STATEMENT ON

FUTURE OF THE MILITARY HEALTH SYSTEM

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BEFORE THE

SUBCOMMITTEE ON MILITARY PERSONNEL

ARMED SERVICES COMMITTEE

UNITED STATES HOUSE OF REPRESENTATIVES

MARCH 12, 2008

Madam Chairwoman, distinguished members of this committee, thank you for the opportunity to discuss the Military Health System (MHS). The MHS serves more than 2.2 million members of the Active, Reserve, and National Guard components with more than 272,000 Service members deployed overseas.

Nearly a year ago, the Secretary of Defense charged me with being the guarantor of quality health care for Service members and their families. Quality health care is one of the Secretary's top goals. In the past year, we have reexamined our mission, vision and core competencies and made important steps to prepare the MHS to better support U.S. strategic objectives as we prepare our military forces and our military medical forces for a future in which the U.S. champions aspirations for human dignity.

We are pleased to share the following data just one year after the *Washington Post* addressed important issues in rehabilitative services for transitioning Service members. According to an independent telephone survey conducted by Zogby International, more than 75% of Service members who served in Operation Iraqi Freedom or Operation Enduring Freedom agree that the MHS is doing all it can and should do to meet their health care needs. Fifty-eight percent agree that their trust and confidence in the MHS has increased since their care began. Approximately 54% say their expectations for health care recovery have increased since they returned from deployment (that is, they insist on more service and better care than they previously did). Finally, 70% say the MHS is on the right track with regard to providing medical care to ill and injured military personnel.

We are also pleased that the Government Accountability Office recognized in its February 27, 2008, testimony that "Over the past year, the Army significantly increased support for Service members undergoing medical treatment and disability evaluations, but challenges remain." We are working on the challenges of hiring enough staff to help Service members earlier in the process of transition.

Seven years ago, the MHS had more of a peacetime focus. Military commanders, defense leaders and our elected officials rightly expected the MHS to simultaneously manage health care costs and provide outstanding health care to its beneficiaries. The MHS worked hard to manage its business more efficiently and effectively.

With the influx of Service members with complex war wounds to some of the Department's older hospitals and outpatient facilities – where caregivers were removed from the military treatment facilities through deployment – the MHS needed a new focus. We rewrote the MHS mission to: Sustain a medically ready military force and prove world-class health services for those injured and wounded in combat.

One thing is clear: There is a lot of coherence in how Health Affairs and the Services see the future. We are working on new performance measures to transform the MHS into a performance-based organization that creates value for its staff, customers, and stakeholders. We agree that well understood, objective measures of success and business plans that link with the strategic plan will help us respond more rapidly to

change, such as the incidence and prevalence of the wounds caused by improvised explosive devices (IEDs).

The future of the MHS also requires us to develop a program to better understand and treat a not-well-understood diagnosis – mild traumatic brain injury (TBI). We also understand that the seven-year war has put additional stress on military families. We are committed to working closely with the Under Secretary of Defense for Personnel and Readiness to reduce even further our low levels of binge drinking, smoking, accidents, illicit drug use, domestic abuse and divorce.

The MHS Strategic Plan – Keeping Warfighters Ready. For Life.

Our goal is excellence in clinical care (including prevention and protection), teaching, and research. We focus on combat care, humanitarian assistance, and disaster readiness, especially in those areas where others cannot operate. We strive to foster communication and "jointness" among our Services; key government agencies, such as the Departments of Health and Human Services (HHS), Homeland Security and State; nongovernmental organizations; and international organizations.

We are shaping our strategic plan with the recommendations contained in the 2006 Quadrennial Defense Review (QDR), Medical Readiness Review (MRR), Base Realignment and Closure Commission (BRAC) reports, the six task forces and independent review groups from whom we have heard in the last year, as well as several MHS strategic offsite meetings in 2007 and 2008.

This plan – developed in concert with the Surgeons General, the Joint Staff and our line leaders – recognizes that our stakeholders, including this congressional body representing the American people, expect the following outcomes from the resources invested in military medicine:

- A fit, healthy and protected force;
- The lowest possible deaths, injuries and diseases during military operations, superior follow-up care, and seamless transition with the Department of Veterans Affairs (VA);
- Medical advancement through education and research opportunities that only the MHS can do;
- Satisfied beneficiaries;
- Creation of healthy communities;
- Humanitarian and disaster relief at home and abroad; and
- Effective management of health care costs.

We are revamping our internal measures, so we can better determine what is working and what is not. We welcome open competition and reward cooperation. We encourage innovation from all of our personnel while maintaining a disciplined focus on our mission.

A Fit, Healthy and Protected Force & Lowest Possible Deaths, Injuries and Diseases

Our primary objective is ensuring that every Service member is medically protected and fit for duty. Together with the military commanders, we use a variety of tools to achieve this outcome.

Based on outcomes data, process measures, and independent assessments by health care organizations around the country, our military medical personnel have performed extraordinarily on the battlefield and in our military treatment facilities (MTFs) worldwide. We are proud of these accomplishments – improving virtually every major category of wartime medicine, and many areas of peacetime medicine, including:

- Lowest Disease, Non Battle Injury (DNBI) Rate. As a testament to training, medical readiness and preparedness, preventive medicine approach and occupational health capabilities, we are successfully addressing the single largest contributor to loss of forces – disease. The present DNBI rates for Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) are the lowest ever reported, 5% and 4% per week respectively. By comparison, the DNBI rates in Desert Shield/Desert Storm were 6.5% per week, Operation Joint Endeavor (Bosnia) were 7.1% per week, and Operation Joint Guardian (Kosovo) were 8.1% per week.

- Lowest Death to Wounded Ratio. Our agility in reaching wounded Service members, and capability in treating them, has altered our perspective on what constitutes timeliness in life-saving care from the "golden hour" to the "platinum fifteen minutes." We are saving lives of wounded troops who would not have survived even 10 years ago. For example, the wounded-in-action in-theater survival rate has been 97%, compared with 75% in World War II and 81% in Vietnam.

- Reduced time to evacuation. We now expedite the evacuation of Service members following forward-deployed surgery to stateside definitive care. Using airborne intensive care units and the latest technology, we have moved wounded Service members from the battlefield to the highest quality of definitive care in the United States in as little as 48 hours.

Our commanders expect the MHS to ensure that Service members are physically fit and that we promote healthy behaviors. We instituted an Individual Medical Readiness (IMR) metric to assess each Service member's preparedness for deployment. The IMR provides commanders with a picture of the medical readiness of their soldiers, sailors, airmen and marines down to the individual level. Current health assessments and

dental examinations and up-to-date medical vaccination records comprise some of the measures we use to calculate the IMR of U.S. military forces.

Global Infectious Disease. The Department has programs to protect our Service members against a variety of illnesses. We continue to view smallpox and anthrax as real threats that may be used as potential bioterrorism weapons against our soldiers, sailors, airmen and marines. To date, with vaccines we have protected almost 1.6 million Service members against anthrax spores and more than 1.1 million against the smallpox virus. These vaccination programs have an unparalleled safety record and are setting the standard for the civilian sector. Since the Food and Drug Administration (FDA) published the Final Order confirming that the anthrax vaccine absorbed (AVA) is safe and effective for its labeled indication to protect individuals at high risk for anthrax disease, we restarted the mandatory anthrax vaccination program.

The DoD has also been a leader in planning for a possible global epidemic of avian influenza. The lessons of the 1918 pandemic, which killed more American soldiers in WWI than the enemy did, has not been lost on the military. We recognize that as a globally deployed force we are uniquely vulnerable, and also responsible for contributing to the global efforts in surveillance, education (i.e., hygiene) and rapid eradication.

Health Assessments. We are also ensuring our Service members are medically evaluated before deployments (through the Periodic Health Assessment), upon return (through the Post-Deployment Health Assessment) and then again 90–180 days after deployment (through the Post-Deployment Health Reassessment). These health assessments provide a comprehensive picture of the fitness of our forces and highlight areas where we need to intervene. For example, we have learned that Service members do not always recognize or voice health concerns at the time they return from deployment.

For the period of June 1, 2005, to January 31, 2008, 495,526 Service members have completed a post-deployment health reassessment, with 147,638 (29.8%) of these individuals receiving at least one referral for additional evaluation. By reaching out to Service members three to six months post-deployment, we have found that the most prevalent concerns are physical concerns, e.g., back or joint pain and mental health concerns. This additional evaluation gives medical staff an opportunity to provide education, reassurance, or additional clinical evaluation and treatment, as appropriate. Fortunately, as these clinical interactions occur, we have learned that only a fraction of those with concerns have diagnosed clinical conditions. These surveys have also revealed an unexpected failing: Very few of the Service members who reported concerns about alcohol were offered counseling. This is now being addressed.

Seven years ago, TBI was not part of our nation's vernacular. Today the MHS is working on a number of measures to evaluate and treat Service members affected or possibly affected by TBI. (I will discuss the new Defense Center of Excellence for TBI and psychological health under the section titled Creation of Healthy Communities, Physical Facility Issues.) We published the new assessment forms with the TBI screening questions and other improvements on September 11, 2007. Since then, the

Services have worked hard to modify their respective electronic data collection systems. They finished this work in late December. In addition, the Armed Forces Health Surveillance Center-Provisional (AFHSC-P), which is the repository for the electronic forms, has successfully tested data feeds from the Army, Air Force, and Navy systems. No problems were identified.

The Services will start using the new forms for health assessments, and dates will vary with each Service. To ensure a smooth and timely start, we issued a policy memorandum to establish a 60-day implementation phase during which AFHSC-P will accept both the old and new versions of the forms. We have encouraged the Services to start using the new versions of the forms immediately rather than waiting for the formal announcement. The Army plans to start selected pilot tests of the new forms between now and April 1, 2008. The Navy, Air Force, and Coast Guard all expect to start using the forms in March 2008.

The Department is working on a number of additional measures to evaluate and treat Service members affected or possibly affected by TBI. In August 2006, we developed a clinical practice guideline for the Services for the management of mild TBI in-theater. We sent detailed guidance to Army and Marine Corps line medical personnel in the field to advise them on ways to look for signs and to treat TBI.

The "Clinical Guidance for Mild Traumatic Brain Injury (mTBI) in Non-Deployed Medical Activities," October 2007, included a standard Military Acute Concussion Evaluation (MACE) form for field personnel to assess and document TBI for the medical record. The tool guides the evaluator through a short series of standardized questions to obtain history, orientation (day, date, and time), immediate memory (repeat a list of words), neurological screening (altered level of consciousness, pupil asymmetry), concentration (repeat a list of numbers backwards), and delayed recall (repeat the list of words asked early in the evaluation). The evaluator calculates and documents a score, which guides the need for additional evaluation and follow-up. The MACE also may be repeated (different versions are available to preclude "learning the test"), and scores may be recorded to track changes in cognitive functioning.

U.S. Central Command (USCENTCOM) has mandated the use of clinical guidelines, which include use of the MACE screening tool, at all levels of care in theater, after a Service member has a possible TBI-inducing event. Furthermore, Landstuhl Regional Medical Center is using MACE to screen all patients evacuated from the USCENTCOM area of responsibility with polytrauma injuries for co-morbid TBI. In addition, MACE is used in MTFs throughout the MHS.

To supplement mental health screening and education resources, we added the Mental Health Self-Assessment Program (MHSAP) in 2006. This program provides military families, including National Guard and Reserve families, web-based, phone-based and in-person screening for common mental health conditions and customized referrals to appropriate local treatment resources. The program includes screening tools for parents to assess depression and risk for self-injurious behavior in their children. The MHSAP also includes a suicide-prevention program that is available in DoD schools.

Spanish versions of these screening tools are also available. This voluntary and anonymous program is designed to provide increased awareness education in the area of mental health conditions and concerns. It supplements the more formal assessment programs and extends the educational process to families. Our robust outreach program increased awareness for military and family members around the globe. More than 2,000 participants a month use the Web-based education and more than 160,000 participants each year use the in-person educational events. With this program, our goal is to reduce the stigma of suffering from mental health conditions, and to foster an environment that encourages self-referral and/or colleagues and battle buddies looking out for one another.

In 2006, we published a new DoD Deployment Health Instruction. Among its many measures to enhance force health protection is a requirement for the Services to track and record daily locations of DoD personnel as they move about in-theater and report data weekly to the Defense Manpower Data Center. We can use the data collected to study long-term health effects of deployments and mitigate those health effects in future conflicts. An example might be to determine where an outbreak of dysentery or tuberculosis began in order to identify and treat those who were exposed or to learn more about some mystery illness by studying what geographic location was visited by those who came down with it.

At the direction of Congress, we executed new health benefits which extend TRICARE coverage to members of the National Guard and Reserve. We implemented an expanded TRICARE Reserve Select (TRS) health plan for Reserve Component personnel and their families, as mandated by the NDAA for fiscal year (FY) 2007. Today, more than 61,000 reservists and their families are paying premiums to receive TRS coverage. In addition, we made permanent their early access to TRICARE upon receipt of call-up orders and their continued access to TRICARE for six months following active duty service for both individuals and their families. Our FY 2009 budget request includes $407 million to cover the costs of this expanded benefit.

Medicine on the Global Stage. Internationally, our medical forces deploy with great speed, skill and compassion. Their accomplishments in responding to international disasters further our national security objectives; allow us to constructively engage with a number of foreign nations; and save civilian lives throughout the world. Our military-civilian teams are working well with the State Department, Centers for Disease Control and Prevention, and World Health Organization (WHO).

Operating on the global stage, our medics – from the youngest technicians to the most experienced neurosurgeons – perform in an exemplary manner in service to this country. We must make necessary changes to our policies and processes, while remaining mindful of the skills, dedication, and courage of our medical forces.

At the 2008 Military Health System Conference we held our first medical ethics panel to address the issues that military medical professionals face, such as when health policy and even the law may not be aligned with their personal values. We also traveled to Guantanamo Bay where we found excellent medical care. To be sure, we invited the American Correctional Association physicians to make their own visit, and we conferred

with the American Medical Association and Physicians for Human Rights and suggested some modifications to procedures.

We also found good medical care at Camp Cropper and applauded the new strategy of focusing on education in what Islam really stands for, which together with job training and a generally gentler approach, has reduced recidivism by 90%. We also are exploring whether the daily physical exams of new detainees from all over Iraq could provide information about the health of Iraqis that could be helpful to the Minister of Health.

We need to do more to recruit and train health personnel who want to understand how to help people help themselves, whether in the diverse nations of Africa, with varied needs, or a predominantly Arabic and Islamic country such as Iraq, with multiple passionate religious sects and decades of brutalization and corruption, but a glorious past. To this end, we organized an interagency orientation for Bruno Himmler, M.D., the new HHS Health attaché to Ambassador Crocker in Iraq, and appointed Colonel (retired) Warner Anderson, M.D., director of our new International Health directorate, where he has assembled a multi-disciplinary team. We also co-led the first national meeting of doctors in two decades in Baghdad last month, and we are doing a needs assessment based on what we learned. We already know we need to do more in training trainers in medicine and in bioengineering. Some of this has begun with our meetings there and with the start of a telehealth consultation service to connect provincial doctors with Iraqi medical school professors and U.S. experts, including Iraqi-American doctors. We are also supporting Gen. Petraeus' efforts to build primary health clinics, and we are working with him and Ambassador Crocker to be sure each Provincial Reconstruction Team has a health expert.

Medical Advancement through Education and Research Opportunities That Only the MHS Can Do

As of February 2008, a total of 1,123 Service members had suffered an amputation while serving in support of Operation Enduring Freedom or Operation Iraqi Freedom. The majority (70 to 80%) of these amputations involve the loss of an entire limb, hand or foot. Half of all the amputations resulted from IEDs. Under the leadership at Walter Reed, the Military Advanced Training Center opened in September 2007 to accelerate improvements in amputee care. Together with prosthetics research and innovations developed and tested at the Center for the Intrepid in San Antonio – a great gift from the Fisher family – nearly 15% of amputees now remain on active duty. Many others are helped by Health Affairs' Computer/Electronic Accommodations Program.

Military Medical Research. On May 25, 1961, President John F. Kennedy said in his Man on the Moon address, "I believe we possess all the resources and talents necessary. But the facts of the matter are that we have never made the national decisions or marshaled the national resources required for such leadership."

We have an opportunity to restore military medicine to the greatness of the Walter Reed era. We have an opportunity through breakthroughs in stem-cell research to be leaders in regenerative research – to heal burns, restore sight, regrow limbs, and repair brain damage.

The MHS is excited to bring these opportunities together. No one knows how fast stem-cell technology can move, but we do know that we must not let bureaucracy get in the way of improving military medical research. Nor should we find comfort in old ways. While training leaders is something we do well, we also need the services to promote those with the talent and desire to excel in medical or public health research, which requires they build a team in one location for a decade, foregoing the frequent moves that are the traditional path to promotion.

Medical Education. The MHS needs to continue to recruit people who are willing to go in harm's way. We have challenges – some from the concern over the obligations of military service; some from the internal competition from within the Services; and some from the larger demographic and cultural trends in our society that lead people down other career paths.

In the past, the Health Professions Scholarship Program – or HPSP – helped the MHS meet its recruitment and retention numbers for its medical forces. Today, however, health professions are competing against many other professional opportunities for young people – and some seem to appear more lucrative or more interesting. Young people entering the health work force want greater job flexibility, which is not a feature of life in the military. We need to acknowledge that and confront it – head on. To this end, we have made a recruiting video that we will show at schools and have supported by the new movie *Fighting For Life* about our Uniformed Services University of the Health Sciences (USUHS). Our retired leaders will be speaking at colleges and medical meetings across the country. We have also urged USUHS and the Services to use their statutory flexibility to offer a menu of programs to students who hesitate to apply when they learn of the seven-year service requirement.

The MHS will pay special attention to recruiting and educational programs, especially through USUHS, or as the MHS calls it "America's medical school." Over the next few years, the MHS will strive to help USUHS to be the best in the country in training for combat casualty care, infectious disease, psychological health, brain and eye injuries, regenerative medicine (stem cells), health information technology, medical ethics, TBI, health system administration, graduate nursing and global public health efforts. The MHS hopes to demonstrate that it does not just train experts and managers, it trains leaders.

We see USUHS as the premier training center, offering telehealth and distance learning for our international partners.

Particularly important in health care is that we recruit women leaders. We also need to recognize the sacrifices of the selfless leaders whom we attract. We do this now on our website.

Finally, we see USUHS as the institution that will add to the 17 Nobelists who got their start in military medicine. We see future scientists winning the prize at USUHS for work done at USUHS.

Medical Training. The MHS also supports the joint training of medics and corpsmen in the new Medical Education and Training Center at Fort Sam Houston. We are working to add to the skill sets of these heroes – 168 of whom have been lost in Iraq or Afghanistan. We are looking for new opportunities to honor their courage and selflessness.

Satisfied Beneficiaries

Here in the United States, our beneficiaries continue to give the TRICARE program high marks in satisfaction. MHS beneficiaries' overall satisfaction with medical care in the outpatient and inpatient settings compares very favorably against national civilian benchmarks. The quality of our medical care is further attested to by the fact that all DoD fixed MTFs are accredited by one of these two nationally recognized accrediting organizations (The Joint Commission and the Accreditation Association for Ambulatory Health Care).

We also fared well on the 2007 American Customer Satisfaction Index survey produced by the University of Michigan and other groups to rate satisfaction with the federal government. Those surveyed gave DoD medical centers a score of 89% satisfaction with their inpatient care – the second highest satisfaction score by federal agencies/departments surveyed in the benefits-recipients segment.

In our own surveys, overall satisfaction with the TRICARE health plan has risen consistently each year since 2001 from 44 percent to 59 percent. Given the stresses of war during this time period, this is a remarkable achievement. The annual Outpatient Satisfaction Survey of MHS beneficiaries provides feedback that permits us to benchmark the satisfaction of beneficiaries with their outpatient experience at MTFs against civilian health maintenance organizations. For the period of October 2006 through September 2007, MHS beneficiaries' overall satisfaction with medical care in the outpatient setting was 6.13 compared with the national civilian benchmark of 6.23 (on a seven-point scale where 7 is completely satisfied). For the same time period, MHS beneficiaries' overall satisfaction with outpatient clinics was 6.07 compared with the national civilian benchmark of 6.13.

The MHS also administers the TRICARE Inpatient Satisfaction Survey to assess beneficiary satisfaction with inpatient care (MTF and civilian network). We administer the survey in two formats. First, we conduct the mail survey annually and mail it to 45,000 inpatients in CONUS and OCONUS. The telephone survey is administered on a quarterly basis to 620 (per quarter) inpatients. Sixty-two percent of 620 inpatients (July-September 2007) surveyed by telephone indicated they were very satisfied with the inpatient care provided by the MHS. In addition, 11% reported dissatisfaction and 27% reported they were somewhat satisfied.

Moreover, we added financial incentives to our managed care support contracts to improve beneficiary satisfaction from our contract partners and to ensure our contractors are financially rewarded for care delivered in the private sector. Through our new MHS governance and strategic plan, we are focusing on the effectiveness and efficiencies of MTFs and adding performance-based management and patient-centered care initiatives to transform our patients' experiences.

TRICARE launched a new website in 2007 with a new approach to delivering information to its beneficiaries that is based on extensive user research and analysis. The redesigned My Benefit portal at www.tricare.mil offers comprehensive information with a more user-friendly layout and an updated look, while providing up-to-date TRICARE benefit information in seconds. The My Benefit portal's simplified navigation system makes using the site easier than ever before. A key feature of the redesign is that users now receive personalized information about their health care benefits by answering a few simple questions about their location, beneficiary status and current TRICARE plan.

Recently, my staff launched a new website, www.health.mil. Its purpose is to inspire innovation, creativity and information sharing across the MHS. Our website is transparent in that every feature includes a comment box. I invite everyone to use the website as a tool to break down barriers and share information among military medical personnel and other government agencies and organizations outside the government.

The site provides a way to create a partnership for health that brings the Service members and family, the military leader and the medical provider-planner together with the objective of patient-focused health care. Visitors to the site can post comments, take surveys, watch web cams, subscribe to podcasts, and read unfiltered opinion from MHS leaders on our blog.

Creation of Healthy Communities

We have the internal ability to expand upon two major initiatives in the coming years: 1) increasing the use of evidence-based medicine, and 2) increasing the patient-provider partnership in sustaining health.

Competent medical care is comprehensive, conscientious, compassionate, coordinated, confidential, computable, communicated clearly, controlled by consumer choices and cost effective. Getting there requires continuous commitment (and courage).

We also have a responsibility to prevent disease by educational campaigns that promote a healthy diet, exercise, vaccines, use of seatbelts, responsible consumption of alcohol, and tobacco cessation. We are actively seeking innovative ways to incentivize beneficiaries and caregivers to reach these goals.

We need to do more to enlist patients as partners in their health care. We are increasing the services available to specific populations – seeking to stem the adverse effects of alcohol abuse, tobacco usage, and obesity. The DoD has developed and implemented a series of demonstration and pilot projects to address the key health

behaviors associated with premature and preventable death identified in the 2002 Health Related Behavior Survey.

Healthy Lifestyles Initiatives. These projects address the increase in tobacco use, obesity, and alcohol misuse and abuse among beneficiaries, both active and non-active duty identified in the survey. We are primarily focusing these health promotion activities on disease prevention and the adoption of healthy behaviors, while testing the effectiveness of comprehensive benefits not currently covered by TRICARE.

The tobacco cessation and weight management demonstration projects are comprehensive behavioral interventions. The tobacco cessation demonstration provides pharmacotherapy in addition to a telephone hotline, a web-based educational tool, and personalized quit kits. Preliminary demonstration study results indicate all cessation rates have shown increases in abstinence as measured at the completion of each milestone quarterly survey. The weight management demonstration provides health/weight loss coaching, as well as telephone and web-based educational and motivational information. The study enrollment period ended March 2007. There are 1,755 beneficiaries enrolled in the randomized control trial and 716 in the participation of self-motivated programs. Final study results are projected to be completed in December 2008.

The Program for Alcohol, Training, Research and Online Learning (PATROL), a web-based alcohol abuse pilot project targeting young, active duty Service members on eight military installations started in May 2006 and ended in September 2007. One month after the pilot study rollout, participants who received one of the programs had a significant reduction in heavy and binge drinking. These results were sustained at the six month follow-up survey. The program results will be used to enhance and complement other efforts being undertaken in this important area, which will result in an improved state of military readiness.

Disease Management. The MHS has implemented a system-wide approach to disease management to improve the health status of our beneficiaries with specific chronic disease conditions through the provision of proactive, evidence-based care to patients and their families. Our disease management initiatives are patient centered; with goals of educating and empowering patients to live a healthier lifestyle, designing and implementing preventive care services, and reducing the need for costly emergency visits and inpatient stays through effective monitoring of patient conditions.

As of June 2007, the program now includes patients with diabetes, in addition to the asthma and congestive heart failure patients enrolled since September 2006. These three chronic conditions are among the diseases identified by Disease Management Association of America (DMAA) as having the greatest potential for reducing the medical expenditures and improving patient quality of life through disease management.

As mandated by the NDAA for FY 2007, a report on the design, development, and implementation of the program on disease and chronic care management, which is due to Congress this year, describes our plan to address: diabetes; cancer; heart disease; asthma; chronic obstructive pulmonary disease; and depression and anxiety disorders.

The ongoing centralized evaluations by the TRICARE Management Activity (TMA) and the Services are providing valuable information regarding the effectiveness and efficiency of our disease management program. In addition to measuring select processes (e.g., engagement rates), we will also assess clinical outcomes, utilization outcomes, humanistic outcomes, and financial outcomes consistently across the MHS. Once enough data become available, we will use a scorecard to facilitate oversight and evaluation of disease management services. Moreover, the scorecard will be instrumental in identifying best practices for use throughout the MHS.

High quality care involves the provision of safe care, which includes employing steps to minimize preventable harm to patients. We are placing emphasis on and reinforcing to the health care professionals, as well as the patients, how important it is to be informed, educated and active participants in their care. Within the MHS, we use Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS) as a mechanism to improve quality and patient safety. Developed by the Department of Defense (DoD) Patient Safety Program in collaboration with the HHS Agency for Healthcare Research and Quality (AHRQ), TeamSTEPPS provides an evidence-based teamwork system aimed at optimizing patient outcomes by improving communication and other teamwork skills among health care professionals. After 20 years of research and evidence on teams and team performance in such diverse areas as aviation, nuclear power, and other High-Reliability Organizations (HROs), we have learned that teams of individuals who communicate effectively – and back each other up – compensate for individual fallibility and dramatically reduce the consequences of inevitable human error, resulting in enhanced safety and improved performance. Communication and coordination are critical elements in any medical environment. TeamSTEPPS leads the way in improving this vital area, giving both military and civilian medicine a roadmap for a safer health care system, and a vehicle to accomplish it worldwide.

Electronic Medical Record. The future is the Personal Health Record, which will empower patients, so they may take responsibility for their care and exercise some oversight over their care. Because so many MHS patients go back and forth to caregivers in the private sector, it is good news that DoD and VA are among the leaders of the American Health Information community led by the HHS Secretary.

AHLTA – DoD's global electronic health record and clinical data repository – significantly enhances MHS efforts to build healthy communities. AHLTA creates a life-long, computer-based patient record for each military health beneficiary, regardless of location, and provides seamless visibility of health information across our entire continuum of medical care. This gives our providers unprecedented access to critical health information whenever and wherever care is provided to our Service members and beneficiaries. In addition, AHLTA offers clinical reminders for preventive care and clinical practice guidelines for those with chronic conditions.

In November 2006, we successfully completed worldwide deployment of AHLTA Block 1 at all DoD MTFs. Our implementation support activities spanned 11 time zones and included training for 55,242 users, including 18,065 health care providers. DoD's Clinical Data Repository is operational and contains electronic clinical records for more

than nine million beneficiaries. AHLTA use continues to grow at a significant pace. As of February 29, 2008, our providers had used AHLTA to process 71,412,847 outpatient encounters, and they currently process more than 124,000 patient visits per workday.

As we add dental capabilities to AHLTA, the number of providers using the system, and encounters documented, will increase. We expect a deployment decision for AHLTA Block 2, which includes a dental module, in this quarter. We expect it will take two years to fully deploy AHLTA Block 2.

We are working to add additional components to AHLTA. For example, we are working with the VA to implement a new inpatient capability. Its implementation will provide VA and DoD clinicians a fully integrated electronic health record for essential DoD and VA ambulatory and inpatient information. Our project team has completed a six-month assessment of DoD and VA inpatient clinical processes and is beginning an assessment of potential technical solutions to meet that goal, with recommendations due to us in the summer of 2008. A jointly agreed upon technical solution for the inpatient electronic health record module will further enhance our clinical data sharing. Our current data sharing is already decreasing redundant tests and procedures for our patients, and reducing errors that are inherent to a paper records system.

AHLTA contains the largest computable and structured medical data repository, leading the nation in standards adoption and interoperability. Before the end of this decade, we will be using AHLTA as a central research and planning tool, leveraging its computable health data to improve patient outcomes through prevention, early detection, and proper intervention. We are determined to make further improvements to make the system faster and easier, more private and secure, so that doctors, nurses, and patients all begin to use it to promote safe and cost-effective health care.

We are also using our DoD and VA information sharing experience to advance the President's health information technology goals. We are working closely in a leadership role with other federal agencies, e.g., the American Health Information Community, Health Information Technology Policy Council and Healthcare Information Technology Standards Panel (HITSP), to lead the nation toward adopting electronic health records. In particular, our DoD and VA collaboration work has helped HITSP to accelerate the establishment of national standards. We foresee significant benefits in advancing health informatics and standards through better quality and greater efficiency in health care delivery. The Certification Commission for Healthcare Information Technology (CCHIT) announced that DoD's product AHLTA Version 3.3 is pre-market, conditionally CCHIT Certified and meets CCHIT ambulatory electronic health record (EHR) criteria for 2006. Pre-market, conditionally certified EHRs are new products that are fully certified once their operational use at a physician office site has been verified.

It is important to note that the MHS is in transition from a paper medical record to an electronic medical record. The paper medical file is the National Archives and Records Administration- (NARA) recognized MHS medical record. NARA has just begun the AHLTA data inventory, which is the first step in having AHLTA recognized as an official government record. NARA certification will take approximately two years.

The MHS will not have a completely paperless medical record for many years. In the meantime, like the vast majority of organizations converting to electronic health records, we will have a hybrid system.

Identifying the Way Forward for Rehabilitative Care and Transition. Last year, the *Washington Post* addressed important issues that deserved and received our immediate and focused attention. First and foremost, we are listening. We are actively surveying (by telephone, on the web and in person) our wounded Service members and their families, and we are acting on the answers they provide. Our goal is to improve patient satisfaction, and these surveys let us know where we need to put resources to continuously improve. In addition to surveys, I encourage leadership to spend time with Service members and their families who are receiving long-term rehabilitative care. On February 14, we held our first webcast town-hall meeting on our new website www.health.mil to receive additional, anonymous feedback from the wounded, injured, ill and their families. We are taking all of this input back to DoD leadership – where we have clear leadership – as we develop and implement solutions.

The Army and the Department have taken swift action to improve existing conditions and enhance services provided at Walter Reed Army Medical Center (WRAMC). We are also identifying areas that need further study and improvement. Army leadership initiated immediate steps to control security, improve access, and complete repairs at identified facilities to provide for the health and welfare of our nation's heroes. They also held accountable the personnel responsible for the failures, as only the military will do.

Six task forces and commissions have provided recommendations to the MHS over the past year. The most challenging recommendations came out of the independent review group (IRG) commissioned by Secretary Gates on March 1, 2007. The IRG reported its final findings to the Secretary of the Army, the Secretary of the Navy, and me on April 16, 2007.

- An underlying theme in their report was the recognition of the moral obligations and the human and budgetary costs of war/national security, and that the Department, the government, and the nation must be prepared to meet those obligations.

- The 25 specific findings and over 60 recommendations provided in the IRG's final report addressed two main areas of concern: 1) continuum of care and 2) leadership, policy and oversight. Key among the findings was the cumbersome and adversarial nature of the current DoD disability evaluation system.

- Among findings and recommendations related to health care delivery, the IRG concluded that while we provide first class trauma and inpatient care to Service members at the medical centers, there is a breakdown in health services and care management during transition to outpatient status.

- The IRG also found room for improvement in comprehensive care, treatment and administrative services, with a need for a more interdisciplinary collaborative approach. The need for sufficient and properly trained case managers to help wounded Service members navigate the health system was paramount in the IRG's conclusions.

- TBI, post traumatic stress disorder, along with a shortage in mental health staff, were issues requiring particular attention.

- Specific to WRAMC, the IRG outlined a "Perfect Storm" of events impacted by BRAC, A-76, staffing and training limitations, and funding constraints.

DoD and VA are working together to address these issues through a Senior Oversight Committee (SOC), co-chaired by the Deputy Secretaries of each Department. The SOC is developing implementation plans and future funding requirements for eight "lines of action" that address such issues as the disability system, case management, data sharing between the Departments, facilities requirements, personnel and pay support, among other issues, as well as such wounded warrior health issues as TBI and psychological health. The recommendations and decisions from this group are being implemented now.

In all cases, we will regularly inform the people we serve – Service members, families, military leaders, Congress, the Secretary and the President – on our progress. We will share our progress with the public.

I am confident that each of these items is fixable with sustained leadership and oversight. The Department categorizes the problems as follows:

1. Physical Facility Issues.

MHS clinics and hospitals must be healing environments that lift the spirit by their bright colors and views of nature, and by the sight and sound of falling water. They must be quiet, clean and clean-smelling, and have features that promote independence, patient control, and welcome family participation. MHS facilities must have the latest technology, such as imaging and electronics, and the latest features that promote safety, such as HEPA-filtered air, carpeting, design that reduces the risk of falls, and informatics safeguards that reduce the risks of medical errors and breaches of privacy. We can best meet the rising expectations of our beneficiaries and the especially unique health needs of our wounded Service members through the planned consolidation of health services and facilities in the National Capital Region. The 2005 BRAC decision preserves a precious national asset, Walter Reed, by sustaining a high-quality, world-class military medical center with a robust graduate medical education program in the Nation's Capital. The plan is to open this facility by 2011.

On March 3, 2008, we awarded a $109,025,544 (first increment) contract for the design and construction of the Walter Reed National Military Medical Center in Bethesda, Maryland. The total contract amount is not to exceed $641,400,000 to

establish the medical center at the current Bethesda, Maryland, location of the National Naval Medical Center.

In the interim, we will not deprive the current WRAMC of resources to function as the premier medical center it is. In fact, in 2005 we funded $10 million in capital improvements at WRAMC's Amputee Center – recognizing the immediate needs of our warrior population. The new facility opened its doors on September 12, 2007. The sight of amputees running the track or climbing the wall will never be forgotten by those who visited that day, and since.

Many of the health issues our wounded warriors face are slow to emerge and are extremely complex to fully evaluate and treat.

Our new Defense Center of Excellence for Psychological Health and Traumatic Brain Injury will integrate quality programs and advanced medical technology to give us unprecedented expertise in dealing with psychological health and TBI. In developing the national collaborative network, the Center will coordinate existing medical, academic, research, and advocacy assets within the Services, with those of the VA and HHS, other federal, state and local agencies, as well as academic institutions. The Center will lead a national collaborative network to advance and disseminate psychological health and traumatic brain injury knowledge, enhance clinical and management approaches, and facilitate other vital services to best serve the urgent and enduring needs of our wounded warriors and their families.

2. Process of Disability Determinations. We believe resources and processes need to be better aligned. Our first step in assessing processes will be to identify the desired outcome. We must redraw our processes with the outcomes we have in mind, with as much simplicity and timeliness as possible. We know that both the Service member and the Department expect:

- Full rehabilitation of the Service member to the greatest degree medically possible;
- A fair and consistent adjudication of disability; and
- A timely adjudication of disability requests – neither hurried nor slowed due to bureaucratic processes.

We currently have a pilot program in place to improve the disability process and implement one system. Our goal is to create a process that requires one exam and one rating, for use by both DoD and VA within current law. The new Disability Evaluation System pilot program, which began in late November, will provide smoother post-separation transition for veterans and their families – including medical treatment, evaluation, and delivery of compensation, benefits and entitlements.

3. Process of Care Coordination. The quality of medical care we deliver to our Service members is exceptional. Independent review supports this assertion. Yet, we need to better attend to the process of coordinating delivery of services to members in long-term

outpatient, residential rehabilitation. The Army has assessed, and our office is reviewing, the proper ratio of case managers to wounded Service members. We are also reviewing the administrative and information systems in place to properly manage workload in support of Service members and their families.

The Army's new Warrior Transition Brigade became operational at WRAMC on April 26, 2007, to assist soldiers assigned to medical holdover. As of February 4, 2008, the 35 Warrior Transition Units throughout the Army had 9,774 wounded warriors assigned to them (this number includes Active Component and Reserve Component members). Many of the Warrior Transition Unit cadre have volunteered for their assignments, and each officer or noncommissioned officer goes through an interview process before he or she is selected.

Each wounded warrior is also assigned a primary care manager, a nurse case manager and a squad leader to ensure no Soldier falls through the cracks. They even follow up with Soldiers after they return to their units or transfer to the VA. We are beginning to receive external recognition of the success of the Warrior Transition Units and we will monitor this initiative to ensure we meet and exceed future expectations of Service members and their families.

We receive beneficiary input through the Army's toll-free hotline. In addition, the MHS and the Army are conducting surveys of wounded warriors and their families, so we may assess what is going well and areas that need improvement. The bottom line – we will continue to serve our warriors and other beneficiaries until we move to the new campus at Bethesda.

Early Signposts on the Road to Recovery. Our goal is to ensure everyone who needs care has access to it, and that we have no heroes-cum-lost sheep living on the street or under bridges. Our deserving men and women need facilities that attract the best doctors, nurses, and techs and are places of choice for our beneficiaries to receive care.

There are areas in which we lead the nation, and as we focus our research efforts, we will add to the areas in which we already lead, such as influenza vaccination, pneumovax vaccination, colon cancer screening, burn survival, and inpatient and outpatient satisfaction with TRICARE. We are also monitoring patient confidence, which is improving much sooner than we expected. We are creating a dashboard to review our performance on the issues that matter to patients, and we will hold ourselves and the Services accountable to the same standards across the MHS.

Humanitarian and Disaster Relief at Home and Abroad

In the past year, we also have reexamined our mission, vision and core competencies and made important steps to prepare the MHS to better support U.S. Strategic objectives as we prepare our military forces and our military medical forces for a future in which the U.S. champions aspirations for human dignity. The MHS is a big part of the soft-power equation. Our medical forces deploy with great speed, skill, and compassion to provide humanitarian assistance and disaster relief. Surveys have shown

that after we provide humanitarian assistance, public opinion toward the United States improves.

I believe our role in humanitarian assistance and disaster relief, combat casualty care, and trauma care have been greatly undervalued in the past. We are revamping our internal measures to better quantify these contributions and to determine what is working and what is not. As the world's 9-1-1 emergency service, people around the globe look to the MHS in a catastrophe, such as the tsunami in Indonesia, earthquake in Pakistan, hurricanes in the United States, and earthquake in Peru. Many military medical professionals also have participated in the humanitarian assistance missions of the Comfort and the Mercy and elsewhere. Last August, the president of Peru was surprised to see the Assistant Secretary of Defense for Health Affairs get off the plane with the Red Cross from the adjacent country of Ecuador – less than 48 hours after the earthquake.

Humanitarian assistance plays a critical role in winning hearts and minds. As Secretary Gates said in November, 2007, "We can expect that asymmetric warfare will be the mainstay…success will be less a matter of imposing one's will and more a function of shaping behavior of friends, adversaries and most importantly the people in between." President Bush said in March 2007, "The U.S. military is a symbol of strength for this nation; they're also a symbol of the great compassion of the American people."

A great humanitarian opportunity for the MHS is coming with the stand-up of the Africa command. AFRICOM will allow the MHS to test whether an unarmed doctor and nurse assisting people in a troubled country can do as much to protect the brigade as barbwire, T-Walls, and MRAPs. Their efforts will say that the U.S. military cares, protects, builds, teaches, and trusts – enough to go out unarmed.

I predict the people we serve in Africa – like the Iraqis I worked with – will be deeply impressed that the MIL-CIV teams are male and female, of every complexion, of many ethic origins and religions, all working as a team.

Effective Management of Health Care Costs

The Department is committed to protecting the health of our Service members and providing the best health care to more than nine million eligible beneficiaries. The FY 2009 Defense Health Program funding request is $23.6 billion for Operations and Maintenance, Procurement and Research, and Development, Test and Evaluation Appropriations to finance the MHS mission. Total military health program requirements, including personnel expenses, is $42.8 billion for FY 2009. This includes payment of $10.4 billion to the Department of Defense Medicare Eligible Retiree Health Care Fund, and excludes projected savings of $1.2 billion, based on recommendations provided by the Department of Defense Task Force on the Future of Military Health Care for benefit reform found in the President's Budget.

The Task Force on the Future of Military Health Care published its final report on December 20, 2007. The Department embraces the recommendations developed by the Task Force, including using best practices and striving for greater efficiencies in the

MHS, as well as adjustments to enrollment fees. In particular, the Task Force recognized the need to rebalance the share of health care costs borne between the government and the military retiree. In accordance with the Task Force's recommendation, the fee increases for FY 2009 will mirror the Task Force's ramp to the steady state fees. On average, the enrollment fee for a retiree and family (not Medicare eligible) in TRICARE Prime will increase from $460 to $827 per year, with the majority of families (those with retired pay of less than $20,000) seeing a modest increase to $728 per year, which is roughly an increase of $22 per month. The Task Force also included in the recommendations an introduction of an enrollment fee for TRICARE Standard, as well as increases in the Prime visit co-pays, the Standard Deductible, and pharmacy co-pays. Accordingly, we revised the savings assumption to reflect Task Force recommendations implemented over a three-year phase-in period; this assumption yields $1.2 billion in savings.

Our primary mission is sustaining a medically ready military force and providing world-class health services for those injured and wounded in combat. Military commanders, defense leaders and our elected officials rightly expect us to simultaneously manage health care costs and provide outstanding health care to our beneficiaries. We are working hard to manage all the MHS more efficiently and effectively.

We are bringing about the most comprehensive changes to our system in a generation through the BRAC. The BRAC recommendations will improve use and distribution of our facilities nationwide, and affect health care delivery and medical training across the MHS. The consolidation of medical centers in the National Capital Area and San Antonio will improve operations by reducing unnecessary infrastructure, rationalizing staff, and providing more robust platforms to support Graduate Medical Education. In some areas, we expect to significantly enhance care by providing services closer to where our beneficiaries reside, for example at Fort Belvoir, Virginia. By contrast, in smaller markets, MHS facilities will cease to provide inpatient services and instead focus on the delivery of high-quality ambulatory care. The BRAC recommendations will bring most medical enlisted training programs to Fort Sam Houston. As a result, the MHS will reduce its overall technical-training infrastructure while strengthening the consistency and quality of training across the Services.

We have important activities underway at all facilities affected by BRAC. The key to our success in BRAC is a sound planning principle that is shaping these new structures in ways that are joint, interoperable, non-redundant, and effective. In short, we will build the platforms necessary to "train as we fight."

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We do have an unprecedented opportunity now to take the first steps in modernizing many of our key facilities through the BRAC program, global re-stationing, Army Modularity, and the regular medical MILCON program. We can ensure our hospital designs promote integrity during the clinical encounter, empower our patients and families, relieve suffering, and promote long-term health and wellness. Hospitals

that say "we care and are not satisfied with anything but excellence" attract patients and clinicians.

We can deliver this healing environment, and we can use evidence-based design and quantify the outcomes. For example, there is compelling evidence of the relationship between providing high-efficiency particulate air (HEPA) filtration in areas where we care for severely immunocompromised patients. If HEPA filtration exists where we treat burn patients, surgical patients, neutropenic patients, bone-marrow transplant patients, and children with acute myelogenous leukemia, we will avoid unnecessary infections. And, we will save lives. In addition, increasing natural light, reducing noise, and maximizing exposure to nature all have quantitative outcomes that can – and are – being measured.

We will also replace the aging and overcrowded facilities at the United States Army Medical Research Institute for Infectious Diseases (USAMRIID) with a cutting-edge, modern research facility that will continue to produce medical countermeasures to the world's deadliest diseases. The new USAMRIID will serve as the cornerstone of the emerging National Biodefense Campus at Fort Detrick, Maryland, which is currently under development with the Department of Homeland Security and the National Institute of Allergy and Infectious Diseases. We are building a replacement facility to support the U.S. Army Institute of Chemical Defense (USAICD) at Aberdeen, Maryland, the nation's premier center of excellence to identify and develop medical countermeasures for chemical warfare agents. The transformation of our physical infrastructure helps us meet the demands of the evolving war on terrorism and the potential threats we face today.

Despite efficiently managing health care costs and utilizing a variety of initiatives, we have much work to do. We continue to use a number of proven means to reduce health care costs in our system. These include:

- Obtaining significant discounts for pharmaceuticals at our MTFs and mail-order venue, making voluntary pricing agreements with pharmaceutical manufacturers to lower our costs in the TRICARE Retail Pharmacy Network, and implementing discounted federal pricing for prescription drugs dispensed through the TRICARE retail pharmacy program;

- Continuing to effectively manage the DoD Uniform Formulary. We avoided approximately $450 million in drug costs in FY 2006, and over $900 million in drug costs in FY 2007 due to key formulary-management changes and decisions;

- Contract strategies. We have reduced administrative costs through effective TRICARE contracting strategies, and our effort to further enhance the next generation of the TRICARE contracts is well underway;

- Further increases in VA and DoD sharing of facilities, capabilities, and joint procurements; and

- The introduction of new prime vendor agreements to lower costs of MTF medical and surgical supplies. The MHS has aggressively negotiated preferential pricing with medical supply vendors across the country, and we project cost avoidance of $28.3 million.

We began implementation of the Prospective Payment System (PPS) in FY 2005. Its purpose is to adjust the medical budgets of the three direct care components (Army, Navy, Air Force) based on their performance, rather than previous spending levels. Up to the present, that performance has been measured in basic units of outputs. Performance, however, is not just a function of the number of activities, but also the quality of those activities in meeting the needs of the beneficiary population. We are exploring ways to modify our budgeting approach to recognize that the quality of those activities is also key.

Using our strategic planning tool – The Balanced Scorecard – we are identifying the most critical mission activities, and then applying Lean Six Sigma methodology to create a data-driven, decision-making culture for process improvement. The Service Surgeons General have aggressively incorporated this methodology into their business operations, and we are already witnessing the fruits of this commitment to building better processes. We have also hired a nationally recognized expert in Lean Six Sigma to help facilitate integration of the National Capital Area and San Antonio under our BRAC work.

In the fall 2006, we began the Innovations Investment Program, to identify the best practices in place at select MTFs or best practices utilized by private-sector health care firms and introduce them to DoD on a global scale. Our intent is to accelerate the use of best practices, using a joint-service, interdisciplinary team of experts to evaluate, validate and then implement proven approaches to better health care delivery. The evaluation phase is already underway, and we plan to begin substantive program changes in the coming year.

As the civil and military leaders of the Department have testified, we must place the health benefit program on a sound fiscal foundation or face adverse consequences. Costs have more than doubled in six years – from $19 billion in FY 2001 to $39 billion in FY 2007 – despite MHS management actions to make the system more efficient. Our analysts project this program will cost taxpayers at least $64 billion by 2015. These increases are attributable to the extension of TRICARE coverage to Reservists, TRICARE for Life, TRICARE's increasing services (which have led many to drop their employer plan), an aging population, the war, and medical inflation. .

Over the last 13 years, the TRICARE benefit was enhanced through reductions in co-pays, expansions in covered services (particularly for Medicare-eligible beneficiaries), new benefits for the Reserve Component, and other additions, but the premiums paid by beneficiaries have not changed. The benefit enhancements have come at a time when private-sector employers are shifting substantially more costs to employees for their health care.

The twin effect of greater benefits for DoD beneficiaries with no change in premiums, coupled with reduced civilian benefits for military retirees employed in second careers in the private sector, has led to a significant increase in military retirees electing to drop their private health insurance and become entirely reliant on TRICARE for their health benefit.

Simply put, the Department and Congress must work together to allow the Department to make necessary changes to the TRICARE benefit to better manage the long-term cost structure of our program. Failure to do so will harm military health care and the overall capabilities of the DoD – outcomes we cannot afford. To this end, we must promote innovation and choice and use individual and team incentives in order to improve quality, satisfaction, and cost effectiveness.

Sharing Initiatives with VA. We have fallen short in several areas relating to those recuperating from injury and those seeking to move forward with their lives. We are committed to identifying and correcting the shortcomings that involve the joint responsibilities of DoD and VA. We have already begun working with our colleagues on corrective action.

DoD and VA are currently working on five major areas: Facilities, including housing for soldiers; case-worker and family-support personnel; improved disability determination processes; special care for TBI and the severely injured; and emphasis on care for those diagnosed with mental health conditions and post-traumatic stress disorder. Together, the DoD and our colleagues at VA will not rest until we can provide that same level of health care when the wounded come home to begin their rehabilitation and recovery.

While Service members and their families have been satisfied with health care, change is needed in the delivery of benefits. The Federal Recovery Coordination program began in November 2007 as a pilot. The role of Federal Recovery Coordinators is to be the ultimate resource to oversee the development and implementation of services across the continuum of care from recovery through rehabilitation to reintegration, in coordination with relevant governmental, private, and non-profit programs.

The 2008–2010 VA/DoD Joint Strategic Plan will improve the quality, efficiency, and effectiveness of the delivery of benefits and services to veterans, Service members, military retirees, and their families through an enhanced VA and DoD partnership. The plan incorporates the ability for a Service member to transition from one department to another and back again. The plan also has concrete performance measures and strategies that link directly to the actions of the SOC, such as joint communications, improved case management, better information sharing, and collaborative training and continuing education for health care providers.

As we continue to seek ways to improve the health care for our beneficiaries, we constantly explore new avenues of partnership with the VA. In FY07, we established 280 direct sharing agreements covering 148 unique health services with the VA. Also in FY07, 104 VA medical centers reported reimbursable earnings as TRICARE network

providers. Every day we collaborate to further improve the health care system for our Service members. We have substantially increased joint procurement, and we have completed four new jointly used evidence-based clinical practice guidelines for amputation, chronic obstructive pulmonary disease, chronic kidney disease, and low back pain to improve patient outcomes.

We are committed to working with the VA on appropriate electronic health information exchanges to support veterans. The Federal Health Information Exchange (FHIE) enables the transfer of protected electronic health information from DoD to the VA at the time of a Service member's separation. We have transmitted messages to the FHIE data repository on more than 4.1 million retired or separated Service members.

Building on the success of FHIE, we also send electronic pre- and post-deployment health assessment and post-deployment health reassessment information to the VA. We began this monthly transmission of electronic pre- and post-deployment health assessment data to the FHIE data repository in September 2005, and the post-deployment health reassessment in December 2005. As of January 2008, VA had access to more than 2.0 million pre- and post-deployment health assessments and post-deployment health re-assessment forms on more than 838,000 separated Service members and demobilized National Guard and Reserve members who had been deployed.

The Bidirectional Health Information Exchange (BHIE) enables real-time sharing of health data for patients being treated by DoD and VA. Access to BHIE data is available through AHLTA and through VistA, the VA's electronic health record, for patients treated by both departments.

To increase the availability of clinical information on a shared patient population, VA and DoD have collaborated to further leverage the BHIE functionality to allow bidirectional access to inpatient documentation from DoD's Essentris System. In December 2007, we announced the enterprise-wide release of enhancements to the BHIE and the Clinical Data Repository/Health Data Repository (CHDR) interfaces. With these enhancements, DoD and VA are now able to view each other's clinical encounters, procedures, and problems lists on shared patients using the BHIE. This adds to the pharmacy, allergy, microbiology, chemistry/hematology data, and radiology reports we made available previously.

Additionally, DoD and VA providers may now view theater data (including inpatient data) from the Theater Medical Data Store (TMDS). And, DoD providers no longer have to log out of AHLTA and into another application to see it.

To support our most severely wounded and injured Service members transferring to VA Polytrauma Centers for care, DoD continues to send radiology images and scanned paper medical records electronically to the VA Polytrauma Centers. WRAMC, National Naval Medical Center (NNMC) Bethesda, and Brooke Army Medical Center (BAMC) are providing radiology images electronically for patients transferring to the VA Polytrauma Centers in Tampa, Richmond, Palo Alto, and Minneapolis. Additionally,

WRAMC, BAMC and NNMC scan medical records to create portable document format (PDF) documents for electronic transmission for patients transferring to the four VA Polytrauma Centers.

We have worked closely with our partners in the VA, in our shared commitment to provide our Service members a seamless transition from the MHS to the Department of Veterans Affairs. DoD implemented a policy entitled "Expediting Veterans Benefits to Members with Serious Injuries and Illness," which provides guidance for collecting and transmitting critical data elements for Service members involved in a medical or physical evaluation board. DoD began electronically transmitting pertinent data to the VA in October 2005 and continues to provide monthly updates, allowing the VA to better project future workload and resource needs.

We have provided information for more than 28,000 Service members while they were still on active duty, allowing the VA to better project future workload and resource needs. When the VA receives these data directly from DoD before Service members separate, it helps to reduce potential delays in developing a benefits claim. This process ensures that the VA has all the relevant information to decide claims for benefits and services in a timely manner.

The Legacy of Military Medicine

American military medicine has led the world in epidemic surveillance, response, trauma care, disaster medicine, health information technology, fitness and prevention.

U.S. military medicine and our medical personnel are national assets, representing a readiness capability that does not exist anywhere else, and – if allowed to dwindle – could not be easily reconstituted. We must preserve these assets.

As we address the problems that lie at the intersection of personnel issues and health care delivery, it is our shared responsibility to focus on the specific problems, and not the people who have done so much to improve the health of our military Service members. We are blessed with a rich cadre of dedicated, hard-working, skilled professionals. I have complete confidence that they are rising to the occasion, learning from what went wrong, and building an even stronger, more responsive system for all.

Conclusion

Our military engagements in Iraq, Afghanistan and other locations, combined with our medical humanitarian missions and our peacetime health delivery mission have simultaneously tested the MHS. Our medics, corpsmen, nurses and surgeons operating in tents, on ships, and in planes, continue to exceed the expectations of all our stakeholders.

Yet, the critical concept that MHS leaders share is simple – we can never be satisfied with our accomplishments. The people we serve – our line commanders and civilian leadership; our Service members and military families; and the representatives of

the American people in the Congress – expect us to accomplish even more, and to build upon our successes.

There is more work to do: We must invest in medical technologies to protect and defend our military community against future threats; provide wise stewardship of limited taxpayer dollars to sustain a quality health system serving more than nine million Americans; and commit to continued military and professional development of medical professionals of all types – physicians, dentists, nurses, enlisted specialists, and administrators.

Many people in many places have very high expectations for this country's military health system. Our responsibility in the coming years is to exceed these expectations. Our obligations are to those who follow us – today's sergeants and corporals, lieutenants and captains, and civilians now rising through the system.

With the support of the DoD leadership and of the Congress, the MHS remains committed to sustaining and passing on this legacy of achievement and stewardship for the medical leaders of the future. On behalf of the MHS, I am grateful for the resources and encouragement you provide to all who serve, and look forward to working with you this year.

- END -