RECORD VERSION

STATEMENT BY
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Chairman Cochran, Ranking Member Durbin, and distinguished members of the subcommittee, thank you for the opportunity to appear before you to discuss the future of Army Medicine and highlight the important work the Soldiers and DoD civilians of this world-class organization perform daily. On behalf of these dedicated professionals, I extend our appreciation to Congress for your faithful support to military medicine.

Let me open by recognizing America's sons and daughters currently in harm's way – 9,800 U.S. troops are committed to operations in Afghanistan, approximately 3,500 in Iraq, and over 176,000 forward-stationed or deployed around the world.

Army Medicine is comprised of a committed team of over 150,000 Active Duty, Reserve Component, Civilian and Contract professionals who serve on five continents and across 18 time zones, providing cutting edge medical readiness and healthcare throughout the world.

I am honored to have the privilege of serving as The Army Surgeon General and Commanding General of US Army Medical Command. Since 1775, Army Medicine has supported our Nation and our Nation's Army whenever and wherever needed. For the past 14 years we supported Joint campaigns in Iraq and Afghanistan, responded to natural disasters, and took decisive action during other contingencies such as the US Government response to the Ebola outbreak in West Africa. Because demands on the Army will remain constant, Readiness is my #1 priority.

As always, we fully intend to maintain our long-standing commitment not only to treating the wounds of war, but also the non-combat injuries and illnesses of our Soldiers, their families, and our retirees. My four priorities are: (1) Readiness and Health; (2) Healthcare Delivery; (3) Force Development; and (4) Taking care of Soldiers, their families, DA civilians, and retirees. These four priorities are strategically nested with those of the US Army and the Joint Health Services enterprise (JHSent). No matter the challenge, these priorities will allow Army medicine to provide the support necessary for our Soldiers to fight and win in a complex world.

BUDGET OVERVIEW

Our FY 2017 budget request provides adequate funding to support the essential elements of our four priorities. Military medicine and the Army have seen almost no budget increases in the past 4 years. To control expenditures we have achieved efficiency and productivity gains to control our costs. We have done that while improving access and ensuring quality. Our FY17 request is lean but adequate.

I would like to highlight the people aspects of our budget which supports a military, civilian and contracted workforce that is essential to our ability to deliver healthcare. Healthcare is still a touch business and requires skilled professionals to deliver services. In recent years Army Medicine has struggled to attract and retain the civilian workforce necessary to ensure mission success and achieve improvements in healthcare access and quality among other programs; having lost nearly 5,000 civilian employees as a result of sequestration. Because our workforce has been smaller than needed, for the last two years Congress reduced our labor budget below requested levels. However, our civilian workforce has finally stabilized at budgeted levels. Our FY17 request reflects the amounts necessary to sustain our current workforce. Additional reductions by Congress will require us to reduce services and curtail programs that we rely on to maintain our readiness.

While the Bipartisan Budget Agreement Act of 2015 provides short-term predictability for FY16 and FY17, the fiscal uncertainty beyond FY17 presents a significant challenge. If sequestration returns, Army Medicine will face further reductions to military and civilian personnel which will likely force us to reduce services and cause us to convert more hospitals to clinics. Operating under these conditions would exacerbate our challenges with access and not allow sufficient mitigation strategies to address potential safety concerns that may be provoked by low patient volume. In addition, this would negatively impact our ability to support the health readiness of our Soldiers, impact the readiness of our providers, and break trust with our Soldiers, Families, and Retirees, by forcing them to the TRICARE network.

READINESS AND HEALTH: OUR TOP PRIORITY

The global security environment continues to degrade and place high demands on the United States Army. The Army's number one priority is Readiness.

Army Medicine's primary mission is supporting the Warfighter. In supporting the Warfighter, we uphold the solemn commitment our Nation's Army has made to our Soldiers when sending them in harm's way. Army Medicine has a two-fold readiness mission. We must ensure Soldiers are medically ready to deploy, and we must generate and maintain a rapidly responsive and broad spectrum of medical capabilities—properly trained and equipped individuals and units—while supporting our Soldiers, Families, and Retirees at home.

Soldier Health Readiness

The Army derives its power from the collective strength of its Soldiers rather than advanced platforms. Our Soldiers are our most prized and effective weapons system. A Soldier's health is an essential component of his or her readiness. Although, medical readiness of the force has increased from 73% to 83% since 2012, more than 57,000 Soldiers across all Components were medically non-deployable as of January 31, 2016. In the Active Component alone, 29,800 were medically non-deployable, equivalent to approximately 6.5 Brigade Combat Teams worth of Soldiers. In 2015, Army Medicine published the inaugural 'Health of the Force' report to provide leaders with a more holistic understanding of the health readiness of the force.

Seventy-six percent of the non-deployable Soldiers have a related musculoskeletal injury (MSKI). Many MSKI are preventable; 80% are the result of physical training overuse and sports related injuries. Obesity and low levels of fitness also degrade medical readiness. Despite current body composition standards, 13% of Soldiers have body mass index (BMI) ≥ 30, which is considered clinically obese. These Soldiers are 86% less likely to be medically deployable. Obese service members in a brigade in Afghanistan were 40% more likely to experience an injury than those with a healthy weight. Sleep deprivation, fatigue and insomnia are comorbid with mental illnesses and injuries, reduce mission readiness and contribute to Service Member medically non-deployable profiles.

In 2012, Army Medicine continued our evolution to aggressively transition from a healthcare system—a system that primarily focused on treating injuries and illness—to a System for Health to proactively focuses on improving health and wellness of all Service Members, Families, and Retirees. Health readiness and fitness are fundamental to Soldier performance and comprise the foundation of the Army's combat power and land dominance. Army Medicine has partnered with key stakeholders across the Army to develop the Performance Triad Strategy. This is a comprehensive strategy to invest in our Soldiers, DA-Civilians, Retirees, and their Families with the goal to enhance personal health readiness, sustain resilience, and optimize performance. As part of our comprehensive strategy, programs like the Performance Triad (P3) augment other initiatives such as Army Wellness Centers, Move to Health, and Go Dental First Class. Our medical readiness transformation is aimed to improve health readiness while providing better tools and resources for Command Teams.

Performance Triad Training Programs & Products

The Performance Triad (P3) training programs and products are the cornerstone of the System for Health and link directly to the Army's Ready and Resilient Campaign and the Army Human Dimension Strategy. The P3 strategy provides tools for unit and installation leaders to improve the physical, cognitive, and emotional fitness and health of their Soldiers through techniques that optimize restful sleep, regular physical activity, and good nutrition. Based on pilot study results beginning in FY14, the Performance Triad is a solution and key enabler to improve individual and unit readiness. It synchronizes the best advances in sports science and technology to improve knowledge, attitudes and behaviors in relation to sleep, activity, and nutrition.

The FY14 pilot was conducted in three active duty battalions from August 2013 to May 2014. It confirmed Soldiers are not meeting the basic Performance Triad targets essential for health, performance, and readiness. Only 4-5% of Soldiers met all sleep targets, 29-42% met all activity targets, and only 2.4-3.6% met all of the nutrition targets across the three units.

The FY14 pilot yielded valuable insights which shaped the FY15-16 pilot to improve the reach, adoption, implementation, and maintenance of the program Army

wide. The FY15-16 pilot expanded the program to approximately 11,000 active duty Soldiers across five FORSCOM brigades, the Army Medical Department Center and School (AMEDDC&S), one Army Reserve brigade, and one Army National Guard brigade. The cost of the current study is $6.7M which we believe is an investment in Total Army Family and health readiness. The FY15-16 pilot will conclude Summer of 2016 and the formal analysis will be completed Fall of 2016, and will inform Army wide implementation.

Preliminary FY15-16 pilot results indicate that Soldiers expect the Army to treat them as tactical athletes. Army-wide implementation can impact at a minimum, preventable disease, illness, and injury. Also, we anticipate a rising trend in self-monitoring of personal health readiness and an increase in peer support. While these are promising mid-point findings, the formal analyses this fall will garner more accurate results. Successful implementation of Performance Triad across the Total Army will improve the health readiness of the force. Optimization of each individual's performance becomes more critical as the Army end strength decreases and budgets decline. By applying the lessons learned from the FY14 pilot and through the ongoing FY15-16 pilot, we are changing the culture of the Army by embedding the Performance Triad into the Army's DNA.

Move-to-Health Program

The "Move to Health" Program educates health care teams to focus on improving health outcomes, by integrating the Performance Triad, mindfulness, and other health and wellness initiatives for our beneficiaries. It provides clinic personnel with additional tools to engage Solders and their Families to empower them to be active partners in their health and healthcare outside of clinic or hospital settings. The curriculum is adapted from the Veteran's Health Administration (VHA) "Whole Health" program.

The "Move to Health" pilot was launched at eight of our facilities and trained 376 physicians, nurses, and other health professionals. The Army Public Health Center (Provisional) provided oversight. Although the final evaluation results are pending, the initial results are promising. Based on improved team performance noted locally, Madigan Army Medical Center has already decided to train 100% of its teams on "Move

to Health". The initial results demonstrated significant improvements in self-efficacy, attitudes towards patient-centered care, and an increased willingness to engage in holistic health and behavior approaches to address pain management, cardiovascular disease, and gastrointestinal disease.

Army Wellness Centers

Army Wellness Centers (AWC) provide community based health promotion services to promote and sustain healthy lifestyles and to enhance the readiness of the force. AWCs represent an actionable platform to deliver evidence based practices designed to promote positive lifestyle change. All staff members of our Army Wellness Centers are trained in wellness coaching. Equipment utilized in an AWC is composed of advanced technology to measure the four components of physical fitness--cardiorespiratory, body composition, muscular fitness, and flexibility. Stress, nutritional habits, and other health behaviors are also assessed. These services are supported by a budget of nearly $70M.

In 2015, 27 locations met the standards and were classified as AWCs. In FY16, we will add four new sites with full implementation of 37 AWCs occurring by the end of 2018. Active Duty Soldiers made up the majority of AWC participants served (63%), followed by Family members (20%), Department of the Army civilians (9%), Retirees (3%), Unreported (3%), and Reservists (2%). The overall consumer satisfaction rating was 97%, and each individual Army Wellness Center either met or exceeded the goal of 95% satisfaction.

Forty-eight to 58% of participants who set a goal with the Army Wellness Center health educator to lose weight saw a significant decrease in BMI. Clients who returned for follow-up within one year generally improved their risk factors for disease. Improvements were observed in body fat, body mass index (BMI), diet and nutritional habits, perceived stress, cardiorespiratory fitness, and blood pressure.

Dental Readiness

Go First Class (GFC) is a comprehensive Army-wide initiative that simultaneously addresses dental readiness, wellness, and prevention while returning

valuable training time to Soldiers and their units. During their annual dental exam, Soldiers now routinely receive a dental cleaning, and if needed dental fillings. Soldier benefits include spending less time traveling to and from dental appointments, reducing the number of hours spent in the clinic, and eliminating the requirement for follow-on appointments.

Since January 2011, Go First Class and other initiatives have contributed to a 25% decrease in acute care appointments, a 50% reduction in Dental Readiness Classification 3 (non-deployable), and a 60% reduction in all treatment needs. GFC has directly improved Soldiers' Dental Readiness (deployable) and Dental Wellness (no dental needs), reaching all-time historic highs of 96% and 60%, respectively.

Medical Readiness Transformation

As the Army downsizes from its peak of 566,000 Active Duty personnel to 450,000 by the end of FY17, the Army must reduce the number of medically non-deployable Soldiers to retain combat power. Therefore, Army Medicine is leading a medical readiness transformation to improve Command Teams' visibility of medical readiness information at all levels. This will simplify the process by which they make deployability determinations and lead to timely identification, corrective action, and accountable oversight of unit and individual medical readiness.

We are redesigning the process of profiling, which documents Soldier's temporary and permanent medical and behavioral health conditions as well as any functional limitations, in order to improve transparency and consistency in communicating medical readiness information to Commanders. Soldiers will no longer have overlapping temporary profiles, and will instead have a single active profile for all conditions. The Army is simplifying the Medical Readiness Classification (MRC) codes used to identify Soldiers as being "deployable" or "non-deployable." We have developed a new "Commander's Portal" to allow Command teams to more easily view Medical Readiness data and make deployability determinations without requiring log on to multiple systems.

The newly developed Medical Readiness Assessment Tool (MRAT) allows commanders and clinicians to proactively address medical readiness by identifying

Soldiers with recurring medical profiles that are headed down a trajectory that could result in a permanent deployment limiting profile. It does this through a predictive model that identifies a Soldier's risk for becoming medically non-deployable during the next 12 months. Awareness of these high risk Soldiers enables clinicians to intervene to determine root causes for medical issues and develop courses of action to maximize readiness of the Soldier and ensure he or she receives the care needed.

We are aggressively training the force to fully implement the Medical Readiness Transformation by June 1, 2016.

Responsive Medical Capabilities

The Army must maintain a rapidly responsive and broad spectrum of medical capabilities that can conduct rapid deployment in support of Combatant Commanders' requirements. Our medical capabilities must be prepared to support the full range of military operations with mission ready personnel able to rapidly transition from garrison to delivering the appropriate health service support in an area of operation.

During the past 14 years of combat operations, our trained and ready medical providers contributed to a survivability rate of 92%, the highest in the history of warfare, despite the increasing severity of battle injuries. These advances in combat casualty care resulted from our integrated healthcare system that spans the continuum of care from prevention, to treatment of illness or injury, to recovery and rehabilitation in garrison.

However, focusing exclusively on sustainment of combat trauma, surgery and burn capabilities would be a failure born of shortsightedness and could potentially lead to catastrophic consequences for the future. Our experience shows that the Army must maintain a broad range of medical capabilities to support the full range of military requirements. From 2001 to 2015, only 16% of those evacuated from Iraq and 21% of those evacuated from Afghanistan were injured in battle. The remaining Service members, 84% in Iraq and 79% in Afghanistan, were evacuated for disease or non-battle injuries. Similarly, greater than 95% of those that received care and remained in theater were treated for disease and non-battle injuries rather than combat injuries.

The 2014 deployment of over 2,500 personnel to support Operation United Assistance in Liberia demonstrated the value of non-trauma related medical specialties. Infectious disease is often a major threat to our Soldiers rather than armed combatants. The geographically endemic medical risks to our forces in support of the rebalance to Asia and operations in Africa point to the continued need to remain ready to utilize the entire spectrum of Army medicine in the execution of all manner of military contingency operations.

In FY15, the MEDCOM deployed 1,998 Soldiers to support a variety of missions supporting Combatant Command requirements. Of these, 238 personnel deployed to support 38 theater security cooperation missions; 129 Soldiers and civilians conducted 55 subject matter expert exchanges; and 139 employees were integral team members on 59 Defense Threat Reduction Agency (DTRA) missions. As of January 6, 2016, 354 MEDCOM Soldiers were deployed and another 159 were in a prepared to deploy status in support of globally integrated operations.

Army Medicine capabilities employed in Global Health-related engagements contributed in numerous areas in support of Combatant Commands to include battling Ebola (Africa), rabies wildlife prevention program (Kosovo), regional tropical disease research, bio surveillance and threat reduction (Thailand, Republic of Georgia and Kenya), proliferation of best practices in prosthetics and rehabilitation (UK, Pakistan, Republic of Georgia), advancement of professional military nursing (France, Vietnam, and Japan) and support to exceptional medical care cases through the DOD Secretarial Designee Program (Norway, Afghanistan, Australia, Ecuador, Italy, Romania, and the Republic of Georgia).

We see our medical centers, hospitals and clinics as our health readiness platforms. They ensure we maintain trained and ready medical personnel. Our large medical centers serve as specialized training centers for our medical teams to provide care and clinical research for complex battle injury and illness. Our medical centers are complemented by a variety of military treatment facility types, from ambulatory clinics to community hospitals that prepare our medical force to provide primary and routine specialty care in a myriad of settings and conditions around the world. These facilities

must be capable of enrolling a broad range of patients with a wide variety of illnesses and injuries.

Army Graduate Medical Education (GME) programs are critical to develop trained and ready medical personnel. Army GME is the largest GME platform in the DoD and supplies more than 90% of all Medical Corps (MC) physicians for the Army. Our GME programs have nearly 1,500 trainees in 149 programs. The vast majority (93%) of Army GME training is conducted at 10 military treatment facilities. The remaining 7% is conducted in approximately 64 civilian academic institutions, primarily for fellowships. Civilian GME programs do not have the capacity to absorb our interns, residents, and fellows. Our GME programs continue to lead the nation in training. The first time board certification pass rate of 95% across Army GME exceeds the 87% national rate. Agile GME program management assures ongoing alignment of training slots with deployment and readiness requirements.

The Army continues to increase its partnerships with the VA through sharing agreements that provide care to VA beneficiaries in various healthcare facilities that have excess capacity. Treating VA beneficiaries supports Army GME programs and provider readiness. This is due to the fact that VA patients typically have needs that are much more complex and extensive than normally seen in Soldiers and family members. Further, this enables VA beneficiaries to receive high quality, cost effective, and timely care in locations where the VA may have limited capability or resources. In FY14, Army Medicine provided $50.3 million in healthcare services to VA beneficiaries at 19 locations across the country.

I would also like to highlight our partnership with the US Army Special Operations Command, Joint Special Operations Medical Training Center (JSOMTC), to identify where we can collaborate to identify best practices and disseminate those to the entirety of the Total Force. JSOMTC provides a unique opportunity to capture lessons learned from the battlefield as special operations medical personnel provide support. The best practices they identify are instrumental in educating our medical personnel in the conventional force. To that end, we will continue efforts to bring the conventional and unconventional forces closer together and learn from each other. We anticipate this will

motivate leaders at all levels to take a more active role in medical training and incorporate casualty-play into all other training.

Education and Training

Army Medicine continues to enjoy tremendous success in attracting and educating the best medical minds. The multi-discipline Health Professions Scholarship Program (HPSP) produces over 450 graduates annually - 80% of active duty physicians, dentists, optometrists, veterinarians, and clinical psychologists. Currently, we have 1596 HPSP students in medical, dental, veterinary, optometry, nurse anesthetist, clinical psychology and psychiatric nurse schools. Additionally, the Uniformed Services University of the Health Sciences (USUHS) is a critical institution dedicated to developing and training clinicians in leadership, clinical, and combat casualty care as well as operational medicine. USUHS is a critical source of accessions for the Medical Corps and provides valuable post-graduate education for nurses, dentists, administrators and other public health professionals.

Our education programs are consistently recognized nationally. US News and World Report's most recent survey of graduate schools ranked the US Army Baylor Doctoral Program in Physical Therapy 5th in the country; the Inter-service Physician Assistant Program 11th; and the Army-Baylor University Graduate Program in Health Administration program 7th nationally. Furthermore, the US Army Graduate Program in Anesthesia Nursing (USAGPAN) and the USUHS Daniel K. Inouye Graduate School of Nursing Doctor of Nursing Practice (DNP) Nurse Anesthesia program are regarded among the best in the Nation with graduates surpassing national averages on National Certification Exam first-time pass rates and overall scores.

The Army has partnered with the Uniformed Service University of the Health Sciences to develop and implement the Enlisted to Medical Degree Preparatory Program (EMDP2). This 24-month program enables enlisted Service members to complete the preparatory course work for entry into medical school while maintaining active duty status. Four of the five Soldiers in the 2014 cohort have already been offered positions in the military medical school. This program will recruit and grow talent from within the ranks, optimize force development and enhance medic retention.

HEALTHCARE DELIVERY

Army Medicine's fundamental tasks are promoting, improving, conserving, and restoring the behavioral and physical well-being of those entrusted to our care. From the battlefield to the garrison environment, we will support the Operational requirements of Combatant Commanders while also ensuring the delivery of the healthcare benefit to our beneficiaries. We must provide our beneficiaries with access to high quality care. We will continue to focus on expanding Telehealth, sustaining Warrior Care and Behavioral Health, and supporting women in the Army.

Access to Care Initiatives

Improving access to care remains a priority for Army Medicine. Specifically, our beneficiaries expect better primary care access. While we have improved access by 21% since 2014, we are still not fully meeting our beneficiaries' expectations. Therefore, I have directed actions to radically improve access to primary care in our MTFs. I have established a goal of creating 260,000 (4%) more primary care visits above the 6.1 million visits we provided in FY15 and 119,000 (1.5%) more specialty care visits above the 7.9 million we visits provided in FY15.

We are standardizing processes across the Services to drive improvement with access. Last year, Army Medicine instituted a “First Call Resolution” policy to ensure all enrolled beneficiaries receive a direct care system appointment or network authorization on their first call. In addition, Army Medicine implemented a simplified appointing policy to reduce the types of primary care appointments from 12 to 5 with a focus on 24-hour acute appointments and future/follow-up appointments.

Army Medicine continues to expand our off-installation healthcare program by placing Community Based Medical Homes (CBMH) in communities surrounding our military installations closer to where our beneficiaries live and work. Today over 10% of our enrolled beneficiaries receive their primary care in a CBMH, many of which have extended hours and offer behavioral health and prescription refill services. We currently have 20 CBMHs supporting 13 installations. In FY16, we will open three more CBMHs at three installations and in FY17, we will open two more CBMHs and our first open access acute care clinic in San Antonio.

To further improve access to routine and specialty care, I am directing our MTFs to allow beneficiaries to book an appointment up to six months in advance. This will allow beneficiaries to book follow-up appointments before departing at the conclusion of their MTF visit, eliminating the need for them to call back to make an appointment after they have left our facilities. We will increase the number of available appointments by increasing the time our physicians are available to see patients and reducing the number of unfilled appointments. Additionally, we are also conducting a comprehensive assessment across our installations to determine where we must expand clinic hours or establish Urgent Care Clinics to take care of our people.

Army Medicine is also aggressively expanding the use of virtual tools, such as the Nurse Advice Line (NAL), TRICARE online, and Secure Messaging. In 2015, 55,000 beneficiaries were given self-care instructions through the NAL avoiding an unnecessary trip to the Emergency Department or Urgent Care Center. On January 15, 2016, Tricare Online (TOL) Pharmacy Refill went live. During the first week in February alone, 5,400 prescriptions were refilled via TOL allowing providers to focus more time on clinical care.

Army Medical Homes

The Army Medical Home (AMH) is a multidisciplinary approach to deliver comprehensive primary care. Care is delivered through an integrated healthcare team who proactively engages patients as partners in health. The Army Medical Home model encompasses all primary care delivery sites in the direct care system, including our MTF-based Medical Homes, Community Based Medical Homes (CBMH) and the Soldier Centered Medical Homes (SCMHs).

Primary Care is delivered through an integrated team of healthcare professionals that proactively engages patients as partners in health, with a stronger focus on prevention. Each patient will partner with a team of healthcare providers – physicians, nurses, behavioral health professionals, pharmacists, and others – to develop a comprehensive, personal healthcare plan. Currently, 134 AMHs across the United States, Europe, and the Pacific are caring for 1.3 million beneficiaries supported by a budget of $74.5M. All of the AMHs have been recognized by the National Committee for

Quality Assurance (NCQA) representing the gold standard of patient-centered medical care.

The integration of Internal Behavioral Health Consultants (IBHC) and Behavioral Health Care Facilitators (BHCF) into Army Medical Homes has increased the availability of behavioral health services to all beneficiaries and reduced the stigma of behavioral health treatment. In addition, these Behavioral Health providers are an integral component of the treatment and prevention of behavioral health and behavioral medicine disorders in the beneficiary population. IBHCs address common behavioral health issues including depression and anxiety as well as assist with the treatment and prevention of many chronic medical conditions that can improve with lifestyle changes (diabetes, chronic pain, insomnia, obesity, nicotine use, etc.). Currently, 99 IBHCs and 58 BHCFs are integrated within the Army Medical Homes.

Telehealth (TH)

Army Medicine will continue to leverage technology to enhance access, readiness, quality, and safety for our beneficiaries. Army Telehealth (TH) currently provides clinical services across 18 time zones in over 30 countries and territories. Army Medicine executes approximately $14 million per year on clinical uses of TH such as Tele-Behavioral Health (TBH). In FY15, Army clinicians provided over 40K provider-patient encounters and provider-provider consultations in garrison and operational environments in over 30 specialties via TH. Army TH accounts for over 90% of all clinical TH encounters in the DoD.

Army Medicine invests in three TBH provider hubs with the majority of current spending for provider and staff salaries. These hubs are strategically located across the world to ensure 24/7 routine and emergency coverage. The April 2014 Fort Hood shooting is an example of emergency surge support. After the shooting, clinical support from Washington D.C., Honolulu, HI, and San Antonio, TX, was surged quickly to offer services to our Soldiers at Ft. Hood, TX. Other key programs include teleconsultations systems connecting deployed providers with specialty expertise in garrison; a mobile application system supporting warriors in transition; tele-mentoring programs in Pain Management; and a world class research portfolio innovating deployed TH systems.

Because of its tremendous benefits, Army Medicine is expanding TH to create Connected, Consistent Patient Experience (CCPE) -- a 360º care continuum around patients using advanced TH modalities. The core elements of the CCPE include: (1) implement TH visits to patients' locations (such as their homes); (2) optimize provider-provider teleconsultations systems; (3) pilot remote health monitoring; (4) enhance the current TH Operating Company Model for standardized global operations; and (5) mature Army TH in operational environments.

As a glimpse of the future, Army Medicine is building a seamless, global teleconsultations platform. From battlefield to bedside, providers will be able to access specialty expertise from their colleagues – wherever in the world they are working. This enables patients to receive the best specialty expertise Army Medicine has to offer no matter where they are stationed.

Behavioral Health (BH)

Behavioral healthcare is one of the most important factors in the readiness of the Force. I anticipate continued growth in the demand for behavioral health care, including TBH, even as overseas contingency operations decrease. This is mainly due to the cumulative strain of over 14 years of war on Soldiers and families, the unique stressors of military service, and the Army's continued emphasis on Soldiers seeking help. In FY16, the Army will resource an estimated $300M to support BH programs.

The Army is helping to decrease the stigma that others may feel in seeking behavioral health care. Programs such as Embedded Behavioral Health (EBH), Primary Care Behavioral Health and School Behavioral Health focus on reaching Soldiers and their families outside the MTF to improve access and reduce stigma.

Embedded Behavioral Health teams now support 141 operational units, including all Brigade Combat Teams. EBH provides multidisciplinary behavioral healthcare to Soldiers in close proximity to their units. EBH has correlated with an increase in Soldiers' use of outpatient behavioral healthcare and a reduction in the need for acute inpatient psychiatric care. This indicates that Soldiers are receiving care earlier in the course of their BH condition, before crises occur. We will extend the EBH model of care

to support all operational units across the Force no later than October 2016. Special Forces units on Army installations have the priority of support.

The Army regularly screens Soldiers for BH conditions, including PTSD, at several points in the Force Generation cycle. The Army's screening program exceeds Department of Defense requirements and includes assessments annually and before and after every deployment. Also, screenings for BH conditions are performed at every primary care visit and BH professional have been placed in medical homes to expedite consultation and treatment. To expand behavioral healthcare to Children and other Family Members, MEDCOM has established clinics within 51 schools and will expand to approximately 50 more to enhance access to and continuity of care.

We are proud of the implementation of the Behavioral Health Data Portal (BHDP) at every MTF. BHDP is a web-application that gathers standardized, automated clinical data from Soldiers receiving care in BH clinics. The program analyzes and presents data to BH providers to support their clinical decisions and treatment planning. It tracks patient outcomes, satisfaction, and risk factors via web application to improve program assessment and treatment efficacy. This innovative program has been identified by the Department of Defense as a best practice and is being implemented by the Navy and Air Force.

In March 2015, the Secretary of the Army (SA) directed the Assistant Secretary of the Army for Manpower and Reserve Affairs to conduct a comprehensive review of the Army Substance Abuse Program (ASAP). In October 2015, the Secretary approved ASA(M&RA)'s recommendation to realign clinical care under MEDCOM and integrate it with the Behavioral Health System of Care. The MEDCOM is developing a Substance Use Disorder Clinical Care capability that ensures holistic and integrated medical care for our Soldiers in accordance with published DoD policy, national standards, and best practices. The new $40M program will provide additional opportunities for Soldiers to receive care for substance use disorders from over 300 specially trained counselors.

Improving Quality and Safety

Since 1775, Army Medicine has reliably served our Nation, our Army and all those entrusted to our care. Army Medicine's commitment to patient safety has been,

and remains, unwavering. In 2012, we began to incorporate elements of the "High Reliability Organization" (HRO) concept to continue to improve our practices in achieving the highest levels of patient safety. In 2015, we established the Deputy Chief of Staff for Quality and Safety to align all quality, patient safety, and organizational environmental and equipment safety elements within the same directorate. This alignment provides a synergistic environment to take advantage of analysis of problem areas and best practices across the full spectrum of quality and safety from within the command and in consultation with external experts and leaders.

Army Medicine is collaborating with The Joint Commission Center for Healthcare Transformation to pilot an assessment program that gauges the HRO maturity of Army MTFs. The Joint Commission team completed three assessments in 2015 and one in January 2016. The evaluations revealed several leading practices that include the routine conduct of Command team safety walk-rounds and the incorporation of HRO concepts into staff orientation. Opportunities for improvement identified were clearly linking Commander's priorities to quality and safety and advancing training in the use of Lean and Six Sigma for process improvement and reduction of variance across the facility. These assessments are valuable to our facilities. Therefore we plan on conducting four more MTF assessments per year over the next five years. As the assessments are completed and analyzed, the lessons learned will be shared across the entire MEDCOM and with our Sister Services.

Army Medicine is increasing its participation in the American College of Surgeons' National Surgical Quality Improvement Program (NSQIP) to reduce surgical complications, improve outcomes, and improve patient satisfaction. Currently, nine Army MTFs participate in NSQIP. By the end of 2016, all 22 Army MTFs with surgical services will participate in NSQIP. In 2015, Dwight D. Eisenhower Army Medical Center at Fort Gordon, GA was recognized by the American College of Surgeons as one of the nation's Top 50 Hospitals for Surgical Quality out of the 528 hospitals in the US that participate in NSQIP.

To drive further improvement, MEDCOM will design, develop and implement a Quality and Safety Center to more effectively use patient safety data, improve sharing of lessons learned across the MEDCOM, and increase transparency and availability of

quality and safety information available to our leaders, staff, and beneficiaries. This center will be established in coordination with the Army Combat Readiness Center (CRC) and will leverage many of the successful practices incorporated by the CRC.

Wounded Warrior Care

Caring for wounded, ill, and injured Soldiers is a sacred obligation and will remain an enduring mission. Since 2007, nearly 70,000 wounded, ill, or injured Soldiers and their families received care from dedicated Warrior Care and Transition Program (WCTP) health care professionals with more than 30,000 (~44%) returned to the force. This is a fully-funded program and the budget for FY16 is approximately $810M.

The Warrior Transition Units (WTUs) provide mission command, medical management assistance, and transition assistance to Soldiers as they navigate the Army's medical treatment system. Within the WTUs, Soldiers receive personalized support from a Triad of Care that includes a nurse case manager, a squad leader, and the primary care manager. The Triad of Care is augmented by an interdisciplinary team of health care and transition specialists, to include social workers, physical therapists, occupational therapists, Army Wounded Warrior (AW2) Advocates, and many other professionals.

Community Care Units (CCUs) are within most WTUs and extend WTU capabilities into the community. Soldiers assigned to a CCU heal at their home with the support of their families and communities, with the support of the Triad of Care.

Since February 2014, Soldiers receiving care and oversight through the WCTP has decreased from approximately 7,000 to 2,659. Based on the declining population in WTUs, on August 27, 2015 the Army announced its plan to reduce the number of WTUs from 25 to 14 by August 2016.

The WTU locations scheduled for inactivation are Fort Gordon, GA; Fort Knox, KY; JB Langley-Eustis, VA; Fort Leonard Wood, MO; Fort Sill, OK; Fort Polk, LA; Fort Wainwright, AK; JB Elmendorf-Richardson, AK; Fort Meade, MD; and Naval Medical Center, San Diego, CA. As of 8 February 2016, there were a total of 171 Soldiers assigned to these WTUs.

The remaining 14 WTUs are aligned to major power projection platforms or those co-located with major Army medical activities and centers providing support to wounded, ill and injured Soldiers who require at least six months of rehabilitative care and complex medical management.

Throughout the consolidation effort, the WCTP will maintain a scalable and reversible posture to ensure uninterrupted care to our wounded, ill and injured population. The CCU mission of allowing Soldiers who do not require day-to-day care to recover closer to home and receive their care from the TRICARE network will not be affected by these consolidation efforts. The opportunity to recover closer to home will continue to be an option our Soldiers can exercise.

Civilian employees impacted by the consolidation will be reassigned based on skill match, the needs of the Army, and available employment opportunities. Every attempt will be made to allow Reserve Component cadre to serve out their tours. Transferring Soldiers and their families will be managed closely during this operation.

The Army will host the 2016 DoD Warrior Games in June 2016 at the U.S. Military Academy at West Point. The Warrior Games is the pinnacle event in the Army's adaptive reconditioning program for Soldiers recovering at the Army's Warrior Transition Units (WTUs). The Warrior Games feature 8 sporting events with approximately 200 athletes representing teams from each Service, SOCOM, and the British Armed Forces. As part of the Warrior Games, Soldiers can participate in a wide range of physical activities that support their physical and emotional well-being and contribute to a successful recovery, whether they are transitioning back to active duty or to civilian life.

Supporting Women in the Army

In January 2013, then Secretary of the Defense (SECDEF) Leon Panetta rescinded the 1994 Direct Ground Combat Definition and Assignment Rule. Following three years of careful and comprehensive study, the Army recommended all military occupational specialties (MOS) be open to women. The Army believes the best-qualified Soldier, regardless of gender, should be allowed to serve in any position. In December 2015, SECDEF Ashton Carter directed the full integration of women in the Armed Forces.

Since 2011, the Army has opened 9 military occupational specialties and approximately 95,000 positions in Combat Arms units down to company and platoon level. To achieve full gender integration, the Army will implement published, measurable, gender-neutral standards, then initiate gender-neutral training, followed by deliberate and methodical assignment of female leaders (officers, then enlisted) to Infantry and Armor units.

Army Medicine is supporting several tasks required for full gender integration. From October 2013 to June 2015, MEDCOM led the Soldier 2020 Injury Rates/Attrition Rates Working Group that conducted a thorough review of current literature, identified gaps in research and surveillance requirements to provide strategic-level recommendations to for policies and injury surveillance concerning mitigation of musculoskeletal injuries, gender-specific attrition, performance, behavioral health disorders and women's health issues

Soldiers' injury rates have been consistently higher in female than male Soldiers in the basic training setting (2:1) for 30 years. The injury rates become closer in the Operational and Deployed Army (1.2-1.4:1). This is likely due to improved levels of physical fitness and regular physical training sessions once Soldiers are assigned to units. Some studies compared male and female trainees of similar fitness levels and showed injury rates were nearly the same in a Basic Combat Training (BCT) environment. This suggests there is a subset of females that can perform at high fitness levels and who are less likely to be injured. Currently there is no medical data or research on long-term injury and disability rates for combat arms MOSs/AOCs for men or women. Consequently there is no foundation for predicting long-term injury rates and disability in Soldiers.

Nutrition is key factor in performance. Blood iron levels declines in female service members during rigorous training, particularly in BCT and Advanced Individual Training (AIT). MEDCOM and TRADOC implemented a multivitamin with iron program for female Army trainees in January of FY16 aimed at increasing performance and decreasing attrition rates. Other nutritional supplementation (primarily Calcium and Vitamin D) is being considered to address the incidence of stress fractures in Individual Entry Training (IET) Soldiers.

The US Army Research Institute of Environmental Medicine (USARIEM) worked closely with the Training and Doctrine Command (TRADOC) to develop the Occupational Physical Assessment Test (OPAT); a new criterion-based physical testing procedure for entry into seven physically demanding Combat Arms MOSs.

The Women's Health Service Line (WHSL) manages the unique needs of women by building sound fundamentals in perinatal and newborn services, as well as gender-based programs. The WHSL was instrumental in the development of the MEDCOM Breastfeeding and Lactation Support Policy to ensure the MTFs incorporate the "Ten Steps to Successful Breastfeeding" concepts and ensure standardized breastfeeding education for all personnel who care for the mother and infant. This policy also supports the Army Directive 2015-43, Revised Breastfeeding and Lactation Support Policy, to ensure a designated place to express milk when employees/Soldiers return to work.

Sexual Assault / Sexual Harassment Prevention

The Army and Army Medicine continue to confront the complex challenges of sexual assault. As an integral participant in the Army's Sexual Harassment/Assault Response and Prevention (SHARP) program, Army Medicine continues to be at the forefront of the management, regulatory guidance, and oversight of care for all sexual assault victims. Our goal is to be a nationally recognized leader in providing patient-centered responses to all victims of sexual violence

Regardless of evidence of physical injury, all patients presenting to a MTF with an allegation of sexual assault receive comprehensive and compassionate treatment. All examinations are completed in accordance with Department of Justice (DOJ) "National Protocol for the Sexual Assault Medical Forensic Examinations Adult/Adolescents" current recommendations and training guidelines. They are offered a sexual assault medical forensic examination (SAMFE) conducted by a trained and competent SAMFE professional at the MTF or at a local facility through a memorandum of agreement. USAMEDCOM also provides at least one Sexual Assault Nurse Examiner (SANE) at every Military Treatment Facility (MTF) with a 24/7 emergency room (ER).

Follow on care is coordinated and managed through the Sexual Assault Medical Management Team (SAMMT) at each MTF and the Sexual Assault Response Coordinators (SARCs), and Victim Advocates (VAs). The AMEDD SAMMT is designed to provide immediate and long-term patient care, from assessment of risk for pregnancy, options for emergency contraception, risk of sexually transmitted diseases/infections to include HIV prophylaxis, and necessary follow-up care and services. All patients, whether victims or suspects, are offered a referral to Behavioral Health at their first encounter and are encouraged to receive follow on psychological care. Long-term care plans are tailored to the meet the individual patient's medical and behavioral healthcare needs.

Victims will not be re-victimized through loss of privacy and dignity. Whether the victim elects restricted or unrestricted reporting, confidentiality of medical information will be maintained in accordance with Health Insurance Portability and Accountability Act (HIPAA) guidelines. Scope and standards of medical care are the same, regardless of restricted or unrestricted reporting.

The Office of the Surgeon General (OTSG) developed the first Sexual Assault Medical Forensic Examiner for Adult/Adolescent curriculum now universally taught by the AMEDDC&S. The SAMFE curriculum and training will be taught as a tri-service program effective FY17 and meets or exceeds the Department of Justice (DOJ) national protocols and training standards. This inter-service effort for training will standardize the delivery of care provided to sexual assault patients and suspects.

Womack Army Medical Center at Fort Bragg, NC could serve as a case-study in bringing the medical facility and community closer together in responding to SHARP incidents. Womack has established a monthly training session that includes a forensics community of interest comprised of the MTF, installation, community, law enforcement, and prosecutors. This session allows personnel to review cases, identify best practices, and work together to address SHARP requirements. Womack is also currently planning to conduct a 2-day recertification session for SAFME personnel as well as a yearly summit for the local forensics community. The efforts at Womack are indicative of an engaged, proactive community of experts.

FORCE DEVELOPMENT

The Joint Concept for Health Services (JCHS) describes how the future Joint Force will provide Globally Integrated Health Services in support of Globally Integrated Operations. It describes a future operating environment that is more unpredictable, complex, and potentially more dangerous than today. The JCHS envisions a shift from the relatively static operations in Iraq and Afghanistan to sustained engagement and force projection/crisis response operations.

In future operations, Army Medicine capabilities must be able to rapidly aggregate and disaggregate in support of forces that are dispersed over long distances. Army Medicine capabilities must be sufficiently modular, interoperable, agile, tailorable, and networked to enable the Joint Force Commander to quickly and efficiently combine and synchronize capabilities. Additionally, we must be prepared to operate in austere, expeditionary environments without the benefit of a robust theater medical infrastructure. We must continue to develop agile and adaptive leaders who are able to effectively operate in complex environments.

The Army Medical Department Center and School (AMEDDC&S) / Health Readiness Center of Excellence (HRCoE) is leading our efforts to develop agile and adaptive leaders while evaluating our training, doctrine, and capabilities to ensure we are postured to support the Army in future operations.

Published in August 2015, The Early Entry Medical Capabilities (EEMC) Concept of Operations (CONOP) is the product of analysis conducted by the AMEDDC&S to identify medical capabilities required to support future Joint and Army entry operations. The CONOP identifies six major capability areas: Battlefield Trauma Management, Trauma System, Medical Evacuation and En-Route Critical Care, Medical Training and Preparedness, Medical Information Management, and Mobility, Protection and Sustainment. AMEDDC&S is conducting ongoing studies in these areas to improve medical capabilities in support of early entry operations in the future.

To provide more realistic combat casualty care training at the squad level, AMEDDC&S developed the Exportable Tactical Combat Casualty Care training. This training provides units with three days of progressive training beginning with classroom instruction, progressing to practice using virtual environments, and culminating in

application using advanced combat casualty mannequins that breathe, bleed and are visually modeled realistically portray severe trauma. Also, to enhance training we are looking at bringing the Ranger First Responder model of medical care to the greater Army.

In 2012, the AMEDDC&S began the Critical Care Flight Paramedic (CCFP) Training Program to provide flight medics with additional paramedic, critical care training, and civilian certifications. Since 2012, 350 critical care paramedics from all components have graduated from this program. In 2015, the AMEDDC&S opened the CCFP Transport Medical Training Laboratory to enhance training for critical care paramedics. This immersive training environment utilizes multiple state-of-the-art Human Patient Simulators, a static airframe medical suite, and a configurable room that supports simulated combat casualty care from the point of injury through medical evacuation, forward surgical hospital, and the combat support hospital.

AMEDDC&S is developing the science of Prolonged Field Care (PFC) to support a future operating environment where historic evacuation planning timelines may not be achievable. It is evaluating data from the Department of Defense Trauma Registry (DoDTR), Joint Trauma System (JTS), and Armed Forces Medical Examiner (AFME) and conducting a review of all Clinical Practice Guidelines to determine what should or could be accomplished in the field. It is also developing the criteria for the enhanced medic of the future including Prolonged Field Care (PFC) principles, telemedicine capabilities and remote primary care to be incorporated into future training programs of instruction.

AMEDDC&S developed the Forward Resuscitative and Surgical Team (FRST) based on lessons learned from Iraq and Afghanistan. The design was approved in 2015 with the medical equipment set approved in 2016. The FRST provides two surgical elements and two resuscitative elements that enable it to conduct split based operations. It is rapidly deployable and equipped to provide continuous operations in conjunction with the supporting medical company for up to 72 hours. It allows for urgent initial resuscitation and surgery for otherwise non-transportable patients.

Demonstrating institutional agility, the AMEDDC&S is currently organizing, training, equipping and deploying a regionally aligned medical team capable of

providing immediate forward resuscitative field care, prolonged field care and enroute critical care in support of enduring AFRICOM operations. This initiative enhances the AMEDD training strategy development with San Antonio Military Medical Center (SAMMC), Walter Reid Army Institute of Research (WRAIR)/Global Emerging Infections Surveillance (GEIS), US Army School of Aviation Medicine and MEDCOM education and training capabilities integrated into the pre-deployment CONOPs and mission analysis.

Medical Research

The U.S. Army Medical Research and Materiel Command (USAMRMC) is the Army's medical materiel developer, with responsibility for medical research, development, and acquisition (RDA), as well as medical logistics management. The USAMRMC manages the full life-cycle of medical technologies and materiel, from discovery through development, procurement, maintenance and disposal to support the readiness and optimal health of our armed forces; to provide our health care providers with technologies to protect Soldiers from disease and injury and to provide optimal care for casualties, particularly on the battlefield. USAMRMC conducts or manages ground-breaking research in combat casualty care (CCC); Traumatic Brain Injury (TBI); Psychological Health; and infectious diseases to protect against global disease threats as well as post-injury research in rehabilitative and regenerative medicine to improve the care and quality of life of severely injured Service Members. It is important that funding and planning decisions made today must preserve the Army's core medical research competencies through continued medical research investments. These investments sustain critical capabilities that ensure strategic flexibility to avoid technological surprise as we respond to future operational threats.

The USAMRMC has spearheaded many major advances in trauma research and development. A recent success is a first-of-its-kind endovascular (inside the blood vessel) device (ER-REBOA™) for hemorrhage control and resuscitation that recently obtain a Food and Drug Administration clearance. The ER-REBOA™ catheter recently had its first known use by a military surgeon working at a civilian trauma center, where a gun-shot victim was resuscitated after nearly bleeding to death. In an effort to

conserve and maximize the return on trauma research investments, the USAMRMC has awarded the first-of-its-kind National Trauma Research Database contract to develop a common repository of data stemming from DoD-funded trauma research. Advances stemming from this research program and lessons learned from operational trauma care in Iraq and Afghanistan are transforming care of civilians injured as a result of violence, accidents and natural disasters.

The U.S. Army Medical Research and Materiel Command's TBI research portfolio includes projects not only related to TBI, but also to brain health. With Congress' investment, the DoD funded the development of an FDA approved TBI assessment technology, the "Ahead 200." This device uses a disposable headset and commercial smartphone technology as an adjunct to standard clinical practice to aid in the evaluation of patients who present as having a mild traumatic brain injury within 24 hours of injury, but may have a severe or life-threatening TBI and are being considered for a head Computed Tomography (CT).

Historically, infectious diseases are responsible for more US casualties than enemy fire. Continued progress to address these emerging threats requires sustained commitment to funding; developing personnel with expertise in infectious diseases; and maintaining stateside and overseas laboratory infrastructure and overseas field sites for clinical studies and response to emerging disease threats. Our research efforts in this area are leading to progress in the development of vaccines, treatment and preventive drugs, human diagnostics, and vector control tools. Two malaria treatment drugs are expected to be licensed in 2018; two malaria vaccine candidates are expected to be transitioned to advanced development (AD) in FY18 (safety and effectiveness clinical trials); and one malaria prophylaxis drug is expected to transition to AD in FY19. Finally, we are conducting early clinical trials to evaluate the safety and immunogenicity of vaccines targeting Hemorrhagic Fever with Renal Syndrome and organisms causing bacterial diarrhea.

The coordinated and swift response to the Ebola virus outbreak demonstrated the value of continued investment in infectious disease research and development capabilities, to include critical subject matter expertise and overseas laboratory infrastructure. The Ebola Virus Disease (EVD) research and development (R&D) efforts,

executed at the USAMRMC and funded by the Chemical and Biological Defense Program (CBDP) and industry partners, contributed to the development of investigational EVD therapeutics, vaccines and developed the first Emergency Use Authorization (EUA) Ebola Virus Diagnostic Assay. The portfolio of potential treatments for Ebola under development includes biologics, engineered antivirals, and products to boost the host's own immune system.

The latest Public Health concern that has Global Health implications is the Zika virus. This mosquito-borne Flavivirus is currently progressing through the Americas; local transmission has been reported in over 30 countries and territories in the region. There is no vaccine or effective therapeutic yet for disease prevention or treatment. There is a need for better diagnostic assays to quickly and clearly differentiate between similar viruses and to detect past Zika infection. The USAMRMC has resident Subject Matter Experts (SME) with years of R&D experience in the study of the Flavivirus family of infectious diseases and the Aedes mosquito. Our SMEs are currently participating as Army and DoD representatives in several interagency and international meetings and committees as they communicate and coordinate efforts to address the current concerns with the Zika virus outbreak.

Further, the USAMRMC is continuing bio-surveillance and virus characterization activities through the overseas and domestic laboratories. USAMRMC laboratories have Zika virus isolates and are in the process of obtaining more geographically distinct isolates to support current biosurveillance and potentially expanded R&D activities. The Centers for Disease Control (CDC) lead the efforts to submit an Emergency Use Authorization (EUA) to the Food and Drug Administration (FDA). On February 26, 2016, the FDA approved an Emergency Use Authorization (EUA) for CDC Zika Immunoglobulin M (IgM) Antibody Capture Enzyme-Linked Immunosorbent Assay ("Zika MAC-ELISA"). USAMRMC is now working in support of the National Laboratory Response Network.

Streamlining Structure

Army Medicine continues to evaluate its headquarters structure to ensure it is properly sized and aligned to support the Army. In Fall 2013, the AMEDD Futures Task

Force was established to review the MEDCOM headquarters structure and provide recommendations on how to best balance and align it. The Task Force recommended a flattened and more integrated structure that is geographically aligned to support the Army. The Secretary of the Army approved this reorganization on April 27, 2015 and MEDCOM initiated its transformation on July 8, 2015.

By the end of the two year implementation in FY17, the MEDCOM will transform from 20 to 14 subordinate Command HQs. This 30% reduction of headquarters will reduce our administrative overhead structure to less than 4.2% of MEDCOM's total requirements and authorizations. We have completed transformation of fifteen functional regional command HQs to four multi-disciplinary Regional Health Commands (RHCs) by merging regional headquarters for public health and dental. RHCs are a single point of accountability for health readiness to regionally aligned forces around the globe. Within the Continental United States, RHC-Atlantic and RHC-Central are aligned with XVIII Airborne Corps and III Corps installations respectively. Overseas, RHC-Pacific aligned with U.S. Army Pacific to support the Army's strategic Rebalance to the Pacific. RHC-Europe is aligned with U.S. Army Europe and U.S. Army Africa. Finally, we transitioned the headquarters for the Public Health Command, Warrior Transition Command, and Dental Command to elevate and integrate them as functional key staff at the MEDCOM headquarters.

Simultaneously, a work group was established to review the executive leadership within our MTFs. The results of this study led to an executive leadership model borrowed from the US Navy, the AMEDD Health Executive Leadership Organization Structure (HELOS), which was approved for implementation on 12 Jun 15. The model standardizes the leadership structure for medical centers, large hospitals, small hospitals, and clinics. It provides increased leadership opportunities at the deputy level and enhances oversight of quality, safety, the patient experience, staff development, and productivity within all MTFs. The new leadership positions will provide additional opportunities to groom future hospital and medical center commanders. The endstate will be more experienced leaders who are more accountable.

Caring of Our Beneficiaries

TRICARE is an excellent benefit tailored to support our beneficiaries and their unique needs and situations while also supporting readiness by providing reinforcing capacity for our medical treatment facilities. Most agree that change is necessary to ensure the long-term sustainability of the program and to improve performance. However, reform must preserve the All-Volunteer Force and honor the sacrifices of our Soldiers and their Families. I support the TRICARE reforms proposed in the FY17 President's Budget.

Reforms should inspire beneficiaries to return to our direct care system and military run medical facilities. I believe the best place for them to receive care is in our military treatment facilities where we understand their needs, can manage and document their care, ensure quality, and can ensure their readiness.

Reforms should incentivize health and healthy lifestyles. This is key to long-term cost control.

We must ensure our beneficiaries have access to high quality, safe healthcare in our MTFs and in the TRICARE network. To this end, we must increase transparency and exchange of data between both healthcare systems.

Reforms must not increase the financial burden on Active Duty Soldiers or Active Duty Family Members and minimize impact to our retired population. Any increased financial burden on retirees must be modest and not inhibit them seeking necessary medical care in our facilities.

Conclusion

Army Medicine is the Nation’s premier and most versatile medical organization meeting the ever-changing challenges of today. No other healthcare organization in the world has the scale and scope of Army Medicine. No other healthcare organization in the world has the diversity, depth, and breadth of Army Medicine. No other healthcare organization in the world has the ability to support the continuum of care from the battlefield to garrison and in any environment imaginable. No other healthcare organization in the world provides the unique and integrated capabilities that Army Medicine delivers on a daily basis, around the world, in support of our Nation and our

Army. As the military health care reform discussion continues we must remain focused on maintaining readiness while continuing to improve the health of all those entrusted to our care.

While our system has proven very successful over the last 14 years of supporting the Warfighter, we need to continue to improve and evolve it to meet the changing needs of our Nation's Army. No other health organization is required to provide, nor is capable of providing, the full spectrum of care from point of injury or illness on a battlefield through rehabilitative care while continuing to maintain high quality care in garrison environments for its beneficiaries.

I am committed to improving readiness, enhancing the healthcare delivered to our beneficiaries, evolving to support the Army in future conflicts, and to taking care of our Soldiers, civilians, and their Families.

We remain fully committed to work with Congress, DoD, and all those entrusted to our care to improve our system.

I want to thank my partners in the DoD, the VA, my colleagues here on the panel and the Congress for your continued support.