Advance Questions for Jonathan Woodson, M.D.
Nominee for the Position of Assistant Secretary of Defense for Health Affairs

Defense Reforms

The Goldwater-Nichols Department of Defense Reorganization Act of 1986 and the Special Operations reforms have strengthened the warfighting readiness of our Armed Forces. They have enhanced civilian control and clearly delineated the operational chain of command and the responsibilities and authorities of the combatant commanders, and the role of the Chairman of the Joint Chiefs of Staff. They have also clarified the responsibility of the Military Departments to recruit, organize, train, equip, and maintain forces for assignment to the combatant commanders.

Do you see the need for modifications of any Goldwater-Nichols Act provisions?

Not at this time.

If so, what areas do you believe might be appropriate to address in these modifications?

N/A

Duties

What is your understanding of the duties and functions of the Assistant Secretary of Defense for Health Affairs?

It is my understanding that the Assistant Secretary of Defense (ASD) for Health Affairs (HA) assists the Under Secretary of Defense for Personnel and Readiness (USD/P&R) and the Secretary of Defense in promoting and safeguarding the health of military personnel and their families, retirees and others eligible for DoD health benefits. The role is primarily one of setting health policies, in consultation with other OSD Components, the Chairman of the Joint Chiefs of Staff, the Joint Staff, the Military Departments and Services' Surgeons General. These health policies include deployment health, both physical and mental. The ASD also has an important, though less direct, role in health education and research. Health Affairs is directly responsible for managing TRICARE and the Uniform Services University.

If confirmed, what duties and functions do you expect that the Secretary of Defense would prescribe for you?

In May 2007, Secretary Gates said, "…Our nation is truly blessed that so many talented and patriotic young people have stepped forward to serve. They deserve the very best facilities and care to recuperate from their injuries and ample assistance to navigate the next step in their lives, and that is what we intend to give them. Apart from the war itself, this department and I have no higher priority." I know that the ASD(HA) has been actively engaged with and leading efforts in the Department of Defense, in collaboration with partners in the Department of Veterans Affairs, to address this priority – caring for our Nation's wounded, ill, and injured service members, and their families. If confirmed, it would be my highest privilege to serve these great Americans and support this monumental Department of Defense priority.

I understand that the ASD(HA) portfolio includes the breadth of policy and programmatic issues related to force health protection and readiness, deployment health, clinical activities, health budget/fiscal management, medical education and training, medical research, and TRICARE/healthcare benefits. I believe the Secretary of Defense may call on the ASD(HA) for advice on disaster relief and humanitarian operations, civil/military operations, and global health issues. The DoD has played an increasingly frequent and important role in disaster preparedness and response, both in the US and abroad. Medical care is a critical part of this effort – both in the provision of health care, as well as in capacity-building (education and facilities) and pandemic prevention and surveillance.

Finally, I realize that healthcare costs have garnered increasing attention in recent months. The Secretary may call upon the ASD(HA) to continue the efforts to work within and outside the Department of Defense to examine this important issue.

In carrying out your duties, how will you work with the following:

A. The Under Secretary of Defense for Personnel and Readiness.

B. The Under Secretary of Defense (Comptroller).

C. The Assistant Secretaries for Manpower and Reserve Affairs of the Services.

D. The Assistant Secretary of Defense for Reserve Affairs.

E. The Surgeons General of each of the Services.

F. The Joint Staff.

G. The TRICARE Regional Offices.

H. Commander, Joint Task Force National Capital Region Medical

I. The TRICARE Support Contractors.

J. The U.S. Family Health Plan Designated Providers.

K. Beneficiary Groups.

L. Department of Veterans Affairs.

M. Centers for Medicare and Medicaid Services.

If confirmed as ASD(HA), I will work collaboratively with leaders from other DoD components, interdepartmental government agencies, and civilian organizations in order to tackle challenges and create new opportunities. Like most leaders, I have learned that most problems arise from poor communication, and success relies on building partnerships through regular, frank meetings in order to gain consensus on near-term and long-term goals. If confirmed, I would commit to performing my duties with a spirit of simple, fair and transparent processes, and personal and organizational accountability.

Goals and Priorities

If confirmed, what are the major goals that you would seek to accomplish as the Assistant Secretary of Defense for Health Affairs?

First, I would focus on efforts to improve care and support for our Nation's wounded, ill, and injured service members, and their families.

I also understand the power of an electronic health record (EHR), and would, if confirmed, work within the Department and with other Federal agencies and the private sector to advance EHR initiatives and interoperability.

If confirmed, I also promise to work with Congress and the Department to find ways to address the rising cost of healthcare while ensuring benefit levels worthy of attracting and retaining the highest quality All Volunteer Force, as well as recognizing the service of our retired beneficiaries.

If confirmed, what priorities would you establish for achieving those goals?

I would re-assess and enhance the effectiveness of the Warrior Transition Units (WTUs) and Wounded Warrior Regiments (WWRs) to serve the needs of

wounded warriors and their families and to bring greater focus on the efficiency of the Medical Evaluation Board (MEB)/Disability Evaluation System (DES) process. In doing so, I would work diligently with VA officials to validate demonstration pilot projects.

With regard to the EHR, I would work closely with USD(AT&L) to complete the analysis of alternatives (operational effectiveness, suitability and life-cycle cost). In addition, I would work quickly to have the appointment of a program manager and the establishment of a formal program office completed.

If confirmed, I would move diligently and rapidly to reform processes and algorithms for care to reduce costs, waste and inefficiency in the MHS. In concert with the EHR efforts, I look forward to developing decision tools to allow health providers to work smarter and deliver a higher quality of care that is evidence-based.

How would you work with Health Affairs staff and the TRICARE Management Activity workforce to achieve these goals?

I understand that the chartering documents for these organizations state that the Health Affairs staff develops policies that reflect legislative, executive and Department priorities, to include health budget and financial plans, while the TRICARE Management Activity implements programs and policies to manage the health plan. If confirmed, I would look forward to working not only internally, with Health Affairs and the TRICARE Management Activity, but also with the Military Departments and Services' Surgeons General to achieve our common goals for the Military Health System.

Major Challenges and Problems

In your view, what are the major challenges and problems that confront the Assistant Secretary of Defense for Health Affairs?

Delivering care to 9.6 million beneficiaries is a great challenge, and one worthy of our most ardent efforts. Ensuring quality health care and, particularly, mental health support will be paramount. The DoD must deliver world-class support to families and to wounded, ill, and injured service members. And for our Wounded Warriors, ensuring comprehensive care from point of injury to point of definitive care – whether in DoD or in the Department of Veterans Affairs – and caring for their families and caregivers, are sacred obligations.

If confirmed, what plans would you put in place to address these challenges?

I do not have specific recommendations at this time. However, if confirmed, I would review the plans that are currently in place to address these challenges, and determine

whether they need to be modified or amplified. I would collaborate with my colleagues in the Office of the Secretary of Defense, the Military Departments, and the Joint Staff in charting the right course for the Department.

If confirmed, what management actions and time lines are needed in order to address these problems?

I would have to evaluate this further to determine the most appropriate actions, milestones and timelines.

Background

You currently hold the rank of brigadier general in the U.S. Army Reserve and are assigned as the Assistant Surgeon General for Reserve Affairs, Force Structure and Mobilization, and as Deputy Commander, Army Reserve Medical Command.

Please describe your military experiences, particularly your service in Operations Iraq Freedom and Enduring Freedom. What do you consider to be your most significant accomplishments as an Army medical officer?

It has been an honor and privilege to serve in the Army Reserves for nearly a quarter of a century. For me, any day I can wear the uniform is a good day because it ties me to the great men and women who currently serve and those who served before me and protected the freedoms we enjoy today. I am especially humbled to have served in support of those men and women who are asked to put themselves in harms way and sacrifice everything for this great nation. I have served as a health care provider (physician/surgeon), teacher and leader/commander.

As a surgeon, I have been there at those life-altering moments in a wounded warrior's life when they are told their limbs must be amputated, and I will never forget the courage of these resilient men and women who in these moments of pain and anguish will think not of themselves but will express concern for their fellow soldiers or a sense of having let their sister and brother soldiers down. Repeatedly I have heard from the wounded warriors their desire to return to the ranks to complete the mission. Throughout my entire career, I have been dedicated to helping sick and injured military men and women achieve the best possible health outcomes and to developing strategies to improve the military health system.

I have participated in military medical missions in Central America, Europe, Balkans, Operations Desert Shield, Desert Storm, OIF and OEF. I have staffed and commanded combat support hospitals, forward surgical teams and medical brigades.

I consider my contribution significant every time I add to the team effort of saving a life or limb. However, I am most proud of the times when I have deployed as a leader,

commander and surgeon. Functioning in these roles, I have been challenged not only with optimizing outcomes one injured soldier at a time, but with improving the performance of the organization I led, inspiring the men and women who followed, and solving problems which contributed to mission success. Developing and articulating a clear vision, in the volatile, uncertain, complex and ambiguous (or VUCA) environments as they are known and motivating people to work to achieve that vision has matured and exhilarated me.

What is the nature of your current duties?

I currently serve in the dual-hatted position of Assistant Surgeon General for Reserve Affairs, Force Structure and Mobilization and Deputy Commander Army Reserve Medical Command.

In the role of Assistant Surgeon General, I provide consultative services to the active component, USAR and Army National Guard on issues relating to the medical readiness (individual and unit) of the USAR and provide consultative services on strategic planning for all health care of USAR personnel, recruitment of medical personnel, and operational training issues relating to the USAR.

In the role of DCG, AR- MEDCOM, I assume the duties of the Commanding General in his absence and provide oversight and guidance to the staff, particularly on operations and training issues, monitor readiness of subordinate units and guide training strategy.

If confirmed, what are your intentions regarding continued service in the Army Reserve?

If confirmed, I intend to continue as a reserve officer and will take appropriate action to de-conflict any roles. I consider my participation in the reserves to be important in maintaining credibility with those I seek to serve in my role as ASD(HA), should I be confirmed. Military men and women should always know that I will be subject to the policies and procedures I promote, and that if necessary, I stand ready to deploy to any theater of operation.

What is your assessment of the readiness of the Army Reserve Medical Command?

The Army Reserve Medical Command currently has more soldiers mobilized than any other reserve medical command and has met every requirement for mobilization. We contribute to CONUS-based Temporary Duty Assignment (TDA) mobilizations as well as units deploying to theaters of operation. In addition, we have assumed some responsibilities for HLD medical support. AR-MEDCOM has experienced and is experiencing the expected turbulence associated with the past years of transformation, reshaping, and right sizing the force.

What background and experience do you possess that you believe qualifies you to perform these duties?

I believe I have had many experiences that qualify me to perform the duties of ASD (HA). I have been a military and civilian health care provider, health care administrator, teacher, researcher and leader. My interests and career have provided me with experience in leading, strategic goal setting, health insurance issues, health care costs issues, quality improvement, research methods, ethical issues and medical error reduction. I have cared for military men and women (and dependents) at all echelons of the military health care system from forward surgical teams and medical detachments to combat support hospitals and medical centers such as Landstuhl, Tripler AMC and Walter Reed AMC. I have, as part of my military duties, trained with the Air Force (CCAT- first army officer to do so) and served in joint exercises, as well as cared for sick and injured military personnel in medical treatment facilities (both deployed and otherwise) staffed by the three Services. At the U.S. Army War College, we studied and gained experience in the interagency, POM and legislative processes. I have had an adjunct faculty appointment at the Uniformed Services University of the Health Sciences. I have taught medical students, nurses, medics and health executives. I have extensive experience with trauma care. As an administrator, military commander and staff officer, I have experience in directing and managing staffs. Most of all, I am fiercely dedicated to providing the best care to wounded and sick soldiers and DoD beneficiaries to ensure the best health outcomes.

Do you believe that there are actions you need to take to enhance your ability to perform the duties of the Assistant Secretary of Defense for Health Affairs?

Not at this time.

<u>Managing the Cost of Health Care</u>

According to DOD, and using 2010 constant dollars, the Defense Health Program base budget, including retiree health care costs, has increased from $16.6 billion in 2001 to $51.7 billion in 2011, an increase of over 151%. Secretary Gates made the statement last year that "health care is eating the Department alive." In February of this year he said he "would like to work with the Congress in figuring out a way to try and bring some modest control to this program."

If confirmed, how would you address the rising cost of providing health care to 9.5 million eligible beneficiaries?

If confirmed, I promise to work with Congress and the Department to find ways to address the rising cost of healthcare, while ensuring benefit levels worthy of attracting and retaining the highest quality All Volunteer Force, as well as recognizing the service of our retired beneficiaries.

If confirmed, do you plan to engage with Congress on this issue?

Yes.

Commitment to Military Retirees

By law, the DOD and the military departments must provide health care through the Military Health Care System to those who have retired from the uniformed services and their eligible family members until they are eligible for Medicare. According to the report of the Task Force on the Future of Military Health Care, as of 2007, 56% of TRICARE beneficiaries were retirees or their dependents.

What is your view of the importance of delivering health care services to military retirees and their family members?

Ensuring competitive compensation and benefits for today's All Volunteer Force is paramount in attracting and retaining the highest quality service members. Also, ensuring we "keep faith" with those who served before is also of great importance. I understand the significant commitment to delivering the highest quality care to all 9.6 million Department of Defense healthcare beneficiaries.

The retired service members and their families, who comprise the vast majority of those for whom DoD cares, are an integral part of clinical experience base that providers and staff require in DoD Military Treatment Facilities and in Graduate Medical Education programs to develop, maintain and advance their clinical skills.

As you know, military facility health care is a finite resource. Healthcare services under TRICARE, now available to retirees over 65 as well as under 65, provide assurance of comprehensive coverage for our retirees even when military providers are not available.

What is the current percentage of the TRICARE beneficiary population that consists of retirees or their dependents?

It is my understanding that retirees and their family members constitute about 53% of the eligible beneficiaries.

What percentage of the current Department of Defense budget goes towards paying for retirees' health care?

It is my understanding that for FY 2009, retiree health care was 57% of the health care budget or 3.0% of the total DoD budget.

TRICARE

If confirmed, what would be your short-term and long-term goals for TRICARE?

From my review, I believe TRICARE offers robust coverage to the Department's beneficiaries. If confirmed, I would look for opportunities to make the link stronger between the direct care system and the vast purchased care network in order to make the benefit better, more seamless, of higher quality, and more affordable. I understand that one of TRICARE's strengths is that it is very inexpensive for the beneficiary, compared to commercial or other government health plans. I believe we need to look for ways to leverage the best public and private sector ideas to make the TRICARE system an example that beneficiaries and our nations' taxpayers can be proud of.

If confirmed, how would you strengthen the partnership between the military treatment facilities of the Services and the TRICARE support contractors that is necessary for the successful delivery of health care within the TRICARE Program?

If confirmed, I would wholeheartedly commit to the strengthening of these relationships. I understand that in the past few years, key performance measures for TRICARE have improved dramatically -- for example, claims processing and customer satisfaction. I am also told that enrollment, especially for the retiree population, has also increased. A key feature of my commitment would be to seek further improvements in the program, building on its many past successes. There may be even more opportunities to learn from commercial health plan experiences by building even stronger bonds with the Department's contract partners, to coordinate TRICARE with other Federal health care programs, and to better capitalize on the unique capabilities of military medicine.

Do you have any views on how health care support contracts could be restructured to incentivize effective disease management programs and cost-efficient delivery of health care services?

I understand that this issue is a focus of the third generation of TRICARE contracts, and I believe it is a good example of how lessons learned from the private sector can be leveraged. I would look forward to working within the Department on this key health plan feature.

There continues to be concern expressed by TRICARE beneficiaries about the adequacy and availability of health care providers in some areas of the country. In a Personnel Subcommittee hearing last year, military spouses who testified said that access to health care was among military families' top issues. While health care support contracts have access standards and timeliness requirements to ensure beneficiaries have access to appropriate providers within a reasonable period of time, this does not always happen. In addition, many beneficiaries who choose the TRICARE Standard option report a lack of availability of health care providers willing to accept new TRICARE patients.

I understand that the TRICARE contracts are working well and the contractors have developed robust networks. However, I understand that all health care is local. If confirmed and if a local problem exists, I will work to understand what contributes to the problem and then work with the appropriate Service Surgeon General and TRICARE contractor to take steps to ensure access is improved.

What recommendations, if any, do you have for improving the number and adequacy of providers under the TRICARE program?

I do not have specific recommendations at this time. If confirmed, I would work with the TRICARE contractors to ensure appropriate access for the Department's healthcare beneficiaries.

Quality of DOD Medical Care

Please describe your knowledge of quality improvement programs in the civilian sector, and comment on how they compare to military health care quality programs.

For approximately ten years I was the medical director and associate chief medical officer for quality improvement at Boston Medical Center. I have formal training in Health Services Research and completed the nationally recognized Institute for Healthcare Improvement Patient Safety Officer Executive Development Program. I am very familiar with the Joint Commission on the Accreditation of Healthcare Organization's processes and standards and helped BMC through several successful accreditation reviews. At this time, I do not have details of where each of the military MTFs stands with regard to quality improvement programs, but in general, my experience is that they are good. In both the civilian and military setting, there is an ongoing question as to whether the right things are being looked at to optimize quality outcomes. This will be an important focus of mine, if confirmed.

If confirmed, what would your goals be in the area of improving quality and patient safety throughout the military health care system?

Improving quality and patient safety have been high priorities for the health systems with which I have worked, and finding solutions to the problems we confront requires a multifaceted, team approach. Quality care begins with well-trained and qualified professionals who work together as a team. These professionals must be provided appropriate ancillary support services and facilities to create a safe "environment of care" focused upon the needs of patients and their families. We must have automated systems for documentation of care, surveillance, supply support, and to meet the information needs of the health care team. Finally, Senior Leaders must be committed to supporting health care quality and safety by establishing strategic objectives and providing the resources necessary to achieve them.

I am aware that the Military Health System has been engaged in addressing quality and safety along with its civilian counterparts. Military professionals, graduate medical education programs, and facilities, also meet the same standards as those established for civilian sector professionals and organizations. If confirmed, I can assure you that providing high quality, safe health care for the men and women who serve, their families, and all other beneficiaries of the Military Health System would be one of my highest priorities.

Wounded Warriors

Despite the revelations in 2007 about outpatient care at Walter Reed and significant systemic improvements, some wounded warriors and their families still perceive that care, management, and transition to the VA are inadequate.

What is your assessment of the factors that led to the inadequate wounded warrior outpatient conditions at Walter Reed Army Medical Center in 2007?

It has been said that the first Commander-in-Chief of our country, George Washington, once said that the extent to which future generations of Americans will be willing to serve will be directly proportional to how they view current veterans are treated. He was and is right. Care and respect for veterans, particularly those wounded and ill, needs to be the highest priority. The factors, as I understand them as documented in the Washington Post's articles in February 2007, which led to the situation at Walter Reed, and particularly Building 18, were many. Most factors reflected problems with a bureaucratic system ill-prepared for the current influx of wounded warriors and included: poor housing facilities; lack of case management; complex documentation systems; communication issues; a slow complex, inefficient, unevenly applied DES; and failure of

leaders at many levels to recognize emerging and existing soldier issues and to advocate for appropriate funds and changes on behalf of soldiers and their families.

What is your assessment of the Army Warrior Transition Unit and Marine Corps Wounded Warrior Regiment concept?

It is my understanding that both the WTUs and the Marine Corp WWRs have several goals and features in common. Both have as a central mission to provide soldier (WTU) and Marine/sailor (WWR) centered programs to provide seamless (predominately) non-medical care, assistance and coordination during the transition of the soldier/marine/sailor in the recovery phase of injury. The intent is to provide support to military personnel and families to ensure the best and most efficient possible outcome, which may include return to active service or transition to veteran status with disability determination and the highest functional/rehabilitation/employment status in civilian life. These administrative activities are carried out while soldiers, sailors, and marines receive coordinated, high quality follow-on medical care and rehabilitation services.

In your view, is it beneficial to assign wounded, ill, and injured service members to these units?

I believe this issue needs further study. I suspect one size does not fit all. Follow-on care and coordination for some minimally-injured service personnel might be more effectively done close to home with the supportive care of family members and the community. In other cases, where more complex resources are needed or families are not able to assist, more centralized service units are necessary.

If confirmed, and if casualties increase in Afghanistan as anticipated as a result of the troop increase ordered by the President, what will you do to ensure that care for wounded and seriously ill service members and their families is of the highest quality?

If confirmed, I will bring unrelenting leadership focus to this issue. Understanding that the potential exists for breakdown in care at many points in the system, leaders at all levels must be held accountable for the highest quality of care. We must constantly look forward to anticipate problems and improve the system, and not wait for problems to arise and find ourselves scrambling for answers. We need to understand that we need to constantly seek improvement, not only in specific medical treatments and technology, but in how we organize and deliver care (including administrative procedures) and how we communicate and show compassion to sick and injured service members and their families—and we must do this while remaining good stewards of public resources.

Walter Reed National Military Medical Center

The Base Realignment and Closure Commission Act of 2005 realigned medical operations from the current Walter Reed Army Medical Center to the Walter Reed National Military Medical Center, Bethesda, and the Fort Belvoir Community Hospital. The National Defense Authorization Act for 2008 required that the new medical facilities be constructed as "world class" medical facilities, incorporating the best practices of premier private health care facilities throughout the country. When the new facilities open in 2011, DoD will have achieved the most significant realignment of military medical resources in history, through both "world class" facilities and an integrated health care delivery system serving wounded and ill service members and their families in the National Capitol Region.

If confirmed, how would you ensure that Walter Reed National Military Medical Center achieves these goals?

I understand that there has been much public discussion regarding the "world class" nature of construction of and integration at WRNMMC and other BRAC healthcare facilities in the National Capital Region. If confirmed, I will quickly familiarize myself with the history of these discussions and decisions in order to guide the efforts to effectively bring to fruition the goals for healthcare in the National Capital Region.

Are you committed to ensuring that any additional construction requirements based on the facilities masterplan for the NCR are completed as quickly as possible?

Yes.

Dental Benefits

The Committee has increasingly heard complaints that DOD dental benefits are less attractive than those offered by other employers. Also, DOD beneficiaries, especially members of the Reserve Components, have shown a reluctance to use their dental benefits.

If confirmed, what action would you take to evaluate the effectiveness of dental programs for the active duty, reservists, retirees, and their dependents?

If confirmed, I would expect my staff to evaluate the benefit on an ongoing basis, including analysis of enrollment and utilization, and surveys of members to determine their satisfaction. Additionally, if confirmed, I would to work with the Congress to make any necessary changes to the program.

Effect of Private Sector Care on Medical Readiness

Currently more than 60 percent of military medical care is provided by civilian provider networks outside of military treatment facilities (MTF).

In your view, has this shift from MTF-based care to the TRICARE network affected military medical training programs in any way?

If confirmed, I will study this issue and develop appropriate courses of action to insure the military medical training programs remain of the highest quality.

If confirmed, how would you ensure that if we continue to see an increase in the use of private sector care, military medical training programs will remain viable?

. If confirmed, I will study this issue and develop appropriate courses of action to insure the military medical training programs remain of the highest quality. There are several potential ways to ensure viability of military medical training programs, which include, but are not limited to; simulation training, changing rotation sites for trainees, and more effective use of work hours. A big issue we have in medical training now is the growth of information and turning it into useable knowledge. In some ways, the Military Health System is better positioned to deal with needed changes in medical training than our civilian counterparts. All the elements of the training system are within our influence, including a medical school and advanced nursing programs, an insurance plan, medical training facilities, outpatient practices, simulation training platforms and research opportunities. We can shape the continuum of the training spectrum to produce the best educational outcomes while providing the best care and experiences for our beneficiaries.

Military Health Professional Recruiting and Retention

The DOD is facing severe shortages of military medical professionals, including physicians, dentists, and nurses, needed for its peacetime and wartime missions. The Department relies on a combination of bonuses and incentives to recruit and retain military health care professionals to provide care to military members and their families.

What are your views on the adequacy of existing bonus and pay incentive programs for both active and reserve components?

The Department of Defense, like any other major employer, must be able to use effective, competitive and fair financial tools to be able to attract and retain highly-qualified professionals in both the Active and Reserve Components. Having fewer than the optimum number of uniformed health care professionals could result in increased private sector care costs and lower medical force morale. It is important to properly manage recruiting, pay, and retention programs to ensure appropriate balance for Department missions and beneficiary needs. If

confirmed, I would fully commit to working within the Department and with the Congress to address this issue.

Based on your service as the Assistant Surgeon General for Reserve Affairs, Force Structure, and Mobilization and as Deputy Commander of the Army Reserve Medical Command, do you have any recommendations about the effectiveness of incentives for medical personnel to serve in the reserve forces?

Not at this time. As medical specialties change and requirements for manpower shift, this issue will need constant review and updating.

What other steps can be taken to eliminate shortages of medical personnel, including nurses and mental health providers?

I do not have any specific recommendations at this point, but if confirmed, I will work to understand what factors contribute to these shortages and take action to resolve these issues.

Disability Evaluation System Pilot Program and Seamless Transition

The Department of Defense and the Department of Veterans Affairs are conducting a Disability Evaluation System Pilot in which the VA conducts a single medical examination for both VA and DOD purposes. This pilot was recently expanded.

What is your assessment of the effectiveness of this pilot program?

I have not been briefed on the effectiveness of current programs, but I understand that there is still room to improve. If confirmed, I will work with colleagues at the VA and the USD(P&R) to optimize programs, policies and procedures to produce the most efficient DES that serves the needs of service members and future veterans.

What are the critical elements necessary for a seamless transition of health services from one agency's responsibility to another?

Based on my past experience, I believe the critical elements for a seamless transition of health services from one agency to another are: a full understanding of medical care capabilities within both agencies by all medical providers involved; clear communications of the transition plan between providers in each agency and with the patient and patient's family; timely transfer of all pertinent medical records before or at the time of transfer of the patient; and, ongoing

communication after the transfer of the patient between the medical providers in each agency and with the patient and patient's family.

How can the transition for disabled service members between DOD and the VA be improved, especially in the area of health care?

Improvements in the transition of health care between DoD and VA can be achieved by early and concise communications to Service members and their families about the DoD and VA benefits and programs they are entitled to based on their military status and service. Based on my experiences, I believe that two principal efforts would facilitate the early and concise communication we desire. The first would be to establish a program that assigns a specific DoD-VA team comprised of medical staff to support each patient and his/her family during the transition process. The second initiative would be to establish a single, user friendly disability evaluation system that is evidence-based, medically-endorsed, and most importantly, consistent with the civilian disability system. If confirmed, I would give this issue my fullest attention.

Even with accelerated processing in the Disability Evaluation System Pilot, required times for medical evaluation boards can be well over a year.

Do you have any views about improvements that can be made quickly to the medical evaluation board process in order to reduce case processing times?

I am aware that there are ongoing high-level efforts between the Departments of Defense and Veterans Affairs to improve the Disability Evaluation System. Based on my experience, I understand that DoD's Physical Disability Evaluation System was designed to evaluate an individual's loss of capability to function once the medical condition has reached maximum benefit from continued medical care. The period of time necessary to make that assessment varies widely from person to person, and is dependent on individual rates of healing and response to restorative therapies. The medical evaluation board process requires that maximum benefits of medical care be completed. A change that would streamline the process would require care providers to make an early, initial medical prediction of capability after maximum benefits of medical care are complete, and, once the patient's medical condition is stable, then proceed with the disability benefits determination based on that assessment. This would require frequent re-evaluation of medical capability as the healing process is continuing, and possible redetermination of benefits. If confirmed, I would give this issue my fullest attention.

Traumatic Brain Injury

In Iraq and Afghanistan, our troops are facing the threat of Improvised Explosive Devices (IED). Because of improved body armor, troops are surviving IED blasts, but frequently suffer traumatic brain injuries (TBI) from the concussive effects of the blasts.

What tools are needed by medical personnel to adequately diagnose and treat TBI on the battlefield, and do you think the services have adequate capabilities in Iraq and Afghanistan?

Based on my experience, I understand that our medical personnel are doing a superb job identifying and treating the severe TBI incidents on the battlefield. Far forward surgical care is saving lives, and neurosurgical care is a significant contributor. I have learned that in August 2006, the Department started using the Military Acute Concussion Assessment (MACE), along with a clinical practice guideline, to help identify and document mild and moderate TBI. I greatly appreciate the significance of educating troops and their leadership about the importance of this evaluation as soon as possible, after even a mild injury, as well as educating medical providers on this new tool.

What is your understanding of the ability of medical personnel to diagnose and treat TBI in CONUS medical facilities?

Medical personnel are cognizant of the potential for TBI in our personnel, both at home and on the battlefield. There is no easy, definitive test, such as a blood test, available today to quantify the nature and extent of injury associated with TBI. However, we are extending the use of neurocognitive assessment tools throughout the DoD system to help identify patients who had TBI and determine if they still have symptoms. The majority of mild TBI does not require specific treatment other than time to heal, but we now believe we must document the incident and an assessment of acute signs and symptoms as close to the time of injury as possible. I understand that treatment for persistent symptoms is available in military treatment facility neurology clinics.

What is your understanding of the adequacy of the DOD physical evaluation system and its ratings to fairly address the conditions that result from traumatic brain injuries?

I am aware that there are ongoing high-level efforts between the Departments of Defense and Veterans Affairs to improve the Disability Evaluation System. I am told that the DoD Physical Evaluation Board evaluates impaired function and rates individuals against established criteria for disability compensation, and that when that disability is severe, the system works very well. However, as DoD and VA shape a comprehensive DoD/VA system to assess, diagnose and treat mild and moderate TBI, the potential exists that the two Departments may have to

modify the disability evaluation system. If confirmed, I would commit to ensuring the adequacy of the physical disability system to fairly address these conditions.

Mental Health Care

The mental health of service members and their families is of intense concern to the Committee.

What is your understanding of the scope of the problem of diagnosing and treating post traumatic stress and other mental health conditions in the Armed Forces?

I am told that DoD is educating its personnel about PTSD. From my experience, I know that DoD assesses Service member concerns and symptoms of PTSD and related mental health issues upon return from deployments and again three to six months later. Individuals who identify symptoms are medically evaluated and referred for further diagnosis and treatment if needed. PTSD and other mental health conditions are treatable.

If confirmed, what actions would you take to ensure that health care providers are appropriately trained in diagnosing post traumatic stress and other conditions including potential suicide?

I understand that DoD and the VA have developed clinical practice guidelines for the diagnosis and treatment of PTSD. Continuing Medical Education is a requirement for all practicing physicians and DoD has many educational resources available to not only ensure its providers have the expertise to diagnose PTSD, but that its Service members and their families will be educated. I understand that the Defense Centers of Excellence for Psychological Health and TBI develop research and knowledge products that further expand the state of the art in diagnosis and treatment.

If confirmed, what steps would you take to destigmatize seeking care for post traumatic stress and other mental health conditions?

Applying my professional experience as a physician, I understand that the first step to de-stigmatize PTSD and other mental health conditions is education of the military population. A major next step would be to validate that those who seek and receive mental health care are successful in continuing their military careers. Concerns about loss of status with peers, leaders, and family members, and loss of military career are the two major causes for individuals not seeking care for PTSD and other mental health conditions.

What would you recommend to the Secretary of Defense to reduce suicide among members of the Armed Forces?

At this time I do not have specific recommendations for reducing suicides. This problem has received a lot of study and requires more. There are many initiatives that have been started to address this issue (as well as PTSD and TBI which may be related in some cases). We need to bring better evaluation of the programs that exist and enhance those that work and eliminate those that are of no value and perhaps harmful. Program evaluation should be grouped into tracts that can be validated, such as; prevention (including service member selection and resiliency training), identification of service members at risk (tools), medical/behavioral therapies and interventions, follow-on care, long term outcomes, administrative and cultural issues that prevent optimizing identification and care of those at risk, and family issues.

Psychotropic Prescription Drug Use

According to a recent *Military Times* article, "one in six service members is on some form of psychiatric drug," "seventeen percent of the active-duty force and as much as 6 percent of deployed troops are on antidepressants," and the "use of psychiatric medications has increased…about 76 percent overall…since the start of the current wars."

What is your understanding of the accuracy of these reports?

It is my understanding that this data is based on information collected in the Army and the rates likely differ across the Services. Further data collection and analyses across the Services could provide the additional information needed to determine accurate rates both across and within each service. This will allow comparisons and monitoring for differences that may be of statistical significance.

However, the data cited by the Military Times does direct us to important questions to be further studied and addressed about medication use in the deployed setting.

In your view, what is driving this increase in the use of psychotropic drugs?

From my experience, I understand that a new era of combat has emerged, where counterinsurgency and asymmetric warfare are the norm. This places a great amount of strain on our service members. Despite the challenges, they remain incredibly resilient, motivated and well-trained. Resources and programs are necessary to maintain resilience and motivation. The earlier the intervention the better; and Service members should be encouraged to reach out as an act of

courage and strength. Psychopharmacological treatments are an important component of mental health care. Scientific evidence over the past several decades shows that medications limit the severity and duration of illness as well as being a key factor in preventing relapses and recurrences. I am aware that experience and clinical evidence have also been translated into recommendations for clinicians in the VA-DoD Clinical Practice Guidelines for Major Depressive Disorder, Post-Traumatic Stress Disorder, Psychoses and Substance Use Disorder; and that these guidelines are updated periodically, as required, to reflect the most current knowledge concerning each of these conditions.

In your view, is it appropriate to prescribe psychotropic medication to military personnel in combat zones?

Each clinical case must be evaluated individually. For some conditions, psychotropic medication may alleviate symptoms and permit the individual to continue to function well. However, other conditions could require medical evacuation for treatment or evaluation.

If confirmed, what actions will you take to monitor the issuance of psychotropic medications in combat theaters?

If confirmed, I will work with the Services and Combatant Commanders to conduct a review of issuance of psychotropic medications in combat theaters.

Medication Management

The Committee continuously receives reports that many wounded, ill, and injured military personnel are overly medicated.

If confirmed, what action will you take to ensure that medications prescribed for wounded, ill, and injured service members are medically appropriate and compatible with other prescriptions?

I understand that the MHS does currently have a sophisticated and effective electronic prescribing process in place in MTF's that minimizes prescribing errors and provides real time feedback to providers on potential drug interactions. I am also aware that the DoD/VA Clinical Practice Guidelines especially focus on appropriate prescribing for common medical conditions in our population. If confirmed, I would strongly promote the continued development and refinement of these and other patient safety and provider education evidenced-based initiatives. I would also encourage the Services to ensure that processes are in place that both promote these and other evidenced-based safe prescribing initiatives through monitoring and incentive programs for healthcare providers

that target the optimization of safe and effective health care outcomes for all DoD beneficiaries.

If confirmed, what policies and programs will you implement to improve pain management?

I am aware that DoD currently reviews how individual facilities are doing in the assessment and treatment of pain through the mandated accreditation process; and that DoD/VA Clinical Practice Guidelines are also in place for the promotion of optimal management of Low Back Pain, Post Operative Pain, and Chronic Opioid Therapy. The NDAA for Fiscal Year 2009 further mandated 'the development & implementation of a comprehensive policy on pain management by the military health care system.' I am also aware that all three Services and TMA have initiated programs to further assess pain management within the MHS. If confirmed, I would ensure that the NDAA requirements are met, that the results of these programs are thoroughly evaluated, and valid conclusions are considered for implementation where appropriate.

Drug Maintenance Treatments

The drug buprenorphine, which is similar to methadone, is used in private sector care to treat opioid-dependent patients in drug maintenance programs. The use of buprenorphine for this purpose is also covered by Medicare, Medicaid, and the VA health care program.

What are your views on the use of buprenorphine for drug maintenance treatment for opioid dependence?

In your view, should the use of buprenorphine for drug maintenance treatment be covered under the TRICARE benefit?

I understand that while TRICARE does cover the cost of buprenorphine or methadone when used in detoxification or medically-supervised withdrawal from opioids, regulation prohibits its use in the maintenance treatment of opioid dependence. There currently exists ample scientific support for the use of medications such as buprenorphine and methadone in the maintenance treatment of opioid dependence.

I am also aware that TRICARE is pursuing changes in the Code of Federal Regulations that would permit the use of buprenorphine for opioid dependence maintenance treatment in non-active-duty beneficiaries.

Electronic Medical Records

An area of frustration for both patients and providers is the inadequacy of seamless electronic medical records, despite nearly two decades of development by DOD.

What experience do you possess in the area of health information technology?

My career has spanned the transition from paper health records to the EHR. Boston Medical Center was one of the first health institutions in the Boston area to commit to an EHR. Many lessons have been learned about implementation of such an initiative including problems that arise with off-the-shelf components that do not communicate easily with each other (often requiring multiple data systems), development of novel in-house systems that do not communicate with outside data bases (and become obsolete quickly) and require great costs to maintain, requirements for training, poor acceptance by users (especially when end user issues are not considered in development) and portability of information as patients change health care venues frequently. Data systems need to be modifiable to accommodate the unique needs of departments and sub-activities within the organization if they are to get useful data for quality improvement processes. Intuitive systems with comprehensive data that are reliable, fast, portable, and communicate well internally and externally are some of the key features needed in the EHR.

What lessons from the civilian community are applicable to improving DOD electronic medical records?

Civilian EHR and data systems struggle with solving the problems noted above and meeting the requirements of a good system as outlined. If confirmed, I would work with USD(AT&L) and the VA to find suitable, financially sound and sustainable answers to these issues. Success would be determined by implementing a system meeting the aforementioned requirements.

If confirmed, what priorities would you pursue to improve electronic medical records, and in your view what are the measures of success?

See above answer.

<u>Women's Health</u>

In view of the expanding roles of women serving in the Armed Forces, what are the health challenges that DOD and the Services must address both in deployed and non-deployed environments?

The contributions of women in the military increase every day as opportunities and roles expand for them. OEF and OIF have seen an unprecedented deployment of female military members from all Services and Components. We need to continue to expand our

understanding of how best to support women's health needs both in the deployed and non-deployed status and as they transition to veterans status. Better understanding and delivery of services includes, but is not limited to, gynecologic and pregnancy care, urinary tract infection treatment and prevention, hygiene in the deployed environment, ergonomics and prevention of injury, fitness and strength development, weight and nutrition advice, psychological stress, eliminating and responding to sexual harassment and sexual assault and PTSD/TBI. Many of these issues overlap with general health promotion concerns for the force, but may require special focus to evaluate specific issues related to women.

If confirmed, how would you assess the adequacy of current health services for female service members, and what steps would you take to improve them?

If confirmed, I would seek input from a women's health advisory committee to evaluate current practices and future directions for addressing and improving women's health issues in the military. The committee would have broad input from health professionals, enlisted personnel and officers from constituent services. Priorities for care and research in women's health will be reviewed with the Surgeons General.

Fort Hood

Based on published reports assessing the tragic shooting at Fort Hood in November of 2009 in which 13 people were murdered and 43 injured, what, in your view, are the most important lessons learned for the medical departments of the Department of Defense?

I have not been briefed on the findings of the official investigation into the tragic events that took place at Ft. Hood on November 5, 2009 and therefore cannot comment on specific issues. However, it would appear that collectively we need to improve our abilities to identify home grown terrorists and those susceptible to radicalization. Furthermore, leaders at all levels need to accurately, honestly and with courage, assess the behaviors of those they are responsible for and call into question those who exhibit behaviors not compatible with military service and the oath to protect and defend the constitution of the U.S. If confirmed, I will hold my leaders accountable for these responsibilities.

HIV/AIDS Surveillance and Treatment

According to the Centers for Disease Control and Prevention, the annual rate of AIDS diagnoses reported among males aged 15-19 has nearly doubled in the past 10 years within the United States. In addition, the Committee has received information that DOD surveillance programs and access to care need improvement.

What is your assessment of the increase in AIDS diagnoses among this age group, and its potential impact on the military?

The increasing incidence of HIV infection in the demographic group identified (male age 15-19) suggests that the lessons learned about prevention two and a half decades ago have been forgotten. We must redouble our efforts at education. The consequences of not reversing this trend are enormous, not only for the individuals at risk for death and complications from this disease, but also it will limit the number of individuals who might otherwise honorably serve in the military. In addition, the cost of treating those infected with HIV is substantial.

If confirmed, what steps would you take to ensure that DOD is effectively identifying and treating individuals diagnosed with HIV/AIDS?

If confirmed, I would enhance programs aimed at HIV and STD education, prevention and surveillance.

Use of Live Animals in Medical Education and Training

The Committee understands that the Department allows some limited use of live animals for medical research, education, and training purposes.

Based on your background in medical education, please describe your views on the use of live animals for medical education and training given the many technologically advanced simulators in existence today.

In the future I believe advanced simulation platforms should and will supplant the need for live animal use in medical education. Simulators will need to be validated to provide similar or superior training for medical personnel before they can substitute fully for live tissue training. Some simulators can breathe, bleed, urinate, speak and respond to stimuli and drugs. These simulators, combined with patient actors and scenario based training may offer superior training models over live animals in the future. Live tissue training should only be used when, after exhaustive analysis, no other satisfactory substitute exists. Since student medics need to be able to repeat a realistic training experience to gain skill and confidence to prepare to be ready to save lives in battle, live tissue training remains a valuable training tool today.

Research on Gulf War Illness

Both the DOD and the Department of Veterans Affairs have conducted research on Gulf War Illness stemming from health concerns of veterans.

What is your assessment of the evolution of research in this field to date?

I have witnessed the fact that more research has been done to understand the health concerns of veterans of the Gulf War than in any other war. A recent Institute of Medicine review of the medical literature from this research has stated that while there is no unique syndrome that has been identified, the Gulf War veterans experience a wide spectrum of symptoms at a rate nearly double that of military personnel who were on active duty at that time but did not deploy. The medical challenge is to better understand the causes of symptoms in our patients, particularly for the subjective symptoms.

What, in your view, are the promising areas for further research, especially for the treatment of symptoms resulting from neurological damage due to chemical exposures?

Medical science is developing a better understanding of brain function and brain physiology due to better tools and better understanding from research that has been ongoing in the fields of mental health, traumatic brain injury and the spectrum of neurological diseases like Alzheimer's, Parkinson's disease, amyolotrophic lateral sclerosis and others. Research focused on relating symptoms to specific brain functions, insults, or neurotransmitter changes would have major importance, not only to Gulf War veterans, but to the broader population.

If confirmed, what approach would you take to assess the core biomedical research programs of the DOD to ensure that the objectives and resourcing of such research is consistent with future potential threats to U.S. Forces?

I understand that the core biomedical research programs in the DoD are requirement-driven, and those requirements are based on military unique issues. I also understand that the governance of the biomedical research is through the Armed Services Biomedical Research Evaluation and Management committee, which the ASD(HA) co-chairs. If confirmed, I would welcome the opportunity to fulfill this critical leadership role.

Congressional Oversight

In order to exercise its legislative and oversight responsibilities, it is important that this Committee and other appropriate committees of the Congress are able to receive testimony, briefings, and other communications of information.

Do you agree, if confirmed for this high position, to appear before this Committee and other appropriate committees of the Congress?

Yes.

Do you agree, if confirmed, to appear before this Committee, or designated members of this Committee, and provide information, subject to appropriate and necessary security protection, with respect to your responsibilities as the Assistant Secretary of Defense for Health Affairs?

Yes.

Do you agree to ensure that testimony, briefings and other communications of information are provided to this Committee and its staff and other appropriate Committees?

Yes.

Do you agree to provide documents, including copies of electronic forms of communication, in a timely manner when requested by a duly constituted Committee, or to consult with the Committee regarding the basis for any good faith delay or denial in providing such documents?

Yes.