Prepared Statement

of

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on

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Mr. Chairman and members of this distinguished committee, thank you for the opportunity to be here today to discuss the Department of Defense's Force Health Protection programs and how they impact our reserve component service members. Today, we have nearly 190, 000 National Guard and Reserve service men and women activated for federal service, including those serving in Afghanistan and Iraq. DoD is firmly committed to protecting the health of our Reserve component members.

Protecting our forces is a primary mission of the Military Health System. Our Force Health Protection program is designed to ensure that all members of the total force – active, Guard and Reserve – receive the same world class of health care. The objectives of the Force Health Protection program are to recruit and maintain a healthy and fit force, to prevent disease and injury, and to provide medical and rehabilitative care to those who become ill or injured.

The rigorous medical requirements of the armed forces entrance physical examination and our periodic physical examinations, HIV screenings, annual dental examinations, physical fitness training and testing, immunizations and regular medical record reviews contribute to maintaining a healthy force. One of our most recently developed DoD policies requires all deployable forces to achieve a new Individual Medical Readiness (IMR) standard. The IMR is now used as the measure for the services' preparation of service members to deploy and execute the mission. The services are now using a common set of individual medical readiness standards to monitor the collective readiness of the force. For service members to be fully medically ready, all immunizations must be current and they must not need any dental work done. They must have all medical readiness lab tests done, including HIV tests, have no deployment-limiting medical conditions, have completed a current health assessment, and have all the medical equipment they need, including ear plugs, eyeglasses and mask inserts. By tracking the

individual medical readiness against this standard, commanders can monitor the percentage of personnel who meet each of the criteria. This is an important new commander's tool.

Pre-deployment health assessments ensure that deploying Guard and Reserve members are still as fit and healthy to carry out the mission as previously documented. More than 193,000 pre-deployment health assessments have been done on reserve component troops since January 2003. Until October 2003, Army policy was to hold those reserve component troops called to active duty, but found not medically fit to deploy, on active duty until treatment returned them to deployable status or they were medically separated. The unexpectedly large number of Guardsmen and reservists activated but not medically fit for deployment created a backlog of more than 4,400 Army National Guard and Reserve members in medical holdover status. A total of 3,265 of those troops were mobilized but did not deploy. Since October, the Army policy is consistent with the other services and activated reserve component members have 25 days for deployability evaluation. If they are not found to be fit for duty at the end of that 25-day period they are returned to their home station. As of March 17, 2004, 1,103 Army National Guard and Reserve troops remain on medical hold from October 2003 and earlier. This is about 25 percent of the original group. The total number of Army Guard and Reserve on medical hold status as of March 17, 2004 was 4, 372.

Our post-deployment health assessments gather information from deployed service members to help medical personnel evaluate health concerns or problems that may be related to deployment. Almost 127,000 Guardsmen and reservists have had post-deployment health assessments done. Face-to-face health assessments with licensed health care providers determine referrals for appropriate medical follow-up. The Reserve Component referral rate – 22 percent – is comparable to the active component referral rate of 17 percent. Blood samples are taken

within 30 days and are archived. Pre- and post-deployment health assessments and deployment health records are maintained in the individual's permanent health record, which is available to the VA upon the service member's separation from the military.

In January, I published written policy establishing the DoD deployment health quality assurance program, as directed by the Congress and recommended by the General Accounting Office. A key element of this program is the Defense Medical Surveillance System (DMSS), which provides periodic reports on centralized pre- and post-deployment health assessments. The quality assurance program also requires periodic reports on service-specific deployment health quality assurance programs, periodic visits to military installations to assess deployment health programs and an annual report on the DoD-wide program. DMSS retains copies of, and maintains centralized databases for, deployment health assessments. DMSS provides weekly reports on post-deployment health assessments and monthly reports on pre- and post-deployment health assessments. The post-deployment reports include data on service members' health status, medical problems, mental health, exposure concerns, blood samples, and referrals for post-deployment care. Since January 2003, more than 92 percent of the reserve component members returning from deployment have reported their health status as good, very good, or excellent.

In theater, deployed Army, Navy and Air Force preventive medicine units are performing comprehensive occupational and environmental health surveillance in support of Operation Iraqi Freedom and Operation Enduring Freedom. All reports are archived centrally at the U.S. Army Center for Health Promotions and Preventive Medicine (USACHPPM). USACHPPM deployed and maintained a forward liaison and a specialized preventive medicine augmentation team to perform in-theater surveillance and facilitate support in OIF/OEF. When an environmental exposure is identified, DoD records the names of all service members possibly exposed and the

samples are identified with a date/time and location that could potentially be linked to personnel present. This information is archived and available if needed after deployment.

We continue to protect our deploying troops with appropriate vaccines against potential biological weapons. The Department has succeeded in protecting many hundreds of thousands of service members from two deadly diseases - anthrax and smallpox. DoD led the nation in collecting and sharing information about safely administering smallpox vaccine. We protected more than 580,000 people against smallpox in a sophisticated immunization program that included education, screening, and follow-up. Military healthcare workers repeatedly were asked to help our civilian colleagues in improving the preparedness efforts of the communities in which we live.

Our Anthrax Vaccine Immunization Program has now protected over a million service members. Despite the current high operations tempo, we have delivered 82 percent of those doses on time and are working diligently to improve this rate even further. The supply of anthrax vaccine increases steadily.

Our Vaccine Healthcare Center Network is a network of specialty clinics to provide the best possible care in rare situations where serious adverse events follow vaccination. In all our vaccination efforts, we focus on keeping individual service members healthy, so they can return home safely to their families and loved ones. The National Academy of Science' Institute of Medicine, in a congressionally mandated report, concluded that anthrax vaccine is an effective vaccine to protect humans against all forms of anthrax, including inhalational. They also concluded that the vaccine is safe. It is fairly common for people to experience some local discomforts, such as redness, itching or swelling, but these are comparable reactions to those observed with other vaccines given to adults. Most recently, on December 30, 2003, the Food

and Drug Administration issued a final rule and order concluding, "the licensed anthrax vaccine is safe and effective for the prevention of anthrax disease, regardless of the route of exposure."

The Centers for Disease Control and Prevention tracks possible reactions to these and other vaccines through the Vaccine Adverse Event Reporting System(VAERS), which is co-sponsored with FDA. DoD encourages all service members to report any reactions to VAERS. Like all vaccines, most adverse events with the small pox and anthrax vaccine are minor and temporary. Serious events, such as those requiring hospitalization, are extremely rare.

In terms of casualty care in today's military, medical care is available within minutes after injury and is saving lives. Based on current analysis, more than 98 percent of those wounded have survived and one third have returned to their units for duty within 72 hours. Irrespective of the cause of a military member's illness or injury, or of the member's military component, our focus is to provide the care needed and whenever possible, to return that person to duty. Clearly some injuries are much more serious than others, but it is also clear that military medicine, improved personal protection devices, and operational risk management techniques are saving lives. For Operation Iraqi Freedom, the rate of non-combat disease or injury is lower than in any previous U.S. conflict. Cumulative data through March 4, 2004, shows that four out of 100 deployed personnel sought clinical care in theater for a health concern or complaint each week . At home, the usual rate of clinic visits for active duty military personnel is at least twelve out of 100 per week.

As of March 13, 2004, data from the Transportation Command shows 18,004 total evacuations out of theater. Service members were transported from the theater of operations for medical care that couldn't be provided in theater, including a wide variety of medical conditions, very few of which were life threatening. With our smaller, more flexible healthcare capabilities

in theater, we can expect to evacuate patients for medical care not available in theater. The vast majority of medical evacuations – 92 percent – were routine. The remaining eight percent were urgent or high priority.

We are moving toward implementing fully automated patient care records systems, and we are working with the service surgeons general to establish a trauma registry that will capture information from the point of care.

Of course, physical trauma isn't the only kind of injury that deployed service members can face. Behavioral health issues, from combat stress to acute anxiety reactions, threaten our troops and we've made a great deal of progress in the areas of prevention, identification, and care of these potential risks.

At the request of the Operation Iraqi Freedom leadership, General Peake, the Army Surgeon General, sent a 12-person Mental Health Advisory Team to Iraq and Kuwait from August to October 2003, to assess behavioral health care for OIF soldiers and mental health issues. The advisory team's recommendations include adapting current garrison-based Army suicide prevention initiatives to the OIF deployed force. The team briefed its findings and recommendations to the coalition forces Commander and the commander of the joint task force, and is scheduled to brief Congress.

While we monitor stress casualties, we have a renewed focus on suicide prevention during this deployment. As of March 18, 2004, the Office of the Armed Forces Medical Examiner has classified 26 service members' deaths as suicide for those deployed to Iraq and Kuwait during 2003 and 2004. The 26 confirmed Army and Marine Corps suicides during Operation Iraqi Freedom represent an annualized rate of 15.9 suicides per 100,000 soldiers per year. This rate compares with a rate of 9.1 to 14.8 per 100,000 in the Army between 1995 and

2002. It is important to note that suicide rates in the military are lower than in the civilian population. In the overall U.S. male population, when age-matched with the Army, the rate is 20.5 per 100,000. Of course, every suicide is a tragic loss. The Human Resources Policy Directorate is funding additional Applied Suicide Intervention Skills Training for personnel in units preparing for OIF deployment.

We continue to deploy troops to areas where malaria is an endemic hazard. In 2003, we had 80 cases in Liberia, 44 between Afghanistan and Iraq, and 10 in South Korea. Studies have shown that troops need constant reminders and reinforcement to keep up their guard against the biting insects that transmit disease. Preventive measures include applying skin repellant several times a day, use of repellant-impregnated uniforms, using bed nets and taking preventive medications as prescribed.

The preventive medications for malaria most often used by the U.S. military are chloroquine, doxycycline, primaquine and mefloquine, also called Larium. All of these are FDA-approved drugs. As with any medication, precautions in prescribing and taking the medication must be taken. Investigations to date have not identified mefloquine as a cause in military murders or suicides. However, according to the FDA, mefloquine should not be prescribed for persons with active depression, a recent history of depression, generalized anxiety disorder, psychosis, schizophrenia or other major psychiatric disorders, or with a history of seizures. DoD follows FDA guidelines on the use of mefloquine, and it is DoD's policy that every service member who receives this medication also receives information about possible adverse effects.

I have directed a study to assess the rate of adverse events, to include suicide and neuropsychiatric outcomes, associated with antimalarial medications, particularly mefloquine,

prescribed to deployed service members. DoD will appoint a panel of experts in malaria and malaria medications that can articulate the best science options and provide guidance on how best to perform the study.

While we protect the health of deployed service members, we are also working to support their families back home. We endeavor to make sure every reserve family member is in contact with a commander's family support group, ombudsman, key volunteer network, or family readiness point of contact. We issue members and eligible family members a distinct identification card (ID) authorizing them to receive Uniformed Services' benefits and privileges. The ID card serves as proof that individuals have been pre-enrolled in the Defense Eligibility Enrollment System (DEERS). This is an important first step in obtaining family member medical treatment when the service member is called to active duty for 31 consecutive days or more. Eligible family members may be treated on a space-available basis at any military medical treatment facility. Availability is often very limited. However, TRICARE offers several cost-effective options, including a fee-for-service type option — TRICARE Standard, a preferred-provider organization type option — TRICARE Extra, and an HMO type options that require enrollment – TRICARE Prime.

The Soldiers' and Sailors' Civil Relief Act provides financial protection to anyone entering or called to active duty, including members of the National Guard and Reserve when in active federal service. Protections commence on the date the service member enters active duty. It covers such issues as rental agreements, security deposits, prepaid rent, eviction, installment contracts, credit card interest rates, mortgage interest rates, mortgage foreclosure, civil judicial proceedings, and income tax payments. All military services have legal assistance officers available to assist families with legal problems during periods of active duty. Typical legal

services involve wills, powers of attorney, child support, income tax returns, and contractual disputes.

Children of Reservists on active duty are also eligible patrons of DoD Child Development Programs at over 300 locations. DOD programs offer quality care at approximately 800 child development centers and 9,000 family childcare homes.

In the case of extreme financial difficulties, the Services each have a relief society and other options. The Services keep those family members informed of the help DoD offers through the *Reserve Family Member Benefits Guide*, which DoD distributes to key family support organizations throughout the total force. These guides are also available on line at DoD's DefenseLINK web site. In addition to those valuable guides, the Army's Center for Health Promotion and Preventive Medicine offers a manual entitled *A Soldier and Family Guide to Redeploying*, which covers such topics as assessing medical health, reunions with loved ones, the expectations of both soldiers and spouses, and what children may feel. All the services offer this type of program.

After service members return from deployments, military and VA providers use the jointly developed Post-Deployment Health Clinical Practice Guideline to give health care focused on post-deployment problems and concerns. The guideline provides a structure for the evaluation and care of service members and veterans with deployment-related concerns. The Deployment Health Clinical Center provides health care professionals access to expert clinical support for patients with difficult symptoms and illnesses, as well as deployment-related information.

While we are able to monitor the health status of active duty troops after deployments, we need to improve the visibility of the health care obtained by deactivated reserve component

members post-deployment. I have recently assembled a task force whose job is to put systems in place that allow us to better monitor the health status of Guardsmen and reservists after their return to civilian life. The extended period of eligibility for TRICARE following deactivation, for up to six months and their eligibility for VA health care benefits provides an excellent way for us to capture information and follow-up medical concerns. After deployment, our goal for injured or ill service members is, when necessary, to effect a seamless transition of care from DoD to VA's health care system. An injured service member's ability to return to full duty is based on a careful health evaluation by a physician. If a member is found to be unfit for continued active duty by their attending physician, the service member is referred to a Physical Evaluation Board where it is determined if the individual is fit to perform duties. All members referred to a Physical Evaluation Board must attend Disability Transition Assistance Program training. During this training, a counselor from VA informs members of VA benefits, disability ratings and how to file a claim. Prior to separation, members with disabilities are required to file, or decline to file, a claim with VA for compensation or health care benefits. I am informed that VA has recently hired personnelto assist with that process.

At the time of demobilization, all reserve component members are offered a separation physical examination. Those deactivated but not referred to the Physical Evaluation Board, are required to receive mandatory pre-separation counseling through the Transition Assistance Management Program (TAMP). Separating members are required to fill out a pre-separation counseling checklist, and to receive both a briefing and a booklet on VA benefits and health care services.

The Federal Health Information Exchange transfers electronic health information on separating Service members to VA. Currently, DoD sends VA laboratory results, outpatient

military treatment facility pharmacy data, radiology results, discharge summaries, demographic information and admission, disposition and transfer information, allergy information and consult results. I understand that this valuable medical information is now being used widely and regularly by medical providers in the VA system. DoD and VA have created integration points that will permit VA to access the Defense Enrollment and Eligibility Reporting System – DEERS - in real time by the end of 2005. To further strengthen DoD/VA electronic medical information exchange, while leveraging departmental systems investments, we are working with our VA counterparts to ensure the interoperability of our electronic medical records by the end of FY 2005.

As you can see, DoD has made tremendous progress in instituting truly total force health care. The groundwork has been laid for even greater progress in the near future and I am firmly committed to continued improvement in protection for the health of all our service members. The medical personnel of our combined services, active and reserve, have my heartfelt appreciation and full support for the outstanding work they are doing to develop and implement the force health protection programs necessary to keep our military fully fit and capable.