

**HEARING TO RECEIVE TESTIMONY ON MILITARY HEALTH SYSTEM PROGRAMS, POLICIES, AND INITIATIVES IN REVIEW OF THE DEFENSE AUTHORIZATION REQUEST FOR FISCAL YEAR 2011 AND THE FUTURE YEARS DEFENSE PROGRAM**

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**WEDNESDAY, MARCH 24, 2010**

U.S. SENATE,  
SUBCOMMITTEE ON PERSONNEL,  
COMMITTEE ON ARMED SERVICES,  
*Washington, DC.*

The subcommittee met, pursuant to notice, at 10:02 a.m. in room SR-232A, Russell Senate Office Building, Senator Jim Webb (chairman of the subcommittee) presiding.

Committee members present: Senators Webb, McCaskill, Begich, Graham, and Thune.

Also present: Senator Cardin.

Majority staff members present: Jonathan D. Clark, counsel; Gabriella Eisen, counsel; and Gerald J. Leeling, counsel.

Minority staff members present: Diana G. Tabler, professional staff member; and Richard F. Walsh, minority counsel.

Staff assistants present: Paul J. Hubbard and Jennifer R. Knowles.

Committee members' assistants present: Nick Ikeda, assistant to Senator Akaka; Gordon I. Peterson, assistant to Senator Webb; Tressa Steffen Guenov, assistant to Senator McCaskill; Lindsay Kavanaugh, assistant to Senator Begich; and Walt Kuhn, assistant to Senator Graham.

**OPENING STATEMENT OF SENATOR JIM WEBB, CHAIRMAN**

Senator WEBB. Good morning. The subcommittee meets today to receive testimony on Military Health System programs, policies, and initiatives in review of the Defense Authorization Request for fiscal year 2011 and the Future Years Defense Program.

The Military Health System serves as a—serves a population of more than 9.5 million eligible beneficiaries, both in military treatment facilities and through contracted private-sector care.

The primary mission of the Military Health System is to maintain the health and readiness of our Active Duty military personnel, both at home and on the battlefield. The system also provides medical care for millions of dependents of Active Duty per-

sonnel, military retirees and their dependents, certain Guard and Reserve members and their families, and others.

As one who's spent most of his life in and around the military, I care deeply about our special obligation to provide our military servicemembers, their families, retirees, and our veterans—I note the presence of the ranking Republican.

Senator GRAHAM. Thanks for starting on time.

Senator WEBB. Yes.

I care deeply about our special obligation to provide our military servicemembers, their families, retirees, and our veterans with the finest healthcare treatment available.

For this reason, I introduced a companion bill in the Senate on Monday, when it was recognized that legislation was needed to explicitly state in the law that TRICARE and Department of Defense nonappropriated-fund health plans meet the minimum essential coverage for individual healthcare insurance required by the Healthcare Reform bill. My bill was based on one introduced in the House of Representatives last Friday by Congressman Skelton.

I appreciate the support demonstrated by Senator Graham and other members of this subcommittee for this bipartisan legislation. The measure was hotlined last night. I'm hopeful that our members will agree to pass it soon so that we can take this issue off the table as a matter of concern for our servicemembers, their families, and other beneficiaries.

Nine years of conflict have stressed our military in ways that were not contemplated at the inception of the All-Volunteer Force. As I noted 3 years ago, and 2 weeks ago again, during this subcommittee's initial hearing in this session, we are in uncharted territory as a result of past rotation cycles, multiple combat deployments, and an unsatisfactory deployment-to-dwell ratio.

Many of you will remember that I introduced what was called "dwell-time" legislation 3 years ago, trying to put a safety net underneath our military members who are—been deployed when the rotational cycles went below one-to-one, although traditionally they were supposed to be, and have been, around 2-to-1—2 years home for every year deployed, 1 year home for every 6 months deployed.

A lot of people at that time, I think, interpreted this legislation as politically motivated. I can say again, and reaffirm today, that it was not, that the well-being and proper leadership of our men and women in uniform is not the sole prerogative or the sole responsibility of our military commanders. The circumstances under which they serve, where, for how long, and under what conditions is very much the subject of the stewardship of the Congress.

My perspective on this issue is also shaped by 4 years spent as a counsel to the House Committee on Veterans Affairs, when we did pioneering work in the areas of post-traumatic stress and other issues posing long-term consequences for veterans of the Vietnam war.

During the past 3 years, we've seen a marked improvement in areas such as the treatment of traumatic brain injury and wounded warrior care management, but the Military Health System is still a work in progress. It's not enough simply to provide healthcare. It must also be the most appropriate and effective professional care

given in a timely way. And in this regard, I believe it's always important to point out our appreciation to the healthcare providers in each branch of the Armed Forces who treat and stabilize servicemembers wounded in battle. Our dedicated medical teams bring wounded warriors from the battlefield to the operating room with when—within what is called the “golden hour,” enabling our medical professionals to achieve the best wartime survival rates, by far, in our Nation's history.

The budget request for 2011 includes more than a billion dollars for research into traumatic brain injury and post-traumatic stress. Last year, the Army established a Warrior Transition Command to oversee the care and management of wounded, ill, and injured soldiers. Navy Medicine has created programs, such as the Marine Corps Wounded Warrior Regiments, the Navy's Safe Harbor, to support a full-spectrum recovery process for sailors, marines, and their families.

Our most pressing concern is the health of our servicemembers who are deployed, and who have been deployed repeatedly. Despite shortages of healthcare professionals, we must adequately assess the medical condition of our servicemen—members, before and after they deploy, to include effective mental health screenings.

We've seen recent reports of increased prescription drug use that are deeply troubling. In fact, the data is stunning, when you look at it. According to an article published this month by the Military Times, at least one in six servicemembers is on some form of psychiatric-related drug. The newspaper reported that the use of such medications is estimated to have increased by 76 percent since combat operations began in Afghanistan and Iraq, with antipsychotic prescriptions more than tripling from 2001 to 2009. Whether these drugs are antidepressants, pain medications, muscle relaxants, or anti-anxiety drugs, we really do need to understand the dynamic of this problem. And we look to today's witnesses to help us understand the scope of these alarming trends and to describe what is being done to address them.

I would say that there is a larger issue in play here that I have a great deal of concern about, and that is the transparency of what is actually happening to our Active Duty military when they are deployed, whether it is in the context of the combat operations that they are on, the living circumstances that they have in these deployed areas, or issues such as this.

This subcommittee is also hearing reports of increased substance abuse, growing numbers of servicemembers with emotional difficulties across the services, and a lack of access to mental healthcare. It's not enough to address these issues piecemeal, we must approach them holistically, because their effects, clearly, tend to overlap.

At a hearing held by Personnel Subcommittee last year, we were told by a number of military spouses that access to healthcare, including access to mental healthcare and specialty care was a top concern. Clearly, our servicemembers must be secure in the knowledge that their family members are receiving the medical care that they need.

And we must also be mindful of the cost of providing this care. Secretary Gates said, last year, and I quote, that “healthcare is eat-

ing the Department alive.” And this year, he stated his desire to, quote, “work with the Congress, in figuring out a way to bring some modest control to this program.”

We welcome any suggestions the Department and the services may have to address the steadily increasing costs of providing healthcare under the Military Health System.

Our military men and women in uniform and their families have given much to this country. We must do everything we can to ensure that they continue to receive the finest healthcare available. We cannot achieve that goal without open communication with the Department of Defense and with the services. If we are not aware of a problem, we cannot be a part of a solution.

I'd like, now, to recognize our ranking member, Senator Graham, if he has any opening statement.

Senator Graham.

Senator GRAHAM. Well, thank you, Mr. Chairman, for holding the hearing.

And I'll tell you what, I'll just work my comments in with the witnesses. I know Senator Cardin's a busy man. I look forward to hearing what he's got to say.

Senator WEBB. Without objection, all witness written testimony submitted for today's hearing will be included in the record.

In addition, the National Military Family Association in Georgetown University's Medical Center's Palliative Care Program have submitted testimony, and, without objection, this will also be included in the record.

[The information referred to follows:]

Senator WEBB. Now, I'm very pleased to introduce our colleague Senator Ben Cardin, who is the lone witness here. Senator Cardin shares with me a great concern about the dramatic increase in the use of prescription drugs by servicemembers, and I would like to express my appreciation to Senator Cardin, for having really gotten out in front of this issue and helped make all of us aware of what—you know, the data that ended up being reported in the USA Today. I invited him. I sought his testimony today.

And I would like to welcome you, this morning.

Senator CARDIN.

**STATEMENT OF HON. BENJAMIN L. CARDIN, U.S. SENATOR  
FROM THE STATE OF MARYLAND**

Senator CARDIN. Well, Chairman Webb, first of all, thank you very much for holding this hearing and for your interest in this subject.

Senator Graham, thank you for your continued interest in fighting for our soldiers in so many different ways. I'm honored to be before your committee, and I bring to you attention of a serious issue concerning the health of our combat troops and how the military is dealing with the stress of combat and repeated deployments.

There are some very disturbing statistics that the Chairman mentioned in his opening statement. But, let me try to just fill in a few more of the details. In 2009, there were 160 Active Duty Army suicides. That's a 15-percent increase from the previous year. We have an alarming use in the increase of antidepressants. In 2005, there were a little over 4,000 combat troops using

antidepressants. That's about 1 percent. By 2007, it grew to over 19,000, or 5 percent, of our troops on antidepressants. That's a huge increase in the use of antidepressants. And that number remained pretty constant for 2008.

We do know that there is information that's been made available to us. I can cite just one source. The Army's fifth health advisory team tells us that the use of antidepressants and the medication for sleep—sleeping pills—that number, in our combat troops in Iraq, is 12 percent, and our combat troops in Afghanistan, is 17 percent and—Chairman, as you said, one out of every six. So, we know that there's a huge number of those that are using these types of medications.

There's a real question as to whether they're receiving the proper medical supervision, the proper monitoring. This is particularly true during the first 6 weeks, when medications are taken and when your body adjusts to the medicines that you're taking, so that the adverse reactions are less likely.

In combat, the antidepressant that's most likely used is SSRIs. Since 2004, the FDA has required a warning on the use of these types of antidepressants by the increased risk of suicidal thoughts. The vulnerable age that the FDA tells us is 18 to 24. Well, 41 percent of those deployed in Iraq and Afghanistan fall within that age group, which should have all of us concerned.

The—I want to say, I think the Department of Defense has made some strides in the right direction. As part of the National Defense Authorization Act, I offered an amendment that requested information to be made available to our congressional committees on the numbers taking these drugs over the next 5-year period. It was included in the Senate version. It was not included in the conference version. I did send a letter to Secretary Gates. And I want to compliment Secretary Gates. He supplied the information to my office. I have had a chance to talk to him personally. I think he understands the seriousness of this matter.

There's been significant improvements in the predeployment screening for healthcare issues for our soldiers before they go to combat. And there's been post-deployment healthcare assessment and treatment. I acknowledge that. But, I still think we need the Department of Defense's help in trying to understand what is happening, as far as the use of these prescribed drugs.

There's certain—we've got a lot of dots, but we haven't connected the dots. And I really do ask this committee, and I'll be asking my colleagues in the Senate, to help in trying to understand what is happening here. Why has there been such a large increase in the use of antidepressants? I think we need to have the answers to the questions. We need to know whether there is proper medical supervision for those who are taking prescribed antidepressants. We need to know what the policy is in those soldiers that are in combat. If they start on antidepressants, what is their—what is the policy of the military during those first 6 weeks? Are they to be sent into combat itself, which—again, there is a particular vulnerability during that 6-week period. I'm not aware if there is a policy, and I think this committee needs to know, and the U.S. Senate needs to know.

I think we need to have a better understanding on the relationship between the use of antidepressants and suicide within the military. I would urge us to make the resources available for a scientific study, with peer review, so that we can try to connect the dots. I think we need to know whether there are other treatment options, rather than the use of prescribed medicines. And I certainly would urge us to request relevant data be made available to Congress on the use of antidepressants, so that we can be part of the oversight responsibilities that we have as members of the U.S. Senate.

And I look forward to working with the committee. I look forward to working with my two colleagues. And I think this is an important issue, and I thank you for giving it its attention.

[The prepared statement of Senator Cardin follows:]

[COMMITTEE INSERT]

Senator WEBB. Senator Cardin, thank you very much for having worked so hard to bring this matter to the attention of the Senate and of the Congress. And you have our commitment that we will be working on it. And we will actually be seeking observations of the witnesses that follow you today.

Thank you for being with us.

Senator CARDIN. Thank you.

Senator GRAHAM. Thank you, Senator. What you're pointing out is very important to the country, and I appreciate your interest, and we'll get some answers to these real legitimate questions.

Senator CARDIN. Appreciate it.

Senator WEBB. I'm pleased now to welcome and introduce the witnesses for our second panel. They are Dr. Charles L. Rice, who is performing the duties of the assistant Secretary of Defense for Health Affairs and acting director of TRICARE Management Activity—you could join us as we announce your names—Rear Admiral Christine Hunter, United States Navy deputy director of TRICARE Management Activity; Lieutenant General Eric B. Schoomaker, United States Army, Surgeon General of the Army and Commander of U.S. Army Medical Command; Vice Admiral Adam Robinson, Jr., United States Navy, Surgeon General of the Navy, and Chief of the Navy Bureau of Medicine and Surgery; Lieutenant General Charles B. Green, United States Air Force, Surgeon General of the Air Force; and Rear Admiral Richard R. Jeffries, United States Navy, who is the medical officer of the United States Marine Corps.

I'd like to thank all of you for joining us today to discuss the vital issues associated with military healthcare. And I would like to ask Dr. Rice to begin the panel's opening statements. And unless there's some special protocol, maybe we could—

Senator GRAHAM. Sounds good to me.

Senator WEBB. We'll just work across the table.

And welcome, to you all.

Dr. Rice, the floor is yours.

**STATEMENT OF CHARLES L. RICE, M.D., PERFORMING THE DUTIES OF THE ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS, AND ACTING DIRECTOR, TRICARE MANAGEMENT ACTIVITY**

Dr. RICE. Thank you, Mr. Chairman, Senator Graham, for the opportunity to come before you today.

Late February, I was asked by Dr. Stanley, the Under Secretary of Defense for Personnel and Readiness, to perform the duties of the assistant Secretary of Defense for Health Affairs, stepping away from my permanent position as the president of the Uniformed Services University until President Obama's choice for this job is confirmed by the Senate and sworn in, whereupon I will happily return to Uniformed Services University.

I'm honored to be here and to be able to represent the men and women who serve in our Military Health System and deeply appreciative of the support you have always provided military medicine and for your unwavering support to the University.

I have submitted my written comments to the committee. And with your indulgence, I'd like to make just some very brief opening remarks.

I approach my role as the senior medical advisor to Secretary Gates and Secretary Stanley with advantages of multiple perspectives. As a trauma surgeon, as an educator, as a retired Navy medical officer, and, like you, Mr. Chairman, as the father of an Active Duty servicemember, this issue is personal to me.

There is much to be proud of in the military healthcare system. The performance of our military medics in combat remains nothing short of remarkable. In addition to the lifesaving care on the battlefield, we're continuously improving the medical readiness of the total force.

We monitor and record the health of servicemembers in the most comprehensive manner ever witnessed throughout the cycle of deployment, before, during, and after their service in combat theaters. And despite the breakneck pace of combat, our medical personnel have responded heroically to natural disasters in Haiti and Chile.

I know that you share this pride in the people who serve our Nation, and so, today I want to focus on those areas where greater attention is required from me, so that you will understand where I focus my energies.

First, our deepest obligations are Reserved for the casualties returning to the United States and to their families and the caregivers who support them. Substantial progress has been made since problems with wounded warrior support first came to light in 2007. This committee has played an important role for driving change, standing up new programs, and ensuring substantial new resources to address any shortcomings. We are grateful for that.

More needs to happen on our end to ensure that the programs, services, health information and communication are knitted together more tightly so that we can provide more clear and cohesive services to those families who continue to sacrifice so much.

Second, I am intently focused on the performance and the perception of our electronic health record, Alta. My intent is not to micro-manage the many technological issues, but to determine whether

our proposed solutions will result in better capability for our providers—nurses, physicians, pharmacists—all the key members of the healthcare team, and to deliver value for patients. The key test for a successful electronic health record is whether it leads to better quality care. If our current effort fails that test, we will find one that can deliver on that crucial expectation.

Third, the Department continues to implement the broad changes required by the 2005 BRAC Commission. Our approach to the right organizational construct and how we build medical facilities design must result in better service, better quality, and better access for our patients. Investments in evidence-based design concepts for our new facilities are critically important. They offer a better healing environment for patients and for their families.

The hospital at Fort Belvoir will be a showcase for this new approach. I was there last week with General Schoomaker and was truly dazzled by the design concepts that have been incorporated to create an unmatched healing environment. If you haven't been down to see it, I urge you to try to work a visit in to your busy schedules.

In addition to design, we need to better integrate service delivery across the military branches, an effort that will require sustained effort in decisions in the months ahead to better serve our patients.

Fourth, we're working to resolve the serious matters identified in the protests upheld by the GAO regarding the T3 contract awards. While the issues that we must address are serious, I am reassured, and want to reassure you, that the internal issues affecting these awards have not affected the day-to-day service for our beneficiaries. Nonetheless, our efforts to control TRICARE cost growth are closely linked to the effective implementation of new contracts. And it is in the best interests of the government and of the organizations who are involved in these contract decisions to move toward a definitive conclusion. I'm grateful to Admiral Hunter for her leadership in this area.

Finally, I'd like to briefly comment on the larger issue of national healthcare reform, that you alluded to, Mr. Chairman. It has been the focus of much attention this week. Although the Military Health System is in many ways a unique system of care, we do not function apart the civilian healthcare system used by the American people. In fact, almost 70 percent of the care our beneficiaries receive is delivered by our civilian colleagues.

TRICARE benefits will not be affected at all by the passage of reform. We know that the DOD medical benefit is, appropriately, one of the most comprehensive medical benefits of any employer. One visit to Walter Reed or Bethesda demonstrates why this should be so more than any words I can offer here.

Yet, there are other potential benefits that will accrue to the Department when more Americans are covered by insurance. This includes a more medically fit recruiting pool, greater investments in comparative effectiveness research that will help all practitioners of care with delivering scientifically valid approaches to medicine, and a more secure transition for those members of our Armed Forces who decide to separate prior to full retirement.

I will be working with my healthcare colleagues at HHS and elsewhere to ensure that we're appropriately involved in the imple-

mentation of healthcare reform initiatives that both reassure our beneficiaries and promote the goals of reform.

Mr. Chairman, I want to thank you again for your steadfast support of the military healthcare system. Look forward to your questions.

[The prepared statement of Dr. Rice follows:]

Senator WEBB. Thank you very much, Dr. Rice.

Admiral Hunter, welcome.

**STATEMENT OF RADM CHRISTINE S. HUNTER, USN, DEPUTY DIRECTOR, TRICARE MANAGEMENT ACTIVITY**

Admiral HUNTER. Thank you, Mr. Chairman, Senator Graham. I'm really honored to be able to appear before you today.

Together with Dr. Rice, I have the responsibility for operating the TRICARE Management Activity and administering the TRICARE benefit.

As you said, 9.6 million Americans rely on us to ensure they receive high-quality healthcare whenever they need it and wherever they are in the world. Along with the growth in the Army and Marine Corps, our program has grown by over 370,000 servicemembers, families, and retirees since 2008.

Since assuming my responsibilities, 10 months ago, I've been fortunate to work closely on many critical initiatives with DOD leaders, the service Surgeons General, and key stakeholders who represent our beneficiaries.

Initially, we focused our efforts on the care of wounded warriors, access to care, particularly behavioral healthcare, and services for families whose children have special needs.

More recently, we introduced the construct of the Quadruple Aim and carefully examined how we're performing in each domain. The Quadruple Aim builds on the Institute for Healthcare Improvement's Triple Aim for Health Systems, which advocates that we achieve excellence in population health, the patient experience, and responsibly manage the costs.

In the Military Health System, our Quadruple Aim adds the fourth aim, a specific emphasis on our core mission of readiness. And I'm pleased to report that we're making progress. To support readiness, certainly the Surgeons General will share many of their observations. But, at TMA we have concentrated on our Reserve and Guard populations, as well as behavioral health.

Participation in our TRICARE Reserve Select product is growing, ensuring that reservists and guardsmen have coverage to maintain their health between mobilizations. We've also made it easier for physicians around the country to participate in this plan and receive timely payment.

Our efforts to reduce the stigma associated with seeking mental healthcare have been accompanied by an increase in providers to meet the growing demand. Together with the Surgeons General and our TRICARE contractors, we've added over 1900 providers to the military hospitals and clinics, and more than 10,000 added to the networks. Visits have increased dramatically, with 112,000 behavioral health outpatients now seen every week. In addition, servicemembers and their families can access the TRICARE Assist-

ance Program for supportive counseling via Webcam from their homes, 24 hours a day.

To improve health overall, we're putting a priority on prevention, eliminating copays for preventive services under TRICARE standard, recently adding immunizations like flu vaccine to our retail pharmacy program, and tracking our performance. Since 2007, we can demonstrate significant improvement in the number of patients who receive cancer screening that's appropriate to their age, immunizations, and medications to control diabetes, asthma, and cholesterol.

Patients are beginning to notice the difference. On surveys, they're telling us that they receive timely care, needed care, and see their assigned primary care manager more often. We certainly still have room to improve, but this is a very encouraging beginning trend.

To address the costs of care, we're focused on ensuring that patients with acute minor conditions visit their primary care site or an urgent care clinic, rather than the emergency room, and choose the convenience and lower out-of-pocket cost, as well as lower government cost, of our mail-order pharmacy, rather than the retail pharmacy, whenever that's possible.

Our partnerships at the interface between the direct care and private-sector care are thriving. On a regular basis, TRICARE regional directors engage with Army MTF commanders in rehearsal of capability drills. We work together to develop the medical capacity that's needed as the Army grows and shifts its population concentrations.

When Navy medical personnel ably responded to the disaster in Haiti, we staffed a fusion cell to make daily adjustments to network referrals and assist with interservice crossleveling, to ensure that all patients continue to receive timely care.

And the Air Force has led the other services to articulate the challenges with access to care in Alaska, and we've been able to stabilize reimbursement to encourage more providers to participate.

We appreciate the Senate's leadership in this area, and we're engaged with the VA and other Federal partners to develop comprehensive solutions.

In the months ahead, we'll work diligently to address all concerns cited by the GAO and move forward to delivery of healthcare under the TRICARE third-generation contracts.

We proudly anticipate the introduction of our TRICARE Reserve Retiree Program for those gray-area reservists who have served our Nation so honorably, and are excited by pending improvements to our overseas and dental programs.

There's certainly much more to do, but my staff and I come to work every day mindful of all those that we serve and striving to make a positive difference.

Thank you again, Mr. Chairman, for your advocacy on behalf of our servicemembers, and I look forward to your questions.

[The prepared statement of Admiral Hunter follows:]

Senator WEBB. Thank you, Admiral Hunter.

General Schoomaker.

**STATEMENT OF LTG ERIC B. SCHOOMAKER, USA, SURGEON  
GENERAL OF THE UNITED STATES ARMY, AND COMMANDER,  
U.S. ARMY MEDICAL COMMAND**

General SCHOOMAKER. Chairman Webb, Senator Graham, and distinguished members of the Personnel Subcommittee, thank you for inviting us to discuss the Defense Health Program and our respective service medical programs.

Now in my third congressional hearing cycle as the Army Surgeon General and commanding general of the United States Army Medical Command, or MEDCOM, I can tell you that these hearings are valuable opportunities for me to talk about the accomplishments and challenges of Army Medicine, and to hear your collective perspectives regarding military health promotion and healthcare.

I'm pleased to tell you that the President's budget submission for fiscal year 2011 fully funds the Army Medical Department's needs. Your support of the proposed President's budget is greatly appreciated.

I know, in your recent hearing with the Under Secretary of Defense for Personnel and Readiness and the assistant Secretaries for Manpower and Reserve Affairs, that much concern was expressed regarding the increasing size of the defense health budget within the overall defense budget. So, I'd like to share with you some of the efforts that we are making in Army Medicine that complement what Admiral Hunter just discussed, to maximize the value in health services that we deliver, one of our—Army Medicine's five strategic themes.

This theme is built on a belief that providing high-quality evidence-based services is not only right for soldiers and families, it results in the most efficient use of resources within the healthcare system, thus delivering value not only for our patients, but indeed for the Nation as a whole. In fact, what we really want to do is move from a healthcare system, one that is focused on delivering care, simply, to one that is a system of health and a system for health, which optimizes health and well-being through enhanced prevention and in a holistic approach.

We've resisted simply inventing new processes and inserting new diagnostic tests or therapeutic options, although we are keeping abreast of all of the cutting-edge changes in the American healthcare and international healthcare terrain. Or we've resisted adding just more layers of bureaucracy, but we're really, truly adding value to the products we deliver, the care we provide, and the training of our people.

This requires focusing on the clinical outcome for the patient and the community, and maintaining or even reducing the overall resource expenditure that's needed to achieve this objective. I was—my own wife reminds me, she's not interested in sitting in waiting rooms or going through the turnstile of medicine, she wants to know, at the end of the day, Is she better for what she came to seek care for? And I think we can tell here unequivocally, and all of our patients and soldiers and families, that we are.

It's—we've—this has occurred, for us, through adoption of evidence-based practices, that you heard both of my colleagues here talk about, and reducing unwarranted variation in our practices,

even unwarranted administrative practice variation for all the transactional processes that go on in our work.

One example of this in Army Medicine is that we are expanding upon a performance-based budget model that links resources to clinical and quality outputs. Since 2007, we've been providing financial incentives to our hospitals, our clinics, our clinical commanders, and our clinicians for superior compliance in key preventive measures and other measures of evidence-based practices.

Currently, we track nine measures and compare our performance to a national benchmark. Our performance has improved on every measure, in one case by 63 percent. We've demonstrated that these incentives work to change organizational behavior to achieve desired outcomes in our health system.

Put quite simply, our beneficiaries, our patients, and our communities are serving—are receiving not only better access to care, but for better care once they get that access, that we can objectively measure.

We've undertaken major initiatives to improve both access and continuity of care. This is one of the Army Chief of Staff's and my top priorities, and it's reflected in what you've heard Admiral Hunter talk about. After conducting thorough business-case analyses, Army Medicine is expanding healthcare product lines in some communities, and we're expanding clinical space in others. In 14 locations across the country, we're establishing community-based primary care clinics by leasing and operating clinics located in off-post communities that are close to where our Active Duty families live and work and go to school. These clinics will provide a Patient-Centered Medical Home for families, an effort with is warmly embraced and resourced by all three of the medical services in the Military Health System and will provide a range of benefits, to include improved readiness for our Army and our Army family, improved access to and continuity of care, reduced emergency room visits, and improved patient satisfaction, which is growing.

Both our community-based Primary Care Clinic Initiative and the three medical services Patient-Centered Medical Home implementation has been well-supported by Rear Admiral Chris Hunter and the TRICARE Management Agency and the assistant Secretary of Defense for Health Affairs. And we are very appreciative of—are working closely on these efforts.

I look for 2010 to be the first—to be the year that Army Medicine achieves what we set out to improve, 2 years ago, in access and continuity, key elements of our covenant with the Army family, led by our Chief of Staff and by the Secretary of the Army.

Army leadership is also engaged in an all-out effort to change the Department of Defense culture, regarding traumatic brain injury, or mild traumatic brain injury, as it's called, especially the milder form, or what we call concussion. So, traumatic brain injury, which has a very wide spectrum, from concussive injury to much more unusual penetrating injuries or moderate crush injuries, of those, we are really focusing very, very closely on concussive injury, the most common injury. Our goal is nothing less than a cultural change in the management of soldiers after potential concussive events in combat or, frankly, on the football fields or sports fields or in motor vehicle accidents.

Every warrior requires appropriate treatment to minimize concussive injury and maximize recovery. To achieve this goal, we're educating the force so as to have a trained and prepared soldier, a leader, and our medical professional and personnel to provide early recognition, treatment, and tracking of these concussive injuries, ultimately designed to protect warrior health.

The Army is issuing very direct standards and protocols to commanders and healthcare providers, similar to aviation incident actions. There's an automatic grounding and medical assessment which is required for any soldier that meets specified criteria. The end state of these efforts is that every servicemember sustaining a possible concussion will receive early detection, state-of-the-art treatment, and return-to-duty evaluations, with long-term digital health-record tracking of their management.

We're combining our efforts to identify and manage concussive brain injury as close as possible, both in time and geographic proximity, to the actual blast event, with more aggressive battlefield management of post-traumatic stress symptoms. Our experts tell us that the closer we can manage those symptoms as they emerge in combat, the more likely we are to reduce long-term post-traumatic stress disorder problems.

Treatment of concussive injuries is an emerging science. The Army is leading the way in implementing these new treatment protocols for the Department of Defense, and the DOD is leading the Nation.

I brought with me today our Brain Injury Awareness Toolkit. I'd like to share this with you and your staff. If you don't have anything else—any other time, I'd really urge you to look at the DVD that we've put together with our senior leadership, because this is really a commanders-led program—the Chief of Staff, the Vice Chief of Staff, Pete Chiarelli, and our sergeant major of the Army is very, very actively involved in. They contain patient information materials, as well as this DVD, which we're using to educate soldiers before they deploy overseas. And we're training them as to what they should do, should they have a concussion.

I truly believe that this evidence-based directive approach to concussive management will change the military culture regarding head injuries and significantly impact the well-being of our force.

In closing, I'm very optimistic about the next 2 years. I feel very privileged to serve with the men and women of Army Medicine, as soldiers, as Americans, and as global citizens.

Thanks for holding this hearing and your unwavering support of the Military Health System and Army Medicine.

I look forward to answering questions. And, in particular, I'd be happy to discuss the Army's approach to pain management, to the treatment of post-traumatic stress, and the use of medications across the force, those other concerns that were raised by Senator Cardin.

Thank you.

[The prepared statement of General Schoomaker follows:]

Senator WEBB. Thank you, General Schoomaker.

And I'd—let me just very quickly thank you for those comments about TBI and concussive injuries. This really is a different phenomenon from, I think, anything we've ever seen, as you know, be-

cause of the—sort of, the echo effect of so many of these actually occurring inside vehicles. It's almost like shaped charge. So, you can't even directly compare this with football injuries—

General SCHOOMAKER. No, sir.

Senator WEBB.—or any of these others.

We've got a great program, down at Virginia Tech, that's examining this concept, and I thank you for that detailed analysis.

General SCHOOMAKER. This has been a great collaborative effort with my colleagues here, too, sir.

Thank you.

Senator WEBB. Admiral Robinson, welcome.

**STATEMENT OF VADM ADAM M. ROBINSON, JR., USN, SURGEON GENERAL OF THE UNITED STATES NAVY, AND CHIEF, NAVY BUREAU OF MEDICINE AND SURGERY**

Admiral ROBINSON. Good morning, sir. Good morning, Chairman Webb, Senator Graham, distinguished members of the subcommittee.

I want to thank you for your unwavering support of Navy Medicine, particularly as we continue to care for those who go into harm's way, our Marine Corps, our Navy, their families, and all beneficiaries.

I am honored to be with you today to provide an update of the state of Navy Medicine, including some of our accomplishments, our challenges, and strategic priorities.

Navy Medicine: World-Class Care, Anytime, Anywhere. This poignant phrase is arguably the most telling description of Navy Medicine's accomplishments in 2009 and continues to drive our operational tempo and priorities for the coming year and beyond.

Throughout the last year, we saw challenges and opportunities. And moving forward, I anticipate the pace of operations and demands will continue to increase. We have been stretched in our ability to meet our increasing operational and humanitarian assistance requirements, as well as maintain our commitment to provide care to a growing number of beneficiaries. However, I am proud to say that we are responding to this demand with more flexibility and agility than ever before.

The foundation of Navy Medicine is force-health protection; it's what we do and why we exist. Nowhere is our commitment more evident than in Iraq and Afghanistan. During my October 2009 trip to theater, I again saw the outstanding work of our medical personnel. The Navy Medicine team is working side by side with Army and Air Force medical personnel and coalition forces to deliver outstanding healthcare to our troops and civilians alike.

As our wounded warriors return from combat and begin the healing process, they deserve a seamless and comprehensive approach to their recovery. We want them to mend in body, mind, and spirit. Our patient- and family- centered approach brings together medical treatment providers, social workers, care managers, behavioral health providers, and chaplains. We are working closely with our line counterparts in the Marine Corps, Wounded Warrior Regiments, and the Navy's Safe Harbor, to support the full- spectrum recovery process for sailors, marines, and for their families.

We must act with a sense of urgency to continue to help build resiliency among our sailors and marines, as well as the caregivers who support them. We are aggressively working to reduce the stigma surrounding psychological health and operational stress concerns, which can be a significant barrier to seeking mental health services.

Programs such as Navy Operational Stress Control, Marine Corps Combat Operational Stress Control, FOCUS—Families Overcoming Under Stress—Caregiver Occupational Stress Control, and our Suicide Prevention Program are in place and maturing to provide support to personnel and to their families.

An important focus for all of us continues to be caring for our warriors suffering from traumatic brain injuries. We are expanding TBI training to help—to healthcare providers throughout the fleet and the Marine Corps. We are also implementing a new in-theater TBI surveillance system and conducting important research. This is in collaboration with my sister services and medical colleagues.

We are also employing a strategy that is both collaborative and integrative by actively partnering with other services, the Defense Center of Excellence for Psychological Health and Traumatic Brain Injury, the Veterans Affairs—Department of Veterans Affairs and leading academic, medical, and research centers, to make the best care available to our warriors.

We must continue to recognize the occupational stress on our caregivers. They are subject to the psychological demands of exposure to trauma, loss, fatigue, and inner conflict. This is why our Caregiver Occupational Stress Control programs are so important to building and sustaining the resiliency of our providers. Mental health specialists are being placed in operational environments and forward deployed to provide services where and when they are needed. The Marine Corps is sending more mental health teams to the front lines, with the goal of better treating an emotionally strained force. Operational Stress Control and Readiness teams known as OSCAR will soon be expanded to include the battalion level. This will put mental health support services much closer to combat troops. A mobile care team of Navy medical—Navy Medicine mental health professionals is currently deployed to Afghanistan, conducting mental health surveillance, command leadership consultation, and coordinate mental health care for sailors throughout the AOR.

As you know, an integral part of the Navy's maritime strategy is humanitarian assistance and disaster relief. In support of Operation Unified Response Haiti, Navy Medicine answered the call. We deployed the Hospital Ship Comfort from her homeport in Baltimore within 77 hours of order—of the order and ahead of schedule.

Senator WEBB. Admiral?

Admiral ROBINSON. Yes, sir?

Senator WEBB. Just make an announcement, here.

Apparently, the Republicans are objecting to all hearings after 11:00 this morning, except for one. Senator Graham is going to try to see—

Senator GRAHAM. Yes, I would like to—

Senator WEBB.—if we can't get ours also excluded, but—

Senator GRAHAM. Yes, I want to hear what you've got to say, if I can.

Senator WEBB. How do we do this, Senator?

Senator GRAHAM. They're checking with it, now. Let's just keep going, and we'll figure out what the rules are.

Senator BEGICH. Mr. Chairman?

Senator WEBB. Yes?

Senator BEGICH. Can we—with or without it, can we just continue on and just have it as a non-hearing hearing?

Make the rules as we go, is my rule.

[Laughter.]

Senator BEGICH. Why not?

I mean these guys have come—

Senator WEBB. I suppose we could go into informal conversation, if they cancel the hearing at 11:00. I don't know what that would do to the official transcript of the hearing, or that sort of thing. But, I—what—

Senator BEGICH. I think this is an important issue.

Senator GRAHAM. I want to hear what they've got to say. But—

Senator WEBB. Okay.

Senator GRAHAM.—we'll figure out—

Senator WEBB. Let's proceed.

Senator BEGICH. I don't think you have support, bipartisan, for this effort, Mr. Chairman.

[Laughter.]

Admiral ROBINSON. Thank you very much, sir.

As you know, an integral part of Navy's maritime strategy is humanitarian assistance and disaster response. In support of Operation Unified Response Haiti, Navy Medicine answered the call. We deployed Comfort—Naval Hospital Ship Comfort within 77 hours of the order and ahead of schedule. She was on station in Port-au-Prince 5 days later. From the beginning, the operational tempo on board Comfort was high and our personnel were challenged, both professionally and personally. For many, this was a career-defining experience, and I was proud to welcome the crew home last week and congratulate them for their outstanding performance. The men and women of Comfort and all involved in this mission saved lives, alleviated suffering, and brought hope in the midst of devastation.

I'm also encouraged with our recruiting efforts within Navy Medicine, and we are starting to see the results of new incentive programs. But, while overall manning levels for both officer and enlisted personnel are relatively high, ensuring we have the proper specialty mix continues to be a challenge in both the active and Reserve components. Several wartime critical specialties, as well as advanced practice nursing and physicians' assistants are undermanned. We are also facing shortfall for general dentists, oral maxilla facial surgeons, and many of our mental health specialists, including clinical psychologists and social workers. We continue to work hard to meet this demand, but fulfilling the requirements among these specialties is expected to present a continuing challenge.

Research and development is critical to Navy Medicine's success and our ability to remain agile to meet the evolving needs of our warfighters. It is where we find solutions to our most challenging

problems and, at the same time, provide some of medicine's most significant innovations and discoveries. Research efforts targeted at wound management, including enhanced wound repair and reconstruction, as well as extremity and internal hemorrhage control and phantom limb pain in amputees, present definitive benefits. These efforts support our emerging expeditionary medical operations and aid in support of our wounded warriors.

Clearly, one of the most important priorities for leadership of all the services is the successful transition to the Walter Reed National Military Medical Center on board the campus of the National Naval Medical Center in Bethesda. We are working diligently with the lead DOD organization, Joint Task Force National Capital Region Medical, to ensure that this significant and ambitious project is executed properly and without disruption of services to our wounded warrior, our sailors, marines, and their families, and all other beneficiaries that we are privileged to serve.

In summary, I believe we are at an important crossroads for military medicine. How we respond to challenges facing us today will likely set the stage for decades to come. Commitment to our wounded warriors and their family—families must never waver, and our programs to support and hope—and our programs of support and hope must be built and sustained for the long haul. And the long haul is the rest of the century, when the young wounded warriors of today mature into aging heroes in the years to come. They will need our care and support, as will their families, for a lifetime.

On behalf of the men and women of Navy Medicine, I want to thank the committee for your tremendous support, your confidence, and your leadership. It has been my pleasure to speak before you today, and I look forward to your questions.

[The prepared statement of Admiral Robinson follows:]

Senator WEBB. Thank you very much, Admiral Robinson.

General Green, welcome.

**STATEMENT OF LT. GEN. CHARLES B. GREEN, USAF, SURGEON  
GENERAL OF THE UNITED STATES AIR FORCE**

General GREEN. Thank you, sir.

Have I got it this time? There we go.

Chairman Webb, Senator Graham, and distinguished members of the committee, it's an honor and a privilege to appear before you, representing the Air Force Medical Service.

I look forward to working with you and pledge to do all in my power to support the men and women of our Armed Forces and this great country. Thank you for your immeasurable contributions to the success of our mission.

"Trusted Care Anywhere" is our vision for 2010 and beyond. Our nearly 60,000 total-force medics contribute world-class medical capabilities to Air Force, joint, and coalition teams around the world. Seventeen hundred Air Force medics are currently deployed to 40 locations in 20 countries, delivering state-of-the-art preventive medicine, rapid life-saving care, and critical air evacuation. Since November 2001, we've air-evac'd over 70,000 patients from Afghanistan and Iraq, and have lost only four patients during evacuation.

Air Force medics are responding globally in humanitarian missions, as well as on the battlefield, and in just the last 6 months, we contributed significant support to Indonesia, Haiti, and the Chilean earthquake victims.

This is a year of firsts. The first known successful air evacuation of a patient with traumatic lung removal was done last July. The patient is doing well in Birmingham, England, today.

In January 2010, a U.S. marine sustained dislocation of both knees, with loss of blood flow to his lower legs, following an IED attack in the Helmand Province. Air Force surgeons performed definitive vascular reconstruction within hours of the injury, and the marine is now recovering in the National Naval Medical Center in Bethesda, and is expected to have fully functional limbs.

And airman shot three times in the back will not be a diabetic, despite the absence of his pancreas, because surgeons across three continents harvested and grew his pancreatic cells then implanted the cells into his liver at Walter Reed.

These success stories are possible only because of tireless efforts of Air Force, Army, Navy, and coalition medics to continuously improve our care.

At home, our healthcare teams provide patient-centered full-spectrum healthcare to our beneficiaries. We're improving patient and provider satisfaction through our Patient-Centered Medical Home by building strong partnerships between patients and their healthcare teams. Our Family Health Initiative and Surgical Care Optimization Initiatives are improving healthcare continuity, quality, access, and patient satisfaction.

Our Air Force Suicide Prevention Program, implemented in 1997, continues to be effective, but we have noted a slowly increasing rate of suicides since 2007. We are enhancing our prevention programs to further decrease suicides by targeting the most stressed by our high operations tempo. We now target more indepth interventions and training to Air Force security forces and intelligence career fields, whom we have identified as having double the incidence of suicide, compared to the rest of the Air Force.

We continue training the entire force on suicide prevention and coping skills, to improve both airmen and family resilience. We adapted new concepts rapidly, such as "Ask, Care, and Escort" and collaborative care, wherein mental health providers are now embedded in the majority of our family health clinics.

We have also studied and targeted interventions for our civilian workforce identified at high risk. Collaborative care, online help, mandatory post-deployment surveys, and family-life counselors at our Airman and Family Readiness centers, have decreased stigma and allowed those in need to get help earlier.

We're encouraged by the continued low indicators for stress in the Air Force. Alcohol abuse remains low and stable, as does illegal and prescription drug abuse. We target programs to further reduce underage drinking and enhance safety. Our numbers in domestic violence are trending downward. We continue to monitor these indicators carefully to target effective interventions.

To achieve our vision of "Trusted Care Anywhere," we require highly-trained, current, and qualified providers, and we're ex-

tremely grateful to this committee for your many efforts to strengthen our recruiting and retention programs.

The Air Force Medical Service is committed to the health and wellness of all entrusted to our care. We are, indeed, all in to meet our Nation's call, and will achieve our vision through determined, continuous improvement. We could not achieve our goals of better readiness, better health, better care, and best value for our heroes and their families without your support, and we thank you.

And I stand ready for your questions, sir.

[The prepared statement of General Green follows:]

Senator WEBB. Thank you, General Green.

Admiral Jeffries, welcome. Major General Jeffries.

**STATEMENT OF RADM RICHARD R. JEFFRIES, USN, MEDICAL OFFICER OF THE UNITED STATES MARINE CORPS**

Admiral JEFFRIES. Make sure it's on, here, sir. Yes, thank you. That's kind of you. It's not.

Chairman Webb, Senator Graham, distinguished members of the subcommittee, good morning.

I'm honored to be with you, the Senate Armed Services Personnel Subcommittee, today to discuss the state of Navy Medicine as it pertains to the health services support to the United States Marine Corps.

I want to thank the committee members for your unwavering support of Navy Medicine and the United States Marine Corps, particularly as it relates to our healthcare advances and continuum of quality care for marines and sailors. Our warriors who go into harm's way for this great Nation, their families, and those who have gone before in service to our country deserve the very best in care and support that we can provide.

Marine Medicine is all about a special bond—the one of complete trust between a marine and a doc. They know that all will be given, each for the other, when the Nation's mission calls for their total commitment and potential sacrifice to the defense of our country. Corpsmen up with life-saving skills, and yet, the potential risk of injury or death is just as real today as it was over 50 years ago.

Navy Medicine is a dedicated, fully integrated worldwide healthcare system meeting the needs of our marines and sailors, their families, retirees, and, at times, those whose fortunes are beset with a disaster. We specialize in health, prevention, and readiness, and, when called upon, casualty and humanitarian life-saving care to all we touch.

Marine Medicine lives first and foremost at the point of injury, but is founded in primary care, prevention, wellness, and resilience, skills that are the hallmark of readiness. When called upon to deploy, they are ready to provide the best in damage control, resuscitation, and stabilization, with evacuation to a higher level of care anywhere, anytime.

The numbers speak for themselves, even now, in Afghanistan. In the toughest battle, with single-digit percentages in ultimate sacrifices, astonishing mass transfusion, lives saved, and the lowest disease/nonbattle injury levels in history.

Yes, we continue to research and advance the latest in tip-of-the-spear advances in healthcare. We focus on equipment, like tour-

niquets and blood-clotting combat gauze, techniques in traumatic combat casualty care, and forward-resuscitate surgical and nonsurgical care, and the skills of embedded resilient and post-traumatic stress teams, plus early treatment protocols for mild traumatic brain injury.

Last year, the Commandant directed immediate development and fielding of the Mobil Trauma Bay, mini emergency rooms in protected vehicles from lessons learned in the field, and by the end of the year, several prototypes were already deployed to Afghanistan, where they're saving lives and mitigating injuries at the tip of the spear today.

We continue to push for solutions to some of medicine's toughest challenges. We are fully engaged partners with our "sister scissors," the VA, and civilian experts, to advance research rapidly and post-traumatic stress disorder treatment, casualty care, recovery, and rehabilitation for the return of our wounded warriors.

Collaboration with new innovative research consortia, like under the Armed Forces Institute for Regenerative Medicine, AFIRM, and early transitional enablers, like the Department of Defense's Office for Technological Transition, that can quickly navigate through our complex bureaucratic systems and policies, can and are making a difference to those in the front lines, getting the latest advancements in medicine quickly to our providers and casualties.

As we all know now, today's irregular warfare in this complex, protracted war is adversely affecting our forces in many devastating ways. Most blast injuries and horrors witnessed on the battlefield are putting astonishing stresses on our warriors—mentally, emotionally, physically, and spiritually. We are seeing severe amputations, burns, traumatic stresses and brain injuries on an unbelievable scale.

Our greatness in saving lives has a significant cost in the degree of injury and loss our warriors have suffered. Navy Marine Corps Medicine has been a leader in changing the way our military engages the mental health challenges of this war with providers embedded in front-line units under the Marine Corps Operational Stress Control and Readiness Program begun at the beginning of the war. The three Marine Expeditionary Force commanders demanded a Total Force Combat Operational Stress Control Program to combat stigma, mitigate suicides, and properly address stress. A Total Marine Corps Family Response has been initiated. Last year, Total Force trained suicide prevention with video vignettes, group discussions, identification and referral tools, took place in a new Marine Corps program involving a total team engaged leadership concept with OSCAR Extenders is being instituted.

The 1st Marine Expeditionary Force, 1MEF, ground combat units going to Afghanistan with this current surge, will have trained OSCAR Extender peer and senior mentors, besides primary care mental health embed specialists. With this patient-centered Marine and Navy Medicine team effort, stigma will be further challenged, and seeking and receiving help will become a normal part of the ever-improving marine culture. For TBI, the assistant Commandant of the Marine Corps and the current Marine Expeditionary Brigade commander in Afghanistan have led the advancement of a revolutionary concept in prevention and care. They have

a “three strikes and you’re out.” And you will stay inside the wire, if you’ve had three major concussions, until you get a—comprehensive health evaluations.

Plans have been developed for an event-driven reporting, all-involved identification, medical evaluation and recovery timeout program to enhance early identification care of TBI, protecting our warriors with care of traumatic brain injury, protecting our warriors at the front, and decreasing long-term sequelae.

1MEF Forward will also be piloting a new restoration center concept for earlier recovery, rehabilitation, and care at the forward operating bases later this year.

Many challenges remain. One concern has been the high demand on many of our healthcare provider areas. The Surgeons Generals in Health Affairs have identified shortfalls in key specialties and supporters that could adversely affect our abilities to care and support our forces. More demands will come as we improve traumatic brain injury restorative care, enhance en route casualty care, expand OSCAR Extender, add Medical Home Patient-Centered Care initiatives, and initiate other discovered advances in healthcare.

Marine Corps is working closely with Navy Medicine and Health Affairs to address current and future needs. In the end, that special bond between marine and docs propels us to do our very best for our warriors.

On behalf of the men and women of Navy Medicine working inside the United States Marine Corps, I want to thank the committee for your exceptional leadership, help, and support. We appreciate your continuing confidence in our abilities to meet mission and to show you how we continue to address and succeed in meeting the healthcare needs of our marines and sailors.

I look forward to your questions, sir.

[The prepared statement of Admiral Jeffries follows.]

Senator WEBB. Thank you very much, Admiral.

And—appreciate all of the testimony this morning.

I assume we’re going to continue.

Senator GRAHAM. Yes, Mr. Chairman. I’ll take responsibility for not informing our leadership about this hearing. [Laughter.]

So, they obviously are letting a TSA nomination go forward, and I’m sure every member of the Senate would like to continue this hearing. And if I need to, I’ll—because the rules do matter—I’ll be glad to go over to the floor, take 5 minutes, and make a UC request to continue the hearing, if that’s necessary. But, I’m very much committed to allowing you to stay here, and us, to answer questions, because there’s a lot of things hanging in the air—

Senator WEBB. Appreciate that very much.

Senator GRAHAM.—and I want to know the outcome of—

Where are folks at? What do we need to do here?

Senator WEBB. We’ll assume we’re fine, unless told otherwise.

Senator GRAHAM. Sure.

Senator WEBB. And I will start with a question, and then, I suppose, among the three of us, we can rotate through questions.

Senator GRAHAM. Sure.

Senator WEBB. I would like to get into this data that I mentioned in my opening statement, with respect to prescription drug use. And let me review what I said in my statement.

From a recent Military Times article, “One in six servicemembers is on some form of psychiatric drug.” That’s a quote. “Seventeen percent of the active Duty Force, and as much as 6 percent of deployed troops, are on anti-depressants.” That’s a quote. “The use of psychiatric medications has increased about 76 percent overall since the start of the current wars.”

Now, I have some other data here. I’m going to ask unanimous consent to put this chart into the record at this point, as well.

[The information referred to follows:]

Senator WEBB. I have data here from DOD that goes from ’01 to ’09, in terms of a breakdown of different prescription drug uses. I’m going to start with ’02, just to put this in front of the panel.

And I want to lay this out, because we all know that we’ve got to be careful with statistics. I’m not going to make a judgment based simply on these statistics. There are a number of potential answers to this. I don’t want to answer them. I want to hear the answers of the panel. And one is, in terms of these numbers in the charts, maybe there is a larger pool of people who are receiving prescriptions. I don’t know. Maybe there is a different approach that’s being used in medicine over the last 8 years, in terms of people with difficulties, or maybe this is the stress of the force. But, if you go from ’02 to ’09, barbiturate usage—or prescriptions increased from 7600 to almost 27,000; that’s three and a half times. Muscle relaxers increased from 139,000 to 312,000; that’s two and a half times. Pain relievers, from 2 million to 3.8 million, almost; that’s almost twice. Tranquilizers, from 131,000 to 517,000, which is about four times. This—on its face, it’s pretty astounding and also very troubling.

And we’ll start. Dr. Rice, I would like your thoughts on what this means.

Dr. RICE. Yes, sir. Thank you, Mr. Chairman.

First, let me echo your comment about—concern about the statistics. Most of the data here come from the Pharmacy Data Transaction Service that the TRICARE Management Activity runs. This is a claims tracking system. And up until April of 2007, the PDTS, the tracking system, did not lock the beneficiary’s status in time. So, the last time a transaction was recorded reflected whatever the servicemember’s status was at that time. So, you could have somebody who was taking an antidepressant in 2005, got another one in 2007. He—in 2005, we wouldn’t—we would not have known that he was Active Duty. So, the underlying denominator here that leads to the substantial increase that you talked about results from a problem that we had with the way we were tracking the data and not locking it down.

The second point I would make is, I think it’s important to keep in mind that the men and women of our military are drawn from the population of the United States, and the use of psychotropic medications in the Nation as a whole has increased. It’s difficult to turn on the television without getting—becoming convinced that you’re bipolar or have some other problem for which there is a drug readymade for you.

With respect to pain medications, we have placed great emphasis on dealing with pain. The Joint Commission for the Accreditation of Healthcare Organizations has had a substantial effort, in the

last several years, to make sure that we recognize pain among our patients, and that we treat it appropriately.

So, I think there are a number of factors that enter into this apparent increase in usage that we're seeing.

But, I would defer to my colleagues for their particular perspectives on this issue, as well.

Senator WEBB. When you say "apparent," you mean apparent from the data or that the data really isn't speaking correctly to reality?

Dr. RICE. No, I—there's no question that the—that there is substantial usage. What I'm referring to is that we don't know how many of the people who were getting the drug in 2005 were actually on Active Duty. So, the denominator may be a problem, since we didn't lock down their status at that time, but used the last time they were in the system to reflect what their status was at any previous time.

Senator WEBB. Are—would you say—are these numbers reflective of Active Duty use in the later years? They are not?

General, I see your shaking your head. General Schoomaker.

General SCHOOMAKER. No, sir. I think, as Dr. Rice was pointing out, until the last 2 years or so, the last entry that the soldier—in our case, soldier—would have been—say, a retiree—would have characterized everything we had in the database before that. So, it was artificially lower than the actual use in 2001. So—

Senator WEBB. Which was artificially lower?

General SCHOOMAKER. The use of drugs.

Senator WEBB. The use of drugs—

General SCHOOMAKER. If a soldier is on—

Senator WEBB.—among Active Duty—

General SCHOOMAKER. Yes, sir.

Senator WEBB.—in the data? That's what—

General SCHOOMAKER. If a soldier was on Active Duty—

Senator WEBB. Right.

General SCHOOMAKER.—in 2001, and was on ongoing sleep medicines or using a tricyclic—excuse me—an SSRI for depression or something, or for pain relief, and then retired in a retirement physical or retirement, you know, setting, in a clinical setting, got turned into a retiree, that was then used to characterize all of the record before then. So, everything attributed to his Active Duty time, or her Active Duty, time would have disappeared from the active Duty roster. So, it appeared much lower in use in 2001, 2002, 2003 than actually was being used by the active Duty.

So, one of the things that you all have discussed here that is quite startling is the very marked increase from 2001 to 2009. Well, some of that, as Dr. Rice has explained—

Senator WEBB. What is the year that this adjustment was made?

General SCHOOMAKER. 2006, 2007.

Dr. RICE. 2000—it was locked in April 2007.

Senator WEBB. April 2007?

Dr. RICE. Yes, sir.

Senator WEBB. So, you—

General SCHOOMAKER. So, we're looking at trends from 2007 and beyond as being much more accurately reflecting the trends in use. And there's no question, sir, as Dr. Rice has said, we're all con-

cerned about the amount of use of drugs and the stress on the force that this reflects. But, the increase is not quite as marked as the data would suggest there.

Senator WEBB. Okay. Well, we will come back to you on this to try to get what your view of accurate data is.

What about the comment that “one in six servicemembers is on some form of psychiatric drug?”

General SCHOOMAKER. Well, sir, I—we have three intersecting sources of data—independent, somewhat—that all corroborate roughly the same number. The Mental Health Advisory Team 6, which I think you referred to, or Senator Cardin referred to, that was conducted in 2009—through direct surveys—scientifically credible surveys of the force deployed, found that, in Iraq and Afghanistan, between 3 and 6 percent of soldiers were on a drug for a mental health or stress-related. So, between 3 and 6 percent. At about the same time, or in the last year, we’ve had the release of the DOD Health-Related Behaviors Among Active Duty Military Personnel. As I recall, that’s a triannual event that the Research Triangle Institute conducts for us. And that’s confidential and anonymous, so you get a much better, probably confidential, report on all of the services. And they report 8.6 percent being treated for depression, anxiety, or sleep. So, that’s a combined—

Senator WEBB. Of the deployed.

General SCHOOMAKER. No, sir. The total force. Total force. Deployed and nondeployed.

So, we’re looking at 3 to 6 percent of the deployed force. Eight to—roughly 8 percent of the total force.

And then, the last thing is this Pharmacy Data Transaction Service, PDTS, snapshot of the Army. We have, in February of this year—last month—done a snapshot of 550,000 Active Duty soldiers, deployed and nondeployed, and we find there a similar number of about 6 percent.

So, I’m looking at the range of between 3 and 6 percent—at most, 8 percent—of being on some sort of medication related to mental health or stress.

Now, admittedly, sleep medicines are being used in a variety of settings as an adjunct. Sleep medicines, short-term, are frequently used for problems of sleep in combat, problems—

Senator WEBB. The—

General SCHOOMAKER.—of sleep at home.

Senator WEBB. Excuse me. The data you’re talking about is Army data?

General SCHOOMAKER. Yes, sir. It’s Army data. The Mental Health Advisory Team 6—the second study I mentioned, the DOD Health Related Behaviors Among Active Duty, actually—

Senator WEBB. Right.

General SCHOOMAKER.—is all services. And the last—

Senator WEBB. The data from Military Times article, again, is one in six servicemembers. And they did say 6 percent of those deployed.

General SCHOOMAKER. Yes, sir.

Senator WEBB. That number fairly well comports—

General SCHOOMAKER. Yes, sir.

Senator WEBB.—with what you're saying. The other number seems higher.

General SCHOOMAKER. And I said, for sleep, I think that there's a broader group of people using sleep medications. Some of them are also on active drugs for stress or mental health. But, I'm—frankly, sir, I probably, myself, appeared in that database, because every time I go overseas, I take a prescription for Ambien.

Senator WEBB. Right.

General SCHOOMAKER. And I think many of us do that. So, it's a sleeper that we use transiently, and it's a prescription drug.

So, that's a little broader, but I think the implication that we've got one in six with a serious mental disorder, I think, is a reach.

Senator WEBB. I would like to express my appreciation to Senator Graham. The cloakroom is now advised that we are legal again in our hearing. [Laughter.]

We have permission to meet.

Admiral, you wanted to say something?

Admiral ROBINSON. Well, there's one more data source, and that's BHNAS, which is the Behavioral Health Needs Assessment Survey, which is very similar to the MHAT, which is Army, but this—the BHNAS is done by Navy Medicine. And the numbers that General Schoomaker gives are approximately correct, in terms of—we were looking at 2010—we're talking about men and women in theater—so, this is in the combat zone—with a 3.2-percent mental health psychotropic medication usage, and probably about a 20-percent—22 percent, actually—of sleeping medication. So, I think that is sort of corroborates, at different points, to be about that. And that's all that I wanted to add.

Senator WEBB. Okay. We will work with you to see if we can't scrub this data. I think it's an extremely troubling—

Admiral ROBINSON. The—

Senator WEBB.—piece of information here.

Admiral ROBINSON. The other point, which is—which is a little—which is off the data, but it's to the point, I think. It's not about the data. In the attempt, at least in the last 3 years, as my tenure as Surgeon General of the Navy, to decrease stigma—we've made a huge drive throughout the military—Navy, Army, Marine Corps—we've done it independently, but we've been together. But, we've tried to increase, in the Navy, Marine Corps, as an example—and I think the Army has done this, too, to a degree—to increase mental health professionals forward deployed—and the Air Force has done this, also—but, we're trying to—forward-deployed mental health experts—psychologists, psychiatrists, social workers, psychiatric nurses—those people and also our medics and corpsmen, who—and our primary care providers—who can, in fact, intervene in mental illnesses and emotional distress amongst our troops, no matter where they may be.

In concert with that is also the utilization of psychotropic medication. But, my point is simply that we're really making a huge desire and a huge effort to destigmatize mental health issues and their treatment and stop—and taking it out of the closet or suppressing it so that it's not coming to light, and bringing it to light, so that we can get effective treatments. I'm not suggesting—

Senator WEBB. Well, said. And in that respect, it probably goes back to one of the possibilities that I was raising here, and that is that this is an indicator of the long-term stress of the force and also different medical practices, or more open medical practices.

Admiral ROBINSON. I think that there is stress on the force. But, I also think that there is an acknowledgment by medical professionals—by medicine and the services that mental illnesses exist and have to be treated. And we have, for a long time, as a society—

Senator WEBB. I agree. That's the second point that I was making, in terms of—

Admiral ROBINSON. Yes.

Senator WEBB.—medical practice. So, I don't want to dominate all the time here.

Admiral ROBINSON. Yes, sir.

Senator WEBB. And I appreciate your answers.

And, Senator Graham, do you want to—

Senator GRAHAM. Well, thank you, Mr. Chairman.

I think the numbers you brought up are very important, because I think most Americans want to make sure that our men and women are functioning as well as possible and getting the help they need. I know we have a shortage of mental health professionals in the military, and we're trying to address that.

But, it goes back to this—I mean, being away from your home in a combat arena is a stressful environment that—if you're not depressed at some times, you're not normal. I mean, it's just a depressing situation to have to be away from your home.

But, what Senator Webb indicates is very important. We want to make sure that, you know, we're tracking the health of the force. So, if each service could provide us a breakdown of the percentage of the force, in theater and outside the theater, that's on psychotropic drugs, and break that out, versus sleep aids, because—I'm supposed to do my Reserve duty next week, overseas, and I've already ordered some Ambien. So, I feel guilty already. I'm spiking up the numbers.

Senator WEBB. Messing up the database. [Laughter.]

Yes. The database.

I just literally ordered it from the Navy physician, so—

Senator WEBB. Well, actually, if I may. If we're going to get a breakdown of this, perhaps you could clean up the timeline for us.

Senator GRAHAM. That's a great idea. What are the real numbers?—so we can judge apples to apples, and—because this is anecdotal evidence, quite frankly, of what Senator Webb's been concerned about a long time. We've got to make sure, you know, that we're not wearing these folks out beyond their ability to respond to the Nation's call. And, at the same time, you do have this counter-competing idea that we want to make sure that every member of the military gets the treatment they need. And there's nothing wrong with going to the mental health professionals in your unit, or the doctor or the surgeon, and saying, "Hey, Doc, you know, I need a little help here. I've had a bad experience. Help me through it." That is exactly what we want to have happen. So, having that concept validated, that it's okay to do this, but, at the same time, understand how widespread these problems are, I think, will help us make some intelligent decisions.

And if each service could give us a breakdown in your service, that would be much appreciated.

[The information referred to follows:]

Senator GRAHAM. Now, about sustainability, I know we don't have all the teams in place yet, but as we look at the budget over time, the healthcare portion of the Department of Defense budget is growing exponentially. In 2007, I had a meeting with some associations representing the retired community in different branches of the service, as well as people who manage TRICARE. And we came up with a list—oh, a dozen more things that we could do to make the system more efficient. Is anybody aware of that meeting? Is there any effort to implement those ideas? And where do we stand with the concept, before we ask more money from retirees, in terms of premiums increases? What have we done to make the system more efficient?

Dr. RICE. Sir, we constantly strive to find efficiencies in the system. The challenges are, as I mentioned, with respect to the use of psychotropic drugs, we exist in a system in the larger national healthcare context. And I know you're—you've been having some conversations about that issue recently, so you know what's happening on the National scene. I think it was a few years ago that Stewart Altman appeared before your committee and said that if present trends continued, healthcare costs as a fraction of the National economy would continue to grow, but he was pretty sure they could not exceed 100 percent of GDP.

So, the—we have more people in the force. We have more beneficiaries. We have more people who have been added to the beneficiary list. And 70 percent of the costs are incurred outside the direct care system, where we have less direct ability to control—

Senator GRAHAM. Well, we haven't had a premium increase in TRICARE since, what, 19—

Admiral HUNTER. 1995.

Dr. RICE. 1995. Right.

Senator GRAHAM. Well, you know, I want to be generous and fair to all those who serve, but there's a cost-containment problem within DOD's budget. Before we ask for premium increases, I think we need to try to make sure that we're telling the force, "We've done everything we can within reason to make it more efficient and to lower the cost, through efficiency, best practices, preventive healthcare."

But, Mr. Chairman, I don't see how we can sustain this forever, where TRICARE is never subject to adjustment, in terms of the premiums to be paid. If we're going to do that, we're going to have to come up with a lot more money for the Department of Defense, because it's going to eat away at readiness and the other things you need to run the military.

What's your view of that, Admiral Hunter and Dr. Rice? What do we do, long term?

Dr. RICE. Well, I think there are a number of things that—of efforts that we can take to try to reduce—General Schoomaker talked about unwanted variation, and that is seen to be a major driver of the increase in healthcare costs. I think we have to focus on that. We have to focus on improving the quality of care. There's no question that better quality care is less—tends to be less expen-

sive care. So, focusing on things like patient safety, I think, is an important dimension.

We think that the full deployment and wide utilization of the Electronic Health Record will be a—an important aid to us in developing that capability. A number of steps we can take.

The—it is—your comment about the TRICARE premium is exactly right; there has not been one since 1995, while the cost of healthcare insurance in the rest of the world has continued to rise. Be happy to work with you on that.

Let me ask Admiral Hunter if she has anything to add to that.

Admiral HUNTER. Yes, Senator, let me add a little bit, in terms of what we're doing internally.

I appreciate all the comments about variation. And we've looked very carefully, for example, at technology variation and our use of technology throughout military medicine, both in direct care and private-sector care, so that it's appropriately applied. And I talked earlier about preventive measures.

Also like to talk a little bit about utilization of care. So, in the last several years, we've seen a dramatic rise in our patients using the emergency room or emergency department as a site of care. And initially, we were concerned that that meant that they didn't have access to care, that they couldn't reach their primary care provider or perhaps they didn't have one assigned. But, as we looked at the data more carefully, we see that the graph is going up in exactly the same way for people who are enrolled to private sector—have a stable primary care relationship, where the provider isn't deploying or those sorts of things, as it is in our direct care systems.

So, to address that, we've looked at all of the different quadrants of our Aims under that—Quadruple Aim that I talked about. First of all, Have we maximized the relationship between provider and patient? And all of the Surgeons talked about the Medical Home. Second of all, Have we made resources available to patients so that they know where else they can go if it's after hours? Do we reach out? Do you have the right refrigerator magnet, you know, or information that says, "This is the urgent care"? How do we help them get to that relationship?

And our contractors are working with us. Many have even added what we call "convenience clinics," the types of clinics that are in drug stores and things like that, to some of their networks so that we are working to add more and more convenient, but lower-cost, after-hours settings of care that would be appropriate for the earache, the respiratory infection, the sore throat, the backache that really doesn't require an emergency room.

So, working with all our partners to get to that effective Medical Home, and then measuring and holding accountable for continuity on our side, is important.

In our contracting area, if I may shift, working hard on the business processes. And General Schoomaker also talked about administrative variation. So, the business processes that bring our processes of care—our back office—to be as efficient as it can: electronic funds transfer, not manual processes, automating, you know, payments and claims and all of those things to the greatest extent possible, so that the administrative dollars on the contracts are mini-

mized. And bringing multiple contracts together into single ones. So, overseas we've just combined six contracts into one, where we'll be getting streamlined services. That's better for our patients—they deal with one overseas contractor—and better for us, because we get a better deal.

And then the last thing I'd point out is fraud prevention. So, we know that, in all major programs, we need to be vigilant for others that may take advantage of the system, and how that might happen. So, we have a program integrity group that works carefully with our contractors, with others in the Federal Government—DOJ, CMS—and also with private providers to look for trends in claims that may suggest behavior that we need to more fully investigate.

In addition, our explanations of benefits that are mailed to patients each time they have a health encounter. We just started mailing them, even with pharmacy encounters. And patients are great policemen on behalf of the services—the service. They call us and say—you know, just like a credit card bill—“There's something on my EOB”—

Senator GRAHAM. That's good. That's very good.

Admiral HUNTER.—“that I didn't get”—

Senator GRAHAM. Yes. No, I—

Admiral HUNTER.—“and can you look at it?”

Senator GRAHAM. Yes, that—I think that is a terrific idea, because all of us, now, are worried about the cost to the country and to—beyond ourselves, which is good, because we all bear these costs.

Senator GRAHAM. Mr. Chairman, I don't have any more questions. I'll make one right—one brief comment to the Surgeon Generals and those under your command.

I think one of the unsung heroes of this war are the medical personnel on the front lines. As Senator Webb said, “the golden hour.” There are people surviving attacks in this war that would never have survived in any other war. I am just amazed and just astonished at what's been able to be done in theater and at Landstuhl and other places.

There was a young man—who is a marine, Mr. Chairman—who lost both legs. He's had 60-something surgeries. He is now at Harvard Law School. He just was medically discharged from the Marine Corps, I think, last year. He was a fellow with me in my office. And I think he's a testament of what people under your command have done for those who put themselves in harm way—harm's way. And I just want to thank you all for your service.

Senator WEBB. Thank you very much, Senator Graham.

And also, again, I appreciate your having gone down to make—allow it—this to be able to continue our hearing, here.

Senator GRAHAM. It's very important.

Senator WEBB. Senator Begich.

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

And I have a couple followup comments and questions, if I can. First, with regards to painkillers and pain management and so forth, once a patient wants to try to get off of those painkillers, what's the—what is the services you have available for them? Because I do hear complaints that they don't think they're adequate,

or where they have to go to get—if they’ve become addicted to the painkillers. Can you—could someone elaborate on that?

General SCHOOMAKER. Yes. Maybe I could take that one, if you don’t mind.

Senator BEGICH. Sure.

General SCHOOMAKER. Sir, I would say that this—to follow on a lot of what we’ve been saying up here—one of the very—one of the nonstandard areas of care right now is in pain management.

Senator BEGICH. Right.

General SCHOOMAKER. This is not a problem just for the military, it’s a problem across the Nation.

I stood up a task force last year, a Pain Management Task Force, to look at practices across the Army, and, frankly, the VA has been very active in helping with this. The other services have joined, as well as support from TRICARE Management Agency on this. I got the latest in-progress review this week. It’s going very well, and I expect the formal report to be out in the next 2 weeks.

I’m trained as an internist and a hematologist, and I can tell you that caring for acute pain and chronic pain is a problem across the country, in terms of how we standardize it, how we transition from one phase to the other. And we’re looking at this in a very holistic way, so that we’re employing all of the tools that we have available.

Specifically within the Warrior Transition Units of the Army, we have a very good, comprehensive program which is increasingly more seamless between the inpatient to the outpatient and then to life beyond, even being within the medical system, and it addresses the issues that you’re talking about.

Senator BEGICH. The—if I can make sure I understand what you’re saying, there. Not only is it managing the—the pain management program, but it’s when they get addicted on these painkillers and they want to get clean. What do you do for them? And I understand you’re working through it. It’s a new—but, what are the services that are available that they can tap into to move from being addicted to the painkillers?

General SCHOOMAKER. All the services have substance abuse programs for those who get addicted to addicting narcotics and the like. Quite honestly, sir, I—the—most of the problems with addictions to narcotics—and I’ll go out on a limb on this—are attributed to social uses, rather than those associated with painkillers for surgical pain and the like.

Senator BEGICH. I guess I would ask you—we don’t have to debate this much further—I would ask you to provide me, if you can at some point, some of the data that shows that, because what I’m starting to hear from is individuals who, you know, experienced an incident during their deployment, have then been prescribed painkillers and may they misuse them or excessive use, now are addicted to them. So, I just want to know—understand that, as you’re trying to develop pain management, another step to this.

General SCHOOMAKER. Yes, sir.

Senator BEGICH. And the step is, you know, some of these are very strong prescription drugs that turn into addictive drugs. So, that’s what—I want to get a better understanding of how you come to that conclusion so we are not missing that boat. In other words,

may they no longer be in the DOD system because they've exited out or whatever, but yet, they're addicted, that our relationship with them has to continue in some way to make sure we clean them. So, that's what I want to understand.

General SCHOOMAKER. Yes, sir. And my comments, quite frankly, are driven by the fear that everybody who prescribes pain medicines, and every patient who receives them, especially for surgical pain—

Senator BEGICH. Right.

General SCHOOMAKER.—and for short-term uses is concerned about addiction. And we don't want to do anything that drives people into having pain and avoiding what's appropriate treatment.

Senator BEGICH. Excellent.

One thing I'll mention. I'm going to go to a very Alaskan item here. But, you were talking about the emergency room increases.

Admiral HUNTER. Yes, Senator.

Senator BEGICH. And, Admiral, thank you for—I wasn't here at the beginning, but I know you mentioned Alaska, and I appreciate that.

There's a really interesting program that Indian Health Services does within Alaska called the "Nuka model"—N-U-K-A. They saw the exact same thing that you were describing. Huge—not huge—well, pretty huge—significant increases in emergency room care, even though they had clinics—

Admiral HUNTER. Yes.

Senator BEGICH.—all around and available in the villages and so forth. But, they were seeing spikes in emergency care.

They created a demonstration project under Indian Health Services, and it's managed by South Central Foundation. They have reduced their emergency care access by 68 percent in the last 2 and a half, 3 years. And many other things. And they have developed a model that—I mean, when you were describing the situation you were laying out, it was very similar to what they had described about 5, 10 years ago, that they were experiencing—and they couldn't understand why, when they were building these clinics in their facilities—but they went through a whole process, and they saw a huge decrease in the last 3 or 4—2 or 3 years, I'd say, at least, maybe longer, on emergency entries, which, of course, is a huge savings, when you don't have to deal with—

General SCHOOMAKER. Yes, sir, we're—

Senator BEGICH.—that process.

General SCHOOMAKER.—seeing this. As we stand up the Patient-Centered, Family-Centered Medical Home concept across the services—all of my clinic and hospital commanders track emergency use—emergency room use, and in those places, like Fort Benning, where these are standing up—Fort Polk—we see emergency room use drop.

Senator BEGICH. That's great.

General SCHOOMAKER. It's a chaotic, episodic kind of care that people are tapped into.

Senator BEGICH. Right. Emergency care is expensive and, you know, last thing you want.

General SCHOOMAKER. Yes, sir.

Senator BEGICH. Doctor, did you have a comment?

Dr. RICE. Yes, Senator. One of the things that I think we hold out a lot of hope for is—with our Electronic Health Record—is providing patients access to their own record online. The experience of several healthcare systems has been that, as patients are able to go online, find out for themselves particular aspects that might influence their care, or get answers to questions, their use of the emergency room and their seeking appointments with their physicians drops off dramatically.

Senator BEGICH. Very good.

Mr. Chairman, I just have two quick, final comments, one for Dr. Rice or Admiral Hunter. Again, thank you for mentioning Alaska. I know we've had a conversation about this.

Admiral HUNTER. Yes, Senator.

Senator BEGICH. As you know, in the Healthcare Insurance Reform bill, we—the President signed yesterday—we have within there a task force, as we've already kind of started the process of trying to deal with healthcare costs in Alaska. It's—now sets it up formally. And I just want to see if you have any comment for the record, while we're here, on the idea of the task force and how you see that moving forward.

Admiral HUNTER. Thank you, Senator. We absolutely appreciate your leadership in this area and bringing all the parties together. As you know, our TRICARE Regional West director, Admiral Niemyer, was up in Alaska recently and visibly engaged and actively engaged all of the Federal health partners in coming together around trying to stabilize the rate schedule.

In addition, we're working to improve what we call the "back offices of care" to make it easier for us to manage the relationships with providers and to bring providers on board for TRICARE. And you will see some changes to the TRICARE manual soon that reflect that change. So, we appreciate the opportunity to work with you and your staff in that endeavor.

Senator BEGICH. Excellent.

And then, the last question. I appreciate—you actually kind of mentioned it, and that was on the whole issue of the reimbursement rate. And we have a differential up there—

Admiral HUNTER. Yes.

Senator BEGICH.—because of some of the high costs and capacity for certain specialties and so forth. Do you have any additional further comment you want to make on that? How that's—I know we're anxious to make that more permanent. I know you're going through a process right now.

Admiral HUNTER. Yes.

Senator BEGICH. Can you elaborate a bit on that, at this point?

Admiral HUNTER. Yes, Senator. So, as you know, but for the other members, we have a demonstration project in progress that allows us to pay a little bit more than the standard TRICARE rates up in Alaska, because of the difficulty in obtaining care. Primary care is obtained in the military medical treatment facilities, and specialty care goes out. And for some specialties, it—there is truly a provider shortage, and it's difficult to get all the care that we need. Air Force has partnered with us, particularly Chief of Staff of the Air Force—an interest item for him—and Army—also Coast Guard—in looking at these issues for, What do we need and where

do we need it? So, what we did for an interim, we extended the demonstration project, and then we put in what we call locality-based waivers for certain specialties, where we had to go even higher—orthopedics, ENT, rheumatology, where some of the specialties for which we have location-specific waivers.

And with the other Federal partners, we're looking long-term solution to move to a Federal rate schedule, so that we don't compete with one another. And we hope to at least have some interim progress on that this summer, so that we don't have to—we see extending the demo as, perhaps, a concern that we aren't committed. So—

Senator BEGICH. Right.

Admiral HUNTER.—I—we want to move forward very deliberately in this area.

Thank you.

Senator BEGICH. Thank you very much.

Mr. Chairman, thank you very much.

Senator WEBB. Thank you Senator Begich.

Senator McCaskill.

Senator MCCASKILL. Thank you, Mr. Chairman.

I had to rush down here, because I—the rumor's all over the Hill that Webb and Graham have gone rogue. And—

[Laughter.]

Senator WEBB. We're getting it done.

Senator GRAHAM. We're getting it done, Yes.

Senator MCCASKILL. Getting it done.

I—in fact, if I'd known that this could have happened—I had a hearing this afternoon on Afghanistan police training contracting in my Contracting Subcommittee—I would have asked you guys to come out with me at 2:30 so we could have gotten that hearing done.

Senator WEBB. Senator Graham—

Senator MCCASKILL. I was sad—

Senator WEBB.—has certain connections.

Senator MCCASKILL. Yes. I don't get it. I would have loved to have that hearing this afternoon. I'm trying to figure out what the point is of not being able to have a hearing this afternoon.

But, I admire you all for forging ahead, in spite of what the rules say. And I think it's great we're talking about this. I think you all know that there are many things that I'm very concerned about in this particular portfolio.

Let me start with stigma about getting help, and how that stigma is such a particular problem because of the training and the peer—appropriate peer pressure that makes our military so successful.

I know that we're doing a confidentiality study at Fort Leonard Wood, on the heels of a scandal there, where we had some problems with the substance abuse program. And, General Schoomaker, I'd like to know, do you have anything you can tell this committee today about the pilot program to look at a program where soldiers can come forward, say, "I need help," without it getting reported up the chain?

General SCHOOMAKER. Yes, ma'am. We identified, some time ago, that the soldiers would tell us, confidentially, that they had prob-

lems, say, with alcohol, and yet, would not be formally referred, because there was an automatic notification of their commanders. So, we started a pilot program in Hawaii and Alaska, in Fort Lewis. And, I know, ma'am, that you're aware of this in Fort Leonard Wood. Many other camps, posting stations, have signed on to the desire to have the program generalized. What we're finding—we call this the Confidential Alcohol Treatment and Education Program—what we find is, a very much larger group of soldiers is now coming forward and getting treatment at an earlier stage, before the misconduct has been performed, before there's family violence, before they have a DUI or some other problem. And the other thing that's very, very encouraging is that we're getting a spectrum of older soldiers, NCOs, and officers that are coming forward.

The interesting part of that is that—and we expected that this would happen—is that a part of any treatment of an alcohol or drug problem, but certainly alcohol, is that it's a chronic-disease model. You're going to have this as a problem for life. And if you're really going to beat this, it's because you get your support system, to include your chain of command, involved in how to stay out of trouble. So that a large number of soldiers, even after they enter confidentially, come back later and inform their chain of command and say, "Look, I've had the treatment. I've been informed. I've been counseled. And I know that I'm going to have to get more people involved in keeping me sober." So, it—so far, it's been very successful. We've got great support from the rest of the Army and the Army leadership to generalize this across the force.

Senator MCCASKILL. Well, I know that the report's due in September, and I'll be looking forward to seeing what the—what's put on paper, because then I think it's a situation—we can look at all the branches—

General SCHOOMAKER. Yes, ma'am.

Senator McCaskill:—and talk about confidentiality and stigma and how we can work around the culture of the military to get us to a point that folks can get help, because many, many times, if they feel like it's going to impact their career, they wait until it's too late, and it really impacts their career. And I think those are men and women that we can't afford to lose in the service of our country.

Let's talk a little bit about counselors. Does anybody have a number of how many counselors we're short right now, in terms of substance abuse counselors? I know this is a—speaking of chronic—this is a chronic problem, having the right number of counselors available.

General SCHOOMAKER. We have the exact numbers. What we're trying to do is keep abreast of the demand. Programs like the KTAP program, the—

Senator MCCASKILL. Right.

General SCHOOMAKER.—the confidential—is generating more need. So, the attempt is to—we've reengineered the Alcohol and Substance Abuse Program so that it's horizontally integrated from the assessment, education—

Senator MCCASKILL. That's good.

General SCHOOMAKER.—targeted at an early intervention to full treatment. In doing that, we're beginning to see what the bow wave

is, and anticipate that. The hire—we're doing, centrally, hiring of counselors. But, I can tell you, ma'am, just as in behavioral health in general, across the Army, we remain with shortages, because it's very hard, in some locations, to find counsels. It's not a money issue. It's not a problem of bureaucracy. It's a problem, quite frankly, of finding—in a Nation which is already strained for having an appropriate number of trained counselors, it's finding people willing to go to some of our locations.

Senator MCCASKILL. Have—has there been any thought given to some kind of pilot program to internalize this function without contractors, to have military people get the substance abuse training, so that it's peer-to-peer, as opposed to an outside contractor that you're going to and talking to about your substance abuse issues?

General SCHOOMAKER. Well, ma'am, I think part of the program of horizontal integration is to start employing peer-to-peer counselors and even groups like former NCOs who want to come in and participate in this, well before the need for formal counseling for treatment. If we can do targeted intervention and education early on, the intent is to obviate the need to have people fall of the cliff before they're approached.

Senator MCCASKILL. Let me talk a little bit about a specific drug, OxyContin. This is a highly addictive drug. In fact, it is not uncommon in many places in the country right now. The street value of OxyContin exceeds heroine. And—I mean, let me just say that again. The street value of OxyContin exceeds heroine. As high as \$80 a pill, on the street. This has really become a drug of choice that is huge problem in this Nation. And I listened to some of the testimony before I got here, and I want to make sure that everyone is aware that this is a growth industry right now, in terms of pain meds. And it is something that—in fact, too late—we're beginning to get a handle on the addictive nature of this drug.

Can you tell me, General, or can any of you tell me—I know that there was some diminishing of the data because of sleeping pills, but I've got to tell you, if you guys aren't on top of this, I—

General SCHOOMAKER. Yes, ma'am.

Senator McCaskill:—guarantee you, if you plot a graph of how much OxyContin is being prescribed, if you all had that number right now, I think it would scare the bejesus out of you.

General SCHOOMAKER. Yes, ma'am. We do track that pretty closely.

Senator MCCASKILL. And what is it, in the Army?

General SCHOOMAKER. I can give you—I can take it for the record and give you the numbers. But, OxyContin is—OxyContin's been with us for almost 100 years. It's a derivative of—

Senator MCCASKILL. Morphine.

General SCHOOMAKER.—many of the drugs that are related to one another—morphine, codeine, heroin, methadone. These are all related to one another, cross-react with one another, have variations in their absorption or how they're administered and how long they last.

OxyContin is a component of a long-acting—or is a long-acting form of Oxycodone that is mixed in other formulations with nonsteroidal anti-inflammatories, like acetaminophen or Motrin or Ibuprofen. So, we use the components of that in many, many dif-

ferent applications for pain management. But, as I said earlier, I think one of our problems here is that prescription drugs have become increasingly used in social environments for recreational use, and have resulted in addictions that are related to morphine and heroin addictions. We're tracking them very closely in the Army, especially in that population of wounded, ill, and injured soldiers that—for whom we know there's a very high use. We have sole provider programs. That is, a single provider prescribes all psychotropic and potentially addictive drugs, and watches and tracks those. And those go on in our hospitals and clinics for other non-wounded, ill, and injured soldiers, where there is high use of pain medicine.

And, frankly, ma'am, I go back to what I said earlier about our Pain Management Task Force. That's one of the reasons we stood it up, is we need a far more holistic and even nonpharmacologic approach to pain management.

Senator MCCASKILL. Thank you very much.

I know I'm out of time.

I would like to put one question on the record, though, about a young man, Lance Corporal Lopez, from Missouri, who had a severe adverse reaction to a vaccine when he was deployed, and he was not allowed the one-time benefit on the Traumatic Service Member group life insurance policy, even though he was in a coma and, you know, in a wheelchair for a while and has ongoing problems. And, for the record, I want to put it in and get your all's reaction as to whether or not that should be a loophole in that coverage.

[The information referred to follows:]

Senator MCCASKILL. It seems to me that that is—his injury has been as traumatic as any battlefield injury, and it doesn't seem fair to me that he is not—that he's denied that benefit because it's an adverse reaction to a vaccine that he had to take for deployment, as opposed to an injury on the battlefield.

General SCHOOMAKER. Is that a soldier, ma'am? This was a soldier?

Senator MCCASKILL. Yes. It was a marine.

Thanks.

Senator WEBB. Thank you, Senator McCaskill.

I have two semi-technical questions, here, I want to ask.

And then, Senator Begich, did you want another round? Are you—

Senator BEGICH. No, I'm good. I was—

Senator WEBB. Okay.

First is—I've been trying to follow—and I think, Dr. Rice, I'd like to ask you to start on the answer—I've been trying to follow this evaluation—ongoing evaluation of the disability evaluation system—the pilot program that's in place. And I'm very familiar with the two different disability systems, having worked as counsel on the Veterans Committee years ago, where traditionally DOD would be rating people based on, (a) whether they were fit for duty in a DOD environment, and then giving a percentage of disability as of the moment they left the military. And VA was sort of known as lifetime reevaluation. Whatever disability you incurred on Active

Duty could be aggravated, and your VA percentage actually could go up over the rest of your life.

They're basically two totally different concepts, and the compensation amounts pretty much reflected that. And now we have been exploring ways, since the Dole Commission, to see if we can merge the process. And could you bring us up to date on how that's working?

Dr. RICE. Well, Senator, the—this issue has been a challenge. And, as you know, it has—it's been a challenge since the early 1950s. It's been the subject of a number of panels and congressional hearings. The challenges that you mention are—that's exactly right, the—we have the Medical Evaluation Board, which determines whether or not somebody can continue on Active Duty, and then the VA has its own separate process.

In all candor, it—from my vantage point at the Uniformed Services University, I didn't deal with that issue on a day-to-day basis, and I'm just beginning to get up to speed. Perhaps I can ask one of my colleagues—

Senator WEBB. Okay.

Dr. RICE.—who could—General Schoomaker, I expect, is a lot more conversant with it than am I.

Senator WEBB. And if there are other—who would like to—

General SCHOOMAKER. Sir, I—

Senator WEBB.—be in that, as well.

General SCHOOMAKER.—I feel very strongly about this topic, because, of course, this surfaced with the problems that we had at Walter Reed in—roughly 3 years ago this month.

We have a highly adversarial, highly bureaucratized program in which two systems are trying to intersect with one another—the DOD system that determines fitness and then begins an adjudication process of disability—and it's—and I focus on disability—physical disability—for the single unfitting—most unfitting condition, and then hands it off to the VA, who adjudicates, based upon a whole-person concept, what problems that soldier, sailor, airman, marine may have. And the fact remains that there are major benefits derivative from certain thresholds, like 30 percent, where you accrue, for yourself and family, TRICARE benefits. And the system, in 3 years, in my view, although we've tried in every way we can to streamline the bureaucracy and to improve the handoff of the VA, continues to be problematic. We've made—we're tweaking the edges. And I think Admiral Robinson has used, you know, language to that effect. We're nibbling at the edges of a system and a process which is inherently and intrinsically antiquated and adversarial.

And so, I say to my soldiers, it's one of the tragedies that the very people who saved you on the battlefield, that evacuated you successfully back through two or three continents, across 8,000 miles, toward the end of your processing, becomes your enemy. And the same people that you looked to, to get you recovered and rehabilitated, now you look upon as not supporting your successful transition into private life. And it needs to be fundamentally changed.

And we need to focus on ability. We need a system that focuses on ability, that's aspirational in its focus, much like our most suc-

cessfully transitioning soldiers, soldiers who have—amputees, much as has already been discussed here, sir. Some of our most—

Senator WEBB. We also need to—

General SCHOOMAKER.—severely injured soldiers—

Senator WEBB.—to focus on properly compensating people who incur lifetime—

General SCHOOMAKER. Absolutely.

Senator WEBB.—difficulties, as a result of their military service.

That's how the—

General SCHOOMAKER. Absolutely.

Senator WEBB.—the whole compensation system began. At one time in our history, if someone were to—just say, to suffer an amputation on a battlefield, have to introduce a private bill in the Congress in order to get relief from the government. And nobody could sue—either that or you would want to sue—you can't sue the government for your disability, so we put this system into place. And, you know, the intention, I think, was to try to make people whole as—in as much—

General SCHOOMAKER. But, sir—

Senator WEBB.—as you can.

General SCHOOMAKER. I think that—to go back to what Dr. Rice said, this was a system that developed during an industrial economy, that focused on physical disability. And in an Information Age economy, we need a far different and better system that allows the services to adjudicate—or to decide upon unfitness, and an adjudication of disability and compensation, but also assesses ability and gives people the tools and the bridging support—

Senator WEBB. But, also—I've heard that argument. I heard it when the Dole-Shalala Commission came in, and I—you know, from my perspective, it's more akin to compensation from a tort claim or an injury, rather than fitting someone to a particular profession in an industrialized economy, other than the military profession. And each service has been very different, over the years, in terms of how they've evaluated people when they left.

I used an example, 3 years ago, when you were testifying, of the two brothers, both of whom are good friends of mine in the Marine Corps, both of whom were badly wounded and returned to Active Duty. One had his patella blown off and had a really bad back injury. Went back to Vietnam and did a tour. He—these are the famous McKay brothers, if anyone is looking for historical documentation that. Jim McKay finished his enlistment and said, "All right, I'm ready to get my disability and go on with my life." And the Marine Corps said, "No, you return to duty. Your disability is zero." And he went across the street to the VA, and I think he got 60 percent.

And John McKay who—classmate of mine in the Naval Academy—got his eyeshot out and broke a piece of the bone up here, so he couldn't even wear an artificial eye, stayed on Active Duty for 26 years, retired as a colonel, and the Marine Corps said, "You're zero disability." He had the anatomical loss of an eye, busted sinus, busted jaw where the bullet went through, and they gave him a zero. I went and testified at his appeal hearing, saying it should have—you know, and the Marine—the VA immediately gave him 90 percent, probably more. But, that's—when you say "an adver-

serial system,” those are two pretty good examples of people who just wanted to give more and the injuries, the wounds that they suffered, even though they were able to do their job, related more to, I think, tort law—how we’ve formalized tort law through statute. That’s really what the disability system is supposed to be.

But, Admiral, I’d like to hear from you. And we’re going to wrap this up fairly soon here.

Admiral ROBINSON. Well, just one addition, and I’m not sure it’s going to be that helpful, but I think that what you and General Schoomaker are talking about is correct. I think, also, that there is—and, by the way, I’m not a lawyer, so the tort part, I’ll have to ask exactly how that—how you’re working that.

DVA: systematic rehabilitative care, generally. DOD: acute care, generally. What’s happened is, that’s been—that’s intermixing now. So, how we’ve done business in the past is not what we’re doing today. So, men and women who are injured today, who would normally never be kept in the service, because you wouldn’t stay in the service with an amputation or with all sorts of different things, are being kept in the service now. Men and women who are amputees, as an example, who would normally have moved to the VA system, but now we have, led by Army, a huge, major, and an excellent amputation program. But, that’s usually—again, that’s a systematic rehab type of condition.

So, you have DOD, and then you have DVA that’s funded for the systematic rehab. And we need to try to blend those two together. And I think a great deal of what we’re doing in the disability evaluation system is the two mammoth organizations that are coming to grips with, Who’s going to fund this now? How is this going to get done? Has to be done, and it has to be done correctly, because the men and women who we’re taking care of are—I’m not thinking of 2010 and ’11, I’m thinking of 2022 and ’25—need to know how they’re going to continue that amputation care, whatever care that they need to have, and how they can actually get their lives back online.

Senator WEBB. Well, I also—I’m really concerned that this whole process is bogged down, and we’ve got people waiting around. You know, we’ve got people waiting around to get evaluated as the pilot programs move forward. I’ve heard a number of stories from the Wounded Warrior Program down at Camp Lejeune, for instance, with, you know, people—marines getting frustrated because they’re waiting to have their cases adjudicated, and then getting in trouble because they’re going stir-crazy down there, et cetera. So, we need to somehow come to a conclusion on this.

Senator Graham, would you—

Senator GRAHAM. Well, I—just along those lines, I mean, you know, you’ve got two systems that have never been melded together before, and we need to do that, and you’re well on your way to doing it. You know, you’ve got—you know, again, you’ve got competing interests. A lot of wounded warriors want to stay in. So, their first goal at that hearing is to convince the military, “Hey, keep me on Active Duty.” And sometimes that doesn’t work out. And then you have to evaluate, Well, how much disability did the person have?

The other problem we have is that, when people are discharged from DOD to the VA, we've got to make that as seamless as possible, and that's why this—what Senator Webb's talking about, having a joint board, where everybody sits at the same time and the same place to evaluate these disabilities without having redundancy, is great.

But, here's just a problem. When you're discharged to rural South Carolina with a major injury, healthcare services are going to be limited. And how we connect people in rural America to these services is a challenge for the country. And I know your heart's right, but, you know, there's just—these are just logistical obstacles that have to be overcome, because when you go into a military treatment facility for amputation, like Walter Reed—I know you've been out there. It's amazing what you all are doing out there to get these folks back up and, you know, prosthetics and traumatic brain injury. So, you get world-class care, then you may be sent to some rural place in South Carolina, where there's just not capacity. And we're trying to connect people up to the best provider possible, with the least amount of logistical problems.

And another problem that we've looked at, Mr. Chairman, is, that spouse, their life changes dramatically. Their hopes and dreams basically take a back seat to this traumatic injury. Not just the spouse, but the entire family. So, I want to keep pushing to create a reimbursement system that we're honoring that spouse's service by having a reimbursement system to pay them, quite frankly, because they don't have the ability to go back to school, some amount of money that would otherwise go to some professional service to help that family, who are the primary care providers in the emotional front, particularly.

So, I look forward to working with you, Mr. Chairman, to get this process moving. People are waiting way too long. But, the sad news is, there are just a lot of people affected by this war, and we were overwhelmed a few years ago; that's what happened at Walter Reed. We just didn't have the capacity built, and we're now building it out. And I want to be your partner in building it out.

As to this hearing, I'm glad we're able to conduct it. I called my leadership. It was an easy lift to allow the hearing to go forward.

My views on healthcare will be known this afternoon. You're welcome to come listen.

[Laughter.]

Senator GRAHAM. Business as usual hasn't been done, in many ways, on both sides of the aisle, and I don't want to get into a healthcare debate, so I'll tell you my views on healthcare, but I'm glad we're able to conduct this hearing.

And I hope and pray the Senate, one day, can—back to doing business as usual. We're not there yet, but maybe we will be.

So, thank you, Mr. Chairman.

Senator WEBB. I appreciate you saying that, Senator Graham. And, you know, we do have people who are working on both sides of the aisle trying to solve problems. And you're one of them, and I hope I'm one of them, and I think Senator McCaskill is one of them.

I would like to request all of you to give me your evaluation of something before I close this hearing—not at this hearing. But, I'd

like you to look at—you know, we've talked a lot about the electronic data management, you know, records and this sort of thing. I'm a little curious about your basic software programs that you use in your hospitals, whether you believe you've got the best programs that are available. And I say that from personal experience, having looked at a really fine software program at the Naval Hospital in Bethesda, which I've used for many, many years, about 6 or 7 years ago, in seeing that it was replaced by something it was less than good, according to the medical people that I was talking to. And just—if you have the—you know, tell us whether you need better software systems in order to manage all your product. And we'd like to get your advice on that.

[The information referred to follows:]

Senator WEBB. Any other questions for the record by anyone on this subcommittee will be welcome by close of business today, which is going to be very late.

And, Senator McCaskill, you have any—anything?

Senator MCCASKILL. I don't

Senator WEBB. Okay.

Again, I appreciate the incredible work that all of you are doing on behalf of the people who are serving, and who have served. I appreciate your coming today.

This hearing's closed.

[Whereupon, at 12:05 p.m., the subcommittee adjourned.]