Advance Policy Questions for Dr. Dean Winslow
Nominee for Assistant Secretary of Defense for Health Affairs

Department of Defense Reforms

The National Defense Authorization Act for Fiscal Year 2017 included the most sweeping reforms since the Goldwater-Nichols Department of Defense Reorganization Act of 1986.

Do you support these reforms? Yes

What other areas for defense reform do you believe might be appropriate for this Committee to address?

I do not have any other reform recommendations for the Committee at this time. If confirmed, I will make appropriate recommendations if I identify any challenges or limitations posed by existing statute, especially as the Department of Defense implements the significant military health care system reforms required by the Fiscal Year 2017 National Defense Authorization Act.

Qualifications

What background and experience do you have that qualify you for this position?

I have 41 years of experience as a physician in a number of settings: private practice, academic medicine, public hospital systems and university hospitals, community hospitals, pharma/biotech industry, and military medicine. My biography lists some of the key assignments I have had as a military physician working in settings as diverse as remote deployed locations and San Antonio Military Medical Center.

Are there are any actions you should take to enhance your current ability to perform the duties of the Assistant Secretary of Defense for Health Affairs (ASD(HA))?

If confirmed by the Senate for this position I intend to go on a listening tour and visit some of our large flagship military medical centers, community hospitals, outpatient facilities, and deployed locations.

Duties

What is your understanding of the duties and functions of the ASD(HA)?

If confirmed, my responsibilities will include oversight of the active duty and reserve component Military Health System, TRICARE, USUHS, and a number of important research institutions.

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

I have spoken briefly with Secretary Mattis regarding this. He concurs with the importance of executing on the roadmap laid out in the previous NDAA. Areas of highest priority include maximizing "tooth to tail" in the MHS, eliminating duplication of administrative functions, and making the Defense Health Agency responsible for the administration of all military medical treatment facilities.

Major Challenges/Priorities

In your view, what are the major challenges confronting the next ASD(HA)?

1. Reduce expenditures on TRICARE. 2. Standardize medical operations across the three services as we place operations more under the direction of DHA. 3. Integrate personnel systems so it is easier for the Services to work together seamlessly. (For example, it is now difficult for an Air Force medical commander to even complete an Officer Performance Report on an Army or Navy medical officer.)

If confirmed, how would you address those challenges?

I would get input from my military healthcare leaders and also get buy in and support from my other colleagues in the civilian leadership in the Pentagon.

If confirmed, what would be your top priorities?

1. Take advantage of our expertise at our large flagship military medical centers to "re-patriate" as many complex patients as we can. (eg. A military member, dependent or retiree who lives on the East Coast should be treated at WRNMMC, not Johns Hopkins using TRICARE.) 2. Expand the scope of practice of our enlisted medics. High functioning practices like the Kaiser system make more extensive use and allow a larger scope of practice (especially in primary care) of non-physicians who often have less training and experience than our enlisted medics. 3. Work closer with the VA to allow VA patients to be cared for at military facilities when it would make sense. 4. Expand care of civilians in our centers of excellence using as a model the SAMMC Trauma Center and Burn Center, which treats the majority of critically injured civilians in San Antonio. 5. Make sure the MHS and VHA Electronic Medical Record systems are integrated. 6. Shift the focus to health outcomes rather than work Relative Value Units (wRVU's). 7. Make sure our military medical research efforts are adequately funded and supported. 8. Expand our military participation in meaningful Global Health activities. (Secretary Mattis is a big advocate for "soft power" as well as combat lethality.) US military efforts in developing anti-malarial agents, responding to natural disasters, and epidemics (e.g., the recent West Africa Ebola outbreak) are examples of unquestionable American "soft power" victories.

Relations with Congress

What are your views on the state of the relationship between the Office of the Assistant Secretary of Defense for Health Affairs (OASD(HA)) and the Senate Armed Services Committee in particular, and with Congress in general?

I am not in a position to have an opinion on the current state of the relationship between OASD(HA) and Congress, but I believe it should be close and collaborative, especially with the Armed Services Committees given the Committees' legislative and oversight responsibilities. If confirmed, I plan to maintain a close working relationship with the Senate Armed Services Committee.

If confirmed, what actions would you take to sustain a productive and mutually beneficial relationship between Congress and the OASD(HA)?

If confirmed, I plan to be accessible and work closely with Congress to ensure open lines of communication.

Torture and Enhanced Interrogation Techniques

Do you support the standards for detainee treatment specified in the revised Army Field Manual on Interrogations, FM 2-22.3, issued in September 2006, and in DOD Directive 2310.01E, the Department of Defense Detainee Program, dated August 19, 2014, and required by section 1045 of the National Defense Authorization Act for Fiscal Year 2016 (Public Law 114-92)?

I fully support using the Army Field Manual as the single standard for all U.S. military interrogations. I am in full agreement with the Chairman and Ranking member of the Committee and the Secretary of Defense as to the prohibition on the use of torture.

Managing the Cost of Health Care

In the President's fiscal year 2018 budget request, the Department of Defense requested $53.5 billion in operation and support funding for the military health system, about 9% of the total funding requested for the Department's base budget. CBO has calculated that those costs will reach $64 billion by 2030 if their growth reflects anticipated national trends in health care costs.

In your view, what is the greatest threat to the long-term viability of the military health system?

It would be the inability to transform the military health system into a much leaner and more efficient organization that still meets the warfighters' and beneficiaries' needs.

What is your assessment of the long-term impact of the Department's health care costs on military readiness and overall national security?

We need to remember we have health professionals in uniform to ensure we can meet our battlefield requirements for medical care. Also our military health care system provides medical care to those in uniform, their families, and retirees. Once we ensure our operational requirements are met, every opportunity for reform and efficiency must be pursued in the delivery of the health benefit, lest we divert essential resources from military readiness.

If confirmed, what actions would you take to mitigate the effect of the Department's medical costs on the Department's budget top-line while simultaneously implementing programs to improve health outcomes and to enhance the experience of care for all beneficiaries?

I believe we need to look at all options to managing the cost of DoD health care. It is my understanding that we are essentially running four separate health care systems within the Department of Defense and have for many years. The potential for greater efficiency and effectiveness is substantial. It also includes looking at how the Department buys health care from the civilian sector to emphasize outcomes and promoting healthy life styles among our beneficiaries to reduce the demand for health services. If confirmed, I will work both within and outside of the Department to eliminate duplication, increase productivity, and set goals, standards and incentives that emphasize medical readiness, excellent outcomes and exceptional return on investment. Please also refer to my comments above regarding re-patriating patients when possible and making better use of enlisted medical personnel.

If confirmed, what would you do to create a value-based military health system – a system that creates value for beneficiaries and the Department by ensuring the delivery of quality health care and improving health outcomes for beneficiaries at reasonable costs to beneficiaries and to the Department?

We must be responsive to our beneficiary population, which includes the warfighter and all other eligible members. If confirmed I would work closely with military health system leadership to improve the experience of care and re-focus our attention on the customer. Additionally, I would capitalize on successes in the commercial health care industry that focus on successful outcomes rather than simply paying in a fee-for-service model.

If confirmed, what reforms in medical infrastructure, benefits, benefit management, contract acquisition, military provider productivity, military-civilian provider mix, and medical personnel strengths would you implement to help control the per capita costs of health care provided by the Department?

I would re-double efforts to consolidate management, overhead, and support services from at least four separate medical entities into one. I would dramatically increase the standardization of operations across the system and put into place aggressive yet achievable production and efficiency targets. I would carefully scrutinize what is needed for operational requirements versus what is a pure benefit and determine the most cost effective strategy to provide those services. Finally, I would look at the benefit structure to see where reasonable changes could occur. In the long term, the promotion of healthy life styles and prevention among our beneficiaries will also help reduce the demand for health services.

Medical Provider Productivity

The Services have established a very low provider efficiency (productivity) standard for military physicians – 40% of the Medical Group Management Association median. This measure assesses provider currency and capacity, determining the readiness potential of providers. The most current data provided to the Committee shows that only 39% of the Department of Defense's providers exceeded the goal in the first quarter of fiscal year 2017. In other words, most of the Department's providers failed to achieve an already very low efficiency standard.

If confirmed, what would you do to increase provider productivity?

If confirmed, I will look into this issue and review the data to determine if this measure is the right measure for assuring a ready medical force and a force that is medically ready. Moreover, I will ensure that we develop policies and procedures to ensure that we are meeting our critical readiness mission along with providing for our robust health care benefit in the most effective and efficient manner possible.

If confirmed, whom would you hold accountable for the low productivity of the Department's medical providers?

I will review the data to determine the appropriate productivity standards for our providers given our readiness mission. I will communicate that both leaders and providers throughout our Department are responsible to provide quality and safe care to our beneficiaries with maximum efficiency and productivity.

An independent study by the Institute for Defense Analyses showed that it costs the Department about 50% less to purchase health care services in the private sector than to provide the same care in military medical treatment facilities. (I question the veracity of these data!)

In your view, how does low provider productivity contribute to the higher relative costs to provide medical care in those facilities?

If confirmed, I will review the data related to the relationship between provider productivity, cost of maintaining providers' military readiness, and any higher relative costs to provide medical care in MTFs to determine the relationship and any actions that may need to be taken. Please also see responses above.

Military Health System Reorganization

Section 702 of the National Defense Authorization Act for Fiscal Year 2017 transferred direct oversight and management of military hospitals and clinics from the Services to the Defense Health Agency (DHA). In March and again in June, the Committee received the Department of Defense's interim reports on Section 702, which described the Department's intent to develop a component model to administer and manage military treatment facilities. Under this component model, the Department would establish intermediary medical commands, and those commands would be subject to two separate lines of authority – the DHA and the Services.

Do you believe that a component model, with establishment of new intermediary medical commands under two separate lines of authority, would make the military health system flatter, more agile, and more efficient?

Presently, the three Service Medical Departments and the Defense Health Agency (DHA) have four separate headquarters functions dedicated to the administration and management of the Military Treatment Facilities. Although I am not privy to the fine details of the Component Model, I believe a construct that dramatically reduces headquarters functions and streamlines management and administration of Military Treatment Facilities is the direction we need to go.

If confirmed, would you reevaluate the Department's decision to proceed with a component model to implement section 702?

I will review the actions of the Department and in conjunction with the Deputy Secretary of Defense evaluate the efficacy of the component model.

If confirmed, would you urge the Secretary of Defense to reevaluate the Department's decision to proceed with a component model to implement section 702?

It would be premature, at this stage, to comment as to whether the Department's decisions should be reevaluated. However, if confirmed, I will remain open to reevaluating the Department's approach, if it is warranted.

In your view, would a component model streamline the administration and management of military treatment facilities?

Presently, the three Service Medical Departments and the DHA have four separate HQ functions (policy, oversight, and resource allocation) dedicated to the administration and management of the MTFs. While I would need to understand the details of the Component Model before I could confidently render an opinion, I do agree with the concept of centralizing HQ functions and having the DHA as the single organization responsible for the MTFs in the areas identified in the Fiscal Year 2017 NDAA.

In your view, would a component model achieve the Committee's goal to eliminate multiple inefficient layers of management and bureaucracy in the Department's medical operations?

If the Component Model effectively and legitimately consolidates management and administration responsibilities for Military Treatment Facilities under one entity, the DHA, then I believe it is possible to eliminate layers of management and reduce bureaucracy and achieve better outcomes at lower cost.

In your view, would a component model eliminate the current stove-piped medical command structures of the Services?

From my limited understanding of a Component Model, it has the potential to eliminate the current stove-piped command structures of the Military Health System. However, it must be implemented correctly such that responsibility and authority shift to the DHA and the status quo is not maintained with a new name. If confirmed, that will be a major priority of mine.

If confirmed, would you ensure a rapid and efficient transfer of the operations of military medical facilities to the DHA?

Absolutely.

If confirmed, would you ensure that the military services reduce their medical headquarters staffs and infrastructure (including regional command staffs and infrastructure) to reflect the more limited scope and size of their health care missions?

I would ensure implementation meets the intent of NDAA-17 and eliminates unnecessary layers of headquarters and overhead functions. If confirmed, I will lead meaningful change that results in a much leaner and more efficient organization that is responsive to the beneficiary and the combatant commanders at less cost to the Department.

TRICARE Contract Acquisition

Section 705 of the National Defense Authorization Act for Fiscal Year 2017 requires the Department of Defense to develop a new medical contract acquisition strategy that: 1)

ensures maximum flexibility in provider network design and development; 2) integrates medical management between military medical treatment facilities and network providers; 3) maximizes use of telehealth services; 4) uses value-based reimbursement methods that transfer financial risk to health care providers and managed care support contractors; 5) uses prevention and wellness incentives to encourage beneficiaries to seek health care services from high-value providers; 6) implements a streamlined enrollment process and timely assignment of primary care managers; 7) eliminates the requirement to seek authorization of referrals for specialty care services; 8) uses incentives to encourage certain beneficiaries to engage in medical and lifestyle intervention programs; and 9) uses financial incentives for contractors and health care providers to receive an equitable share in cost savings resulting from improvement in health outcomes and the experience of care for beneficiaries.

If confirmed, how would you ensure that implementation of these new requirements complies with the law and meet the suspense date prescribed in section 705?

I have been advised that currently, the Department is aggressively working to meet all the requirements prescribed in section 705. Reportedly, the Department is currently developing six value-based pilots scheduled for implementation over the next year and actively collaborating with industry experts to develop strategies to transform contract acquisition strategies to improve value and health outcomes. If confirmed, I will completely review progress, actively become involved and provide direction.

Health Records Management System

The Department of Defense has acquired a new electronic health records management system, which the Department of Veterans Affairs will also adopt. This major information technology initiative presents a significant opportunity to ensure that the transition of service members between the two departments is seamless and makes the provision of health care services more efficient and cost effective. This initiative, however, also carries significant technological risk: This is the largest implementation of a medical records solution in either the public or private sector.

What risks does such a large, high visibility initiative pose to maintaining service members' continuity of care, and what steps would you take to manage them?

I am aware that continuity of care – and the related exchange of clinical information – is a priority for both DoD and VA, who have been actively addressing this through the Joint Legacy Viewer (JLV). Today, it is my understanding that JLV is fully operational and is used to share clinical information between the MHS and VHA legacy systems as well as between MHS GENESIS Initial Operating Capability (OIC) sites in the Pacific Norwest, and that JLV will continue to be the primary portal for sharing clinical information between the agencies as we transition to the new EHR.

Given how valuable and sensitive service members' health information is, what steps would you take to ensure the information is secure?

Currently, the Department of Defense (DoD) is in the midst of a large-scale electronic health record modernization effort, branded MHS GENESIS, managed through the Program Executive Office, Defense Healthcare Management Systems (PEO DHMS). It provides a state of the market solution consisting of Cerner Millennium, an industry-leading EHR. If confirmed, I will ensure that PEO DHMS works closely with the DoD and industry to ensure the data used by MHS GENESIS is protected from cyberattacks. It is my understanding that the DoD maintains some of the most advanced Information Assurance (IA) capabilities in the world.

Creating Health Value

The National Defense Authorization Act for Fiscal Year 2017 requires the Department of Defense to adopt a new acquisition strategy for TRICARE's health plan contracts, which focuses on improving the health value equation (higher quality of care + improved patient experience of care ÷ per capita health care costs = health value) for beneficiaries and the Department.

If confirmed, what would you do to create greater health value throughout the military health system?

If confirmed, I will drive the Department of Defense and acquisition community to establish contract requirements that require value-based reimbursement models that reward improved healthcare outcomes and improve the health value equation.

Quality of Medical Care

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

I have spent my career caring for patients in civilian health care sector facilities and therefore have engaged in quality improvement efforts as a medical provider and as a leader in these health care institutions. If confirmed, I will apply my experience in health care quality improvement to my role as Assistant Secretary of Defense, Health Affairs.

It is my understanding that the Military Health System (MHS) uses the Joint Commission, the same external accreditation organization used by most civilian healthcare facilities, to survey military treatment facilities (MTFs) for standards compliance.

I also understand that the MHS participates in numerous nationally recognized civilian quality programs such as the American College of Surgeons National Surgical Quality Improvement Program (NSQIP); the National Perinatal Information Center; the Centers for Medicare & Medicaid Services' Hospital Compare Program; and the National

Committee for Quality Assurance. If confirmed, I would work to build upon these partnerships to strengthen DoD quality and patient safety programs.

If confirmed, what would you do to improve quality of care and patient safety throughout the military health care system?

If confirmed, I would ensure that the MHS

- strengthens its use of evidence-based guidelines and advances a system for high quality, enterprise data collection to monitor and drive performance against internal and national benchmarks;
- nurtures a culture of safety as a leadership responsibility to become a learning organization committed to the safety of its patients and its workforce; and
- promotes transparency at all levels to catalyze improvements, promote trust and accountability and facilitate patient engagement through education.

If confirmed, how would you eliminate variability in the provision and delivery of health care throughout the direct and purchased care components of the military health system?

If confirmed, I would determine if we could leverage technology to automate non-value added activities to: reduce work load and data collection burden; create the technology infrastructure to support information and analytics systems that are predictive; and allow proactive intervention to avoid adverse events. In support of our clinical activities, I would investigate establishing the infrastructure to apply the latest research and literature for clinical guideline development, implementation and cross system communication to limit variation.

Graduate Medical Education

The Department of Defense spends about $250 million per year on graduate medical education programs. Section 749 of the National Defense Authorization Act for Fiscal Year 2017 requires the Department to establish and implement a process to provide oversight of the graduate medical education programs of the Services to ensure that those programs fully support the operational medical force readiness requirements for health care providers of the Armed Forces and the medical readiness of the Armed Forces.

If confirmed, how would you ensure elimination of those graduate medical education programs that do not support the operational medical force readiness requirements for health care providers within the Armed Forces?

If confirmed, I will ensure the MHS establishes a Joint GME Oversight Council to allow the MHS to implement a process that will ensure that programs are conducted jointly to the greatest extent practicable, and fully support the operational medical force readiness requirements.

Mental Health Care

In your view, are the Department of Defense's current mental health resources adequate to serve all active duty and eligible reserve component members and their families, as well as retirees and their dependents?

If confirmed, what actions would you take to ensure that sufficient mental health resources are available to service members in theater and to service members and families upon return to home station locations with insufficient community-based mental health resources?

If confirmed, sustaining the mental health of the Force and of Service member families would be a high priority, just as we do their physical health. From what I understand, over the past decade the Department has committed considerable resources to increasing the number of mental health professionals delivering care, improving ease of access to mental health care, and decreasing stigma. Further, I understand that the Department is working to ensure clinical and non-clinical resources are available for Service members and their families before, during, and after deployment. If confirmed, I will ensure that the Department of Defense is devoting appropriate resources to mental health, work with the Department of Veterans Affairs, and advise the Committee on what new approaches will be needed.

Are the Department's current mental health resources adequate to address the mental health issues of transgender service members?

If confirmed, I will determine if DoD behavioral health providers are capable to provide behavioral health services to a Service member diagnosed with gender dysphoria. I understand that the Department has implemented specific training in the care of transgender individuals for all primary care and behavioral health providers.

Suicide Prevention

In your view, is there a correlation between the mental health of service members and suicides and suicide attempts?

It is my understanding that from 2012 through 2015, DoD data consistently found that approximately 50 percent of those who die by suicide and approximately 67 percent of those who attempt suicide have had a diagnosis of a mental health disorder. Experts agree that while there is a statistical correlation between mental health disorders and suicide and suicide attempts, the nature of that correlation remains largely unknown.

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

If confirmed, improving our ability to identify individuals at highest risk for suicide will be a high priority. It is an issue that researchers across the nation, mental health providers and families struggle with. Our most fruitful efforts to prevent suicide will only be realized when we have the tools to confidently identify individuals at high risk and tailor specific and effective interventions to help them. If confirmed, I would recommend that we redouble our effort to use the great breadth of information available about our Service members and veterans to more completely understand the circumstances that lie behind suicides in our Service members.

And until we are able to specifically target our care and assistance, if confirmed, I would seek continued support for program efforts in wellness and relationship services recognizing that relationship, administrative/legal and workplace difficulties are the most common stressors endorsed among Service member suicide and suicide attempt cases. We must also continue to encourage innovative efforts to put time and space between an individual's contemplation of suicide and lethal means.

Operational Medical Force Readiness

On December 14, 2015, then-Deputy Secretary of Defense Work signed a memorandum requiring the Services and the Defense Health Agency to define military medical force readiness and to develop a model to determine and project the Department of Defense's cost for medical force readiness.

If confirmed, would you agree to perform an objective evaluation of the operational medical force readiness requirements of the Services and to ensure that staffing models and associated costs to maintain operational medical readiness skills reflect actual combatant command requirements?

Yes, such an evaluation is consistent with my responsibility, if confirmed, to ensure the effective execution of the DoD medical mission, providing and maintaining readiness for medical services and support across the range of military operations. Moreover, such an evaluation of operational medical force readiness requirements would be conducted with the Joint Staff and the planning factors employed by the combatant commands to ensure that the operational medical readiness skills and staffing models of the Services reflect combatant command requirements.

Since 2001, only about 7% of the total active medical force of the Services have deployed to a combat theater to provide medical care, but the Services consider their operational medical force requirements to be significantly higher. The Services believe that their peacetime healthcare mission is essential to the maintenance of operational medicine skills. Additionally, data shows that military hospitals and clinics produce inpatient/outpatient workload at costs about 50% higher than what it would cost if those services were purchased in the private sector. Considering these facts, it is difficult to justify a large, costly medical force simply to provide a medical benefit in the direct care component of the military health system.

If confirmed, what would you do to right-size the active medical force requirements of the Department to optimize operational medical force readiness capabilities and to produce cost savings to the Department and U.S. taxpayers?

If confirmed, I would critically review and implement the forthcoming results of relevant studies and analyses required by specific sections of NDAA-17 for this purpose. That would include implementing changes in the DoD medical infrastructure to ensure those facilities are optimized to provide operational medical force readiness first and foremost. In addition, partnerships with the private sector and VA should be highly leveraged for inpatient/outpatient workload that is not required to produce medical force readiness.

Medical Readiness of the Armed Forces

Recent data from April 2017 shows that 8.9% of the total force (Active and Reserve components) was medically non-deployable.

In your view, what are the primary factors that contribute to the unacceptable levels of medical readiness of the total force?

It is my understanding, a significant contributor to lost duty time and deployment limiting conditions of the total force are musculoskeletal injuries. Many of these injuries occur in training conditions.

If confirmed, what would you do to improve the medical readiness of the total force?

It is my understanding that the Department has put medical policies and procedures in place and increased resources to protect and restore both the physical and psychological health of Service personnel. If confirmed, I will ensure DoD is focusing on prevention, enhancing access to health services, and on medical research, to prevent and treat a broad range of fitness issues to improve resilience and preparedness for our DoD deployed missions.

Pain Management

If confirmed, what policies and programs would you implement to improve pain management in the military health system to reduce and eliminate the misuse and/or abuse of opioid medications?

My understanding is that since the October 21, 2015 Presidential Memorandum ("Addressing Prescription Drug Abuse and Heroin Use") the DoD has taken actions to address the prescription opioid abuse and heroin epidemic use. If confirmed, I will continue to emphasize the critical importance of sustaining these efforts and continually review the program for maximum efficacy.

In your view, should alternative and complimentary therapies for pain management be considered as benefits under the TRICARE program?

Always, any treatment offered through the TRICARE program must be shown to be both safe and effective. If confirmed, I will ensure that various alternative and complimentary therapies to include acupuncture, therapeutic massage, movement therapy (Yoga), and manipulation therapy are considered and that we assess the evidence for effectiveness.

Women's Health

In view of the expanded roles of women serving in the Armed Forces, what are the health challenges that the Department of Defense and the Services must address to ensure appropriate health care for female service members in deployed and non-deployed environments?

My understanding is that the primary health challenges that the Department and the Services must address include unintended pregnancy, adequate hygiene in deployed settings to prevent infections, access to mental health care and non-combat injury prevention. If confirmed, I would pledge access to a full range of contraceptive options, and hormonal methods for menstrual suppression, easing access to mental health care and appropriate training in body mechanics and weight distribution when carrying heavy loads to prevent musculoskeletal injuries. I also believe that therapeutic abortion services should be provided by the military in appropriately staffed facilities.

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

If confirmed, I will make it a high priority to assure that female service members have adequate health services to maintain fitness, prevent unintended pregnancies, injury and illness. If confirmed, I would ask for a review of studies both ongoing and of the recent past to identify opportunities for the development of new policies, to guide the collection of female service members health related information and to inform Service-specific initiatives to promote healthy hygiene practices in deployed settings.

Wounded Warrior Care

If confirmed, what would you do to ensure the Department of Defense continues to advance diagnosis, treatment, and rehabilitation services for wounded, ill, and injured service members?

If confirmed, I will determine the current state of clinical care for our wounded, ill, and injured Service members. I will ensure that all wounded, ill and injured Service members have access to the appropriate care that they require and that the care is delivered in a timely manner. I will investigate the outcomes of care for our Service members at our

military treatment facilities and in care purchased in civilian institutions to ensure that our Service members receive the best care possible. They deserve no less.

Congressional Oversight

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

Do you agree, if confirmed, to appear before this Committee and other appropriate committees of 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 ASD(HA)? 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 in a timely manner? 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 this Committee regarding the basis for any good faith delay or denial in providing such documents? Yes

Do you agree to answer letters and requests for information from individual Senators who are members of this Committee? Yes

If confirmed, do you agree to provide to this Committee relevant information within the jurisdictional oversight of the Committee when requested by the Committee, even in the absence of the formality of a letter from the Chairman? Yes