

RECORD VERSION

STATEMENT BY

**THE HONORABLE PETE GEREN
SECRETARY OF THE ARMY**

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MEMBERS**

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Chairman Levin, Senator McCain, and distinguished members of the Senate Armed Services Committee, I want to thank you for inviting LTG Eric Schoomaker and me to appear before you today. We are pleased to have the opportunity to discuss with you how we are transforming the way we care for our wounded, ill, and injured Warriors.

I'd also like to thank all of you for your unwavering support of our Soldiers and Families. I know they appreciate your ongoing efforts to provide them with the ways and means to accomplish their mission and to improve their quality of life. The Congress has been a valued partner in creating the remarkable Army we have today. And, thank you for the initiatives you included in National Defense Authorization Act (NDAA) 2008 to improve health care for our wounded, ill, and injured Soldiers.

The problems identified by *The Washington Post* were centered in our medical hold and medical holdover populations, the outpatient care of our wounded, ill, and injured Soldiers – they experienced poor facilities, leadership challenges, and an entrenched bureaucracy; however, the improvements we will discuss today go well beyond addressing the shortcomings identified in those articles.

In stark contrast to the shortcomings identified in *The Washington Post* are the phenomenal advances in lifesaving battlefield medicine and overall trauma care, much of which has been accomplished through the efforts of the extraordinary medical professionals at Walter Reed. Survival rates for Soldiers wounded in combat are unprecedented. In the Vietnam War, it took 21 days to evacuate a Soldier from theater. In Iraq we routinely evacuate a Soldier within 36 hours. Improvements such as the Joint Theater Trauma System, state of the art evacuation system, improved body armor and battlefield equipment such as the one-handed

tourniquet mean that, today, more than 90 percent of those wounded in Iraq and Afghanistan survive, making this the highest survival rate in the history of warfare. We have the best medical specialists, doctors and nurses in the history of the Army, and many non-medical Soldiers are skilled emergency medical technicians or combat lifesavers.

The Soldier outpatients at Walter Reed who were highlighted in *The Washington Post* were housed in inadequate facilities, experienced a failure of leadership, and were caught in an unresponsive bureaucracy. The Physical Disability Evaluation System (PDES) was cumbersome and did not allow this increasing number of patients to efficiently move through the system. This put a burden on Walter Reed that it was not prepared to handle.

As an Army, we pledge never to leave a fallen comrade – that means on the battlefield, in the hospital, in the outpatient clinic, or over a lifetime of dependency. We broke that pledge, and we have paid a price for that. I am pleased to report, however, that the Army has made and continues to make significant improvements in the areas of infrastructure, leadership, and processes as part of our Army Medical Action Plan, or AMAP.

First, wounded, ill, and injured Soldiers, Active, Guard and Reserve, have been organized into 35 military units under the command and control of the medical treatment facility commander. The new Warrior Transition Units (WTUs) focus solely on the care of their Soldiers. All 35 of our WTUs are now at full operational capability.

Second, we've given the Soldiers in the WTUs a mission that is codified in the Wounded Warrior Mission Statement:

“I am a Warrior in Transition. My job is to heal as I transition back to duty or become a productive, responsible citizen in society.”

This is not a status, but a mission.

“I will succeed in this mission because I am a Warrior.”

Third, every Soldier in the WTUs is supported by a triad of care, a primary care manager who is a physician, a nurse case manager, and a squad leader.

We've assigned one squad leader for every 12 Soldiers, one Primary Care Manager for every 200 Soldiers, and one nurse case manager for every 18 or 36 Soldiers depending on the medical complexity of the unit. Each unit also has a dedicated ombudsman who reaches out to Soldiers and Families as an extra resource and problem-solver.

Fourth, we've established Soldier and Family Assistance Centers, or SFACs, at medical centers and treatment facilities across the Army to replace the old system that had family services scattered across multiple locations. These are "one-stop shops" where Soldiers and Families can get information and help with services from help with entitlements, to benefits, to finances.

Fifth, we created a 24/7 hotline that provides Warriors in Transition and their Families 24-hour access to information and assistance. The Army has responded to over 7,000 calls on the hotline.

Sixth, we created a new leadership position for warrior care, the Assistant Surgeon General for Warrior Care and Transition, currently held by BG Mike Tucker. He is our designated "bureaucracy buster." His role is to facilitate immediate and sustained assistance to our wounded, ill and injured Soldiers and their Families. Under BG Tucker's leadership, and with the active assistance of many other Soldiers, leaders, and Army civilians, we have made substantial progress in cutting the red tape. Some of the many substantive changes we have made since February of 2007 include:

- Continuing Combat- Related Injury Pay while Soldiers are assigned to the Warrior Transition Unit or Community Based Health Care Organization (CBCHO).

- Created a special duty pay for our WTU non-commissioned leaders (Squad Leaders and Platoon Sergeants).
- Preference for wounded Soldiers for their location of care within constraints of facility capabilities.
- Providing wounded Soldiers top priority in housing.
- Authorized Permanent Changes of Station for Warrior in Transition Families.
- Reduced paper work for Army Physical Disability Evaluation System (PDES) processing.
- Expanded the 14-day window to 90 days for a Soldiers to transition to the VA after disability determination by the Army.
- Provided free internet, phone, and cable TV to WTU barracks.
- Co-located VA Advisors at Army hospitals and facilities.
- Expanded VA access to Army Soldier medical records.

We are developing Comprehensive Care Plans (CCPs) for each Soldier in the WTU that set the conditions for the Soldiers to achieve a successful return to duty or a successful transition to civilian life. We have worked with the National Rehabilitation Hospital on this effort to leverage best practices from the private sector.

We've initiated a Post Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI) education program for every Soldier in the Army. This program is designed to not only educate and assist Soldiers in recognizing, preventing, and treating these conditions, but also to erase the stigma associated with these injuries. We also provide similar training to Family members. Over 800,000 Soldiers have received training since August 2007. We have also completed specialized PTSD/TBI training for social work personnel, nurse case managers, and psychiatric nurse practitioners.

To assist with the identification of TBI, we have initiated a baseline cognitive testing program. So far, 40,000 Soldiers were tested pre-deployment. By July 2008 every Soldier will receive a baseline test before deployment.

An experimental helmet sensor has been developed that will record impacts to the head. Over 1,145 of these helmet sensors are in use in theater today.

Behavioral health care is a critical area of emphasis for Army leaders at every level. I would like to highlight a number of mental health initiatives. We are:

- Hiring over 300 new mental health hiring actions, even in the face of national shortages of health care providers.
- Expanding the “Battlemind” training program that educates Soldiers and Families about deployment-related behavioral health concerns.
- Providing access to confidential mental health counseling for Soldiers and their Family members.

I also want to highlight the U.S. Army Wounded Warrior Program, or AW2, which assists and advocates for severely wounded, ill, or injured Soldiers and their Families throughout their lifetimes, wherever they are located. AW2 currently serves more than 2,300 Soldiers, 600 on active duty and 1,700 veterans. AW2 Program caseworkers work with Soldiers and their Families to proactively address and mitigate issues they encounter in their recovery. AW2 provides unique services to the most severely disabled including:

- Helping wounded Soldiers remain in the Army by educating them on their options and assisting them in the application process.
- Assisting Soldiers with future career plans and employment opportunities beyond their Army careers.

- Supporting Soldiers and families with a staff of subject matter experts proficient in non-medical benefits for wounded Soldiers.

Finally, we have improved the ways we “listen” to the needs of our Wounded Soldiers and their Families and monitor the quality of care and support we provide to our Soldiers. We are using third party-surveys and input from more than 18 internal and external sources.

Our surveys show that Soldiers and their Families continue to have questions about the PDES, but they have seen improvements in Soldiers’ assessment of the care and leadership provided by the WTUs.

We will continue to fine-tune feedback mechanisms that provide us with multiple perspectives from which to see ourselves. Examples of those things we measure are:

- Access to care
- Appointment “no show” rate
- “Leader to led” ratios
- Satisfaction survey results
- MEB processing timeliness
- Awards
- UCMJ actions
- Status of cadre training
- Living conditions

GEN Casey and I also recently directed the Surgeon General to establish a Tiger Team to examine the Soldier deaths that have occurred in Warrior Transition Units. The Tiger Team presented an interim report this week and will continue to work to address this issue.

We are working to reform the current PDES. We have reduced the amount of paperwork Soldiers are required to complete. The assignment

of additional Staff Judge Advocates to provide legal advice to Soldiers undergoing the PDES process has reduced formal Disability Evaluation board requests. We have also instituted standardized training and certification for the Physical Evaluation Board Liaison Officers that support our Soldiers.

We have provided Soldiers and their Families interactive access to their Medical Evaluation Board (MEB) and Physical Evaluation Board (PEB), eliminating the need for appointments to review the paperwork and reducing the uncertainty that can plague the process. MEB and PEB review can now be done via secure Internet on Army Knowledge Online. We have increased the MEB staff so that staff-to-case ratios have dropped from 1:80 to a more effective 1:30 ratio. Finally, we are working with DoD on a PDES pilot study currently ongoing at Walter Reed.

The events of the last year have led to a strengthened partnership between the DoD and the Department of Veterans Affairs. The senior leaders of both departments meet regularly as part of the Senior Oversight Committee (SOC). We are working together to provide a seamless transition for our Soldiers from the DoD disability system either back to service in the Army or to a productive life as a veteran.

The SOC has directed the following:

- Establish a single, comprehensive, standardized medical exam for all Wounded Soldiers;
- Update the VA rating disabilities schedule to include TBI; and
- Establish a TBI/PTSD Center of Excellence.

In close coordination with the VA, the Army has executed the following actions:

- Added 16 VA liaison officers at major medical treatment facilities,
- Provided VA access to DoD medical records and databases as needed,

- Instituted a Federal Recovery Coordinator at Walter Reed and Brooke Army Medical Centers (a SOC initiative),
- Exchanged senior leaders with the VA, and
- Entered into an agreement with the VA governing coordination between VA benefits advisors and personnel at Army installations.

Conclusion

President Lincoln pledged our Nation to care for those who shall have borne the battle, their widows, -- and now, widowers -- and orphans. Working together, we must maintain that pledge not with words, but with deeds.

Before I close I want to note that two brigades' worth of wounded, ill and injured Soldiers are returning to the force every year. Greater than 65 percent of all wounded, injured, or ill Soldiers return to duty. About 27,000 of our Soldiers have returned to the force since 2001, and 88 percent of these Soldiers are noncommissioned officers, the backbone of your Army.

I want to thank the committee for supporting the improvements that we have been able to make under the AMAP and for the flexibility built into the recently passed NDAA. The provisions you carried forward from the Dignified Treatment of Wounded Warriors Act will help Soldiers in critical areas such as TBI/PTSD treatment and research, expanded mental health care, and DoD/VA disability reform. Working together, we have made significant progress but several steps remain incomplete. The Army's ability to process wounded warriors would be improved if it were allowed to focus on fitness for duty and let the Department of Veterans Affairs focus on disability determination and compensation. This is a key and critical provision of the Dole/Shalala recommendations.

Again, thank you for inviting me to testify. I look forward to your questions.