agreement. Our hope is that these new programs will not only serve to retain our current civilian nurses but also entice new nurses to consider entry into federal service with Navy Medicine.

COMMUNICATION

The overarching goal for communications is to optimize the dissemination of official information that is easily accessible, current, and understood. This has been accomplished via monthly "Nurse Corps Live" video tele-conferences on a variety of topics relevant to our nursing communities, electronic publication of "Nurse Corps News" newsletter and the Nurse Corps webpage.

MENTORSHIP

The development of our career planning guide will serve as a mentoring tool for all nurses. Core nursing mentors will be identified at each command to facilitate mentorship to officers, enlisted members, civilians and students alike.

Naval Hospital Bremerton received the University of Washington School of Nursing's Preceptor of the Year Award for 2008 in recognition of the 14 years that the hospital's clinicians, administration and staff have provided exceptional learning opportunities for all nurse practitioner and certified nurse midwife students.

The Director for Nursing Services at Naval Hospital Oak Harbor is working with local Career Counselors to schedule "board interviews" for Naval Air Station Whidbey Island sailors interested in pursuing careers in Navy nursing via one of our commissioning pipeline programs.

The "Nurse Corps Roundtable" is a forum used by nurses from Naval Health Clinic, Great Lakes with local Navy Reserve Officer Training Corps nursing students, to facilitate their understanding of "life as a Navy nurse." Topics include deployment opportunities, duty stations and assignments, and the unique camaraderie that military nurses enjoy.

The division officer of the inpatient mental health unit at Naval Hospital Camp Lejeune has sparked the interest in mental health nursing in five junior nurses. He established a new mental health nurse teaching program, developed 15 individual lectures and provided individual mentoring over a 9 month period to five new military nurses who will be given an opportunity to gain the mental health subspecialty code. He is helping to change the stigma of mental health nursing to positively reflect a fulfilling and respected form of nursing practice to our young staff.

LEADERSHIP

It is the amalgamation of our officers' clinical skills foundation, education, specialization and operational experiences that develop the highest caliber leaders for Navy Medicine today and in the future.

CDR Michele Kane's work on "Genotoxic and Cytotoxic Carcinogenesis Effects of Embedded Weapons Grade Fragments of Tungsten Alloy Shrapnel" was recognized with awards for best in research by the Association of Military Surgeons of the United States, the Uniformed Services University for Health Sciences top award for Research Excellence from the Graduate School of Nursing, and the prestigious Uniformed Service University Board of Regents Scholastic Award for Research (an award normally reserved for medical students).

The Bureau of Medicine and Surgery (BUMED) has partnered with the Chief of Naval Personnel (CNP, N1) to temporarily assign a Nurse Corps officer to establish the position of Navy Operational Stress Control Coordinator (OSC). CAPT Lori Laraway is responsible for OSC program development and execution across the entire Navy Enterprise and chair's the OSC Governance Board. Networking, reducing duplication of effort and formulating effective lines of communication have resulted in a Navy-wide program that addresses the needs of line leaders, Sailors and families.

Previous team leaders for all Embedded Training Teams (ETT) have been Medical Service Corps Captains, until CDR Judith Bellas was selected as team Lead for Kabul ETT. CDR Bellas was recently recognized for her contributions during this

year long deployment with the Bronze Star Medal. LCDR Keith B. Hoekman, a nurse practitioner, was awarded the Bronze Star Medal while deployed as the Medical Officer for the Provincial Reconstruction Team (PRT) in Ghazni Province, Afghanistan. Additionally, he received a Certificate of Recognition from the Ministry of Health, Kabul, Afghanistan for his community outreach initiatives on Women's Health that ultimately reached 30,000 villagers.

LT Tony Wade from Naval Hospital Camp Pendleton recently received a Navy Commendation Medal with "Combat V" as he was directly responsible for saving Marine lives under austere and dangerous conditions in Afghan in support of the 2/7 Marines. When his trauma bay was hit by a mortar round and the surgeon was incapacitated, LT Wade and two corpsmen continued the trauma treatment for a Marine who had sustained life threatening injuries, their efforts directly resulted in saving his life.

CLOSING REMARKS

Chairman Inouye, Senator Cochran, distinguished members of the committee, thank you again for providing me this opportunity to share with you the remarkable accomplishments of Navy nurses as we partner with our colleagues in meeting Navy Medicine's mission. I look forward to continuing our work together over the course of the next year.

Chairman INOUYE. General Horoho.

STATEMENT OF MAJOR GENERAL PATRICIA D. HOROHO, CHIEF, ARMY NURSE CORPS, UNITED STATES ARMY

General HOROHO. Chairman Inouye, Vice Chairman Cochran, and distinguished members of the subcommittee: It's an honor and truly a privilege to be able to speak before you today on behalf of over 40,000 officers, enlisted and civilians of the Army Nurse Corps. It has been your continued unwavering support that has enabled Army nurses as part of the larger Army medical department team to provide the highest quality of care to all those that are entrusted to our care.

Army nurses are a corps of seasoned combat veterans that are highly trained, highly skilled and highly committed. We deploy an average of 400 to 500 Army nurses a year, so we've moved well beyond lessons learned to lessons applied.

For example, Army nurses in Iraq, in the Iraq theater, who fly medevac with critically wounded patients have developed a set of tactics, techniques, and protocols over the last 7 years that we've codified into an intra-theater flight nursing program, a program we'll sustain for the future. Our flight nurses have decreased the incidence of hypothermia for the patients that fly in the back of these medevacs from 20 percent to less than 5 percent.

On my recent trip to Iraq I was absolutely humbled to see the level of care that is provided to not only our servicemembers, but to coalition forces, contractors, and the detainee populations that we serve. I was told how at the Ibn Sina Hospital that's in Baghdad Army nurses moved patients into the hallways away from the glass windows when the hospital was under mortar fire and covered them with their own bodies so that they were protected. These patients were wounded Iraqis.

Army nurses are partnering with Iraqi nurse leaders to help them begin to rebuild their profession of nursing. The nurses of the 345th Reserve Component Combat Support Hospital established training programs on the fundamentals of emergency nursing and subsequently are providing medical diplomacy at the most crucial interface, between two nursing cultures.

During this year of the noncommissioned officer, I want to share a story with you about a particular NCO that established an automatic external defibrillator (AED) program for the entire Iraq theater. This NCO recognized the need to have emergency cardiac care equipment in theater that provides our soldiers with the same standard that we offer in the United States. He created the theater-wide policy that mandated easy accessibility to AEDs. This NCO had an opportunity to put into action his own policy when he encountered a sergeant major that was in cardiac arrest. He quickly responded with the AED and saved the sergeant major's life.

I'd like to introduce to you Sergeant Major Brewer, who's in the audience today. He is my sergeant major—could you please stand. He is my Corps sergeant major and is returning from his second deployment in Iraq. We could not be more proud to have him as part of our team.

Furthermore, I would like to highlight the nurse case management program at Camp Cropper and Camp Bucca detainee camps in Iraq, built and managed by our NCO licensed practical nurse Army nursing team members. To date the program has provided specialized medicine care for over 1,000 Iraq detainees requiring case management care for diabetes, hypertension, and medical management. I am proud of the Army nursing team as they shape the face of deployed nursing.

We are sustaining best practice strategies to provide standardized nursing care from the combat zone to an Army medical treatment facility, through the warrior transition unit, all the way into our VA hospitals.

The Army Nurse Corps is undergoing the most massive transformation that I've seen in my 25 years on active duty. We're using the first-ever Army Nurse Corps campaign plan to operationalize a Nurse Corps that consistently achieves performance excellence, fosters innovation, builds knowledge and capabilities, and ensures organizational credibility and sustainability. We are piloting an inpatient and an ambulatory nursing care delivery system that uses best practices and evidence-based data to optimize patient outcomes.

These pilots are already showing improvements in staff satisfaction and interdisciplinary communication. We're also incorporating data from the military nursing outcomes database study, as well as evidence-based research from the Tri-Service Nursing Research Program, funded studies of which we are extremely grateful for your support into our practice, to reduce the incidence of care indicators like patient falls and medication errors.

We are standardizing nursing care delivery systems to decrease patient variance and improve patient outcomes. For example, nurses at Walter Reed Army Medical Center collaborated with our VA nurse colleagues to develop the first-ever evidence-based nursing transfer note that is electronically exported to a web-based portal, allowing staff to bidirectionally exchange critical patient information in real time. This effort significantly optimized Army and VA nurses' ability to tell the patient's story via the electronic medical record.

We are harnessing the power, the pride and the passion of Army nurses to transform into a corps that by 2012 is leading a culture

of performance innovation and improvement across the entire continuum of care. This is unequaled in the delivery of nursing excellence. We will use the vision to embrace the past, engage the present, and envision the future.

PREPARED STATEMENT

On behalf of the entire Army Nurse Corps team serving worldwide, I'd like to thank each of you for your unwavering support, and I look forward to continuing to work with you. Thank you.

Chairman INOUYE. Thank you very much, General.

[The statement follows:]

PREPARED STATEMENT OF MAJOR GENERAL PATRICIA D. HOROHO

Mr. Chairman and distinguished members of the committee, it is an honor and great privilege to speak before you today on behalf of the nearly 10,000 officers, enlisted, and civilians of the Army Nurse Corps. It has been your continued unwavering support that has enabled Army Nurses, as part of the larger Army Medical Department (AMEDD) team, to provide the highest quality care for our service members, families and all those entrusted to our care.

As I assumed the responsibility of this great Corps, I realized that 4 years as Corps Chief is not much time. Although we cannot eliminate or predict the uncertainty of the future, we are developing a framework to harness every opportunity and manage ambiguity. To this end we have embarked on a campaign plan that will transform the Army Nurse Corps over the next 4 years and prioritize a 15 year blueprint for a vibrant, relevant, and flexible Army Nurse Corps.

The Army Nurse Corps Campaign Plan, which was developed at the first ever Army Nurse Corps Strategic Planning Conference in October, is built around four strategic objectives: Leader Development and Sustainment, Warrior Nursing Care Delivery, Evidence-Based Management and Clinical Practice, and Optimization of Human Capital. It reflects our mission and is aligned with the Department of Defense's, Army's and Army Medical Department's goals and objectives. At the heart of the Campaign Plan is what I call, "the triad of nursing." This triad consists of the active and reserve component officers, Non-commissioned Officers (NCOs), and civilians that make up our great Corps and are vital for ensuring that those who wear and have worn the cloth of our Nation and the families that support them, receive timely, compassionate and high quality care.

Execution of the Campaign Plan will be driven by courage to do the right thing, ingenuity to meet the rapidly evolving battle and medical demands of the 21st century, and constant compassion for those we serve and those with whom we serve.

LEADER DEVELOPMENT AND SUSTAINMENT

The success and sustainability of our campaign plan rests squarely on the shoulders of Army nurse leaders. Accordingly, my first priority is to develop full-spectrum Army nurse leaders through a leader succession plan.

We are creating the next generation of inspiring leaders who are agile in responding to the Army's evolving needs and who have the capabilities and capacities that are required for current and future missions. These leaders will be adaptive to any conditions-based mission, able to provide a persuasive voice at key echelons of influence in the AMEDD, and provide innovative doctrine to blueprint the future of the Army Nurse Corps.

Over half of our Corps has deployed in support of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF). We are leveraging the experience of these returning Army nurse combat veterans to incorporate and codify their lessons learned into our leader training programs and nurse care delivery systems.

Army nurse leaders adapted readily to the intra-theater flight nursing mission in Iraq. Their lessons learned on over 300 missions transporting approximately 500 critically injured patients have been codified into a flight nursing program that includes standardized clinical practice guidelines and patient outcome metrics. Onboard flight nurses decreased the incidence of patient hypothermia during transports from 20 percent to less than 5 percent. One of our Army nurses transported a Soldier who sustained severe burns over 70 percent of his body from a forward surgical team to the 86th Combat Support Hospital (CSH). Last month we heard from the Soldier's wife and three children that he is undergoing full rehabilitation and has made a remarkable recovery. Thanks to our adaptive Army nurse leaders,

we are working to develop the role of the intra-theater flight nurse and codify it with the additional skill identifier of N5.

Army Nurse Leaders are currently commanding two Combat Stress Control (CSC) units in Baghdad and Mosul. In Mosul, the 528th Medical Detachment (Combat Stress Control) is commanded by MAJ Chris Weidlich, a psychiatric nurse practitioner, leading a 46-member team with an area support mission to mentally sustain coalition forces at nine Forward Operating Bases (FOBs) and surrounding areas within the Multi-National Division North (MND–N). Since their deployment from Fort Bragg, North Carolina in March 2008, MAJ Weidlich and his team have led the way in improving far forward mental health assessment and treatment, evaluating approximately 10,000 Soldiers to date. Additionally, they are bringing far forward the latest on mental health resiliency training and assessment of mild Traumatic Brain Injury to over 50 Joint Security Stations (JSS), Military Transition Teams (MiTTs) and Combat Outposts (COP); all while maintaining a 99.4 percent return to duty rate.

Army Nurse Corps leaders are also furthering medical diplomacy aims by continuing to expand Iraqi nurse training partnerships. Nurses with the 345th CSH are helping to re-build Iraq's medical infrastructure by instituting a train-the-trainer emergency nursing program. The first iteration of the "Emergency Nursing Train-the-Trainer Program" concluded its first "Partnership in Patient Care," program with thirteen Iraqi nursing students—four females and nine males. This 6-week course is building sustainability into the Iraqi nurse education program. In the future, these nurses will teach other Iraqi nurses of Salah ad Din Province thereby expanding the expertise of the Iraqi nursing professionals.

345th CSH nurses worked with the local Provisional Reconstruction Team (PRT) to develop, build, and furnish the Iraqi Nursing Skills Learning Lab in the International Business Iraqi Zone (IBIZ). This skills learning lab is known as the "Salah Ad Din Victory Health Care Training Center" and provides classroom space and a separate skills training lab for the Iraqi nursing program and other Iraqi healthcare programs. The training center also facilitates a safe training and collaboration site for both Iraqi medical and nursing professionals and allows our combat support hospital nurses to share knowledge as consultants. This sharing provides the Iraqis with the most up to date nursing education processes that are positively impacting the state of healthcare in Iraq.

While the experiences of deployment produce exceptional nurse leaders, I am concerned about the resiliency and ability of our returning nurses to reintegrate with their families and return to hospital positions where they continue to provide care to wounded warriors—in some cases, the same warriors they helped to resuscitate in theater. Their compassion fatigue is evident when I talk with them, many of whom are on their third and fourth deployments. We are developing retention strategies that allow these caregivers to "take a knee" so they can re-charge their mental, physical, and emotional energies in order to re-engage as Army Nurses.

With respect to leadership training, we currently have 255 new Army Nurse Officers at nine of our Regional Medical Centers receiving individual training and mentoring that emphasizes development and acquisition of clinical deployment skill sets and competencies to bridge the gap between academic preparation and the clinical practice environment. We are leveraging courses such as the Emergency Pediatric Nurse Course and the Trauma Nurse Competency Course (TNCC) to ensure every one of our nurse officers has the right capabilities to deploy in support of any condition-based mission.

Trauma nursing is our core competency. Subsequently we are focusing on emergency and critical care skills required in a disaster or deployed setting to increase the quality of care we provide. To accomplish this, I have directed a top-to-bottom review of all Army Nurse Leader development training programs. This strategic objective emphasizes development of clinical, leader, and deployment skill sets and competencies for Army Nurse Corps personnel as they progress in rank and clinical experience.

Last, we are looking at redesigning the entire leadership lifecycle, from staff nurse through Deputy Commander for Nursing. Our goal is to create a robust program that ensures nurses have the required skill sets and experiences at each step in their careers. This means ensuring that there are appropriate training opportunities phased throughout the lifecycle and a clearly defined job description and associated competencies for each role. In addition, we are looking at a set of potential structural changes to the lifecycle aimed at increasing flexibility and creating new career pathways for our diverse set of nurses.

Warrior Nursing Care Delivery

My second strategic objective is to get back to the basics of delivering high-touch, supported by high tech, nursing care. We are designing nursing care delivery systems that wrap nursing capability around The Surgeon General's goals and mission. I'd like to talk about five special initiatives we are pursuing in support of providing model nursing care.

In our first initiative, we completed a comprehensive evaluation of best practice civilian and federal nurse care delivery systems in order to distill elements into standardized Army Nurse in-patient and ambulatory care delivery systems. For example, nurses at Walter Reed Army Medical Center (WRAMC) are using several patient discharge management tools that are decreasing length of stay, re-admission rates, and improving patient satisfaction. Nurses at Tripler Army Medical Center (TAMC) implemented Relationship Based Care (RBC), a nursing care delivery model, in 2007. This model emphasizes patient and family centered care, a primary-within-team nursing model, as well as well-defined scopes of practice for all nurses. Since implementation of RBC, nursing at TAMC has experienced an increase in both nursing and patient satisfaction, as well as a decrease in civilian nursing staff turnover.

We incorporated several of these perspectives into the professional nursing pilot at Blanchfield Army Community Hospital at Fort Campbell, Kentucky. This pilot combines and capitalizes on care delivery advancements made at individual military treatment facilities (MTFs) and has three aims: develop nursing practice standards across all MTFs, improve patient satisfaction and outcomes, and increase staff satisfaction and retention. These aims will be reached through combining increased nurse autonomy and skill building with structured interdisciplinary communication and patient-centered and evidence-based care. The pilot is still underway, but after only a few weeks there has been a marked improvement in how the nursing staff communicates with their patients and physicians, as well as how they feel their input is valued by hospital leadership. We are implementing results of the pilot across all of Blanchfield's wards, and ultimately to all MTFs, to decrease practice variance and improve inpatient nursing care delivery.

Our second initiative focused on ambulatory nurse role redefinition and developing appropriate, functional nurse staffing models. The Army Nurse Corps ambulatory workgroup developed a primary care staffing model that changes the role of the Registered Nurse (RN) from a reactive, episodic-focused role to a proactive, population-focused role. In September 2008 we initiated a year-long pilot study at Moncrief Army Hospital focusing on nurse role redefinition, staffing mix, and professional nursing care. We were able to develop a model by which patients with unmet medical requirements were targeted by a specific nurse assigned to their case ("My Nurse"), who would then work with the provider to review the patient appointment list prior to appointments and identify tests, labs, x-rays, etc. that a patient may need ahead of time. This not only provides a new role for the clinic nurses, but also expedites the ambulatory care process for both the patient and medical team. Outcome measures for the pilot include improving patient and staff satisfaction, decreased urgent care and emergency rooms visits, improved compliance with Health Effectiveness Data and Information Set (HEDISR), Clinical Practice Guidelines (CPGs) and other health metrics, increased percentage of time seeing their assigned provider and increasing access to care. Initial feedback from patients is that they love the personal attention they receive from "My Nurse" and appreciate having someone they can call with questions or having someone call them to remind them of appointments or follow-up with them with educational materials, etc. The role of "My Nurse" is a paradigm shift in outpatient nursing and will require education and training of all outpatient nurses if identified as a best practice.

Our next initiative is focused on the case management role, both in theatre and stateside. Nurse Case Managers (NCM) remain an integral member of the triad of care in Warrior Transition Units since their inception in April 2007. In addition to ensuring high patient satisfaction with care, NCMs have continued to facilitate other patient care improvements. In October 2008 the Warrior Care Transition Office, in coordination with the AMEDD Center and School conducted the first resident Warrior Transition Unit Cadre Orientation Course. The course is 2 weeks in duration with a 3 day track focused specifically on case management standards and skills. To date, the course has been conducted three times, with over 100 NCMs completing the training. NCMs continue to assist in decreasing the average length of stay for Warriors in Transition.

In the Iraqi Theater of Operations, we established a NCM role aimed at caring for patients who have chronic, complex care requirements. The theater NCM's role includes monitoring average length of stay according to diagnosis, as well as by classification of personnel, such as United States, detainee, contractor, Iraqi Army, Iraqi

Police, and civilian. In addition, the NCM helps facilitate the discharge plan with the physician and the inter-disciplinary team. COL Ron Keene was instrumental in establishing the first Nurse Case Management Program for detainees in a wartime theater with huge patient successes in the management of hypertension, wound care, and even chronic diabetic care management. The dedication of the Army Nurses and physicians focusing on the total care of our chronically ill detainees can be demonstrated by the decrease in admissions for the management of chronic illness by 38 percent. This success has actually enabled reductions in bed requirements at the 115th CSH. Close management of chronically ill detainees follows strict adherence to the DOD/VA Clinical Practice Guidelines (CPG's) which are incorporated in daily detainee healthcare practices. With education and routine contacts, a growing percentage of the detainees have come into greater compliance and medication levels are either reduced or ultimately removed. Detainees are offered customer satisfaction surveys in Arabic and have reflected above average satisfaction with their care—results that rival the best customer satisfaction scores in our premiere Army hospitals. Additionally, Army NCMs insure that Iraqi Imams visit our patients weekly to provide religious support and guidance as a part of their health recovery.

Another Warrior Care initiative focuses on developing a practice model that incorporates the use of our outstanding enlisted corps. At the Bucca detainee hospital, one of the senior NCO Licensed Practical Nurses (LPN's) oversees the 68W (medic) primary care screening of over 14,000 detainees. The LPN ensures that each 68W has completed the Algorithm Directed Troop Medical Care (ADTMC) screening classes and demonstrates a sound understanding of the screening process, documentation and medication administration within the guidelines of the ADTMC scope of practice.

The NCO LPN's are also integral to the new Iraqi nurse partnership. For the first time, an Operating Room and Intensive Care Unit team (includes one NCO/LPN) from one of our small hospitals at Al Kut will be going to one of the local hospitals to help train the Iraqi staff in operating room and post operative care procedures. The RN and LPN team provided hands on demonstrations to the Iraqi nurses helping them improve their clinical practice skills. At the Jamenson Combat Medical Training Center (JCMTC) in Iraqi, 1SG Eric Woodrum volunteered to work in the Air Force hospital Emergency Room to observe Point of Injury care. Those lessons learned were taken back and used at the Jamenson schoolhouse to improve Combat Lifesaver training and patient outcomes.

Last, we are working with other Federal Nursing Service Chiefs to align initiatives and develop compatible practice models. For example, through strong Congressional support, the Army Nurse Corps, along with the Federal Nursing Services Chiefs, started the Psychiatric Nurse Practitioner program at the Uniformed Services University (USU). This program, while providing traditional curriculum, adds clinical training addressing some of the military unique behavioral health challenges and leadership building. The program will pay dividends in the future as we address the behavioral health challenges faced by our Service Members in theaters of operation and after they return home.

We are also furthering cooperation through the Tri-Service Nursing Research Program (TSNRP) to improve trauma and deployment competencies for nurses in all military services. One example of that cooperation is the publication of the evidence-based "Battlefield and Disaster Nursing Pocket Guide". This guide provides a portable, up-to-date, evidence-based source of information for nurses on the battlefield and those responding to disaster or humanitarian situations. TSNRP has provided 7,500 copies of this handbook to both deployed and non-deployed nurses throughout the services. We are also leveraging TSNRP funded research to improve Warrior care delivery. For example: Pain and Sleep Disturbance in Soldiers with Extremity Trauma; Impact of Body Armor on Physical Work Performance; A Comparison of PTSD and Mild TBI in Burned Military Service Members, and Sleep Disturbances in U.S. Army Soldiers after Deployment to Afghanistan and Iraq.

Evidence-based Management and Clinical Practice

Evidence-based management aims to merge best practices in both clinical care and business practice to produce outstanding outcomes. These goals are supported by blending data measurement and analysis and system redesign into the daily performances of all our nurses.

In support of our aims, we are working to train the next generation of nurse researchers by leveraging TSNRP and Army Nurse Corps researchers both stateside and in deployed environments. Developing the expertise of military nursing researchers is paramount to TSNRP's mission, as evidenced through its courses in grant writing, publishing, and advanced research methods. In addition, it is one of

the only research programs to require its investigators to attend a post-award workshop where they are given information pertaining to the regulations of managing a grant. TSNRP provides a very high level of oversight of its awardees, ensuring the research is conducted with the highest rigor. We in the Army Nurse Corps appreciate their dedication to developing nurse researchers of the highest caliber.

Besides training top-notch researchers, we are working to focus our research on improved systems and clinical outcomes, preferably with real-world recommendations that can be easily applied at the patient's bedside. One such research project was the Military Nursing Outcomes Database (MilNOD). Facilitated and implemented as an Army Nurse Corps initiative, MilNOD is the most comprehensive and historical effort of its kind in the United States. Analysis of data from 115,000 nurse shifts established significant associations between nurse staffing and patient outcomes, such as the occurrence of falls and medication administration errors as well as nurse needle stick injuries. Participating MilNOD MTFs decreased patient fall rates by 69 percent, medication administration errors rates by 50 percent and hospital acquired pressure ulcer prevalence by 62 percent, all of which were statistically significant reductions. Participating MTFs also experienced considerable cost avoidance (falls—$900,000/year; medication errors—$230,000/year; pressure ulcers—$450,000/year). As one of the most seminal studies linking nurse care practices with patient outcomes, the study results will be published in an upcoming edition of The New England Journal of Medicine.

Army nursing has made a special effort to support research at all levels, as young researchers of today will become leaders in their fields in years to come. To that end, the nurses of Tripler Army Medical Center (TAMC) started a funded Evidence Based Practice (EBP) research project in 2007 that is now a part of their nursing practice culture. This fiscal year, nurses throughout the facility initiated seven new Evidence Based Practice Projects (EBPP). These studies ranged from improving infection control in ICU settings, to patient satisfaction for pregnant patients on bedrest, to improving communication between nurses on different hospital units. The range of topics studied demonstrates an impressive effort to improve systems while bringing research back to the bedside. I thank our officers, ranging from Lieutenants to Lieutenant Colonels, for their dedication to improving nursing care at every level.

As we move forward with this strategic objective, we are making a special effort to use the power of technology to develop and disseminate best practices throughout the Corps. Integrating technology into best practices has started with ensuring patient safety through proper patient handoffs. Research has demonstrated that smooth, seamless patient handoffs are vital to safe patient care. Nurses at WRAMC in collaboration with the Department of Veterans Affairs (VA) Poly-Trauma Centers have developed a researched based nurse's note that is sent directly to the VA electronic medical record. This nurse-driven project resulted in increased nursing knowledge of patient conditions which enabled the receiving facility to put in place safety mechanisms to improve patient care and diminish risk of patient injury or poor outcomes. This project is one of the first times we have been able to transmit patient data directly from one electronic medical record into another agency's electronic record.

Without dissemination of our collective knowledge, our advances would mean little to the Corps at large. Thus, we have developed a new ANC interactive website that allows for real time exchange of ideas and best practices, and improves communication across the Corps. We are also making a special effort to link research cells at different MTFs to promote Corps-wide collaboration.

Optimization of Human Capital

My final objective, Optimization of Human Capital, is the strategic and coherent approach to the management of our organization's most-valued assets, our people, who individually and collectively contribute to the achievement of the ANC objectives. Investing in human capital requires special attention to the recruitment and retention of our civilian and active duty nurses, while trying to influence the profession of nursing through academic partnerships.

Recognizing that the majority of our organization is our civilian workforce, we are continuing to break down the barriers in recruiting and retaining stellar civilian healthcare professionals. We are committed to streamlining and reducing the gates in the personnel hiring process by setting accountability timelines compared to local averages. To maintain an influence on civilian nursing recruitment and retention, we have placed an ANC Officer in the Civilian Personnel Office in order to partner and facilitate progress on these issues.

We have also started focusing on retention efforts for our civilian workforce. We have been very successful with our civilian nurse loan repayment program which

was initially implemented 2 years ago. For fiscal year 2009, 169 of 186 applicants participated in the nurse loan repayment program. As a result of this program, we will be required to expend fewer resources to recruit and train new nurses. In addition, we have consulted with VA nursing to leverage their concept of clinical ladders for our civilian workforce. We are evaluating how best to use this program to promote clinical leadership opportunities for civilians and establish glide paths for their success in order to retain them on our team.

Turning our focus toward active duty and reserve officers, the Army Nurse Corps has been very successful in recruiting this past year. For the first time in 7 years, United States Army Recruiting Command exceeded mission for both the active and reserve components. Regular Army Nurse Recruiters produced 297 nurse recruits against a mission of 205 and the Army Reserve Recruiters produced 528 nurse recruits against a mission of 362. In addition, the Reserve Officer Training Corps (ROTC) experienced great success this past year and expects the same for the next 2 years. In fiscal year 2008 ROTC was responsible for producing 173 Army Nurses against a mission of 225. This was the highest number of accessions in 10 years. In fiscal year 2009, ROTC predicts a production of 221 Army Nurses against a mission of 225. And in fiscal year 2010, ROTC is projected to exceed their mission of 225 by over 20 nurses (for a total number of 249).

One of our most crucial retention tools is developing a track that will take our ANC officers through a lifecycle that focuses on clinical competencies even at the senior level. We are also evaluating our current force structure to ensure we have the right mix of skills and rank, and that we are assigning based upon capabilities. In addition, one of our most successful programs for retention has been the implementation of Incentive Specialty Pay (ISP) and Critical Skills Retention Bonus (CSRB). To date, 962 (44 percent) Army Nurse Corps officers have taken either the ISP or CSRB.

Looking forward to the recruitment and retention of all our nurses—civilian, active, and reserve—we decided to optimize one of our most important retention strategies: responsive listening to our nurses. Accordingly, I directed dissemination of a Corps-wide organizational survey that asked our nurses what's on their minds. As a result, more than 2,000 Army Nurses identified areas for improvement in Corps performance. A key opportunity area identified is to increase junior officer involvement in setting the Nurse Corps' strategic agenda. In response, we incorporated the voices of Army Nursing's future leaders at our annual "CJ Reddy Junior Leadership Conference", held this past October in Washington, DC. This Conference brings together the most promising junior officers in the Corps for an intensive session built around learning, skill building, and networking. When asked what motivates them each day as a member of the Nurse Corps, these officers answered with five consistent themes: (1) the mission of serving their country and caring for Soldiers; (2) the diversity of opportunities the Corps provides; (3) the Corps' camaraderie and sense of family; (4) the available leadership training; and (5) the abundant rewards and benefits. We believe these five attributes create an unparalleled environment to practice nursing and, under my Human Capital imperative, plan to reinforce each of them to become an even stronger recruiting power.

Last, we feel that to truly optimize our human capital strategy, we must pursue academic partnerships. The professional staff at several MTF's have worked diligently to support the clinical experiences of advanced practice nursing students. In addition, in cooperation with all the Federal Corps Chiefs, we are supporting Uniformed Services University in their active engagement of academic partnerships with nursing leadership organizations and schools of nursing to maintain an active and influential role in the future of nursing in America. Additionally, we are leveraging our retired AN officers, who are professors at a variety of civilian institutions, to serve as nursing role models, mentors, subject matter experts and ambassadors for the ANC.

CONCLUSION

Since becoming Corps Chief last July, I see clearly how to harness the power, passion, and pride of the Army nurses to develop the Army Nurse Corps priorities in support of the national health agenda and our Nation at war. Over the next 2 years we will execute the Army Nurse Corps campaign plan and use it to codify best practices for sustainability. The third year we will begin campaign planning again to ensure we remain relevant and well-postured as a force multiplier for military medicine.

I envision an Army Nurse Corps in 2012 that serves as a model for the Nation, leading a culture of performance improvement across the entire continuum of care that is without peer in the delivery of nursing care excellence—where we measure

our successes in the improvement of healthcare outcomes for patients and families, retention and satisfaction of our staff, and improved stewardship of our precious resources.

I am establishing a culture that evaluates every aspect of traditional practice to ensure that we achieve the desired improvements in our patient's emotional, physical and spiritual well-being. The Army Nurse Corps will be known for the ingenuity and innovation applied to the most challenging opportunities, so characteristic of Army Nurses for the past 233 years. Constant compassion will continue to fuel us, driven by the courage to always do the right thing.

I would like to leave you with a story about one of our nurse heroes. In 2007 we tragically lost a Command Sergeant Major to an apparent heart attack at Camp Victory, Iraq. This incident sparked an NCO to develop and implement a theater-wide Automated External Defibrillator (AED) program. The magnitude of this program was so important that GEN Petraus endorsed the NCO's plan. Just several weeks after the NCO initiated this program, he was confronted with a Soldier who was in cardiac arrest. He used an AED to resuscitate the Soldier, who was treated and sent home to his family. The NCO I've been discussing is SGM Richard Brewer, the LPN I brought into my Corps Chief office to enable my concept of the Army Nurse Triad that includes our LPN colleagues.

I am so proud of our Corps and look forward to speaking with you next year about the progress we've made on our campaign plan. I'll close with our new motto that is the way ahead for the Army Nurse Corps: "Embrace the Past"—leverage our lessons learned; "Engage the Present"—achieve performance excellence; and "Envision the Future"—ensure organizational credibility and sustainability. Thank you.

Chairman INOUYE. Now General Siniscalchi.

STATEMENT OF MAJOR GENERAL KIMBERLY A. SINISCALCHI, ASSISTANT AIR FORCE SURGEON GENERAL FOR NURSING SERVICES, UNITED STATES AIR FORCE

General SINISCALCHI. Mr. Chairman, Mr. Vice Chairman, and distinguished members of the subcommittee: It is an honor to come before you today to represent the United States Air Force Nurse Corps. I am proud to serve alongside Brigadier General Catherine Lutz, Air National Guard; Colonel Ann Manley, Air Force Reserves, and Chief Master Sergeant Joseph Potts, Aerospace Medical Service Career Field Manager. Together we represent a robust total nursing force supporting our Air Force chief of staff's top priorities.

I would like to thank you for your continued support of our Air Force Nurse Corps. Thank you for providing the funding for our accession bonuses, health professions loan repayment and scholarship programs, and our first-ever incentive special pay program. We anticipate the incentive special pay program will positively impact our retention.

Last year 55 percent of our nurses who separated had less than 20 years of military service and 61 percent of those were our young lieutenants and captains. We are diligently working with our Air Force personnelist and our Surgeon General to address and correct this issue. Although the incentive special pay will help retain our nurses, retention may further extend timing and reduce promotion opportunity until we correct our grade structure.

Our enlisted medical technicians, in partnering with A1, secured funds for their critically manned specialties. Our independent duty medical technicians are heavily tasked with deployments and manned at only 72 percent. I along with Chief Potts am eager to see this initiative's impact.

Through your sustained support of our Tri-Service Nursing Research Program, we recently published the "Battlefield and Disaster Nursing Pocket Guide". This guide is utilized throughout our deployed locations.

We continue to conduct state-of-the-art research and validate evidence-based practice. Colonel Margaret McNeil, a Ph.D. Air Force nurse, is in Iraq as a member of the newly deployed combat casualty care research team, exploring advancements in medical therapies for our wounded warriors.

The key to successful peacetime and wartime nursing operations is a robust nursing force, a force with the right numbers, right experience, and the right skills. Recruiting experienced nurses continues to be a significant challenge. Although we reached 93 percent of our accession goal, 56 percent were novice nurses, validating the importance of our nurse transition program. I am pleased to inform you that our first civilian program at the University Hospital in Cincinnati graduated their first class on December 12.

Our enlisted nurse commissioning program grows Air Force nurses from our highly skilled enlisted force. We had our first two graduates this year and we'll have 19 next year.

Air Force nursing is an essential operational capability. In 2008 our total nursing force represented 34 percent of all deployments within our medical service. Our medics deployed to 44 locations in 16 countries. Our total nursing force is well-trained, highly skilled and committed to saving lives. We are called to a mission of caring for America's sons and daughters, and here are a few examples.

Captain James Stewart, a nurse anesthetist, deployed to Joint Base Bilad, received a message from his friend and co-worker Captain Dave Johnson informing him that his son, Army Staff Sergeant Curtis Johnson, had been wounded and was en route to Bilad. Captain Stewart met Curtis on arrival and recalls: "He arrived stable, so we placed a call to his dad so they could talk before we started surgery. Curtis's spirits were high and I was amazed at how well he was taking the loss of both his lower legs." Following surgery, Curtis was aeromedically evacuated to Brooke Army Medical Center and is now undergoing rehabilitation at the Center for the Intrepid.

The commemorative Air Force recognized Captain Bryce Vandersway with the Dolly Vincent Flight Nurse Award for aeromedical evacuation support to 651 sick and injured warriors, including two K9 military working dogs injured by improvised explosive devices (IEDs).

As the trauma nurse coordinator at Joint Base Bilad, Captain Darcy Mortimer recalls her most precious memory: "We simultaneously received five casualties from an IED blast. When the emergency department settled down, the hospital held a ceremony for the soldier we could not save. Two of his wounded comrades requested that their litters be placed so they could salute their fallen comrade and friend."

In the midst of death and heartache, there are stories of hope and joy. This past October, our staff delivered the first Afghan baby born at Craig Joint Theater Hospital, Bagram. The mother sustained massive injuries as a result of an explosion, but with the help of the Air Force medical team she delivered a healthy baby girl. According to Technical Sergeant Jeremiah Diaz: "We had 15 minutes to come up with something. We used a warming blanket

and made a little tent with coat hangers and an egg crate mattress. The newborn's presence was a ray of light."

Mr. Chairman and distinguished members of the subcommittee, thank you for allowing me to share today just a few of the many achievements of Air Force nursing. As our Air Force Medical Service celebrates its 60th anniversary, we recognize and we stand on the shoulders of giants. I commit to you we will continue to meet every challenge with professionalism, pride, and patriotism that have served as the foundation for our success. Our warriors and their families deserve the best possible care we can provide.

It is the nurse's touch, compassion, and care that often wills a patient to recovery or softens the transition from life to death. There has never been a better time to be a member of this great Air Force nursing team.

PREPARED STATEMENT

So on behalf of the men and women of nursing services, thank you for your tremendous advocacy and continued support.

[The statement follows:]

PREPARED STATEMENT OF MAJOR GENERAL KIMBERLY A. SINISCALCHI

Mister Chairman and distinguished members of the Committee, it is an honor and pleasure to come before you to represent Air Force Nursing Services and our Total Nursing Force (TNF). The TNF encompasses officer and enlisted nursing personnel of the Active Duty, Air National Guard (ANG), and Air Force Reserve Command (AFRC) components. The past year has brought many leadership changes to our TNF, and I look forward to serving alongside my senior advisors, Brigadier General Catherine Lutz of the ANG and Colonel Anne Manly of the AFRC. We are glad to have Colonel Manly back after her recent deployment to Joint Base Balad, Iraq where she served as Chief Nurse of the 332nd Expeditionary Medical Group, and saw first-hand the incredible work our nurses and technicians perform daily. Together we will continue to strengthen our TNF by supporting our nursing service personnel as they continue to meet ever-increasing commitments, deployments, and challenges with professionalism and distinction; and supporting the Chief of Staff of the Air Force's (CSAF) top priorities to (1) Reinvigorate the Air Force Nuclear Enterprise, (2) Partner with the Joint and Coalition Team to Win Today's Fight, (3) Develop and Care for Airmen and their Families, (4) Modernize our Aging Air and Space Inventories, Organizations and Training, and (5) Acquisition Excellence.

ORGANIZATIONAL STRUCTURE

On September 29, 2008, the Air Force Medical Service (AFMS) achieved the CSAF"s directive to transform and consolidate headquarters management functions by establishing the Air Force Medical Operations Agency (AFMOA) in San Antonio, Texas. This single support agency was established through an Air Force Smart Operations 21 initiative, and is led by a cadre of experts from across the Air Force Medical Service. They provide premier support and guidance to nine Major Commands (MAJCOM), 75 Military Treatment Facilities (MTF), and 39,000 medics to reduce levels of oversight at the MAJCOM levels. Brigadier General Mark A. Ediger assumed command of AFMOA on September 29, 2008.

This past summer, the AFMOA Surgeon General Nursing (SGN) directorate, led by Colonel Leslie Claravall, in conjunction with the MAJCOM SGNs, successfully transitioned the clinical oversight as well as education and training functions from United States Air Force Europe Command and Air Mobility Command. In May, June, and July of this year, the AFMOA SGN will take on the clinical oversight of Air Education and Training Command, Air Force Material Command and Air Force Special Operations Command respectively. In 2010, the remaining MAJCOM SGN functions will transition to AFMOA. As a result, areas such as education and training, provision of nursing care, inpatient and outpatient, and nursing service resourcing will be centrally located. In short, AFMOA is progressing to a centralized reach-back Field Operating Agency.

BUILDING ENDURING COMPETENCIES

The Air Force Nursing Service Education and Training programs are inherent to, and the foundation of the successful development of our core competencies. The Nurse Transition Program (NTP) is experience by providing hands-on patient care while working side-by-side with nurse preceptors. The program focuses on maximizing skills utilizing real-world patients and minimizing the use of simulation labs. In 2008 we had 10 NTP sites with 212 seats available to novice nurses entering the Nurse Corps with less than 6 months nursing experience. Last year Major General Rank reported the possibility of partnering with University Hospital in Cincinnati, Ohio for our NTP. I am pleased to inform you that our inaugural class of ten students graduated from our first civilian NTP Center of Excellence (CoE) at University Hospital on December 12, 2008. I had the privilege to attend and participate in the ribbon-cutting this past October and I am proud of the phenomenal work course supervisors, Major Chris Berberick and Captain Josh Lindquist, have accomplished. Due to the medical center's trauma census, students were able to acquire 95 percent of the required clinical skills from real-world patients after only 5 weeks into the 11 week course. As a result, we will decrease our Cincinnati course to 9 weeks to accommodate more classes. We have already expanded our total seats available to 241, and will soon add another civilian partner CoE as we open our eleventh site this July with the Scottsdale Healthcare System, in Scottsdale, Arizona. This facility has earned Magnet Status recognition from the American Nurses' Credentialing Center. Magnet status facilities are measured by excellent patient outcomes, high levels of job satisfaction, and low staff turnover. Additionally, they have a proven record of involving nurses in data collection and research-based nursing practice. We look forward to a long and productive partnership with the Scottsdale Healthcare System.

Our enlisted medical technicians, led by Chief Master Sergeant Joseph Potts, are critical to the overall success of our TNF. Our need for highly skilled clinicians continues to rise and we are committed to training and developing enlisted clinical leaders. We continue to enhance our enlisted clinicians through our Critical Care Technician (CCT) Course, based out of Eastern New Mexico University. This program targets medical technicians working in intensive care units (ICU) that have low patient acuity levels, or medical technicians who have previously earned the Critical Care Technician identifier, but no longer work in that clinical setting. We offer twelve classes per year and have doubled the number of rotating training sites from two to four of our larger MTF/Medical Centers. Through this course, we have enabled 115 Airmen to refresh and sharpen their critical care competencies, thus improving quality of care both at home station and abroad.

July 10, 2008 marked another step toward what's being called the largest consolidation of training in the history of the Department of Defense, when the ceremonial groundbreaking service paved the way for the construction of the Medical Education and Training Campus (METC). Currently projected for completion in 2011, METC will serve as a joint campus, co-locating the Army, Navy, and Air Force's five major learning institutions currently spread across four states, into one consolidated medical training facility at Fort Sam Houston, Texas. The development of this tri-service training center will result in standardized training for medical enlisted specialties enhancing interoperability and joint training by educating Soldiers, Sailors, Marines, and Airmen on service-specific capabilities. Chief Master Sergeant Manuel Sarmina, chairman of the METC Tri-Service Enlisted Advisory Committee noted, "America's best and brightest will begin arriving here to work and to train in an environment that will be known and recognized as the premier learning center for our enlisted medical force."

On another front, over the past year David Grant Medical Center at Travis Air Force Base, California has implemented an Optimized Upgrade Training program for nurses. Captain Linda Peavely, who spearheaded the development of this program explains, "Our goal was to increase the knowledge of nurses on medical-surgical units and progress them from the 'competent' to 'proficient' stage of nursing practice." Students participate in both didactic and clinical training in the intensive care unit. The result has yielded many additional benefits including improved wartime readiness skills, increased clinical capability and care of higher acuity patients, improved communication among staff, and recaptured revenue by decreasing the need to transfer patients. To date, David Grant Medical Center has produced 33 graduates, many of whom have recently returned from deployment and commented on how much more prepared and confident they felt stepping into the wartime environment as a direct result of this program. In January, Captain Peavely's hard work paid even more dividends when the Air Force Personnel Center, Nursing Education

Branch, recognized this training platform as an official Air Force course, granting 92 hours of education credits to each graduating student.

The Uniformed Services University of the Health Sciences (USUHS) Graduate School of Nursing (GSN) is yet another source preparing advanced practice nurses and nurse researchers. In 2008, Lieutenant Colonel Julie Bosch and Colonel Lela Holden successfully defended their dissertations, completing their Doctorate in Nursing degree. Major Brenda Morgan and Lieutenant Colonel Karen O'Connell are students currently in the USUHS doctoral program. Major Morgan is focusing her research on "Positive Emotion and Resiliency", while Lieutenant Colonel O'Connell is pursuing a study on "Mild Traumatic Brain Injury."

EXPEDITIONARY NURSING

The cornerstone of our profession is that Air Force Nursing is an essential operational capability. Combined with our enlisted medical forces, we are a critical component of the total AFMS network supporting our warfighters. In 2008, 18 percent (2,802) of our TNF deployed to 44 locations in 16 countries. Our medical forces deployed in support of Operations ENDURING FREEDOM and IRAQI FREEDOM, as well as a myriad of humanitarian missions spanning the globe. I am proud to report that our TNF represents 34 percent of all Total Force deployments within the AFMS. TNF nurses and medical technicians are providing remarkable operational support. We are well-trained, highly-skilled and are committed to saving lives, educating others, and improving quality of life through research. We serve in this capacity not out of obligation, for we are an all-volunteer force. We are called to a mission of putting others first—of caring for America's sons, daughters, brothers, sisters, fathers, and mothers. We are called to a mission of forging international partnerships for a common good, and to aid war-torn countries in developing medical infrastructures, while sharing the message of hope and goodwill. In this regard, I offer you a sampling of our nurses' and medical technicians' experiences.

In September, Lieutenant Colonel Kathryn Weiss, a Certified Registered Nurse Anesthetist (CRNA) assigned to a Critical Care Air Transport Team (CCATT) deployed to Camp Cunningham in Bagram, Afghanistan. CCATTs are a three-person team made up of a physician, nurse, and respiratory therapist, specially trained in critical care transport. Lieutenant Colonel Weiss recalls flying on an Aeromedical Evacuation (AE) mission aboard a C–130 airframe to a Forward Operating Base (FOB) that had an unexpected surprise. She stated, "We'd been told we'd be picking up one CCATT patient, but discovered we had two. Our unexpected patient was a very young boy who had been shot in the head and brought to this desolate outlying FOB by his father." The surgeon had stabilized him, but he was in dire need of more definitive care. Lieutenant Colonel Weiss and crew packaged their patients for transport and returned to Bagram. Most recently she reported "this past month has been especially difficult as we responded to two mass casualties from improvised explosive device (IED) blasts, flying five times in 6 days as patients were stabilized for transport. Two young Servicemen suffered burns on up to 75 percent of their body. The emotional aspect of caring for these young 20-year olds is unimaginable . . . praying for them and their families. We have incredible support from our front-end crews . . . they bend over backwards to assure we have what we need to care for these young men. The bonds and friendship we form here will continue long past this deployment."

Major Terry Vida deployed as a Discharge Planner to Task Force Med in Afghanistan from Travis Air Force Base, California. Shortly after arriving she was instructed to establish relationships with the Afghan hospitals to coordinate supportive care of local nationals once discharged from U.S. facilities. Due to local security threats, she was accompanied by Special Forces. She successfully solidified working relationships with four of the local hospitals and in the process, noted their most compromised areas included patient safety, infection control, and lack of training. As Major Vida stated, "It is evident through observation they need our mentorship. They know about isolation in theory, but have no means or resources to apply what they have learned." She was fortunate enough to make contact with an English-speaking worker at the local rehabilitation center and ultimately coordinated their first patient transfer for supportive orthopedic care. However, her most notable memory of the trip to Kabul was finding out she and her envoy had narrowly missed a suicide bomber's explosion by 10 minutes.

These are but a few examples of the tremendous work our TNF is providing, saving lives, making a difference, and always rising to the challenge, whatever it may be.

READINESS

In order to provide our TNF personnel the critical care, trauma, and deployment skills necessary, we utilize numerous training platforms. The AFMS and Nurse Corps continue to produce hundreds of deployment-ready medics through the Centers for Sustainment of Trauma and Readiness Skills (C–STARS) located at University Hospital in Cincinnati, Ohio, R. Adams Crowley Shock Trauma Center in Baltimore, Maryland, and Saint Louis University Hospital in Saint Louis, Missouri. Each C–STARS site is known for high-quality/high-volume trauma care, cutting-edge research and excellence in education. The C–STARS Baltimore focuses on surgical and emergency care, while the Cincinnati site is designed specifically for clinical sustainment of CCATTs. The C–STARS Saint Louis is a dual Active Duty and ANG platform, with half of the faculty and students represented by the ANG. In 2008, 781 physicians, nurses, and technicians completed this vital operational training. When enrolled in this course, almost half of the students are hard-tasked to deploy, while the remaining students will deploy some time in the next scheduled deployment cycle.

Another building block in our arsenal of educational programs is the Critical Care and Trauma Nursing Fellowships. This fellowship program has consistently produced skilled critical care and trauma nurses, and has helped us in meeting our requirements in these critical specialties. Recruiting fully qualified critical care and trauma nurses continues to be a challenge. Nurse Corps officers are competitively selected to enter an intense 12-month training program at one of the following locations; Wilford Hall Medical Center in San Antonio, Texas, St. Louis University Hospital in St. Louis, Missouri, or the National Naval Medical Center in Bethesda, Maryland. By the time students reach their seventh month in the program, they are clinically and didactically prepared to deploy in their specialty. Last year this fellowship program produced 23 nurses combined, and currently enrolled this academic year are 18 critical care and 5 trauma nurse fellows. Additionally, as part of the preparation for this course, the student must complete either the Essentials of Critical Care Orientation (ECCO) course or the Emergency Nurses Orientation (ENO) course, respective to their specific fellowship. Both courses are online, self-paced, and focus on the skills and theory required to successfully care for critically ill adults. These online courses are available to all Air Force critical care and emergency nurses, so they may continue to hone their skills while earning up to 68 hours of continuing education credits. Over the past year, 117 nurses have enrolled in the ECCO course and 63 nurses have enrolled in the ENO course.

Two additional avenues employed to assist our TNF in remaining deployment-ready are clinical rotations established through Training Affiliation Agreements (TAA) and the Sustaining Trauma and Resuscitation Skills—Program (STARS–P). In 2006 we identified a need to ensure nurses who were assigned to outpatient or non-clinical settings, were maintaining their operational clinical currency, and therefore recommended nurses attain 168-hours of bedside nursing care. Over the past 3 years, this initiative opened the door for 57 TAAs, further strengthening our partnership with civilian and sister-service facilities. Where available, our medical technicians have also capitalized on these joint ventures. These relationships and training opportunities are critical in producing nurses and technicians prepared for diverse patient populations in the deployed environment. For example, in August 2008, nursing personnel from the 3rd Medical Group (MDG) DOD/Veteran's Administration (VA) Joint Venture Hospital and the Alaska Native Medical Center expanded their TAA partnership to include rotations in the pediatric intensive care unit. Unfortunately, up to 40 percent of the patients in military hospitals in both Iraq and Afghanistan are local children. As Major Dais Huisentruit, who deployed to Balad as the Intensive Care Unit Flight Commander explains, "we had nurses from different ICU backgrounds, but most worked with adults. It was amazing to see them work together taking care of these children. At one point we had a total of 6 burned kids in the unit at one time, ranging in age from 2 to 7 years-old. On another occasion, we even had a group of three brothers . . . two of them in the ICU. They all survived." The skills our TNF has garnered through these TAA is saving lives and paying immeasurable dividends.

The STARS–P is a program whose focus will not be on pre-deployment immersion, but ongoing clinical rotations at local civilian treatment facilities with Level I, and in some cases Level II trauma programs. The AFMS currently has five TAAs for STARS–P training sites in cooperation with local MTFs (San Antonio Military Medical Center, Texas, Luke AFB, Arizona, Nellis AFB, Nevada, Wright-Patterson AFB, Ohio, and Travis AFB California), and is looking to add a sixth site connected to Scott AFB, Illinois later this year. Currently projected for full implementation in fis-

cal year 2010, clinical rotations will be scheduled for 1 to 2 weeks and may also include technically-advanced simulation centers.

QUALITY CARE

After 9/11, medical leaders across the military health services enacted a plan to develop and implement a trauma system modeled after the successes of civilian systems, but modified to account for the realities of combat—this plan matured into what is now known as the Joint Theater Trauma System (JTTS). Nursing's role within the JTTS's trauma performance improvement program spans the trauma continuum. Nurses serve as Trauma Nurse Coordinators (TNC) in combat zone MTFs, flight nurses within the Air Force AE system, members of multidisciplinary trauma teams at overseas, stateside, and VA hospitals. Many of the trauma performance improvement initiatives that have occurred since the development of JTTS have been led by nurses serving within this system. One vitally important role is that of the TNC. The TNC is the critical link in the complex continuum of trauma care from point-of-injury to treatment facilities in the Continental United States (CONUS). The TNC provides data to affect local and system-wide changes, in addition to trauma care expertise. Their role is fast-paced and multi-faceted. At the local level, the TNC impacts people and processes in several spheres of influence including primary trauma care, education, process improvement, and collaboration with literally every hospital department and specialty. They review all trauma patients' charts, compile and analyze complex data, and channel the information into the trauma system to improve combat casualty care.

Another program that has positively impacted patient outcomes and safety is the Rapid Response Team (RRT). This nurse-led program, initiated at David Grant Medical Center, was established to provide the nursing staff an avenue for early intervention at the first signs of negative changes in a patient's condition. When the RRT is called upon, an experienced critical care nurse and respiratory technician come to the bedside within 5 minutes to assess the patient and provide pre-emptive care, preventing further deterioration. This pro-active approach has resulted in earlier medical interventions, a lessening of the severity in patient conditions, improved communication, and expected seamless, well-coordinated transfers between units when necessary. RRT is an example of an ICU without walls where critical care teamwork makes a difference for both our patients and staff.

Our enlisted forces have also made great achievements this past year. In August, Special Experience Indicator (SEI) 456 was approved for our enlisted medical technicians who maintain national currency as a Paramedic. Our Career Field Manager, Chief Master Sergeant Joseph Potts is leading a team of experts in building standardized Air Force Paramedic protocols. By establishing this SEI we ensure our medical technicians have a nationally defined advanced care capability to meet operational needs.

One more example of our multi-faceted approach to quality care is the Center of Excellence for Medical Multimedia (CEMM), organizationally aligned at AFMOA. The CEMM's mission is to provide patient education material that improves knowledge, patient compliance, and patient satisfaction. Diseases or conditions must meet certain criteria to be targeted for CEMM program development. Some program examples include Women's Health, Traumatic Brain Injury, and Diabetes Prevention. As CEMM's Director of Education Services, Captain Laurie Migliore's role is diverse as she assists in program design, development, and product deployment. The CEMM has distributed 85,000 programs per year and won over 75 national awards.

Our profession is not one just of caring, but educating others as well. Members of our TNF are filling critical roles in medical Embedded Training Teams (ETT) in areas across Afghanistan. The mission of these ETTs is to strengthen and improve the Afghan National Army (ANA) healthcare system through education and training of Afghan medical personnel.

Lieutenant Colonel Susan Bassett, deployed as a 205th Afghan Regional Security Integration Command Mentor, adds, "We have taught 15 classes so far, with an average of 25–30 attendees including nurses, medics, laboratory technicians, x-ray technicians, and pharmacists. I try to use very animated examples and write key words on the dry-erase board. They are extremely studious and eager to participate. They ask for handouts and complain if they are solely in Dari . . . they want them in English and Dari as they are trying to learn to read English. After giving them power point slides, several of the more experienced Afghan nurses volunteered to teach some of the modules themselves. They were proud as peacocks!" She goes on to share, "The other day one of the nurses told a visiting reporter, in very halted English, 'We . . . love . . . Mama Bassett!' " Lieutenant Colonel Bassett has cer-

tainly made a lifelong difference in the quality of care these Afghan nurses—provide just one more step in winning their hearts and minds.

RESEARCH

The research initiative known as the Deployed Combat Casualty Care Research Team (DCCCRT) consists of six Army and three Air Force members with the purpose of facilitating mission-relevant research in the Multi-National Corps—Iraq Theater. In September 2008, a Balad research team was established which included Colonel Margaret McNeill, an Air Force Ph.D.-prepared nurse, a flight surgeon, and a podiatrist. Colonel McNeill is the first Air Force nurse researcher to join the DCCCRT. The role of the team is to provide guidance and initial review for all research conducted in Iraq. The Ph.D.-prepared nurses provide leadership on human subject protections and the ethical conduct of research. Each team member is involved in collecting data for a variety of research protocols focusing on the care of combat casualties. Over 100 research studies have been conducted or are in planning stages as a result of the team's efforts. More than 12,000 subjects have been enrolled in studies. Areas of research conducted by the military in Iraq that have led to advancement in medical therapies include tourniquet application, resuscitation, blood product administration, burns, wound care, ventilation management, patient transport, Post Traumatic Stress Disorder (PTSD), Traumatic Brain Injury, and infectious diseases. Nurse-led studies have investigated pain management, carbon monoxide exposure, women's healthcare, sleep disturbances in soldiers, and PTSD/burnout and compassion fatigue in nursing personnel.

RECRUITING AND RETENTION

According to the latest projections from the U.S. Bureau of Labor Statistics, more than 1 million new nurses will be needed by 2016. Of those, 587,000 are projected to be new nursing positions, making nursing the nation's top profession in terms of projected job growth (www.bls.gov/opub/mlr/2007/11/art5full.pdf). A separate report, titled "The Future of the Nursing Workforce in the United States: Data, Trends, and Implications", found that the shortage of RNs could reach as high as 500,000 by 2025 (www.jbpub.com/catalog/9780763756840). It is evident Air Force Nursing will need to take advantage of every opportunity to recruit and retain nurses.

In fiscal year 2008, we accessed 302 nurses against our total accession goal of 325 (93 percent). The Air Force Recruiting Service ultimately delivered 226 nurse accessions, filling 69.5 percent of our total accession goal. Our challenge remains with recruiting fully qualified and specialty nurses in the areas of mental health, anesthesia, medical-surgical, emergency and critical care. While 93 percent appears positive, only 44 percent of those were considered "fully qualified," meaning they had a minimum of 6 months previous nursing experience. Fifty-six percent of all nurse accessions were "novice nurses," having less than 6 months nursing experience. The shortage of experienced nurses is a direct reflection of our national nursing shortage. Additionally, it is difficult to compete with our civilian counterparts in recruiting experienced nurses, as they offer many lucrative incentives.

We take advantage of numerous venues to access nurses. In addition to our recruiting services, we bring nurses into the Air Force through a variety of programs. Utilizing the Air Force Reserve Officers' Training Corps, Airmen Education and Commissioning Program, the Enlisted Commissioning Program, and the Health Professions Scholarship Program, we accessed 70 nurses in 2008.

In 2007 we launched our Nurse Enlisted Commissioning Program (NECP). The goal is to grow Air Force nurses from our highly successful enlisted medics. The NECP is an accelerated program for enlisted Airmen to complete a full-time Bachelor of Science in Nursing (BSN) at an accredited university while on active duty. This program produces students completing their BSN and obtaining their nursing license in 24 months or less through either a 2 or 1 year program, depending on their entry level. Airmen who complete this program are then commissioned as second lieutenants. Since its inception we have selected 73 students from 83 applicants and project a steady state NECP quota of 50 per year for the 2 year program beginning fiscal year 2011.

We strive to sustain and exceed our recruitment goals, but Nurse Corps retention remains problematic. In 2008, 55 percent of the nurses who separated had less than 20 years of military service. In 2008 alone, 61 percent of those separating were our young lieutenants and captains. The number of lieutenants separating has nearly tripled over the past 3 years. We are hopeful the implementation of the Nurse Corps Incentive Special Pay (ISP) program will make a positive impact on retention; however, we are concerned about the unintended consequences. A resulting increase in

retention of company grade officers may further extend timing and reduce promotion opportunity due to our small number of field grade requirements.

While we currently offer incentive special pay to CRNAs at variable rates, we have never had the resources to recognize clinical nurses for seeking and earning professional national certification and advanced academic degrees in various nursing specialties. With ISP we offer an even more appealing pay incentive if a nurse with an identified certification, additionally desires and commits to work in an approved clinical area and for a specific amount of time. We are pleased to be able to acknowledge our highly-skilled professional nurses in the clinical arena.

Our active duty enlisted forces also scored a win this past year with their own Selective Re-enlistment Bonus (SRB). Even though their overall manning appears to be strong at 94 percent, our Independent Duty Medical Technicians (IDMT) are heavily tasked with deployments and manned at only 72 percent. This SRB is a first-ever for our IDMTs, and I, along with Chief Master Sergeant Potts, am eager to see the impact of this initiative.

LEADERSHIP

As a Corps, we place heavy emphasis on purposefully developing leaders, clinically and professionally for the AFMS. Our Nurse Corps Development Team (DT) convenes three times a year to ensure Nurse Corps officers are provided deliberate career progression opportunities. The DT competitively selects our squadron commander and chief nurse candidates, both of which represent pivotal career leadership milestones. Furthermore, the DT identifies through a scored-board process, those leaders who would most benefit from developmental education in-residence. In 2008, the Nurse Corps garnered 90 annual quotas to send our best and brightest captains to Squadron Officer School.

Another recent development on the topic of clinical leadership is the creation of master clinician authorizations. This affords an opportunity for our most clinically experienced senior nurses with advanced academic preparations to remain in patient care settings without sacrificing promotion or advancement opportunities. We currently have identified 20 master clinician positions scattered among our larger MTFs as well as the Uniformed Services University of Health Sciences representing the areas of CRNAs, Perioperative Nursing, Education and Training, ICU, Family Nurse Practitioner, and Nursing Research.

Nurse leaders are critical in every environment, especially in deployed locations. Last year we successfully acquired a deployed Colonel Chief Nurse position at Joint Base Balad, Iraq, and we anticipate permanently adding another at Bagram's Craig Theater Hospital. The corporate experience of seasoned chief nurses in the grade of Colonel lends itself to mentoring not only nursing services personnel, but officers from across the AFMS.

Not only do we deploy as chief nurses, but in the role of Commanders as well. Colonel Diana Atwell served as the 332nd Expeditionary Medical Operations Squadron Commander at Joint Base Balad. As commander, she led a squadron of approximately 200 combat medics ranging from trauma surgeons to medical technicians, whose efforts contributed to an overall survival rate of 98 percent at the DOD's largest and busiest level three theater hospital.

ANG AND AFRC

The ANG and AFRC are vitally important contributors to our TNF and the backbone of our highly-successful global AE mission. Since 2007, all AFRC mobilization requirements have been met solely by volunteers. In 2008, 503 AFRC nurses and medics stepped up to meet deployment needs at home and abroad, with 133 of those personnel sourced for missions related to Hurricanes Gustav and Ike. The ANG also played a key role as they deployed 268 medics and AE personnel. They processed and moved 600 patients prior to and after the hurricanes. In addition to activating AE crews, the ANG mobilized AE Liaison teams (AELT), Command and Control (C^2) elements, and Mobile Aeromedical Staging Facilities (MASF). The MASF changed location three times "chasing the storm" and providing evacuation assets to the area in most need. Rounding out TNF representation, the 43d Aeromedical Evacuation Squadron (AES) from Pope AFB, North Carolina, also played a role in responding to Hurricanes Gustav, Hanna, and Ike by deploying MASFs, AELTs, AE crews, and C^2 elements to areas in Louisiana and Texas.

Our AE system provides the vital link in uninterrupted world class medical care from the battlefield to definitive treatment facilities at home. We boast a 98 percent survival rate for those that reach a theater hospital; the highest survival rate in history. It is a total force human weapons system comprised of 32nd AE Squadrons representing 12 percent Regular Air Force, 60 percent AFRC, and 28 percent ANG.

The AE deployment requirements in support of Operations Iraqi and Enduring Freedom have moved nearly 71,000 patients since October 2001. The mission of AE is one close to all our hearts—a mission of carrying the most precious cargo of all, our wounded warriors.

HUMANITARIAN MISSIONS

The TNF nurses and aerospace medical technicians represented a United States presence in locations crossing the globe including Iraq, Afghanistan, Qatar, Kuwait, Europe, Korea, Honduras, Trinidad, El Salvador, Guatemala, Morocco, Cambodia, Peru, and Suriname, to name only a few.

Master Sergeant Jeffrey Stubblefield, an IDMT assigned to the 3rd MDG in Alaska, had the unique opportunity to deploy to Laos on a mission to recover remains of two Raven Intelligence Officers whose plane crashed after taking enemy fire during the Vietnam Conflict. As a medic assigned to Recovery Team One, he provided medical support to 51 team members traversing treacherous terrain to reach our fallen comrades and enable the repatriation of their remains.

Major Susan Perry, a CRNA assigned to Wright-Patterson AFB, Ohio, was part of JTF-Bravo, a medical element surgical team partnering with civilian surgeons in Comayagua, Honduras. Her team was pivotal in responding to and saving the lives of 30 civilians injured in a motor vehicle collision.

Captain Troy Mefferd and First Lieutenant Ranjodh Gill deployed aboard the U.S. Naval Ship Mercy in support of joint humanitarian mission, Pacific Partnership 2008. Through this endeavor, medical care was provided to nearly 8,000 patients as well as 1,200 receiving dental care through Operation Smile.

Lieutenant Colonel Tambra Yates, Flight Commander of Women's Health Services at Elmendorf AFB, was the first women's health provider to accompany a Family Practice Team to three remote Alaskan villages as part of Alaska Taakti Top Cover. She treated 32 patients, diagnosing three with cancer which required immediate surgery. As a result of her many contributions, future Taakti missions will include a Women's Health Service Provider as part of the team.

Seven members of the 43rd AES participated in a historic mission which brought home three American contractors who'd been held captive for over 5 years by leftist Revolutionary Armed Forces of Colombia after their plane crashed in February 2003. The 43rd AES crew, along with 17 Airmen from Charleston AFB, South Carolina cared for and delivered them safely back to the United States on July 2, 2008. The close proximity to July fourth gave an all new meaning to "Independence Day" for these former captives.

RECOGNITION

It was a banner year as Air Force nurses and medical technicians were recognized for outstanding performance by a variety of professional organizations. Technical Sergeant David M. Denton captured the Airlift/Tanker Association's "General P.K. Carlton Award for Valor." This annual award is presented to an individual who demonstrates courage, strength, determination, fearlessness, and bravery during a combat, contingency, or humanitarian mission. Technical Sergeant Denton was also named as the AFMS "Outstanding Non-Commissioned Officer AE Technician of the Year."

Every year the Commemorative Air Force (CAF) recognizes one exceptional flight nurse who engaged in live aeromedical evacuation missions and contributed significantly to in-flight patient care, by awarding them the "Dolly Vinsant Flight Nurse Award." This award pays tribute to Lieutenant Wilma "Dolly" Vinsant who was killed in action over Germany during an AE mission on August 14, 1946. This year the CAF recognized Captain Bryce Vanderzwaag of the 86th AES at Ramstein AB, Germany. Captain Vanderzwaag provided direct AE support to 651 sick and injured patients, including two K–9 military working dogs injured by IEDs, during his deployment.

Lieutenant Colonel Mona P. Ternus, an AFRC nurse, was recognized by the Tri-Service Nursing Research Program, Federal Nursing Section, as she was awarded the "Federal Nursing Service Essay Award" for her research and essay entitled, "Military Women's Perceptions of the Effect of Deployment on their Role as Mothers and on Adolescents' Health." These are but a few examples of the stellar work our nurses and medical technicians perform every day.

OUR WAY AHEAD

Nursing is a profession vital to the success of our healthcare system. Our top priorities include, first and foremost, delivering the highest quality of nursing care while concurrently staging for joint operations today and tomorrow. Second, we are

striving to develop nursing personnel for joint clinical operations and leadership during deployment and at home station, while structuring and positioning the Total Nursing Force with the right specialty mix to meet requirements. Last, but not least, we aim to place priority emphasis on collaborative and professional bedside nursing care.

Mister Chairman and distinguished members of the Committee, it is an honor to be here with you today and represent a dedicated, strong Total Nursing Force of nearly 18,000 men and women from our Active Duty, Air National Guard , Air Force Reserve, civilian, and contract forces. Our warriors and their families deserve nothing less than skilled and educated nurses and technicians who have mastered the art of caring. It is the medic's touch, compassion, and commitment that often wills the patients to recovery and diminishes the pain. As our Air Force Nurse Corps celebrates its 60th Anniversary, I look forward to working with our Sister Services and our Federal Nursing Team, as we partner to shape the future of our profession.

Chairman INOUYE. On behalf of the subcommittee, I thank all of you, but I have a few questions.

There's no secret that there's a national nursing shortage. But somehow you gals have done a good job. The Air Force has met 93 percent of its goal. Army and Navy have exceeded their goals. What's the secret?

NURSE RECRUITMENT AND RETENTION

General HOROHO. Mr. Chairman, I think the secret is a couple things: the support that we've received from Congress with the different incentive specialty pay bonuses, that has had an overarching success with our nurses choosing to remain on active duty. The other is working very collaboratively with the Army Medical Recruiting Brigade. We stood up that brigade in 2007 that focused on recruiting nurses and the entire Army medical team, and so the first time last year since 2001 they actually exceeded the mission by 147 percent for recruitment of nurses on active duty.

So having that specialized—there were also bonuses that were given to the recruiters to be able to target special critical categories. We've also been very, very proactive with telling the Army Nurse Corps story and having our nurses engaged in helping with the recruiting effort.

Admiral BRUZEK-KOHLER. Mr. Chairman, there's no doubt that the support we received from you for our accession bonus increases and in particular our loan repayment program has made a tremendous difference in the numbers of direct accessions, particularly in light of the economic situation. For many of our new students, they come with extremely high student loans, more than I would have anticipated.

In fact, I remember meeting a lieutenant in Bahrain who had not yet heard about the program, a new graduate with over $60,000 worth of school loans. So that has made a major, major difference in their lives.

We've expanded our opportunities with our recruiters to use our own nurses in geographic areas, particularly nurses who are going to many of our professional organizations, both in terms of clinical skills, but also in terms of some of our diversity issues, and selling our story, telling our story as well. That has really made a difference in bringing in some of the diversity that we've not been able to get in the past.

So we will continue to use all of those opportunities to bring in our direct accessions. We also have a huge pipeline, as we've heard

from our sister service in the Air Force, with our medical enlisted programs, and using our corpsmen and other enlisted rating applicants to come into the Nurse Corps has really been our life's blood really for keeping our Corps at a level of being able to provide the kinds of care we provide. We will continue to support those programs, as well as our ROTC programs and our candidate programs.

So again, we thank you for that support for all of those.

General SINISCALCHI. Senator Inouye, thank you, and I would like to reiterate my nursing colleagues' for our Air Force accessions. I can attribute our success has been with recruiting novice nurses, the nurses who are completing their baccalaureate degrees and are coming into the Air Force as novice with less than 6 months experience.

Our loan repayment program, the increase that we received has been very successful. We were able to increase our quotas from 76 to 102. The increase in our health professions loan repayment quotas had a significant impact on our ability to recruit more novice nurses. The accession bonus has also been a very successful recruiting tool, and we appreciate the increased funds that we received in accession bonuses this year.

We are finding that with the $30,000 in accession bonus and up to $40,000 in the loan repayment combination it's very helpful to those students who have large loan repayments. So I would like to thank you again for your support with those programs.

We've taken several initiatives to continue success with recruiting. Dr. Cassells and Dr. Hinshaw from USU had organized a conference for academic partnerships addressing military nursing shortages, and that occurred this past weekend. We had the opportunity to meet with nursing deans and faculty across the country, and our objective was building collaborative relationships among military nursing services with the schools of nursing to foster additional educational opportunities and begin a campaign to educate the faculty from these schools, so as they are mentoring and advising their students they can help direct them toward military nursing as a potential career option.

Chairman INOUYE. Do you believe that we have enough nurse anesthetists, critical care nurses, operating room nurses, these specialties?

Admiral BRUZEK-KOHLER. Those are our critical areas right now that we are looking at in terms of retention as well as accessing. We do not have enough. Critical care nurses are undermanned at about anywhere from 60 to 70 percent. We think anything below 90 percent is critical and we have to pay attention to them.

I will say, our nurse anesthetists actually are very healthy. They aren't really one of the groups that we are focused on this year. Our perioperative nurses, our operating room nurses, our critical care nurses, and our nurse practitioners are below that critical 90 percent at this point in time.

So we're doing a couple of things. When we're recruiting, we are looking to recruit those specialties, which means we will bring in a more seasoned, more experienced clinical nurse at a more senior rank. We don't anticipate, nor do we know at this point, whether these nurses would want to continue on a full naval career or at

least be with us during a very critical time in our history while this war is still going on.

For retention, again the loan repayment program has been helpful. The RNISP has been absolutely the most positive action we could have taken to entice our more senior nurses, particularly those who are at the point of either the 10-year mark where they either make the decision to leave now or they continue on for 20 years, or for some who have come in from the enlisted ranks, who at the 10-year officer mark now have 20 years and can, in fact, retire. Those incentives have actually been positive in making the decision for them to stay in the Navy.

Also, the opportunities to deploy have been remarkable incentives for our people to stay in the Navy.

Chairman INOUYE. General Horoho.

General HOROHO. Mr. Chairman, both the emergency nurse specialty as well as the ICU specialties are two of our highest deployers as we support two theaters of operations. So we have been working very aggressively to expand our critical skill sets by helping them with deployment skills and training. We have increased the number of seats to be able to train more.

We have also started to target the population at the rank of major because I'm at 50 percent strength at that middle grade leadership, and we're trying to force more clinical expertise back at the bedside. So there's a pilot project that's ongoing that gives us the authority to be able to recruit individuals to come on active duty for a 2-year obligation. So what we are doing is working very closely with Recruiting Command and Accessions Command to be able to target that clinical expertise and bring them on active duty for a 2-year obligation to help us bridge that critical shortfall that we have.

NURSE RECRUITING

Chairman INOUYE. General Siniscalchi.

General SINISCALCHI. Sir, direct recruitment of our nurse specialties continues to be a challenge. We've come up with programs, very successful programs, to help us with retention and to help us develop those skill sets that we need ourselves.

The biggest impact on retention has been the incentive specialty pay program. We just started this program in January and so far over 76 percent who decided to participate in the program accepted the 4-year active duty service commitment. So that will have a significant impact on our ability to retain those critical areas.

We've developed fellowships that are year-long in critical care, emergency training, and trauma training. That helps us to grow nurses in those critical areas.

We continue to select nurses annually to attend USU for advanced academic training in critical areas. We've increased our family nurse practitioner quotas from 5 to 20 this year. We have an operating room cross-training course at Wilford Hall and a neonatal intensive care course at Wilford Hall, which is helping us to meet those critical specialties.

Our future plan for this year is to build a mental health nursing course at Travis Air Force Base. We've had difficulty recruiting mental health nurses and, as you know, they are very critical in

the care of our wounded warriors. So we are hoping to see this program come to fruition this year.

We're building master clinician opportunities at the colonel ranks so that we can have senior leaders in anesthesia, in the operating room, in emergency rooms, and in critical care areas that can help grow and mentor those nurses in those critical specialties.

Chairman INOUYE. Thank you very much.

Mr. Vice Chairman.

Senator COCHRAN. Mr. Chairman, thank you.

I'm concerned that the challenges in view of the war and the constant separation from families and friends may have a very serious consequence in terms of the success of recruiting. I was sitting here thinking about what could we do as a subcommittee to be helpful to you in increasing the likelihood that your goals were met and that retention rates are high in what you need.

Would additional funding of specific programs targeted to recruiting and retention be in order, or do you have enough money to do what you need to do?

Admiral BRUZEK-KOHLER. Well, I'll begin by saying that the support that you have given us to this date in time has shown dramatic improvements in the numbers of accessions, direct accessions, and the retention numbers. They have shown that they are successful in enticing people to join the Navy, as well as retaining them for a full commitment to a full career in the Navy.

So I thank you for those and certainly we would appreciate to be able to continue to offer those incentives both as accession bonuses as well as our loan repayment program. As I mentioned, they have been an amazing support to our new students and our new graduates. While there is competition from the civilian sector our retention bonuses give them the opportunity to want to continue to serve their country.

We do exit interviews of all of the nurses that leave the service, and I will tell you that deployments are generally not the reason why they leave the Navy. Usually it's family issues, dual career families and they want to get stable in a community. We also find as we are doing recruiting, particularly at schools of nursing throughout the country, that deployments are not a reason not to join the Navy. In particular, with our ability to provide humanitarian assistance and that type of service to other countries, that again is very enticing to a nurse who really wants to feel like they are fulfilling what the purpose of being a nurse is in the first place.

So at this point I would just say thank you for what you've done for us up to this juncture and we would certainly be thankful for that continued support.

Senator COCHRAN. General Horoho.

NURSE RETENTION

General HOROHO. Yes, sir. I would echo and say continued support of the programs that we do have in place, because when we have looked at our nurses 97 percent of those that are eligible to take those loan repayment programs or the bonuses have accepted them. So I think it does show that they are positive incentives to helping individuals remain on active duty.

The other incentive is that there is tremendous pride with our nurses that deploy, and most of them that come back have echoed that they found great self-worth to be able to know that they were helping to enhance the healthcare of those servicemembers that are supporting our freedoms, as well as helping with the nation building.

One of the things that has truly impacted I think retention is that we have changed our policy for deploying nurses from 12 months down to a 6-month rotation. That in itself has helped to help with the time, to decrease the time away from their family members. So when we look at that, it's the financial incentive programs as well as those support programs that we have in place.

We did a survey across the entire Army Nurse Corps so that I could have a baseline understanding of kind of the health of the Corps. Out of that survey we found two areas that we're going to focus on. One of them is looking at the redefinition of our head nurse role, of wanting to make sure that that role is having the ability to impact patient care and is really focused on outcome-based as well as leader development.

So we have got a team that has stood up to look at best practices across our entire Army medical department, as well as looking at what is being done within our civilian health sector. Then we're going to redesign that leader development role, and we're also looking at the entire leader development training programs that we have in place, because when you look at young nurses during the exit survey—and we do exit surveys on everybody who's leaving—a majority of it is because of family reasons, either starting families or an elderly parent and needing to be home.

So two things that we're doing. We're looking at and partnering with the Army to see how is it that we can have a program in place to help nurses take a leave and be able to still meet their family needs as well as their military obligation. Then we're also looking at how do we ensure that we've got our nurses best prepared for the deployment. So we're redoing—this past year we had 186 lieutenants that were assigned to each one of our medical centers for a year-long clinical immersed program to help them get their clinical skills solidified as well as their critical thinking skills prior to deployment.

So I think those were the major things that came out of the organizational survey.

Senator COCHRAN. Thank you.

General HOROHO. Thank you.

Senator COCHRAN. General Siniscalchi.

NURSE ACCESSION BONUSES

General SINISCALCHI. Sir, I would add, in addition to your support for our nurse accession bonuses and the health professions loan repayment program, it's more than just the financial incentives that incentivize our nurses. The opportunities for advanced education, the opportunities for increased leadership roles and leadership training, has a significant impact on retention.

The support of the health professions scholarship program has been critical. That program, the funding for that program, has allowed us to take nurses who already have baccalaureate degrees

and put them in programs, civilian nurses, sponsor their education, put them in programs for anesthesia training, to become family nurse practitioners, women's health practitioners. And that allows them the opportunity to have advanced education paid for by us and then come on active duty and serve in those critical areas.

So I would submit that continued support of the health professions scholarship program is a big incentive. We do continue to look at opportunities to partner with civilian programs so our nurses can have increased opportunities for advanced education and leadership training.

Senator COCHRAN. Thank you very much.

Chairman INOUYE. Senator Murray.

Senator MURRAY. Thank you very much, Mr. Chairman.

I apologize for having to step out and miss your testimony. But I wanted to personally thank all of you and everyone you oversee for the tremendous work that they do. General Horoho, it's good to see you here. I appreciate everything you've done out at Madigan Army Medical Center and appreciate your leadership.

Time is getting late, so let me just ask one question. I'll submit the other ones for your answers later. General Horoho, as you know, the Army's deployment schedule and adequate care of both soldiers and their families is very important to me. We've had the chance to talk about that. I wanted just to ask you how you are planning to continue to take care of children and families of servicemembers?

MADIGAN ARMY MEDICAL CENTER

General HOROHO. Yes, ma'am. First I'd like to thank you for your support, because we get tremendous support from you and your entire team in Madigan Army Medical Center being able to meet its mission.

Madigan Army Medical Center—the troop strength on Fort Lewis has grown over the years, and so our enrolled population at Madigan has increased from 84,000 to currently we have 106,000 enrolled beneficiaries. When you add on the healthcare benefits of that reliant population, which are those reserve soldiers and National Guard that are able to get extended healthcare, that increases it about 33,000. So we have the third largest enrolled beneficiary population in the Army, so about 133,000.

Of that, 20,000 of those are women, so it's a growing population. The increased strength is 20,000 for women and for children.

So what we've done is we have looked at—we have submitted a proposal for funding for a women's health center that will allow us to consolidate all of those services together to better meet the needs of our women and our children, so it's more of a continuum from infants through the adult parent.

With that, if it's awarded, in 2010 we would look at design and construction beginning and having it completed about 2014. What that would allow us to do is to be able to maximize the efforts. We have a DOD fellowship, the only one in the Army, for developmental pedes as well as maternal-fetal medicine. So we'd have that capability of having the right case mix to be able to help our residents grow and our physicians grow in that specialty.

We also are looking at, if that building is built, then we would take that space that is relieved to further expand our primary care to be able to meet the increased demand that we have from that troop population growth.

Senator MURRAY. Well, I really appreciate your strong push on that and I want to be supportive in any way I can. It's a great way to move forward, I think. Obviously, whatever I can do from my end to support that, I will do.

General HOROHO. Thank you.

Senator MURRAY. I just want all of you to know I'm worried about compassion fatigue with our nurses, and I know that's a recruiting issue, and a retention issue. We have to look at what we can do, Mr. Chairman, to support them. General, you mentioned several good ways to do that, and I want to encourage all of us to continue to do that.

I do have several other questions. I know you've been sitting here a long time, so I will submit them for the record. But I do really appreciate the work that all of you do. So thank you so much.

General HOROHO. Thank you, ma'am.

Chairman INOUYE. The nurses are fortunate to have Senator Murray here.

Senator MURRAY. We all stick together.

Chairman INOUYE. One of the priority projects I had when I first got on this subcommittee was to make certain that nurses got full recognition for their service. The one way to do that in the service was by rank. At that time, I believe I met one nurse who was a colonel. Most of the nurses I knew were captains or lieutenants. I'm happy to see two stars all over the place.

But I note that in the Navy you have a rear admiral one star, rear admiral upper half two stars. But in the Army and Air Force there's no billet for one stars. Why is that?

General HOROHO. I'll go first if you don't mind. Sir, one of the things is that we have the Surgeon General's full support of leader-developing all of our Army Medical Department leaders. Our general officer slots are branch and material. What we do is we work very, very hard as a collective force to be able to ensure that we have the right leadership skill sets, not only the education programs, but the command opportunities, as well as the clinical opportunities to lead at that level.

So we are working very closely to ensure that we have a pool of personnel that will be competitive for general officer at the one-star rank.

COMPETITIVE GRADES

General SINISCALCHI. Sir, having gone from colonel directly to two stars, the current construct has worked very well, and I've had tremendous support from my senior leaders. Within the Air Force, we have a limited number of general officer authorizations and we have elected to allow each of our corps the opportunity to have a star as their pinnacle rank.

So if we add a Nurse Corps one star, we will have to offset it elsewhere. So our current plan is to continue with the current construct and continue to develop our colonel nurses and select those nurses who have more time in grade and more time in service, so

that we're selecting our senior colonels as we promote them to the rank of two stars.

Chairman INOUYE. So it would help if we authorize one star billets with the money that we can provide here. You won't be against that, would you?

ADDITIONAL COMMITTEE QUESTIONS

General SINISCALCHI. Sir, I would never turn down stars.

Chairman INOUYE. Well, I thank you ladies very much. I want to thank General Schoomaker, Admiral Robinson, General Roudebush, General Horoho, Admiral Bruzek-Kohler, and General Siniscalchi for your testimony and for your service to our Nation.

[The following questions were not asked at the hearing, but were submitted to the Department for response subsequent to the hearing:]

QUESTIONS SUBMITTED TO LIEUTENANT GENERAL ERIC B. SCHOOMAKER

QUESTIONS SUBMITTED BY CHAIRMAN DANIEL K. INOUYE

JOINT DOD/VA CLINICS

Question. General Schoomaker, since there are other joint DOD/VA clinics and presumably more to come, are all the Services involved in raising, discussing, and resolving the myriad of issues presented by these joint facilities or is it done on a facility unique basis?

Answer. The Health Executive Council and Joint Executive Council provide the basis for managing efforts related to joint DOD/VA clinics. The recent revival of the VA/DOD Construction Planning Committee will facilitate future joint planning efforts. Army facility pre-planning efforts take into account existing/proposed Community Based Outpatient Clinics (CBOCs) and also consider the possibility of current and future Joint Ventures. For example, the U.S. Army Medical Command (MEDCOM) is currently working with the local VA medical center and the Veterans Integrated Service Network to define the scope for a William Beaumont Army Medical Center (WBAMC) hospital replacement at Fort Bliss, Texas. WBAMC currently shares services through a Joint Venture agreement with the co-located VA medical center. There is potential for additional sharing and this is the heart of the ongoing pre-planning effort. MEDCOM has also incorporated CBOCs within hospital replacement projects such as Bassett Army Community Hospital at Fort Wainwright, Alaska, and DeWitt Army Community Hospital at Fort Belvoir, Virginia. The VA and Army are also working to locate CBOCs on Army installations such as Fort Detrick, Maryland and Fort Meade, Maryland. The VA recently renovated space at the former Lyster Army Community Hospital at Fort Rucker, Alabama, as it was downsized to an Army Health Clinic. The VA was able to vacate a lease for its CBOC in downtown Dothan, Alabama, and move closer to its beneficiary population at Fort Rucker.

CENTERS FOR EXCELLENCE

Question. General Schoomaker, there seems to be an insatiable appetite for creating Centers of Excellence for everything from sensor systems to urban training and now we are creating them for medical research. While I fully support the establishment of the Defense Center of Excellence for Traumatic Brain Injury and Psychological Health, we also created them for amputees, vision, and hearing. All of these areas are critical to the health of our service members but we can't create centers for every issue facing our service members. Therefore, how do we ensure the appropriate level of attention and allocation of resources are devoted to the issues we are faced with today and also those we might encounter in the future?

Answer. A Center of Excellence designation serves to establish priority; whether directed by Congress or within the Department. It results in a specific activity gaining visibility and attention above other areas. COE designation to date has come with costs as we grow organizational structure to oversee a specific area of interest. There is a critical balance that must be kept in check. The Services are operating comprehensive healthcare systems. We are caring for Soldiers and Families with a very broad spectrum of healthcare needs—nearly the entire spectrum of medical

practice. We must be careful not to focus too much effort in too few areas and cause us to fail to meet the true needs of our beneficiaries; the majority of which fall outside the sphere of established COEs. Moreover, every one of my Army hospitals is a Center of Excellence. We provide exceptionally high quality healthcare outcomes. I must be able to appropriately resource every hospital and every patient encounter because every patient is important. A robust and capable direct care system is essential to the Army. I ask for continued support in resourcing our direct care system, as a system with global responsibility, and not fragmenting our system into a series of new Centers of Excellence.

CENTERS FOR VISION AND HEARING

Question. General Schoomaker, Congress is awaiting the Department's detailed plans for establishing the Centers for Vision and Hearing. Can you tell me if you and your colleagues are approaching the staffing and resourcing of all of these Centers strategically or as independent centers?

Answer. The Service Surgeons General do not have an active role in the development of the Department of Defense Centers of Excellence for Hearing and Vision. The approach to funding and staffing these Centers is being managed by the Office of the Assistant Secretary of Defense for Health Affairs.

TRAUMATIC BRAIN INJURY/MALARIA RESEARCH

Question. General Schoomaker, what are the specific mechanisms in place to ensure coordination at the planning, budgeting, and technical levels between the various Federal agencies (including NIH) on areas like Traumatic Brain Injury or Malaria research? Are there examples of DOD, VA, or NIH dollars being moved or redundant activities being terminated as a result of these coordination efforts?

Answer. The U.S. Army medical research and development community coordinates closely with other services and agencies for both the President's Budget and the large Congressional Special Interest (CSI) funded programs to avoid redundancy. We include representation in our planning processes to identify various service or agency research portfolio lead, and gap areas across the spectrum of federally funded research. Through coordination with the other services and agencies we have not needed to terminate programs, but have instead been able to maximize our ability to direct research funds toward the gap areas. Traumatic Brain Injury (TBI) and Malaria are two of several extensively coordinated research areas.

Planning and programming coordination is taking place through involvement of NIH and VA representatives on the expanded Joint Technical Coordinating Groups of the Armed Services Biomedical Research & Management (ASBREM) Committee, which are planning the investment for the future years Defense Health Program Research Development Test and Evaluation investment. At the technical levels, DOD, VA, and NIH scientists and research program managers actively participated in joint planning activities for major TBI and Psychological Health (PH) research programs, including the fiscal year 2007 Congressionally Directed Medical Research Program TBI/PH program and the fiscal year 2008 Deployment Related Medical Research Program. These planning activities included joint program integration and review panels that were responsible for identifying research gaps, developing language for program announcements, and reviewing and recommending research proposals for funding. In fiscal year 2009, an integration panel with DOD, VA, and NIH members identified remaining TBI/PH knowledge gaps and developed a program announcement for research that addresses TBI/PH topics in response to a fiscal year 2009 CSI for TBI/PH research.

The DOD is creating a collaborative network in the area of TBI/PH research. The DOD has partnered with Federal and non-Federal agencies to cosponsor several scientific conferences. The DOD recently partnered with NIH, VA, and the National Institute on Disability and Rehabilitation Research to sponsor a common data elements workshop, which will lead to the ability to compare results and variables across studies. The DOD is sponsoring a state-of-the-science meeting in May 2009 to evaluate non-impact blast-induced mild TBI and identify for future research gaps in our current knowledge. Attendees have been invited from several Federal agencies (NIH, VA, and Environmental Protection Agency) as well as academia and industry. The DOD is planning a conference for November 2009 and will partner with several agencies to sponsor a TBI/PH research portfolio review to help identify gaps and assist with setting funding priorities among the various agencies. While new projects that address residual gaps in the science may overlap with ongoing research objectives, continuous interdepartmental and interagency portfolio analyses ensure that resources obligated through DOD funding mechanisms target residual and emerging gaps in TBI/PH research.

The Defense Centers of Excellence (DCoE) for TBI and PH is establishing a strategic level TBI/PH research working group to further collaboration within the scientific community. This working group will help to prevent unnecessary redundancies and increase communications. The DCoE is collaborating with NIH on developing a research database, which may decrease the need to maintain several different databases.

The U.S. Military Infectious Disease Research Program (MIDRP) is a joint Army/Navy program funded through the Army. To insure that research planning is coordinated between the major funders of malaria vaccine research, the U.S. Military Malaria Vaccine Program conducts an annual strategic review of its program by a Scientific Advisory Board. The membership of this board includes a broad range of internationally recognized experts including members from Vaccine Research Center at NIH; the Division of Intramural Research, National Institute of Allergy and Infectious Disease (NIAID), NIH; industry and academia, and the Bill and Melinda Gates supported Malaria Vaccine Initiative (MVI). Furthermore, a permanent member of the NIAID staff sits on the U.S. Army Medical Research and Materiel Command's Executive Advisory Panel. A broad strategic review was conducted recently by the Institute of Medicine (Battling Malaria Strengthening the U.S. Military Malaria Vaccine Program) and included a distinguished panel of both international experts and members from NIH, industry, and academia. The close review and coordination insures that there is no duplication of effort. The U.S. Army receives funding from the MVI. The U.S. Army malaria drug development program was also reviewed by the Institute of Medicine (Saving Lives, Buying Time, Economics of Malaria Drugs in an Age of Resistance). This program is coordinated and relies heavily on industry to bring anti-malarial drugs to the market. Essentially every U.S. Food and Drug Administration approved anti-malarial drug has been advanced, if not discovered by contribution from the U.S. Military Malaria Drug Program.

CAREGIVERS

Question. General Schoomaker, while attention must be focused on the resilience training of our servicemembers and their families, I also suspect that caring for our wounded takes a considerable toll on our caregivers. What efforts are underway to address the well-being of our caregivers in order to retain these critical personnel?

Answer. In 2006, the Army recognized that there was a need for educating and training its healthcare providers on the signs and symptoms of Compassion Fatigue and Burnout. It began deploying mobile training teams through the Soldier and Family Support Branch, U.S. Army Medical Department Center and School, to various Medical Treatment Facilities (MTFs) to train healthcare providers on the prevention and treatment of Compassion Fatigue and Burnout.

In June 2008, the Army implemented a mandatory Provider Resiliency Training (PRT) program to educate and train all MTF personnel, to include support staff, on the signs and symptoms of Compassion Fatigue and Burnout. Below is a brief description of the phased implementation the PRT program:

—Phase I of the program focuses on organizational and personal assessment of Compassion Fatigue and Burnout using the Professional Quality of Life Scale (ProQol) which measures Compassion Fatigue, Burnout, and Compassion Satisfaction. Over 55,000 medical personnel completed the survey and were provided a 30-minute introductory training session on provider resiliency.

—Phase II involves developing a resiliency-based self-care plan through 2-hour classroom training with PRT trainers based at each major MTF.

—Phase III is an annual reassessment of an individual's stress levels and adjustment to his/her self-care plan based on the reassessment.

The Institute of Surgical Research at the Brooke Army Medical Center also offers a pilot provider resiliency program that supplements the above PRT program. This program provides a Respite Center for its healthcare providers. Providers have the opportunity to receive educational classes on meditation, Alpha-Stim therapy (microcurrent electrical therapy for acute or chronic pain) and relaxation.

COMPETING INITIATIVES

Question. General Schoomaker, do you have any competing initiatives to the new health system architecture development efforts, such as a different Unified User Interface, or a separate electronic health record?

Answer. No. I am not aware of any competing initiatives. Army leadership understands the importance of a coherent, central enterprise architecture.

NEW ENTERPRISE ARCHITECTURE

Question. General Schoomaker, how do you ensure Service specific needs are incorporated in the new enterprise architecture and how do you make sure they don't drive up costs throughout the system?

Answer. There is an established governance process by which the Services provide feedback on health information technology matters. This process is being improved to better meet the needs of the enterprise. However, a governance process for the new enterprise architecture has not yet been established. Once the process is established, the Army looks forward to full and active participation.

QUESTIONS SUBMITTED BY SENATOR PATTY MURRAY

ENTERPRISE ARCHITECTURE

Question. In your opinion, what additional steps need to be taken to ensure that electronic medical information is available to VA?

Answer. We currently exchange an enormous amount of information with the VA, some of which are computable through the bidirectional health information exchange (BHIE). Clearly more can be done, and one recommendation we have is to accelerate the overhaul of our BHIE framework to a National Health Information Network (NHIN) compliant exchange. Not only would this conversion improve the data exchange between VA and DOD, but it would also allow us to exchange information with other Federal and civilian healthcare organizations. Given that over 60 percent of our 9.2 million DOD beneficiaries receive care from the civilian healthcare sector, we have a growing need to be able to exchange information. Furthermore, this is a great opportunity for DOD and VA to help execute President Obama's vision for electronic health records in the United States and to establish a national model for Health Information Exchange. Given the establishment of joint VA–DOD Federal healthcare facilities, we will need to migrate to an interoperable information system that is more closely coupled to meet healthcare, business, and benefits requirements.

Question. How are each of your services obtaining medical records for servicemembers who receive contract care and how big of a problem is this for creating a complete record of care?

Answer. Many facilities currently receive a fax or e-fax from the managed care contractor or from the facility that provided the care. Some facilities manually attach the records into our electronic health record, but others do not. This process varies from treatment facility to treatment facility. There is also no enterprise referral and authorization system that interfaces with our electronic health record, which is a problem. Our adoption of a National Health Information Network will help to address this problem. Further, as part of the managed care support contracts we should require TRICARE contractors to collect and send medical records electronically back to DOD. Furthermore, our central document management system (HAIMS) under development by TMA for military treatment facilities should allow TRICARE contractors to submit consult results to AHLTA. This capability would provide an automated method for tracking and incorporating consult results into AHLTA as the comprehensive electronic health record repository.

JAG PROSECUTIONS

Question. JCS Chairman Mullen has said publically he's trying to break the stigma of psychological health in the active force, yet the JAGs are still prosecuting as a "crime" depressed people who attempt suicide. While the Surgeons General aren't responsible for the UCMJ, it seems to me that they might be concerned about JAG prosecutions of people who have severe mental distress while serving or after serving in combat.

Generals, do you think that the continued criminal prosecution of troops who commit suicide is a problem for the military's efforts to break the stigma of psychological health?

Answer. From a healthcare perspective as The Surgeon General of the Army, I acknowledge that charges of this sort are not helpful to a patient's mental state and probably increase the stress the Soldier is under. The Army and the DOD are working to deal honestly and directly with the behavioral health needs of our Soldiers and Families. This requires that our Soldiers are forthcoming about their own personal histories of behavioral health challenges and actively seek the care of available professional mental health providers both in garrison and on deployments when/if they encounter problems. We cannot help to remove the stigma associated

with behavioral health and its treatment without this proactive approach. Such charges could be counterproductive to the creation of such an environment of trust and healing.

As a Commander, I understand the necessity of good order and discipline. Commanders decide whether to refer cases for prosecution in the military justice system. In every case involving misconduct, the background and needs of the individual must be weighed along with the needs of the Army and the Nation it protects. Commanders and senior leaders weigh these competing needs in the context of often complex cases involving allegations of serious misconduct and equally serious potential psychiatric explanations for this behavior, which may or may not amount to a lack of competence or capacity or negate individual responsibility. All leaders work together in due process under the Uniform Code of Military Justice (UCMJ) where the advice and findings of medical professionals is certainly heard so we do the right thing for the Soldier and the Army. Finally, I assure you that each case is judged on its own merits by individual commanders after a thorough review of the facts, and after advice and counsel by a judge advocate.

I must note that there is no offense under the UCMJ for attempted suicide. There is an offense for malingering, which can include self-injury with intent to avoid duty or service, and another for self-injury without intent to avoid service. I note that while these are technically options under the UCMJ, I am unaware of Soldiers being charged for attempted suicide and, as a result, do not believe it to be a problem as the question suggests.

VISION CENTER OF EXCELLENCE AND EYE TRAUMA REGISTRY

Question. The NDAA fiscal year 2008 Section 1623, required the establishment of joint DOD and VA Vision Center of Excellence and Eye Trauma Registry. Since then, I am not aware of any update on the budget, current and future staffing for fiscal year 2009, the costs of implementation of the information technology development of the registry, or any associated construction costs for placing the headquarters for the Vision Center of Excellence at the future site of the Walter Reed National Medical Center in Bethesda.

What is the status on this effort?

Answer. As the Army Surgeon General and Commanding General of the U.S. Army Medical Command, I do not have an active role in the establishment of the joint DOD and VA Vision Center of Excellence and Eye Trauma Registry. Responsibility for this organization and the registry belongs to the Office of the Assistant Secretary of Defense for Health Affairs.

QUESTION SUBMITTED BY SENATOR THAD COCHRAN

DEPLOYMENT

Question. Over the past few years, new programs have been implemented to assess the health of soldiers after deployment. With the large group of Guardsmen alerted for deployment and who have been deployed, including many from my home state of Mississippi, I am concerned about the continuum of care upon their return into their communities. Are you confident that their medical needs are being met after returning from deployment?

Answer. During the current conflict, the Department of Defense (DOD) developed new strategies to support Soldiers upon redeployment. As a result of these initiatives, I am extremely confident our Reserve Component (RC) Soldiers' medical and dental needs are being met.

Prior to demobilization, each Soldier completes a Post Deployment Health Assessment (PDHA) using DD Form 2795 which includes a questionnaire completed by the Soldier and a face-to-face interview with a privileged healthcare provider. This is the best opportunity for the Soldier to document any health concerns related to their deployment. If significant concerns exist, the Soldier may remain on Active Duty for treatment. It may however be advantageous for some RC wounded warriors, at their discretion, to be released from active duty before the optimal medical benefit has been attained. This option does not release DOD from its moral obligation to render care for conditions sustained in the line of duty. Care for lesser concerns occurs when the Soldier returns home using the 180-day Transitional Assistance Management Program (TAMP) as a TRICARE benefit.

Also at the demobilization station, each Soldier receives a dental exam as part of the Dental Demobilization Reset (DDR) program. Treatment is also now available to Soldiers at the demobilization station. However, treatment that would cause a

delay in returning a Soldier home is deferred and provided at their home station using the Army Selected Reserve Dental Readiness System (ASDRS).

Each Soldier must complete a Post Deployment Health Re-Assessment (PDHRA) using DD Form 2900 between 90–180 days after demobilization and complete another interview. This is a key opportunity for Soldiers to highlight issues they did not document at demobilization or surface after returning home. This documentation is critical to establish a line of duty connection, enabling continuing medical benefits through TRICARE and VA eligibility. Reserve Component Soldiers may also be voluntarily returned to active duty for medical treatment if we identify that treatment is warranted for a medical issue incurred while on active duty.

All Soldiers undergo annual Periodic Health Assessments (PHA), where the Soldier completes an on-line questionnaire and is assessed by a provider using the latest recommendations of the U.S. Preventive Services Task Force.

The PDHA, PDHRA, and PHA create a system of continuous visibility of the medical concerns of our Soldiers and provide regular opportunities for Soldiers to raise deployment-related concerns.

QUESTIONS SUBMITTED BY SENATOR CHRISTOPHER S. BOND

SERVICEMEMBERS TREATMENT

Question. Thank you for your service and for taking the time to present to us your insights into our medical service programs. I know the U.S. Army takes the health of our warfighters personally, and it is clear that our active and reserve medical practitioners are the best in the world.

Johns Hopkins Medical Center defines osteoarthritis as a type of arthritis characterized by pain and stiffness in the joints, such as those in the hands, hips, knees, spine or feet, due to breakdown of cartilage; the gradual breakdown of cartilage that occurs with age and is due to stress on a joint.

Many of our active, reserve, and former servicemembers are currently struggling with cases of severe ligament and joint damage that will later manifest themselves into long term cases of osteoarthritis.

Our service men and women bear the largest physical burden during combat. I am concerned with the large amount of weight our warfighters are forced to carry across considerable distances and unforgiving terrain. Particularly, I am concerned with the physical toll that war exacts from our men and women, most notably in the forms of osteoarthritis that arise when injuries go untreated during combat.

Is the U.S. Army doing everything it can to properly treat our servicemembers' injured limbs and joints while they are simultaneously fighting in austere environments in order to lessen the chance that these particular injuries will manifest themselves into debilitating cases of osteoarthritis later in life?

Answer. This challenge of equipping Soldiers on the battlefield with the right technology and level of protection—without overloading them, is a difficult one. The U.S. Army Research Institute of Environmental Medicine (USARIEM) has an extensive research program aimed at documenting the physiological demands of war fighting, identifying biomedical solutions that facilitate meeting those demands, and optimizing the health and performance of Warriors during operational missions and garrison training.

Arthritis is a degeneration of bone and cartilage that results in progressive wearing down of joint surfaces. Arthritis in a non-rheumatoid patient under 50 is almost uniformly due to post-traumatic conditions. Treatment of injuries leading to arthritis in young people has to do with prevention as well as acute and chronic treatment to mitigate progression. In 2008, U.S. Army orthopedic surgeons performed over 5,000 knee arthroscopies on Soldiers. These joint procedures do not necessarily delay the progression of arthritis. In addition, joint preserving techniques such as cartilage implants and alignment procedures like osteotomies or knee replacement procedures can substantially prolong the useful and functional years of a Soldier's joints. Optimal outcomes from these procedures require coordination between orthopedic surgeons and physical therapists. The bottom line is we do not know how treatment interventions impact long term outcomes.

Currently, a team from the University of Pittsburgh is conducting research on the injury prevention and performance enhancement practices used by 101st Airborne (Air Assault) Soldiers at Fort Campbell, Kentucky. The comprehensive assessment initially evaluated Soldiers' nutrition, anaerobic/aerobic capacity, strength, body composition, balance/agility, etc. Based upon those findings, new training programs were developed. Soldiers participated in an 8-week physical training course, and

then a reassessment was conducted. Initial reports are positive and show a decrease in injury rates and an improvement in overall unit performance.

We know that prevention is a key component to mitigate the progression of arthritis and Soldiers who train and condition properly are much less likely to sustain an injury during or after deployment. To that end, the Army is doing several things to improve the medical readiness of the force. First, the Army is in the process of changing the physical fitness doctrine and training programs to better prepare Soldiers for the demands of military operations. "Physical Readiness Training" (PRT) is the emerging U.S. Army physical training doctrine designed by the U.S. Army Physical Fitness School to improve Soldiers' physical capability for military operations. PRT follows the exercise principles of progressive overload, regularity, specificity, precision, variety, and balance. The Army plans to begin implementing the new PRT doctrine across the Force over the next year.

In the meantime, units across the Army have physical therapists assigned to special operations units, Initial Entry Training, and Brigade Combat Teams that use a sports medicine approach to identify, treat, and rehabilitate musculoskeletal injuries expeditiously—which is critical in a wartime environment as Soldiers are able to stay healthy and "in the fight." Treatments for Soldiers with musculoskeletal injuries include joint manipulation, specific therapeutic exercises, soft tissue mobilization as well as a variety of modalities to mitigate pain, promote healing, and prevent reoccurrence.

Programs focusing on injury prevention and performance enhancement emphasize core strengthening, aerobic endurance, muscular strength and power, muscular endurance (anaerobic endurance), and movement proficiency (incorporates balance, flexibility, coordination, speed and agility) to better prepare Soldiers to physically withstand the rigors of combat.

The U.S. Military Health System is doing a tremendous amount to preserve the active function of Soldiers with limb injuries but more research efforts on clinical outcomes is necessary to determine if what we are doing makes a difference. By making sure Soldiers receive early identification and treatment of their musculoskeletal injuries and improving Soldiers' physical strength and conditioning, we also improve the overall medical readiness of our Force.

QUESTIONS SUBMITTED BY SENATOR MITCH MCCONNELL

SOLDIER SUICIDES

Question. LTG Schoomaker, Congress has established a national suicide hotline for returning troops, as well as increased funding for mental health for active military personnel. However, there remains a high number of soldier suicides. What preventative measures is DOD taking to address this problem? What, if any, legislative action would DOD need Congress to take to expand suicide awareness and education on posts?

Answer. The Army has been vigorously pursuing suicide prevention and intervention efforts. Nevertheless the number of suicides continues to rise, which is an issue of great concern to us.

In March 2009, the Vice Chief of Staff of the Army established a new Suicide Prevention Task Force to integrate all of the efforts across the Army. A Suicide Prevention General Officer Steering Committee (GOSC) was previously established in March 2008. The GOSC's efforts are ongoing, with a focus on targeting the root causes of suicide, while engaging all levels of the chain-of-command.

From February 15, 2009 to March 15, 2009, the Army conducted a total Army "stand-down" to ensure that all Soldiers learned not only the risk factors of suicidal Soldiers, but how to intervene if they are concerned about their buddies. The "Beyond the Front" interactive video is the core training for this effort. It was followed by chain teaching which focuses on a video "Shoulder to Shoulder; No Soldier Stands Alone" and vignettes drawn from real cases. The Army continues to use the ACE "Ask, Care, Escort" tip cards and strategy.

The Army established the Suicide Analysis Cell at the Center for Health Promotion and Preventive Medicine (CHPPM) in July 2008. This is a suicide prevention analysis and reporting cell that has epidemiological consultation capabilities. The Cell gathers suicidal behavior data from numerous sources, including the Army Suicide Event Report (ASER), The U.S. Army Criminal Investigation Division Reports, AR 15–6 investigations, and medical and personnel records.

The Army Suicide Prevention Plan's overarching strategies include: (1) raising Soldier and Leader awareness of the signs and symptoms of suicide and improving intervention skills, (2) providing actionable intelligence to Leaders regarding sui-

cides and attempted suicides; (3) improving Soldiers' access to comprehensive care; (4) reducing the stigma associated with seeking mental healthcare; and (5) improving Soldiers' and their Families' life skills. In the fall of 2008, the Army Science Board studied the issue of suicides in the Army. While their report has not been officially released, it reiterated the Army's strategies and the need for a comprehensive multi-disciplinary approach. It did not find easy, simple solutions to the problem.

The Army has also developed a Memorandum of Agreement (MOA) with the National Institutes of Mental Health (NIMH), which was signed in the fall of 2008. This is an ongoing, 5-year research effort to better understand the root causes of suicide and develop better prevention efforts. This NIMH effort is being coordinated with the CHPPM Suicide Analysis Cell, as well as with suicide prevention efforts from the Walter Reed Army Institute of Research (WRAIR).

These extensive new efforts build upon: (1) development and deployment of numerous updated training and education efforts, including Battlemind and the Chain Teach Program on mTBI/PTSD; (2) widespread training of Soldiers by Chaplains and behavioral health providers; (3) robust combat stress control efforts and Chaplain presence in theater; (4) hiring and recruiting additional behavioral health providers; (5) "Strong Bonds", a relationship-building program developed by the Chaplains; (6) surveillance of all completed suicides and serious suicide attempts via the Army Suicide Event Report; and (7) suicide risk assessment screening of all Soldiers who enter the Warrior Transition Units (WTUs).

We are also partnering with the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury to work on identifying best practices for the identification and intervention of mental health issues that include suicide, PTSD, TBI, and depression. Both the Army and the DOD are studying the addition of tools which will further query Soldiers for symptoms of suicide and depression. All suicide screening tools must be evaluated carefully for sensitivity, specificity, and positive and negative predictive values.

An enhanced and integrated public health approach is needed. We must continue to emphasize Leadership involvement, reducing stigma, training and education, access to mental health care, and a multidisciplinary community approach to suicide prevention.

We must continue to: (1) expand the capacity for behavioral health treatment throughout the system; (2) improve continuity of care between different helping agencies and providers; (3) improve training of all medical personnel and Chaplains in identification and mitigation of risky behaviors; and (4) continue a multi-pronged approach to decrease stigma and encourage help-seeking behavior.

Awareness and education are needed across the nation, as well as on military installations. I am currently unaware of any legislative action required to expand suicide awareness and education on military posts.

IRELAND ARMY HOSPITAL/BLANCHFIELD ARMY HOSPITAL

Question. LTG Schoomaker, what are the authorized manning levels for nurses and medical personnel at the Ireland Army Hospital at Fort Knox and Blanchfield Army Hospital at Fort Campbell? Is there a minimum threshold that must be met under Army rules, regulations or custom? Is that threshold being met at Ireland and Blanchfield Hospitals and is it sufficient?

Answer. The Army Medical Command is meeting minimum staffing requirements at both Blanchfield and Ireland Army Hospitals. Across the command we face staffing challenges due to medical personnel deploying in support of contingency operations, lack of some specialty provider backfills from the Reserve Component, and difficulty with recruiting civilian and/or contract providers in and around some military communities. Despite these obstacles, we are able to staff our treatment facilities and deliver high-quality, evidence-based care to our deserving beneficiaries.

The authorized manning levels for nurses and medical personnel at the Ireland Army Hospital at Fort Knox and Blanchfield Army Hospital at Fort Campbell are as follows:

Ireland Army Hospital

Nurse Authorizations: 57 Military, 87 Civilian equals 144 total
Medical Authorizations: 37 Military, 16 Civilian equals 53 total
Other Medical ancillary personnel that clinically support patients equals 406
Grand total of authorized clinical nurses, physicians and other ancillary personnel equals 603

Blanchfield Army Hospital

Nurse Authorizations: 83 Military, 195 Civilian equals 278 total

Medical Authorizations: 84 Military, 20 Civilian equals 104 total

Other Medical ancillary personnel that clinically support patients equals 635

Grand total of authorized clinical nurses, physicians and other ancillary personnel equals 927.

Authorization numbers above do not include counts of non-clinically focused personnel, in such purely administrative mission areas such as Logistics, Medical Library, Quality Mgt, File Clerks/Transcription, Environmental Services (Housekeeping/Linen Mgt/Facilities), Patient Admin Medical Records, Patient Affairs, Uniform Business Office, Third Party Collections, and Troop Command.

Finally, clinical staffing levels for a hospital are a function of the reliant population to be supported and/or workload demand. Where work centers are open 24/7, there are always minimum staffing requirements independent of workload. All direct patient care units requiring 24/7 staffing at Fort Knox and Fort Campbell have sufficient workload and staffing levels that exceed required manning thresholds and minimums.

PTSD/TBI

Question. LTG Schoomaker, what are the typical steps taken for soldiers who may have post-traumatic stress disorder (PTSD) and traumatic brain injuries (TBI) to ensure they get the proper care? Are there any further legislative steps that Congress could take to improve screening and the delivery of care to soldiers with PTSD and TBI?

Answer. Army Leadership is taking aggressive, far-reaching steps to ensure an array of behavioral health services are available to Soldiers and their Families to help those dealing with PTSD and other psychological effects of war.

The following list of continually evolving programs and initiatives are examples of the integrated and synchronized web of behavioral health services in place to help Soldiers and their Families heal from the effects of multiple deployments and high operational stress:

—The Post Deployment Health Assessment (PDHA), originally developed in 1998, was revised and updated in 2003. All Soldiers receive the PDHA upon re-deployment, usually in the Theater of Operations shortly prior to departure.

—In the fall of 2003, the first Mental Health Assessment Team (MHAT) deployed into Theater. Never before had the mental health of combatants been studied in a systematic manner during conflict. Four subsequent MHATs in 2004, 2005, 2006, and 2007 continue to build upon the success of the original and further influence our policies and procedures not only in theater, but before and after deployment as well. Based on MHAT recommendations, the Army has improved the distribution of behavioral health providers and expertise throughout the theater. Access to care and quality of care have improved as a result. An MHAT is currently in Iraq, and will be deploying to Afghanistan within the next 3 months.

—In 2004, researchers at the Walter Reed Army Institute of Research (WRAIR) published initial results of the groundbreaking "Land Combat Study" which has provided insights related to care and treatment of Soldiers upon return from combat and led to development of the Post Deployment Health Reassessment (PDHRA).

—In 2005, the Army rolled out the PDHRA. The PDHRA provides Soldiers the 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 assessment includes an interview with a healthcare provider and has been a very effective new program for identifying Soldiers who are experiencing some of the symptoms of stress-related disorders and getting them the care they need before their symptoms manifest as more serious problems. We continue to review the effectiveness of the PDHRA and have added and edited questions as needed.

—In 2006 the Army Medical Command (MEDCOM) piloted a program at Fort Bragg intended to reduce the stigma associated with seeking mental healthcare. The Respect-Mil pilot program integrates behavioral healthcare into the primary care setting, providing education, screening tools, and treatment guidelines to primary care providers. It has been so successful that medical personnel have implemented this program at 15 sites across the Army. Another 17 sites should implement it in 2009.

—Also in 2006, the Army incorporated into the Deployment Cycle Support program a new training program developed at WRAIR called "BATTLEMIND" Training. Prior to this war, there were no empirically validated training strategies to mitigate combat-related mental health problems. This post-deployment

training is being evaluated by MEDCOM personnel using scientifically rigorous methods, with good initial results. It is a strengths-based approach highlighting the skills that helped Soldiers survive in combat instead of focusing on the negative effects of combat (www.battlemind.org).

—Two DVD/CDs that deal with Family deployment issues are now available: an animated video program for 6 to 11 year olds, called "Mr. Poe and Friends," and a teen interview for 12 to 19 year olds, "Military Youth Coping with Separation: When Family Members Deploy." Viewing the interactive video programs with children can help decrease some of the negative outcomes of family separation. Parents, guardians and community support providers will learn right along with the children by viewing the video and discussing the questions and issues provided in the facilitator's guides with the children during and/or after the program. This reintegration family tool kit provides a simple, direct way to help communities reduce tension and anxiety, use mental health resources more appropriately, and promote healthy coping mechanisms for the entire deployment cycle that will help Families readjust more quickly on redeployment.

—In mid-July 2007 the Army launched a PTSD and mTBI Chain Teaching Program that reached more than one million Soldiers, a measure that will help ensure early intervention. The objective of the chain teaching package was to educate all Soldiers and Leaders on PTSD and TBI so they can help recognize, prevent and treat these debilitative health issues.

—In 2008 the Department of Defense revised Question #21, the questionnaire for national security positions regarding mental and emotional health. The revised question now excludes non-court ordered counseling related to marital, family, or grief issues, unless related to violence by members; and counseling for adjustments from service in a military combat environment. Seeking professional care for these mental health issues should not be perceived to jeopardize an individual's professional career or security clearance. On the contrary, failure to seek care actually increases the likelihood that psychological distress could escalate to a more serious mental condition, which could preclude an individual from performing sensitive duties.

—In 2008, the Army began piloting Warrior Adventure Quest (WAQ). WAQ combines existing high adventure, extreme sports and outdoor recreation activities (i.e., rock climbing, mountain biking, paintball, scuba, ropes courses, skiing, and others) with a Leader-led after action debriefing (L–LAAD). The L–LAAD is a Leader decompression tool that addresses the potential impact of executing military operations and enhances cohesion and bonding among and within small units. L–LAAD integrates WAQ and bridges operational occurrences to assist Soldiers transition their operational experiences into a "new normal", enhancing military readiness, reintegration, and adjustment to garrison or "home" life.

—Beginning February 15, 2009, the Army started a 30 day "stand-down" to ensure that all Soldiers learned not only the risk factors of suicidal Soldiers, but how to intervene if they are concerned about their buddies. The "Beyond the Front" interactive video is the core training for this effort. It will be followed by a chain teach which focuses on a video "Shoulder to Shoulder; No Soldier Stands Alone" and vignettes drawn from real cases.

Presently, we are partnering with the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury and working to identify best practices for the identification and intervention for mental health issues that include suicide, PTSD, TBI, and depression. We are also directing special attention to the processes and procedures by which we transfer care for affected Soldiers as they redeploy or move from one installation to another or one treatment facility to another.

I am not aware of any legal or regulatory obstacles that impede our efforts to improve screening and the delivery of care to Soldiers with PTSD or TBI.

IRELAND ARMY HOSPITAL/BLANCHFIELD ARMY HOSPTIAL

Question. LTG Schoomaker, do the Ireland and Blanchfield hospitals refer soldiers to regional hospitals that specialize in brain and spinal cord injury rehabilitation? What formal partnerships are established between post hospitals and regional hospitals in Kentucky to ensure soldiers with these conditions are given the best care? If there are no formal partnerships, what is the process for establishing such an affiliation?

Answer. Yes, both Blanchfield Army Community Hospital and Ireland Army Community Hospital refer Soldiers to specialized hospitals for brain and spinal cord injury rehabilitation. Both hospitals use the Department of Veterans Affairs Polytrauma Centers and other Veterans Affairs medical centers within the region, such as the DVA Medical Center in Memphis, Tennessee.

At Blanchfield Army Community Hospital, we use two facilities in Nashville, Skyline and Vanderbilt University Medical Center, for beneficiaries with brain and spinal cord injuries. These facilities are in the TRICARE Managed Care Support Contracts network.

At Ireland Army Community Hospital, Soldiers with brain and spinal cord injuries are regularly referred to regional resources such as Frazier Rehabilitative Services, located in Louisville, Kentucky for comprehensive TBI services as well as to the program at the University of Kentucky at Lexington.

The criteria for selection of the appropriate facility includes the Soldier's unique needs, the ability of the brain and spinal cord injury program to accommodate those needs and related considerations such as the Soldier's hometown and location of family.

The primary mechanism for establishing relationships with regional hospitals is through the Managed Care Network established by our TRICARE Region business partner. The TRICARE Managed Care Support Contractor contacts area facilities to establish the relationship. When Ireland or Blanchfield hospital identifies a facility that is not part of the network, we notify TRICARE with a request that the facility be contacted and considered for credentialing to network status.

DOD/VA FACILITIES

Question. LTG Schoomaker, per the Wounded Warrior legislation enacted in 2007 and the Dole-Shalala Commission's recommendations that were reported in 2007, improvements were to be made to the coordination between DOD and VA facilities to better care for our injured troops who are transitioning between the two healthcare systems. What steps have already taken place to improve coordination between the two Departments? What steps remain? Are these provisions sufficient to provide a seamless transition for wounded warriors from the DOD to the VA system? Does DOD need further legislation to improve matters? If so, what?

Answer. On October 12, 2007, the Vice Chief of Staff of the Army (VCSA), General Cody requested assistance from the Acting Secretary, Department of Veterans Affairs (VA) to reduce transition obstacles between the DOD managed care system and the VA system of care. The VCSA specifically asked the VA Secretary to support three initiatives to ease servicemember transition. The three initiatives include: colocating one Veterans Benefits Administration (VBA) Counselor with the Army Nurse Case Managers at each Warrior Transition Unit (WTU), provide Social Workers (MSW) at seven Army Installations which include, Forts Drum, Stewart, Campbell, Benning, Knox, Riley, and Fort Bliss, and provide VBA Counselors at all Soldier Family Assistance Centers (SFACs).

As of February 2009, there are 57 VA Regional Offices and 10 Satellite VA Offices established at Military Treatment Facilities to provide VA expert counsel on Veterans Benefit Administration (VBA) compensation and entitlement benefits programs as well as clinical care offered to Warriors in Transition (WTs) and their Families by the Veterans Health Administration (VHA). The VBA has representatives at all 35 WTUs. For those WTs that are assigned to Community Based WTU's (CBWTUs), the VA has contracted service providers to care for their administrative and clinical needs. The DVA does not intend to place VA Liaisons in overseas assignments. However, the VA has numerous outreach programs such as www.va.gov, direct mail pieces, booklets, pamphlets, videos, and broadcast shows on AFN (Armed Forces Network) to assist Service and Family Members at remote locations. Soldiers and family members may also contact the VA via telephone worldwide at 800–827–1000.

The Army has also assigned liaison officers to the four VA poly-trauma centers (Richmond, Virginia; Tampa, Florida; Palo Alto, California; and Minneapolis, Minnesota). Furthermore, we have assigned 60 advocates from the Army Wounded Warrior Program to 51 VA medical centers to assist Soldiers and Veterans receiving care.

QUESTIONS SUBMITTED TO VICE ADMIRAL ADAM M. ROBINSON

QUESTIONS SUBMITTED BY CHAIRMAN DANIEL K. INOUYE

Question. Admiral Robinson, North Chicago Veterans Center is scheduled to merge with the Naval Health Clinic Great Lakes on October 1, 2010. Aside from technology requirements, there are several regulatory and legislative challenges that remain unresolved. Could you please describe each of the outstanding issues, the difference between the VA and the Department's positions and a timeline for their resolution?

Answer. Legislation addressing the four issues was introduced as an amendment to the National Defense Authorization Act (NDAA) 2009 but was not included. H.R. 1267 was introduced by Congresswoman Bean (D-IL) and Congressman Kirk (R-IL) to the House of Representatives on March 3, 2009. H.R. 1267 was based on an old legislative version and does not contain the Department of Navy and Veteran's Affairs agreed upon language. Senators Durbin (D-IL) and Akaka (D-HI) are currently working on introducing the legislation on the Senate side and this version contains the agreed upon language. Strategies to reconcile language differences between the two versions are underway. There is anticipation that the legislative package could be passed within 30–40 days as part of a Defense supplemental bill.

The legislation will address four challenges to Great Lakes/North Chicago integration:

—*Designation of the Federal Health Care Center (FHCC) as a Uniformed Treatment Facility*.—Legislative relief is required for the designation of the FHCC as a Uniformed Treatment Facility (UTF). This will determine the cost of available care to DOD beneficiaries. If UTF designation is not achieved, the FHCC will require cost shares for retired TRICARE beneficiaries using the VA portion of the FHCC. Beneficiaries over age 65 enrolled in TRICARE for Life will not be eligible to use the VA portion of the FHCC without significant cost shares. VA and DOD concur on the need for UTF designation.

—*Permission to transfer all DOD civilian employees into the VA personnel system*.—Legislative relief is required to establish a single integrated personnel system that transfers DOD civilian employees into the VA personnel system. This will streamline management functions and reduces the disparity in pay and benefits for individuals working side by side. NHCGL civilian personnel are appointed under Title 5 authority while VA employees are appointed under Title 38. Approximately 450 civilian NHCGL employees will be impacted by this transfer. This includes those working in the Recruit and Student Medical and Dental Clinics on DOD property. The proposed Senate legislation contains language designed to protect DOD civilians transitioning into the VA personnel system by eliminating probationary periods for those that have already completed this as a DOD employee. Additionally, staff will retain at least the same pay and seniority (tenure) as they have in the DOD system.

Long-term success depends on identifying and retaining adequate numbers of leadership positions for uniformed staff at the FHCC. An organizational leadership structure addressing this requirement is in draft form.

Both DOD and VA support the Transfer of Personnel with the agreed upon language as contained in the bill sponsored by Senator Durbin. The National AFGE does not concur, as they do not support the Title 38 appeal process with the loss of Merit Systems Protection Board appeal rights currently afforded for the Hybrid Title 38 and Title 5 employees.

—*Create a funding mechanism to provide a single unified funding stream to the FHCC*.—The VA and DOD have separate appropriations for meeting the healthcare missions of each agency. Each have multiple funding streams that support the various cost components, that when combined, currently comprise the totality of funding required to meet the healthcare mission assigned to each facility. The intent at the FHCC is to have a single budget at the FHCC for the management of all medical and dental care for all beneficiaries. To create a single budget, the proposed solution is to extend Joint Incentive Fund (JIF) authority with the intent to use this authority for dual agency funding of the FHCC. The VA fully supports this but DOD has expressed concern about using this mechanism to fund the FHCC. A JIF-like alternative is being considered by DOD and VA.

—*Create a legislative mechanism to allow DOD to transfer the Navy Ambulatory Care Clinic, parking structure, support facilities, and related personal property and medical equipment to the VA if desired at a later date*.—Both VA and DOD agree with the need to establish a transfer mechanism. DOD plans to retain ownership of the new Ambulatory Care Clinic initially. The transfer of personal property is dependent on the ability of VA systems to effectively track the property and provide accountable data back to DOD. Logistics staff on Navy and VA sides are analyzing this.

NDAA 2009 Section 706 requires nine specific areas be addressed in a written agreement for a Combined Federal Medical Facility. An Executive Sharing Agreement (ESA) is currently being written to address all nine areas. Target date for SECDEF/SECVA signature on this document is November 2009. The framework of this document is dependent on the legislative issues as indicated above.

Question. Admiral Robinson, what are the specific mechanisms in place to ensure coordination at the planning, budgeting, and technical levels between the various

federal agencies (including NIH) on areas like Traumatic Brain Injury or Malaria research? Are there examples of DOD, VA, or NIH dollars being moved or redundant activities being terminated as a result of these coordination efforts?

Answer. In regards to malaria research, the Navy has a long history of recognizing the importance of coordination in those areas mentioned by the Senator. For the past 2 years, the Navy and the Army have run a joint program, the U.S. Military Malaria Vaccine Program. Leaders of this program are members of the Federal Malaria Vaccine Coordination Committee (FMVCC) chaired by USAID which provides a forum for interagency collaboration and coordination in this important area of research so that resources are optimized and overlap minimized.

The Navy collaborates with USAID, NIAID, CDC, and indirectly with NIST on several vaccine projects including recombinant protein-based vaccines, adenovirus-vectored vaccines, an attenuated whole sporozoite vaccine and the development of field testing sites in Africa and elsewhere.

The military uniquely targets its funding for developing vaccines for deployed military populations and civilian travelers where the required level and duration of protection required is much higher, and is currently significantly underfunded for the mission. Currently, the vaccine products in development by all federal agencies except DOD are aimed at the vulnerable populations of children and pregnant women in malaria endemic countries. The primary non-government funding source, the Bill and Melinda Gates Foundation, likewise supports this humanitarian mission.

For TBI, Navy medicine works closely with the Defense Center of Excellence (DCoE) for Psychological Health and Traumatic Brain Injury to coordinate TBI programs. BUMED also collaborates with NIH, CDC, the Uniformed Services University, the Army and Air Force, and the VA for TBI initiatives. The DCoE is planning to fund a central database at NIH which will also include Navy TBI information, for example. In addition, Navy medicine is responsible for tracking/surveillance for TBI and is developing and testing an automated neurocognitive test instrument, called Braincheckers. The Naval Health Research Center is conducting TBI research projects related to surveillance and force protection. The Naval Medical Research Center recently completed a study on the effect of acute blast exposure on cognition in Marine Corps Breachers, an effort funded jointly by the Defense Advanced Research Projects Agency and the Office of Naval Research. The BUMED consultant for TBI programs meets regularly with counterparts in the other services, the DCoE, NIH, CDC, and VA to discuss new collaborative efforts.

Question. Admiral Robinson, while attention must be focused on the resilience training of our service members and their families, I also suspect that caring for our wounded takes a considerable toll on our care givers. What efforts are underway to address the well-being of our caregivers in order to retain these critical personnel?

Answer. Navy Medicine is dedicated to doing what is right for our active duty and retired Sailors, Marines and their families; and, we are just as committed to doing what is right for our caregivers. Occupational stress and compassion fatigue can undermine professional and personal performance, impact job satisfaction, and result in poor retention. The Navy Medicine Caregiver Occupational Stress Control (OSC) Program, sometimes called "Care for the Caregiver", comprises several strategies designed to enhance individual resilience, strengthen unit cohesion, and support command level assessment of the work environments of caregivers. A main strategy of the Navy Medicine Caregiver OSC program is to provide Navy Medicine personnel multidisciplinary occupational stress training that matches the treatment facility OPTEMPO and creating trained intervention teams, with a mix of officer and enlisted, at our major treatment facilities. This strategy will provide staff with skills and knowledge about the stress continuum model, stress first-aid, buddy care assessment and intervention, self-care/compassion fatigue skills, work-environment assessment, and education outreach. The foundation of dedication, knowledge, skills, and passion that results in Navy Medicine's superior quality of care is also the foundation of caring for our caregivers.

Program Elements:

"Rule Number Two" Lecture Series.—Started in January 2008 to educate Navy Medicine Leaders about the operational and occupation stress on caregivers and leadership strategies to mitigate that stress.

Caregiver Occupational Stress Training Teams.—Completed training of 90 team members for 15 medical treatment facilities in January 2009. Expanded MTF team training started in March 2009 designed to have 20 or more stress and coping peer trainers at each MTF.

All Hands Awareness Training.—Medical treatment facility (MTF) focused training to initiate all hands awareness and core peer support skills started in February 2009.

Caregiver OSC Training Resources.—Caregiver OSC video vignettes and Corpsmen focused graphic training novel in production.

Caregiver Stress Assessment.—Navy Medicine wide assessment of caregiver resilience and stress.

Question. Admiral Robinson, the Department and the VA are working on creating an interoperable medical health record that will allow for a seamless transition for our service members and also provide continuity of care at joint DOD/VA facilities like the future James A Lovell Federal Health Care Center. I understand that premature steps have been taken to procure systems for the Lovell Center that would repeat the mistakes of focusing on site specific fixes rather than our joint enterprise as a whole. Since Navy is an equal partner in this endeavor with the VA, could you please detail us on the current situation, the path forward, and how it integrates into the overarching medical enterprise architecture?

Answer. The electronic medical record is an area where there is pressure to move to one system or the other. Neither AHLTA nor VISTA can sustain the requirements of both DOD and VA. The IM/IT solution being crafted must sustain missions of both organizations. The FHCC establishment date of October 1, 2010 creates mounting time pressures. The time passage of pending Congressional legislation is crucial to implementing the full vision of this project. Because Great Lakes is being touted as the model for future fully integrated federal healthcare, there is enormous self-imposed pressure to do it right. System solutions (financial reconciliation, electronic medical record, information management, etc.) cannot be local fixes, but must be crafted in a manner that lends to exportability throughout the enterprise.

Question. Admiral Robinson, how do you ensure Service specific needs are incorporated in the new enterprise architecture and how do you make sure they don't drive up costs throughout the system?

Answer. The Navy will engage with the central program offices developing the solutions to make sure that they meet the needs of the Navy as well as being in line with the direction of the TriCare Management Activity. If the needs are a part of the overarching architecture then that should not drive up the cost any more than would occur as both agencies are charged with more and more sharing of patient data between DOD and VA. The Navy was identified as the first service branch to complete a single site integration with a VA facility but Army and Air Force are in the queue with four proposed integration sites.

QUESTIONS SUBMITTED BY SENATOR PATTY MURRAY

Question. JCS Chairman Mullen has said publically he's trying to break the stigma of psychological health in the active force, yet the JAGs are still prosecuting as a "crime" depressed people who attempt suicide. While the Surgeons General aren't responsible for the UCMJ, it seems to me that they might be concerned about JAG prosecutions of people who have severe mental distress while serving or after serving in combat. Do you think that the continued criminal prosecution of troops who commit suicide is a problem for the military's efforts to break the stigma of psychological health?

Answer. The decision whether to court-martial a sailor and, if so, for what offense, is within the sole discretion of the cognizant commander, usually with the benefit of input from a judge advocate. However, our research covering the last 5 years does not reveal any instance of a Sailor being charged with a criminal offense relating to a failed suicide attempt.

Even in those cases where a Sailor is determined to be free of any serious mental defect, the Uniform Code of Military Justice does not criminalize suicide or attempted suicide. A charge does exist to address malingering (feigning a debilitating condition or intentionally inflicting self-injury specifically to avoid duty). Similarly, a charge exists to address self-injury in those cases where it is prejudicial to good order and discipline. Either of those charges, in certain circumstances, could conceivably support a prosecution arising out of a failed suicide attempt where a commander believes that the attempt was actually an attempt to avoid duty or was otherwise prejudicial to good order and discipline.

In cases where a Sailor's mental health is in question, the Manual for Courts-Martial requires the commander contemplating charges to request a mental health inquiry pursuant to Rule for Court-Martial (RCM) 706. Although the RCM 706 request is issued by the commander, the need for the request, if not immediately identified by the commander him/herself, may be raised by any investigating officer, the

trial counsel, defense counsel, military judge, or a member of the court-martial, if one is already in progress. Pursuant to the rule, the Sailor's mental health will be evaluated by a board which must normally include at least one psychiatrist or clinical psychologist, and may also include one or more physicians.

If a 706 board determines that a Sailor was unable to appreciate the wrongfulness of his actions at the time of the alleged offense, or does not currently have the mental capacity to assist in his own defense, depending on the stage of the proceedings, charges may be dismissed; or the determination may result in a finding of not guilty due to lack of mental responsibility. In any case, such determination would act as a bar to conviction, if not prosecution. If a 706 board determines that no mental defect exists that would affect the Sailor's mental responsibility at the time of the alleged offense or his ability to assist in his own defense, there is nothing to preclude lawful prosecution.

Question. In your opinion, what additional steps need to be taken to ensure that electronic medical information is available to VA?

Answer. Currently we use the Bidirectional Health Information Exchange (BHIE) but it is considered inadequate as not all of the data is available in an easy to read format. BHIE, or a modernized replacement of BHIE, needs to be made more robust and improvements made in the presentation of the data to the provider. Establishment of trusted networks between the DOD and VA would allow greater access to the data by both agencies. Differences in the information assurance regulations of both Departments, and between the military Services, makes this a cumbersome, time consuming, and difficult process.

Question. How are each of your services obtaining medical records for service members who receive contract care and how big of a problem is this for creating a complete record of care?

Answer. There is limited information sharing for patients who receive care in the direct care system but who may also receive some care in the civilian health care sector. For example, in some cases a military healthcare provider may refer a patient to a civilian healthcare specialist for a consult. These consult results are frequently only returned to the military provider in the form of a written document. In some cases they may be sent as a fax or as an email message (or attachment to an email message).

Regardless of whether the information is received in paper form or via an electronic transfer of a scanned document, there are limitations as to how that information can be incorporated into AHLTA (Armed Forces Health Longitudinal Technology Application). Those limitations make it difficult for military healthcare providers to access that information effectively.

In order to address the current limitations, DOD is pursuing a number of initiatives. We are implementing a capability to capture scanned documents and other images as part of our electronic health record. And, we will index those documents so that they are readily retrievable by military healthcare providers. We are also piloting a more robust interchange capability with the civilian sector through the Nationwide Health Information Network (NHIN) initiative. As the civilian healthcare providers adopt electronic health records, we will be able to take advantage of the NHIN infrastructure to share information in a more flexible form.

Question. The NDAA fiscal year 2008 Section 1623, required the establishment of joint DOD and VA Vision Center of Excellence and Eye Trauma Registry. Since then, I am not aware of any update on the budget, current and future staffing for fiscal year 2009, the costs of implementation of the information technology development of the registry, or any associated construction costs for placing the headquarters for the Vision Center of Excellence at the future site of the Walter Reed National Medical Center in Bethesda. What is the status on this effort?

Answer. As the DOD/VA Vision Center of Excellence is an Army run program, they will best be able to provide the status of this effort.

QUESTIONS SUBMITTED BY SENATOR THAD COCHRAN

Question. The Active Duty Navy has only had a 39 percent completion rate on the Post Deployment Health Reassessment form (PDHRA). This is the lowest of all the Services. What are the reasons for this low input? Is it an issue of resources?

Answer. Navy is committed to protecting and promoting the long term health of our Sailors, especially those facing post deployment stress challenges. Navy leadership led efforts to increase the completion rate of the Post Deployment Health Reassessment (DD 2900). These efforts included communicating its importance; issuing PDHRA guidance and lessons learned; distributing by name lists of Sailors required

to complete the PDHRA to individual commands; and committing human and fiscal resources to the administration and execution of the program.

As of March 24, 2009, the Medical Readiness Reporting System (MRRS), Navy's designated database for PDHRA compliance tracking, indicates a Navy-wide compliance rate of 57.4 percent, with the Active Component (AC) at 46 percent and the Reserve Component (RC) at 93.4 percent. Navy, in an effort to ensure no Sailor is overlooked, used two indicators to identify Sailors required to complete the PDHRA. These "identifiers" are a previously completed Post Deployment Health Assessment (DD 2796) or a Sailor's concurrent receipt of Hardship Duty and Imminent Danger Pays. It has since been determined that the use of these two identifiers "cast the net" too wide and erroneously identified persons who do not meet current criteria for completion of the PDHRA as set forth in DOD Instruction 6490.3, Deployment Health, and OPNAVINST 6100.3, The Deployment Health Assessment (DHA) Process. (This erroneous identification affected the active component almost exclusively and accounts for some of the difference in active and reserve reported compliance rates.)

Approximately 25 percent of the overdue PDHRAs for USN personnel are identified by the two pays and the vast majority (approximately 73 percent) of overdue PDHRAs for USN personnel is due to the completion of a PDHA. Navy has taken a conservative approach to reporting PDHRA compliance. For example, all Sailors have been individually canvassed to confirm the requirement for the Deployment Health Assessment process followed by a manual check of records for the presence of a completed DD 2900. Additionally, early in the DHA administrative process, many Sailors who made routine ship deployments erroneously completed a post DHA. Correcting these data entries has proven to be a time consuming, manpower intensive effort.

A more accurate method to determine Navy PDHRA compliance is being implemented. This new method will eliminate those Sailors who are identified as overdue, but in actuality do not require a PDHRA (e.g., Shipboard Sailors). On March 10, 2009, the PDHRA compliance rate was calculated by the use of the more accurate method to identify Sailors required to complete the PDHRA: a completed Post-deployment Health Assessment (DD 2796) preceded by a Pre-deployment Health Assessment (DD 2795). The PDHRA compliance rate was determined to be 78.4 percent for the Active Component and 96.8 percent for the Reserve Component with a Navy-wide level of 85.0 percent.

Navy is making steady improvements in the PDHRA compliance rate. We are pressing to ensure that those Sailors who need the PDHRA complete the assessment and are working to correct the erroneous method for identifying Sailors required to complete the PDHRA. Efforts toward meeting objectives include:

—In fiscal year 2006, Navy Medicine established Deployment Health Centers (DHCs) with the primary mission to augment military treatment facilities to ensure the availability of adequate medical resources to support PDHRA compliance. There are currently 17 DHCs with 117 medical contract positions, including psychiatrists and psychologists, funded with annual costs of $15 million.

—MRRS now provides the capability to reconcile the overdue status of Sailors if indicated by a previously completed PDHA not meeting today's criteria.

—The capability to reconcile the status of those erroneously identified by the two pays will be implemented in MRRS in May.

—Navy (BUMED) has identified the need for additional temporary resources to clear any data entry backlogs that currently exist.

Navy's low compliance rate is not an issue of resources.

Question. This Committee is aware of some of the challenges that the Great Lakes consolidation has come up against. Can you talk about some of the pressures that the Navy is experiencing with this consolidation? Would integration like Keesler-Biloxi make more sense than total consolidation?

Answer. Cultural differences between the Navy and the VA are large, and they present challenges in establishing the template for future integrated federal healthcare facilities. This consolidation will not work unless each agency is willing to waive agency specific policies in order to accommodate the broader mission of the Federal Health Care Center (Health Care and Operational Readiness).

The Great Lakes consolidation model was driven from the Health Executive Council (HEC) and Joint Executive Council (JEC) level to the deckplate level in Great Lakes and North Chicago. There is significant interest by Congressional and Senate members in executing a new model of interagency cooperation, and the North Chicago/Great Lakes consolidation is being looked at as the test bed.

Navy Operational Readiness is our number one mission and our primary reason for existence. As we deal with Command and Control, IM/IT, fiscal and clinical support decisions, this Operational Readiness mission has to constantly be re-affirmed

as it is a new concept for the VA. The electronic medical record is an area where there is pressure to move to one system or the other. Neither AHLTA nor VISTA can sustain the requirements of both DOD and VA. The IM/IT solution being crafted must sustain missions of both organizations.

The FHCC establishment date of October 1, 2010 creates mounting time pressures. The timely passage of pending Congressional legislation is crucial to implementing the full vision of this project. Because Great Lakes is being touted as the model for future fully integrated federal healthcare, there is enormous self-imposed pressure to do it right. System solutions (financial reconciliation, electronic medical record, information management, etc.) cannot be local fixes, but must be crafted in a manner that lends to exportability throughout the enterprise.

The Keesler-Biloxi venture is not an integration. It is a joint side-by-side sharing relationship. Construction decisions made 5 years ago, along with direction from the HEC and JEC, are driving the need for a tighter integration in North Chicago. There is not enough physical space to accommodate two organizations (the original space plan was decreased by 50 percent) working side by side with all the necessary additional infrastructure (personnel, equipment, IM/IT systems and support services) required. We must integrate in a tighter fashion compared with Keesler-Biloxi.

QUESTIONS SUBMITTED BY SENATOR MITCH MCCONNELL

Question. Congress has established a national suicide hotline for returning troops, as well as increased funding for mental health for active military personnel. However, there remains a high number of soldier suicides. What preventative measures is DOD taking to address this problem? What, if any, legislative action would DOD need Congress to take to expand suicide awareness and education on posts?

What preventive measures is Navy taking to reduce suicides?

Answer. The Navy recognizes that multiple demands on our Sailors has become a significant source of stress and limits the time available for addressing problems at an early stage. In response, the Navy is increasing dedicated resources to the development of leadership tools for Operational Stress Control (OSC) and suicide prevention. Current efforts focus on inspiring leaders to understand and take suicide prevention efforts as critical to their ability to do their jobs and missions. Other actions include:

—The Chief of Naval Operations (CNO) directed the establishment of the Navy Preparedness Alliance (NPA) to address a continuum of care that covers all aspects of individual medical, physical, psychological and family readiness across the Navy.

—In February 2009, an interdisciplinary Suicide Prevention Cross Functional Team was established to review current efforts, identify gaps, and develop the way ahead.

—Top leadership vigilance. CNO maintains awareness through monthly and ad hoc suicide reports, quarterly Tone of the Force reports, Behavioral Health Needs Assessment Surveys, and targeted surveys of Sailors and Family members.

—Increased Family Support. Navy hired 40 percent more professional counselors to address Sailor and family needs, resulting in improved staffing from 1,044 to 1,444 at Fleet and Family Service Centers. A Family Outreach Working group was established to improve suicide awareness communication and education of family members.

—Operational Stress Control (OSC), a comprehensive approach designed to address the psychological health needs of Sailors and their families, is a program led by operational leadership and supported by Navy Medicine. To date, more than 13,000 Sailors have received an initial OSC familiarization brief. Formal training curriculum at key points throughout a Sailor's career is under development. The OSC Stress Continuum Model has been integrated into Fleet and Family Service Center programs and education and training programs.

—Reserve Psychological Health Outreach Coordinators Program was implemented in 2008 and provides 2 coordinators and 3 outreach team members (all licensed clinical social workers), to each of the 5 Navy Reserve Regions, to engage in training, active outreach, clinical assessment, referral to care, and ensure follow up services for reserve Sailors.

—Personal Readiness Summits and Fleet Suicide Prevention Conferences/Summits are providing waterfront training opportunities for leaders, command Suicide Prevention Coordinators, and installation first responders.

—Front Line Supervisor Training, train-the-trainer, has been provided at six locations throughout CONUS with additional training scheduled throughout 2009.

The Front Line Supervisor Training is an interactive half-day workshop designed to assist deck-plate leaders in recognizing and responding to Sailors in distress.

—First Responder Seminars provide those individuals likely to encounter a suicide crisis situation (security, fire, EMS, medical, chaplains, or counselors) with a review of safety considerations and de-escalation techniques.

—Commands are required to have written command crisis response plans to guide duty officer actions in response to a suicidal individual or distress call. Navy has been training a network of command Suicide Prevention Coordinators (SPC) to assist Commanding Officers in implementing command level prevention efforts and policy compliance.

—Communications and outreach efforts continue. The new www.suicide.navy.mil web URL went live in September 2008 to provide an easy-to-remember link to helpful information. A new four-poster series was distributed to all installations in November 2008 along with a new tri-fold brochure. A new training video will be distributed this summer.

—Warrior Transition Program (WTP) provides a 3-day respite in Kuwait to all Individual Augmentees returning from theater. Conducted by counselors, chaplains, and peers, the WTP provides time for reflection, rituals of celebration or grief, restoration of normal sleeping patterns, and time to say good-byes.

—Safe Harbor. Non-clinical Case Managers are assigned to individuals who are severely or very severely ill or injured to provide continued support through the treatment and transition process and beyond.

—Chaplain Support. Chaplain education in 2008 and 2009 focused on Operational Stress Control for non-mental healthcare givers and resilience and family care. The Chaplain Corps Human Care initiative is working to understand, evaluate and realign chaplain resources for efficient and effective care.

Question. What, if any, legislative action would DOD need Congress to take to expand suicide awareness and education on posts?

Answer. There are no legislative barriers to expanding suicide awareness and education on posts.

Question. What are the typical steps taken for sailors who may have post-traumatic stress disorder (PTSD) and traumatic brain injuries (TBI) to ensure they get the proper care? Are there any further legislative steps that Congress could take to improve screening and the delivery of care to sailors with PTSD and TBI?

Answer. Sailors and Marines are provided unit-level pre- and post-deployment education about signs and symptoms of post-traumatic stress disorder and traumatic brain injury. Navy Medicine has developed the Stress Injury Model to promote early identification and appropriate referral; early identification of symptoms is the best way to mitigate the effects of combat stress.

Unit medical personnel also receive training in PTSD and TBI surveillance. The Post-Deployment Health Assessment and Post-Deployment Health Reassessment contain screening questions specific to both PTSD and TBI, and can assist healthcare providers in making timely and appropriate referrals for specialty evaluation and treatment. After a diagnosis of PTSD or TBI is made the service member is offered the appropriate medical care. For those diagnosed with PTSD, care would include additional psychological assessment to rule out other mental health conditions followed by appropriate evidence-based cognitive therapies (e.g., Cognitive Processing Therapy, Prolonged Exposure). For those diagnosed with TBI, care may range from 7 days of rest to evacuation from theater and surgical treatment. Service Members diagnosed with TBI are assigned a medical case manager to assist with coordinating medical care. For those Sailors and Marines unable to remain on active duty, Navy Medicine has partnered with the VA to ensure a seamless, coordinated transition of care.

Question. Per the Wounded Warrior legislation enacted in 2007 and the Dole-Shalala Commission's recommendations that were reported in 2007, improvements were to be made to the coordination between DOD and VA facilities to better care for our injured troops who are transitioning between the two healthcare systems. What steps have already taken place to improve coordination between the two Departments?

Answer.

Disability Evaluation System (DES) Pilot

The Pilot originally began in 2007 and was expanded January 2009. Features of the pilot are:

—Single physical exam serving DOD separation and VA disability decisions; and

—Single disability rating (by VA) used by DOD in separation/retirement decision and VA in benefits determination.

Case Management—Federal Recovery Coordinator Programs

The Federal Recovery Coordination Program was created in late 2007 and implemented in 2008 through the signing of two memoranda of understanding between DoN and DVA. The goal of the program is to provide assistance to recovering service members, veterans and their families through recovery, rehabilitation and reintegration and benefits.

The first Recovery Coordinators were hired and trained in early 2008 and placed at military treatment facilities where most newly evacuated wounded, ill or injured service members are taken. NNMC Bethesda and NMC San Diego have Recovery Coordinators assigned to work in their facilities. This program is fully supported and endorsed by both departments and additional Recovery Coordinators will be hired in 2009.

The FRC program also includes DOD liaisons and VA detailed staff.

—1 Navy Liaison, 1 Army Liaison, 2 Marine Liaison Officers, 2 Public Health Service staff members.

Post Traumatic Stress Disorder/Traumatic Brain Injury (PTSD/TBI)

Established Defense Center of Excellence and appointed director; private sector benefactors building facility on Bethesda campus of National Military Medical Center. Both DOD and VA established a policy of Mental health access standards and standardized TBI definitions and reporting criteria.

TBI questions added to Post Deployment Health Assessment and Post Deployment Health Reassessment which may trigger a referral.

DOD/VA Data Sharing

Expanded the availability of DOD theater clinical data to all DOD and VA facilities. As of the beginning of 2008, added the bi-directional transmission of provider/clinical note, problem lists, theater inpatient medical data from Landstuhl and medical images between three Military Treatment Facilities and the VA Polytrauma Centers

DOD and VA have signed Information Technology (IT) Plan to support the Federal Recovery Care Coordinator program. A tri-fold on Wounded Warrior pay and travel entitlements (also on web).

Question. What steps remain?

Answer. Further growth and expansion of DES will greatly assist in this endeavor. Involvement of Case Mangers and education of both staff's on the intent of DES is critical to success.

Further efforts to ensure smooth data sharing between DOD and VA are critical to the transition of care.

Question. Are these provisions sufficient to provide a seamless transition for wounded warriors from the DOD to the VA system?

Answer. Yes, although continued efforts to refine the processes supporting seamless transition should be encouraged.

Question. Does DOD need further legislation to improve matters? If so, what?

Answer. No needs identified at this time.

QUESTIONS SUBMITTED TO LIEUTENANT GENERAL JAMES G. ROUDEBUSH

QUESTIONS SUBMITTED BY CHAIRMAN DANIEL K. INOUYE

WELL-BEING OF OUR CAREGIVERS

Question. General Roudebush, while attention must be focused on the resilience training of our Service members and their families, I also suspect that caring for our wounded takes a considerable toll on our caregivers.

What efforts are underway to address the well-being of our caregivers in order to retain these critical personnel?

Answer. The Air Force is also concerned about the stress experienced by our healthcare providers, as well as their exposure to the injured and killed. In order to address this concern, we provide awareness education to healthcare providers prior to deployment, and we closely monitor psychological symptoms post-deployment. These educational and surveillance processes are provided to all deploying Airmen via Landing Gear; the post-deployment health assessment; the post-deployment health reassessment. A study is currently underway at the theater hospital in Balad that assesses risks and protective factors in our deployed medics. Furthermore, the Air Force has hired 97 additional contract mental health providers in the last year to improve access to mental healthcare and to spread out the workload for our busy uniformed mental health providers.

ENTERPISE ARCHITECTURE

Question. How do you ensure Service specific needs are incorporated in the new enterprise architecture and how do you make sure they don't drive up costs throughout the system?

Answer. The Air Force Medical Service has representation in the MHS integrated requirements and review working groups. These vetting bodies review the initial capability documents and analyze costing before recommending for inclusion in the Central Portfolio. As a general rule, we ensure cost is minimized by finding compatible Tri-Service solutions that use common standards that enhance interoperability.

QUESTIONS SUBMITTED BY SENATOR PATTY MURRAY

SUICIDES

Question. JSC Chairman Admiral Mullen has said publicly he's trying to break the stigma of psychological health in the active force, yet, the Judge Advocates General are still prosecuting as a "crime" depressed people who attempt suicide. While the surgeons general aren't responsible for the enforcement of the Uniformed Code of Military Justice, it seems to me that they might be concerned about prosecutions of people who have severe mental distress while serving or after serving in combat.

Generals, do you think that the continued criminal prosecution of troops who commit suicide is a problem for the military's efforts to break the stigma of psychological health?

Answer. The Air Force is not aware of any instances in which an Airman has been prosecuted based solely on mental distress and/or a suicide attempt. AF leaders work hard to foster a "wingman" culture, in which Airmen look out for one another and seek timely help for both personal and psychological concerns. Our goal is to identify and address psychological concerns before they manifest themselves behaviorally in a way that threatens personal health or safety or that interferes with mission accomplishment. Should those efforts fail, we will continue to provide comprehensive, evidenced-based treatment.

ELECTRONIC MEDICAL INFORMATION

Question. In your opinion, what additional steps need to be taken to ensure that electronic medical information is available to the Department of Veterans Affairs?

Answer. Further interdepartmental collaboration on the creation of common data dictionaries and implementation of Services Oriented Architecture will set a firm footing towards sharing of our data. A dedicated integration program office and a sound funding strategy will do much to ensure data is available to our constituencies.

ACCOUNTING FOR CONTRACT CARE IN THE MEDICAL RECORD

Question. How are each of your Services obtaining medical records for Service members who receive contract care and how big of a problem is this for creating a complete record of care?

Answer. There are two primary scenarios in which the Air Force Medical Service obtains medical records from contracted TRICARE network providers.

Scenario 1:

Military Treatment Facility (MTF) enrolled Active Duty Service Members (ADSMs) referred to a contract TRICARE network provider for specialized health care not available at the MTF.

Records capture process: Following the civilian medical appointment, the referral results or consultation report(s) are submitted to the referring MTF where they are reviewed by the referring provider and permanently filed in the ADSM's record. This process is not considered to be a significant Air Force Medical Service problem or challenge that would otherwise prevent or delay its ability to create a complete record of care.

Scenario 2:

TRICARE Prime Remote (TPR) ADSMs enrolled to a TRICARE network primary care manager instead of an MTF provider.

Records capture process: Health treatment records for Airmen assigned to geographically separated units (GSUs) or remote duty locations (e.g. recruiting squadrons, Military Entrance Processing Centers, unique military detachments, or other similar units without immediate military installation support), are usually maintained at the nearest Air Force MTF.

Prior to PCS reassignment (from the TPR duty location or retirement or separation from the remote duty assignment), Airmen are required to "out-process" through the MTF responsible for maintaining their military health treatment records. At the time of the MTF records department out-processing encounter, MTF records managers and the service member complete a records copy request form. The form is submitted to the Airman's contracted TRICARE network primary care manager. Upon receipt of the requested information, the medical document copies are added to the Airmen's health record and the complete health record is forwarded to the gaining MTF or to the Air Force Personnel Center (for separating and retiring Airmen).

The Air Force continues to educate Airmen regarding installation out-processing procedures whenever and wherever possible. However, sometimes Airmen assigned to GSUs do not always visit or "out-process" through the nearest Air Force MTF responsible for maintaining their military health treatment records. Consequently, the MTF doesn't always know to submit a records copy request to the Airman's contracted TRICARE network primary care manager. The records capture process for Airman assigned to TPR locations currently does not function as well as it should, and we are reviewing this process to identify improvement opportunities.

VA VISION CENTER OF EXCELLENCE AND EYE TRAUMA REGISTRY

Question. The fiscal year 2008 National Defense Authorization Act, Section 1623, required the establishment of a Joint Department of Defense and Department of Veteran's Affairs Vision Center of Excellence and Eye Trauma Registry. Since then, I am not aware of any update on the budget, current and future staffing for fiscal year 2009, the costs of implementation of the information technology development of the registry, or any associated construction costs for placing the headquarters for the Vision Center of Excellence at the future site of the Walter Reed National Medical Center in Bethesda, MD.

What is the status on this effort?

Answer. I believe Col. Donald A. Gagliano, the Executive Director for the DOD Vision Center of Excellence, addressed some of those issues during his March 17, 2009, testimony, and I would defer to the the Army as the lead agent to provide a more comprehensive response.

QUESTIONS SUBMITTED BY SENATOR THAD COCHRAN

POST DEPLOYMENT HEALTH REASSESSMENT

Question. One of the tools used to measure the health and well-being of Service members after they return home is the Post Deployment Health Reassessment form, which everyone is asked to fill out 90 and 190 days after their redeployment. As of January 30, the Air Force Reserve had the second lowest completion rate of this form at 46 percent.

What are some of the reasons for this low number of completed responses and what is the Air Force doing to help ensure returning Airmen and women receive needed care?

Answer. Initial rollout of the Post Deployment Health Reassessment was made available to Reservists through the Reserve Component Periodic Health Assessment (RCPHA) system. However, this system proved unable to monitor completion of the PDHRA (Form 2900) or measure unit compliance. The system was abandoned in July 2008 and the Reserve migrated to the medical information system used by the Air Force active component. The migration resulted in corrupted and incomplete records, reflected in a 7 percent indicated compliance rate immediately following the transition. Efforts to correct these errors have rapidly improved the indicated compliance rate, which is currently at 51 percent. By late summer we project our PDHRA compliance to be on par with the active duty and Air National Guard.

KEESLER MEDICAL CENTER AND BILOXI VETERANS HOSPITAL

Question. I understand the Department of Defense and the Department of Veterans Affairs are working to establish joint ventures in areas where both agencies have co-located facilities around the country. I would hope the goal of these joint ventures would be to increase the quality of care and efficiency without decreasing capability or capacity. I understand the Air Force has been working with the Department of Veterans Affairs to integrate Keesler Medical Center and the Biloxi Veterans Hospital.

Can you give me your assessment on this process and if you believe it has been a good news story?

Answer. Based on our experience to date, the joint venture process is effective and the results are good news stories across the board.

When considering Joint Venture opportunities, the viability of a proposed joint facility is assessed across nine separate domains. Through this structured approach, the work group assesses the organizations' current relationship and the potential for a future joint relationship. Phase I and Ib sites are already joint facilities or are in the process of becoming joint facilities. The efforts at those sites have focused on further integration, and Keesler-Biloxi is part of that group. Detailed plans are complete for the integration of all clinical specialty services between Keesler Medical Center and Biloxi Veterans Hospital, with the exception of General Surgery, which will continue to be available at both facilities.

All Phase II sites have the potential to increase their level of sharing and some sites may have the potential to become joint facilities. An example of Phase II efforts is the Colorado Springs Joint Market area, where the Air Force Academy's 10th Medical Group will share operating room time with the Eastern Colorado Health Care System.

We anticipate all of our joint ventures will be win-win efforts that will improve efficiency and access to care for all participating facilities.

JOINT AIR FORCE AND VETERANS AFFAIRS PROJECTS

Question. I have been informed that it is intended these joint ventures, such as the Keesler-Biloxi project, will achieve complete consolidation, much of what's being attempted at Great Lakes in Illinois with the Navy.

Do you believe that the different mission sets in the Department of Defense and the Department of Veterans Affairs make complete consolidation possible or logical at all locations?

Answer. In our experience, despite disparate missions, joint venture sites have been very successful in taking care of their beneficiaries and provide a win-win scenario for both partners. We believe that there are many forms of joint ventures, and not all joint ventures are, or should be, considered for complete consolidation.

We appreciate your interest in the good news story at Keesler. Keesler Medical Center (KMC) and VA Gulf Coast Veterans Health Care System (VAGCVHCS) have had a long history of sharing, but it wasn't until after Hurricane Katrina that the full benefits of DOD/VA sharing were explored. Dual VA CARES and DOD BRAC funding projects caused the two large medical centers to develop an integration plan as an official joint venture site. Using a "Centers of Excellence" (COE) model, all KMC and VA inpatient and outpatient clinical product lines are being realigned/shared at the site where either party has the greater capability. This produces a synergy between the combined staffs and maximizes capabilities for the patient. This approach also reduces or eliminates duplication of effort of similar services. For services that cannot be realigned or fully integrated, we emphasize exploiting any opportunity to open service availability for each other's beneficiaries. The only limits are access to care and service availability itself.

At the same time, this model retains the independent daily governing structures of both facilities, allowing the Air Force and the VA to carry on their important and distinctive missions unimpeded. An Executive Management Team co-chaired by KMC Commander and VA Director provides oversight linkage for sharing initiatives.

We currently have seven signed operational plans for ongoing shared services. These plans detail the scope of care, business office functions and other important aspects of treating each others' patients. The seven signed plans are: Orthopedics, dermatology, plastic surgery, pulmonology/pulmonology function tests, shared nursing staff, shared neurology technicians and laundry.

We have eight more operational plans we anticipated being signed within the next 60 days: Women's health, sleep lab, radiation oncology, MRI, cardiac cathorization, patient transfer, urology and shared referral staff. All services that are sharing in these areas are doing so under our resource sharing agreement and draft operational plans.

We anticipate taking on a significant amount of VA surgical and inpatient workload as the VA's CARES construction project will limit their operating room usage for several months in fiscal year 2010. The VA will be bringing many of their operating room personnel and inpatient nursing staff.

In summary, the integration process has been a great success thus far, and we anticipate this joint venture will be a win-win proposition for both facilities.

QUESTIONS SUBMITTED BY SENATOR MITCH MCCONNELL

SUICIDES

Question. Congress has established a national suicide hotline for returning troops, as well as increased funding for mental health for active military personnel. However, there remains a high number of Soldier suicides.

What preventive measures is the Department of Defense (DOD) taking to address this problem?

Answer. The DOD has established the Suicide Prevention and Risk Reduction Committee to monitor and address suicide trends across the DOD. The DOD has implemented the DOD Suicide Event Reporting System to improve data tracking, and hosts an annual DOD/Veterans Affairs suicide prevention conference that draws experts from around the world.

The military Services each execute their own suicide prevention programs tailored to the needs and culture of their own Service. We are carefully studying each other's best practices to maximize the effectiveness of our programs. The Air Force Suicide Prevention Program (AFSPP) includes 11 initiatives that must be implemented by every Wing Commander. Our program focuses on a total community effort that has helped to reduce our suicide rate by 28 percent since it was implemented in 1996. The AFSPP is listed on the Department of Health and Human Services National Registry of Evidence-based Programs and Practices.

Question. What, if any, legislative action would the Department of Defense need Congress to take to expand suicide awareness and education on posts?

Answer. The Air Force defers to Department of Defense (DOD) on possible DOD legislative proposals. The Air Force Suicide Prevention Program (AFSPP) is intensely invested in awareness and education down to the grassroots level—the AFSPP is a commander's program that targets every Airman. Through our Landing Gear program, we teach all Airmen how to prepare for the psychological effects of deployment, how to recognize risk factors and to know when and how to get help for themselves or others. We have instilled a Wingman Culture in which we are each responsible for our fellow Airmen. The Air Force does not require any legislative action at this time to support the AFSPP, but we greatly appreciate the Congress' efforts to help us address this critical issue.

PTSD/TBI

Question. What are the typical steps for Airmen who may has post-traumatic stress disorder (PTSD) and traumatic brain injuries (TBI) to ensure they get the proper care?

Answer. The Air Force uses a three-part strategy to address and manage PTSD, TBI and other deployment related health concerns. The first component of our strategy involves training and education efforts to enhance awareness and recognition of common deployment-related health concerns. The second component involves repeated health surveillance before, during, and after deployments, as well as annually. The final component involves intervention. Screening that identifies PTSD and TBI symptoms (as well as other health concerns) results in more thorough assessments and referrals to specialists when indicated. We work closely with the Defense Center of Excellence for Psychological Health and TBI as well as civilian subject matter experts to ensure our treatment efforts are in line with clinical practice guidelines and established standards of care.

Question. Are there any further legislative steps that Congress could take to improve screening and the delivery of care to Airmen with post-traumatic stress disorder (PTSD) and traumatic brain injuries (TBI)?

Answer. The entire Department of Defense has put considerable resources and effort into addressing the identification and treatment of service members with PTSD and TBI in a very short period of time. Any additional legislative support for these critical issues would be best recommended by the newly formed Defense Center of Excellence for Psychological Health and TBI. However, we caution against proposed legislation that would mandate face-to-face provider-to-troop screenings for all redeploying military personnel, the majority of whom are not experiencing significant health concerns. We believe our existing program is successfully and expeditiously capturing those who need intervention and treatment. Expanding the program unnecessarily will further constrain resources needed to focus on those with identified health concerns.

WOUNDED WARRIOR

Question. Per the Wounded Warrior legislation enacted in 2007 and the Dole-Shalala Commission's recommendations that were reported in 2007, improvements

were to be made to the coordination between the DOD and VA facilities to better care for our injured troops who are transitioning between the two healthcare systems.

What steps have already taken place to improve coordination between the two departments? What steps remain? Are these provisions sufficient to provide a seamless transition for wounded warriors from the DOD to the VA system?

Answer. With the passage of Wounded Warrior specific sections of the National Defense Authorization Acts of 2007 and 2008 and the creation of a joint DOD/VA disability evaluation system (DES) demonstration pilot, there now exists an unprecedented amount of cooperation, teamwork and cross-functional communication between the Services and the VA. Similar to our Army and Navy counterparts, the Air Force Medical Service is working very hard with the VA to ensure those Service Members who are "medically" separated or retired from the Armed Forces are fairly evaluated and receive the healthcare, compensation and benefits necessary to ensure a seamless lifestyle transition from military to civilian life.

Representatives from each Service's medical and personnel headquarters offices (including physical evaluation board disability managers) routinely meet with VA and DOD policy officials to evaluate the joint departmental DES demonstration pilot targeted goals and objectives, review disability evaluation findings and trends, and analyze pilot metrics (including process timeliness). Furthermore, the VA/DOD DES demonstration pilot has expanded outside the greater Washington, DC, area (the initial VA/DOD demonstration pilot area) and now includes military installations throughout the Continental United States and Alaska. Within the Air Force, the participating VA/DOD DES pilot expansion sites include Andrews AFB, Maryland; Elmendorf AFB, Alaska; Keesler AFB, Mississippi; MacDill AFB, Florida; Travis AFB, California; and Vance AFB, Oklahoma; with other potential expansion sites currently being considered.

The Office of the Assistant Secretary of Defense for Health Affairs (OASD/HA) has recently obligated an additional $5.5 million to enable our military treatment facilities to hire more Physical Evaluation Board Liaison Officers (PEBLOs). The PEBLOs are one of our most important non-clinical case managers. The individuals are responsible for providing Service Members traversing the DES with non-clinical benefits and referral support counseling.

Additionally, at the direction of Mr. Michael Dominguez, Principal Deputy Under Secretary of Defense for Personnel and Readiness, the Air Force has created a centralized health treatment records disposition process designed to more efficiently transfer complete medical and dental treatment records for retiring and separating Airmen from the Air Force to the VA. This new process prohibits medical and personnel units at over 74 Air Force installations from directly sending health treatment records to the VA and instead funnels all health treatment records to a single military service personnel out-processing center before the records are forwarded to the VA. The process is designed to reduce the amount of "orphaned" or "loose, late-flowing" medical documents unintentionally separated from the Service Member's original health records package. This new process is also intended to ensure the medical and dental records for each retiring and separating Airman are shipped to the VA together and on-time. The main goal of the program is to ensure complete health treatments records for retiring or separating Airman are made available to the VA as soon as possible so VA benefits and disability compensation reviews can be completed with little to zero gaps in veteran benefits or healthcare coverage.

With regard to what steps remain, everyday we move closer to totally transitioning from a paper-based health treatment record to an electronic health record. Billions of dollars and countless man-hours have been spent on improving and refining the information and technology necessary to make this transition a reality. The DOD and VA continue to improve and enhance their electronic health record computer systems, but we're still a few years away from an electronic health record system that offers unfettered bi-directional health information exchange between the two agencies.

Working together with our parallel Service medics and with DOD and VA officials, I believe we're doing all we can to ensure the provisions identified in the NDAA of 2007, 2008, and 2009 are sufficient to provide a seamless transition for Wounded Warriors from the DOD to the VA system.

Question. Does the Department of Defense need further legislation to improve matters? If so, what?

Answer. Working together with our parallel Service medics and with DOD and VA officials, we're doing all we can to ensure the provisions identified in the NDAA of 2007, 2008, and 2009 are sufficient to provide a seamless transition for Wounded Warriors from the DOD to the VA system. The Air Force does not require any further legislative action at this time to improve transition between health systems.

QUESTIONS SUBMITTED TO REAR ADMIRAL CHRISTINE M. BRUZEK-KOHLER

QUESTIONS SUBMITTED BY CHAIRMAN DANIEL K. INOUYE

Question. Admiral Bruzek-Kohler, we recognize that Navy nurses play critical roles in supporting both Disaster Relief and Humanitarian Assistance missions. What staffing support have you received from the Air Force, Army, and civilian organizations to assist you in fulfilling the nursing need for these missions?

Answer. Core nursing teams on these missions are composed of both active and reserve component Navy nurses. We are also supported by nursing colleagues from the Armed Services, U.S. Public Health Services (USPHS), Non Governmental Organizations (NGOs), and partner nation military nurses.

From May 1 to September 25, 2008, USNS MERCY (T–AH 19) embarked a 1,000-person joint, multi-national, Military Sealift Command Civilian Mariner, U.S. Public Health Service and non-governmental organization (NGO) team to conduct Pacific Partnership 2008 (PP08). The core nursing team consisted of active duty Navy and Air Force nurse corps officers. Additional nursing support was provided by Navy reservists. The nursing team was further augmented with partner nation military nurses from Australia, Canada, Indonesia, New Zealand, and the Republic of the Philippines, as well as NGO nurses from International Relief Teams, Project HOPE, and Operation Smile. Nursing specialties embarked for PP08 included medical-surgical, pediatric, neonatal intensive care, obstetric, critical care, and perioperative nursing.

Certified registered nurse anesthetists and family, pediatric, and women's health nurse practitioners were also embarked.

The USNS COMFORT (T–AH 20) is currently deployed in support of Continuing Promise 2009, a 4 month humanitarian assistance mission through Latin America and the Caribbean. Active and reserve component Navy nurses, as well as nurses from the U.S. Army and Air Force, USPHS, various NGOs, (to include Project Hope and Operation Smile) and Canada are embarked on this deployment.

Question. Admiral Bruzek-Kohler, the University of Health Sciences (USU) has determined that conditions are not favorable for the creation of a Bachelors program in nursing at this time. What options for partnering with civilian Schools of Nursing have been discussed as a way to develop and recruit military nurse candidates?

Answer. Navy nurses, at our hospitals in the United States and abroad, passionately support the professional development of America's future nursing workforce by serving as preceptors, mentors, and even adjunct faculty for a myriad of colleges and universities.

Due to the vast array of clinical specialties available at our medical centers at Bethesda, Portsmouth, and San Diego, we have developed multiple Memoranda of Understandings (MOU) with surrounding colleges and universities to provide clinical rotations for nurses in various programs from licensed practical/vocational nursing, baccalaureate, and graduate degrees which include nurse practitioner and certified nurse anesthetist tracks.

In completing their clinical rotations at our military treatment facilities, civilian nursing students are simultaneously exposed to the practice of Navy Nursing and our day to day interactions with members of the multidisciplinary Navy Medicine team. This exposure generates interest in career opportunities in both the active and reserve components of our Corps as well as in our federal civilian nursing workforce.

The Nurse Corps Recruitment liaison officer in the Office of the Navy Nurse Corps at the Bureau of Navy Medicine and Surgery works with a speaker's bureau comprised of junior and mid-grade Nurse Corps officers throughout the country. These officers provide presentations on career opportunities in Navy nursing to students at colleges, high schools, middle and elementary schools. We recognize that the youth of America are contemplating career choices at a much younger age. Over the course of the past year, we have tailored our recruiting initiatives to engage this younger population.

At a recent conference entitled "Academic Partnerships Addressing the Military Nursing Shortage" hosted by Dr. Ada Sue Hinshaw, Dean of the Graduate School of Nursing at the Unformed Services University of the Health Sciences (USUHS), the Navy Nurse Corps presented information on the state of our Corps and the incentive programs that we have successfully utilized to recruit nurses. The conference was sponsored by funding from the Office of the Assistant Secretary of Defense for Health Affairs and was attended by 35 Deans from Schools of Nursing, the Directors and Deputies from each of the Nurse Corps and leaders from national nursing organizations. The conference objectives included: building collaborative relationships among military nursing services and Schools of Nursing to foster edu-

cation opportunities; exploring the types of educational programs in which additional military students can be enrolled and recommending the types of resources and incentives needed for the Schools of Nursing to be able to accommodate additional students. This meeting was very successful. USUHS also intends to conduct a survey to identify what incentives would be most attractive to recruit potential applicants into schools of nursing with obligations to serve in the military after graduation and successful licensure.

Question. Admiral Bruzek-Kohler, Nurse Corps Officers are promoted to the senior rank of Captain (O–6) at a rate significantly less than their physician counterparts. Do you know if this promotion disparity has led to our more senior, experienced nurses leaving active duty service due to lack of promotion opportunities? What is your exit interview data telling you about why nurses are leaving active duty service?

Answer. The Navy Nurse Corps has not identified promotion disparity as a factor in causing experienced nurses to leave active service.

Exit interviews suggest that factors contributing to a decision to leave the service are often multi-faceted and maybe family related: spouse's employment, children's schools, and/or ill elderly parents.

In May 2005, the Chief of Naval Personnel's Quick Poll of the Navy Medical Community identified the top five reasons for leaving the Navy Nurse Corps as: administrative barriers to doing one's job, civilian job opportunities, overall time spent away from home, impact of deployments on family, and the unpredictability of deployments.

In fiscal year 2008, the Navy Nurse Corps implemented an incentive special pay targeted at retaining individuals with critical war-time specialties.

The Bureau of Medicine and Surgery has contracted to do another retention poll and the results will be completed in late summer 2009.

Question. Admiral Bruzek-Kohler, several professional nursing organizations have proposed that the Doctorate of Nursing Practice (DNP) be the entry level into practice for all advanced practice nurses. Many schools of nursing are proposing to convert their Master of Science nursing degrees to DNP programs over the next several years. The DNP educational track adds an extra year onto the typical Masters level curriculum plan. Has there been any discussion of how this might affect Duty under Instruction planning in upcoming years? Could offering this post-Master's education option serve as a retention tool for mid-levels officers who might otherwise choose to leave active duty service?

Answer. The Navy Nurse Corps' Duty Under Instruction (DUINS) training plan is based on the projected losses in our nursing specialties, the number of nurses in each specialty training pipeline, and the overall nursing end-strength. The typical allotted training time is 24 months for completion of a Masters of Science in Nursing (MSN) and 48 months for a doctoral degree (Ph.D.). Post masters certificate programs are allotted 12–24 months for completion. DUINS exists as an avenue for the mid-level officer to apply for advanced education opportunities. This has served as an exceptional retention tool. Additionally, we have not appreciated a scarcity among quality MSN programs for our nurses to attend.

The Doctorate of Nursing Practicum (DNP) curriculum of 36 months has an impact on DUINS, as it affects the overall number of training opportunities availed each year. Additionally, our current inventory of nursing specialties does not require the additional educational preparation conferred via a DNP. We are presently training master's prepared clinical nursing specialists and nurse practitioners to meet our military nursing requirements in only 24 months. They return to our deployable inventory of specialty nurses with greater knowledge and clinical expertise. If they were enrolled in a DNP program, they would still be matriculating and a lost deployable asset to the Navy Nurse Corps. Consideration of the DNP conferral via a post MSN certificate or bridge program may have greater appeal to the Navy Nurse Corps, as the officer would be lost from the deployable inventory for only 12–24 months vice 36.

QUESTIONS SUBMITTED TO MAJOR GENERAL PATRICIA D. HOROHO

QUESTIONS SUBMITTED BY CHAIRMAN DANIEL K. INOUYE

HUMANITARIAN ASSISTANCE MISSIONS

Question. General Horoho, we recognize that Navy nurses play critical roles in supporting both Disaster Relief and Humanitarian Assistance missions. What challenges have you encountered when faced with the need to train Army nurses to ad-

minister humanitarian nursing care, to include the need to provide shipboard training to assist with U.S. Navy missions?

Answer. The Army Nurse Corps is focused on ensuring all nurse officers deploy with skill sets required for the specific mission, whether that mission is for combat or a humanitarian mission. As such, the ANC has training venues to train the nurse officers for missions when deploying with Forward Surgical Teams, Combat Support Hospital, and Brigade Combat Teams. The Navy has pre-deployment training venues to train care providers for shipboard missions. If needed, the ANC will ensure the nurse officers receive this training prior to any deployment in support of the Navy.

MILITARY NURSE CANDIDATES

Question. General Horoho, the University of Health Sciences has determined that conditions are not favorable for the creation of a Bachelors program in nursing at this time. What options for partnering with civilian Schools of Nursing have been discussed as a way to develop and recruit military nurse candidates?

Answer. The Army Nurse Corps, along with the Federal Nursing Chief partners, is actively building collaborative relationships among Military Nursing Services and Schools of Nursing to foster educational opportunities. The Uniformed Services University is taking the lead and has recently sponsored a conference that brought together the Deans from many prestigious Schools of Nursing throughout the nation to discuss partnering with Department of Defense assets. Additionally, the Army Nurse Corps is exploring the types of educational programs in which military students can be enrolled and evaluating the types of resources and incentives needed for civilian Schools of Nursing to accommodate additional students.

NURSE CORPS OFFICER PROMOTION

Question. General Horoho, Nurse Corps Officers are promoted to the senior rank of Colonel (O–6) at a rate significantly less than their physician counterparts. Do you know if this promotion disparity has led to our more senior, experienced nurses leaving active duty service due to lack of promotion opportunities? What is your exit interview data telling you about why nurses are leaving active duty service?

Answer. Our current exit survey data does not demonstrate that senior Army Nurse Corps Officers are leaving due to lack of promotion opportunities. Recent increases in authorizations for Colonel have improved promotion rates. However, we are validating all O–5 and O–6 positions in order to optimize the force structure.

Our exit surveys demonstrate that junior and mid-grade officers are leaving for a myriad of reasons to include a perceived lack of ability to remain in the clinical setting as they progress through their careers. To address this concern, we are developing a lifecycle that will enable more senior leaders to remain at the bedside to ensure we have the right mix of experience and leadership available to develop our junior officers and to ensure we provide world-class care.

DOCTORATE OF NURSING PRACTICE

Question. General Horoho, several professional nursing organizations have proposed that the Doctorate of Nursing Practice (DNP) be the entry level into practice for all advanced practice nurses. Many schools of nursing are proposing to convert their Master of Science nursing degrees to DNP programs over the next several years. The DNP educational track adds an extra year onto the typical Masters level curriculum plan. Has there been any discussion of how this might affect Duty under Instruction planning in upcoming years? Could offering this post-Master's education option serve as a retention tool for mid-levels officers who might otherwise choose to leave active duty service?

Answer. The Army Nurse Corps is actively evaluating the impact of the advent of the DNP educational track on our force modeling and selection opportunities. It is important that we maintain currency in our education options to maintain Long Term Health Education and Training as our primary retention and professional development tool. Both the Uniformed Services University Nurse Anesthesia Program and the U.S. Army Graduate Program in Anesthesia Nursing are transitioning to the DNP model to maintain their excellent standing in the civilian community.

QUESTIONS SUBMITTED TO MAJOR GENERAL KIMBERLY A. SINISCALCHI

QUESTIONS SUBMITTED BY CHAIRMAN DANIEL K. INOUYE

NURSE TRAINING

Question. General Siniscalchi, we recognize that military nurses play critical roles in supporting both Disaster Relief and Humanitarian Assistant missions.

What challenges have you encountered when faced with the need to train Air Force nurses to administer humanitarian nursing care, to include the need to provide shipboard training to assist with U.S. Navy missions?

Answer. The fundamentals of nursing care remain the same regardless of environmental circumstance, whether humanitarian, disaster response, or contingency operations. Air Force nurses play an important role in joint operations. In 2008, U.S. Air Force nurses deployed aboard U.S. naval ships in support of numerous humanitarian missions including Pacific Partnership 2008. In addition to the standard medical deployment training, Air Force medics who are deployed onboard a U.S. Navy ship undergo ship-specific orientation to include: life raft training, ship fire drills, damage control training, and emergency ship egress.

Additionally, Air Force nurses provided humanitarian support alongside U.S. Army personnel in South American locations during Joint Task Force Bravo and also to Central Command and European Command as part of a joint medical team in support of Operations IRAQI FREEDOM and ENDURING FREEDOM.

PARTNERING WITH CIVILIAN NURSING SCHOOLS

Question. General Siniscalchi, the University of Health Sciences has determined that conditions are not favorable for the creation of a Bachelors program in nursing at this time.

What options for partnering with civilian Schools of Nursing have been discussed as a way to develop and recruit military nurse candidates?

Answer. The USAF Nurse Corps is excited at the many opportunities to partner with our healthcare counterparts in civilian universities. As recently as March 14, Ada Sue Hinshaw, the Dean of the Graduate School of Nursing, Uniformed Services University, sponsored a conference that brought together Deans from Colleges of Nursing across the United States and the Tri-Service Military Nurse Corps Chiefs and their deputies. The conference was titled "Conference for Academic Partnership Addressing the Military Nursing Shortage." The objective was to "build collaborative relationships among military nursing services and schools of nursing to foster educational opportunities." It was an invaluable opportunity to share and discuss challenges, options, and ideas among key stakeholders.

As the USAF Nurse Corps continues its collegial relationship with the University of Cincinnati, and as we establish a similar partnership with the Scottsdale Healthcare System in Scottsdale, Arizona, we are encouraged that our presence within these two exceptional civilian medical centers will also draw interest from local nursing students and staff.

The USAF Nurse Corps is also at the precipice of establishing a first-ever Masters in Flight Nursing in collaboration with Wright State University in Dayton, Ohio.

NURSE RETENTION

Question. General Siniscalchi, Nurse Corps officers are promoted to the senior rank of colonel (O–6) at a rate significantly less than their physician counterparts.

Do you know if this promotion disparity has led to our more senior, experienced nurses leaving active duty service due to lack of promotion opportunities?

Answer. The Air Force Nurse Corps has experienced disparity with promotion opportunity, and we believe it may be a factor in some senior nurses leaving active duty. However, we are working closely with Lieutenant General Newton, his team of personnelists and the Air Force Surgeon General to correct this disparity.

Question. What is your exit interview data telling you about why nurses are leaving active duty service?

Answer. We are currently exploring options to initiate/capture data from a Nurse Corps-wide survey, as well as a specific exit-survey. We look forward to obtaining data that will provide us with a more accurate picture of why nurses choose to separate from active duty.

DOCTORATE OF NURSING PRACTICE

Question. General Siniscalchi, several professional nursing organizations have proposed that the Doctorate of Nursing Practice (DNP) be the entry level into prac-

tice for all advanced practical nurses. Many schools of nursing are proposing to convert their Master of Science nursing degrees to DNP programs over the next several years. The DNP educational track adds an extra year onto the typical Masters level curriculum plan.

Has there been any discussion of how this might affect Duty under Instruction planning in upcoming years?

Answer. One of the best recruiting tools in the Air Force is our educational opportunities. Our Nurse Corps officers have the ability to return to school full-time and earn a Masters and/or Doctoral degree. Most chief nurses use educational opportunities as an incentive to join when they do their recruiting interviews. The University of Health Sciences (USU) is uniquely situated in the Washington, DC, metropolitan area giving the university access to a variety of resources to include the National Institutes of Health, Office of the Secretary of Defense, Health Affairs, etc. Our students experience a very rigorous program that prepares them well for the future. Additionally, we are working very closely with Dean Hinshaw from USU to develop a curriculum in which our advance practice nurses can earn a Doctorate in Nursing Practice by 2015 as recommended by the American Nurses Association.

Question. Could offering this post-Masters' education option serve as a retention tool for mid-level officers who might otherwise choose to leave active duty service?

Answer. These opportunities for graduate education are significant retention tools, especially for our star performers. The University of Health Sciences (USU) allows our nurses to work with the other uniformed services in a very collaborative and joint way that is not possible in civilian universities. USU educational options are valuable in both recruitment and retention.

SUBCOMMITTEE RECESS

Chairman INOUYE. This subcommittee will reconvene on Wednesday March 25 at 10:30 a.m. At that time we'll receive testimony from the Guard and Reserve. Until then we'll stand in recess.

[Whereupon, at 12:52 p.m., Wednesday, March 18, the subcommittee was recessed, to reconvene at 10:30 a.m., Wednesday, March 25.]