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CHALLENGES AND OBSTACLES WOUNDED AND INJURED SERVICE MEMBERS FACE DURING RECOVERY

COMMITTEE ON ARMED SERVICES
HOUSE OF REPRESENTATIVES
ONE HUNDRED TENTH CONGRESS
FIRST SESSION

HEARING HELD
MARCH 8, 2007



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CHALLENGES AND OBSTACLES WOUNDED AND INJURED SERVICE MEMBERS FACE DURING RECOVERY

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ARMED SERVICES,
Washington, DC, Thursday, March 8, 2007.

The committee met, pursuant to call, at 10:03 a.m., in room 2118, Rayburn House Office Building, Hon. Vic Snyder presiding.

OPENING STATEMENT OF HON. VIC SNYDER, A REPRESENTATIVE FROM ARKANSAS, COMMITTEE ON ARMED SERVICES

Dr. SNYDER. The hearing will come to order.

We appreciate you all being here on this cold, snowy morning. Mr. Skelton will be joining us probably in the 10:30, 10:45 range, but he wanted us to go ahead and begin the meeting.

It is a pleasure once again to have all of you here with us, well-known to this committee: Dr. Chu, Dr. Winkenwerder, General Kiley.

And, General Schoomaker, you are a bit like the old pair of slippers that just keeps coming back in the house once it is set outside. And I think we said goodbye to you the last time that you were here, thinking it was going to be your last time to testify. But we appreciate your service and appreciate you being with us.

Yesterday evening, Mr. McHugh and I met with some of our staff members for an hour or so, because this body, this house, is very interested in trying to help resolve some of these issues involving the medical holdovers, the Walter Reed situation, with legislation.

And so, you all may interpret that as bad news. We interpret that as good news. But the good news part of it is Mr. McHugh and I really want the legislation to be helpful. And we also recognize that sometimes legislation may not be helpful.

So I think some of the questions today will try to get at things that we may at least take a first bite at this here in the next few weeks, recognizing that there is no one piece of legislation or one decision by any one of you that is going to solve the kinds of issues that we are dealing with.

And before going to the witnesses, I will defer to Mr. Hunter for any comments he would like to make for as much time as he needs.

STATEMENT OF HON. DUNCAN HUNTER, A REPRESENTATIVE FROM CALIFORNIA, RANKING MEMBER, COMMITTEE ON ARMED SERVICES

Mr. HUNTER. Thank you, Mr. Chairman.

And, gentlemen, good to be with you. I look forward to your testimony this morning.

I think the position of the committee clearly is, let's figure out what went wrong and fix it.

One thing that I did want to say to my colleagues on the committee is that we have had a bipartisan team of staff members, Democrat and Republican staff members, attending medical facilities throughout the country and in other areas where we have American troops for the last several years.

And, Mr. Chairman, we did something several years ago that I think had never been done by the Armed Services Committee before, and that was to dedicate a staff member from the committee to simply handle issues that patients of our Department of Defense (DOD) medical system experienced, and to talk to their families and try to assist them as they go through the process of coming back from Landstuhl and other areas to Walter Reed, Bethesda, and then, ultimately, out to satellite hospitals throughout the DOD complex.

So, gentlemen, I look forward to your testimony. There certainly appears to be a lot of work to be done.

And, Mr. Chairman, thank you for calling this important hearing this morning.

Dr. SNYDER. Thank you, Mr. Hunter.

Our four witnesses today are well-known to this committee and this Congress and this country for their service: Dr. David Chu, the undersecretary of defense for personnel and readiness; Dr. William Winkenwerder, the assistant secretary of defense for health affairs; General Peter Schoomaker.

Did I pronounce that right, General? Schoomaker?

General SCHOOMAKER. Schoomaker, sir.

Dr. SNYDER. Schoomaker?

General SCHOOMAKER. Yes, sir.

Dr. SNYDER. Okay. At the last hearing, you are entitled to have your name pronounced right for the first time, perhaps, in your career—Schoomaker, chief of staff of the U.S. Army; and Lieutenant General Kevin Kiley, the surgeon general of the U.S. Army.

And we will have your opening statements in that order.

Dr. Chu.

STATEMENT OF HON. DAVID S.C. CHU, UNDER SECRETARY OF DEFENSE (PERSONNEL AND READINESS)

Dr. CHU. Thank you, Mr. Chairman, Congressman Hunter, members of the committee. My colleagues and I each have prepared statements which I hope you would accept for the record.

Dr. SNYDER. Without objection, all the statements will be part of the record.

Dr. CHU. Thank you, sir.

I am deeply chagrined by the events that bring us to this hearing today. As you appreciate, we set high standards in the Department for our personnel programs and their administration.

You can see the achievement of those high standards in the conduct of our medical personnel in caring for the wounded on the battlefield, bringing them home to the United States and placing them on the road to recovery.

It is evident in the fact that we have the lowest disease and non-battle injury rate in the history of the republic and the highest rate of survival from wounds the American military has ever sustained.

And you can see it also in the generally favorable ratings that our patient population—active, reserve, retired—gives to the TRICARE medical program. Indeed, the Congress has added communities to that program over the last several years, as a result of the high regard in which it is held.

But I wish to apologize this morning on behalf of the Department to those individuals where we fell short in administration, in billeting, in how we carry out the disability claims process.

And I apologize likewise to the American public.

I would like to ask my colleagues to speak to medical programs, per se, and I would return very briefly, if I may, Mr. Chairman, to speak to the disability evaluation system, which I do think is the area in which long-term legislative change may be meritorious.

STATEMENT OF HON. WILLIAM WINKENWERDER, JR., MD, MBA, ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS

Dr. WINKENWERDER. Thank you, Mr. Chairman. Thank you for your support to all of our efforts over the year.

Mr. Chairman and distinguished members of this committee, thank you for the opportunity to be here today to talk about the serious concerns raised about housing conditions and inappropriate bureaucratic delays and hurdles for service members at Walter Reed Army Medical Center while those individuals are receiving long-term rehabilitation and care.

Our wounded service members and their families expect, and they deserve, quality housing and family support along with well-coordinated services. In the case of the incidents at Walter Reed, we failed them.

Today, I welcome the chance to talk about these issues and what the Department is doing, even at this time, to move forward.

Corrective action plans in the Army and across the Department will take the following approach.

One, the top priority is finding problems and fixing them. Where policy, process, or administrative change is required, the Department will do it.

Second, we welcome public scrutiny, and that—this point—that is a difficult thing to say, but we do, as painful as it is. The problems cannot be solved and the people properly served if the light is not shed on the problem, and that is happening.

I endorse the statements of Secretary Gates. He has made it clear that defensiveness and explanations are not the route to getting things done. Standing up and making things happen to meet the needs of our service members and their families is our only job right now.

Let me just assess the problems before us as follows. And I think Dr. Chu is kind of touched on this.

It relates to physical facility issues, process of disability determination—and there will be a lot more to talk about with that—and the process of care coordination in the outpatient long-term setting, not in terms of acute outpatient care.

With regard to the housing, I understand that the Army has already begun correcting problems and is reviewing all housing for wounded service members at other locations. The other services have also undertaken a review, and that review is ongoing.

With respect to the disability determination process, let me just say that service members deserve fair, consistent and timely determinations. The complex procedures must be streamlined or removed. The system must not be adversarial, and people should not have to go through a maze or prove or defend themselves to the benefits that they deserve.

Likewise, regarding coordination of services, there must be a higher ratio of case workers to wounded service members, so that people get personalized care, a better support and communication system with the families, and simpler administrative processes.

Now let me just address one issue, and I think this is important—we will have more discussion about it today; make that very clear. The problems sighted in the press reports are not result of unavailable or insufficient resources. Nor are they in any way related to the base realignment and closure (BRAC) decision to close the Walter Reed campus as part of the planned consolidation with the National Naval Medical Center.

Significant resources have always been available, and we continue to invest, even at this day, at Walter Reed for whatever is needed.

For example, there were some who questioned the decision in 2005 to fund $10 million to construct Walter Reed's new amputee center. But we have proceeded with that without hesitation. We think that is the right thing to do. And we will simply not allow for plans for a new medical center to interfere with ongoing issues of care or any needed facility improvements.

Secretary Gates' decision to establish an independent review group to evaluate and make recommendations on this matter will be very beneficial. The group is a highly qualified and, again, bipartisan team of former congressmen, line, medical and enlisted leaders who have already begun their work. And, of course, in addition to that, there is the commission that the President just announced here within the last couple of days, who will also be looking at these issues even more broadly, including the Veterans Administration (VA).

The entire Department has been informed of the review group's charter. Group members can go to any installation, talk to any personnel, review any policy or procedure to get the information and answers they need. They will have full support of the Department.

The Department will be driven for results in the actions that we take in the weeks ahead: engaged, action-oriented, and focused on making real and permanent improvements.

The people we serve—the service members, families, military leaders, Congress and the President, the secretary, everybody—they deserve to know that we are getting the job done. We have attacked problems in the past and solved them and come out stronger as a result, and I believe that we can do that again.

We have established new standards, as Dr. Chu noted, in virtually every category of wartime medicine. Many people don't know that we have established new standards in everyday medicine for

America that has a great impact on improving health care in America.

The quality of our medical care for our service members is excellent. No one should question that aspect of this issue. There is no question about that.

On the other hand, with regard to the quality of life for people while they are receiving that care, that is where our focus is. That is where we did not meet our standards.

In the current news reports, the trust that has been earned through our historic achievements has been damaged. And that trust was earned through a lot of hard work, but we have got to work even harder to re-earn that trust.

So, in closing, let me just say that, as we work together on all these issues, I would like to point out one other important thing, and that is, I believe it is very important at this time that we maintain the morale of our medical professionals, of all those who serve our warriors.

And we need to maintain the confidence of our entire military in the military health system. It is critically important. People should not question, should not lose their confidence about the care that they will receive. And I urge that you work together with us on that matter.

I look forward to working together with you and with the leaders within the services in the Department in the remaining weeks of my tenure, and I am grateful to have had the opportunity to have worked with selfless and committed and dedicated professionals and patriots who care for our wounded warriors. They are our Nation's heroes, and, as such they deserve our very best.

Thank you.

[The prepared statement of Dr. Winkenwerder can be found in the Appendix on page 86.]

Dr. SNYDER. Thank you.

General Schoomaker.

STATEMENT OF GEN. PETER J. SCHOOMAKER, CHIEF OF STAFF, U.S. ARMY

General SCHOOMAKER. Mr. Chairman, distinguished members of the committee, you know, as chief of staff of the Army, as a senior uniform military officer in the Army, I am responsible for everything that happens and fails to happen in the United States Army. And so I take full responsibility for the situation that has caused us to appear before you again today.

As you have already stated, I had hoped that the last appearance before you would have been my last, and I am disappointed that these circumstances are the ones that bring me before you again.

But we have worked well together in the past, and we are going to need your help to fix the things that we have found in this.

I will tell you that one of the things that is disturbing is, with the amount of attention and the amount of resources that we have placed into this area, that we find the kinds of conditions and situations that have been reported.

And one of the things we need to find out is why, within the leadership structure, that these kinds of surprises surface. It doesn't make sense. We have had hundreds and hundreds, if not

thousands, of visits to all of our medical facilities. You have visited a great many times. I certainly have. The leadership has. And to have these kinds of things appear the way they were is—doesn't make sense to me.

There is an opportunity here that I hope we take, and that is fix this comprehensively. This isn't about painting things and dealing with mildew and fixing some administrative processes. There needs to be a really top-down look at the statutes that underpin the kinds of things that we do, the fact that there are different laws—Title 10 for DOD in terms of compensation, Title 38 for the VA, which has a different structure for compensation, and I understand even Social Security/Medicare business is another statute.

We, clearly, have differences in the services and how our administrative procedures are put together. The policies aren't uniformly administered.

And so I think that this really, as difficult as it is, is an opportunity to do a comprehensive fix. And I hope that is what we are all committed to doing, you know, as we look at this.

Again, I would like to remind everybody that every day there are thousands of very dedicated medical professionals that are tending to our soldiers and their families.

And I really am concerned that we paint broadly across this entire professional community with some of the things that have been reported, and we fail to recognize that there are real heroes in our hospitals—and on the battlefield and everywhere else in the medical community—that, every day, are working against great odds and great obstacles, great bureaucracy, to tend to our soldiers and their families well.

And I hope you will keep that in mind as we go through not only our discussions, but the subsequent fixes to what we do.

I am very, very proud of these people. And, as you know, one of them happens to be my brother, and so I have some great insights into it.

Finally, what I would like to say is, we have been aggressively fixing this and pursuing fixes, not only with massive so-called tiger team approach, but we are doing surveys all across the country, going out and inspecting all over the place, not just Walter Reed.

But at Walter Reed, we have appointed a new commander there. He happens to have the same last name as I have. He is a very talented individual. And I know that he will go about this.

I want to make it clear that I was recused from participating in the decision to select him, but in my view, he is the right man to go into there.

We are going to give him—and it will be announced this week—a brigadier general combat arms officer who will be his deputy. And that combat arms officer will help look at the situation at Walter Reed from a perspective of the battlefield and as a leader of combat soldiers.

We have already appointed a combat arms brigade commander with experience in the war on terrorism, and he has a command sergeant major. And we have restructured the entire team out there to make sure that the soldiers are getting the leadership and the assistance that they require.

We have established a hotline directly into the Army Operations Center, which means that every call is recorded and is required to be reported to the very top leadership of the Army on anybody that has a problem out there. It would be a toll-free number. And that will occur.

And there are many other things that we are doing to make this right, to include looking at an ombudsman program so that we have advocates that are outside this adversarial system that can assist our soldiers and their families as they go through this very difficult bureaucratic process.

So I will wrap up with that, because I know the important thing is that we have a discussion about this and that you pursue those things that you are interested in.

But, again, I want to make sure that there is no mistake about it: I accept responsibility for these failures that have occurred, and we are committed to fixing them. And as long as I am in position, there will be great energy behind getting this done.

And, again, with your help, I believe that we can fix this in a very comprehensive fashion that will stand the long test of time. Because I do believe that this long war is going to require us to continue to have the very best medical care for our great soldiers and their families.

Thank you very much.

[The prepared statement of General Schoomaker can be found in the Appendix on page 92.]

Dr. SNYDER. Thank you, General.

General Kiley.

STATEMENT OF LT. GEN. KEVIN C. KILEY, THE SURGEON GENERAL, U.S. ARMY

General KILEY. Mr. Chairman, Congressman Hunter, distinguished members of the committee, I am here today to address your questions about the circumstances at Walter Reed.

A commander is charged with the health and welfare of his soldiers, and a physician is charged with the health and welfare of his patients. And as you know, in the last few weeks we have failed in the housing at Walter Reed, and we are addressing that and many other issues.

I want to offer my personal apology to the soldiers and families, to the Department of the Army, the Department of Defense, to you and to the American people for these circumstances.

I am personally and professionally very sorry that we are sitting here today, and I take full responsibility and accountability as the Medical Command (MEDCOM) commander.

There are bureaucratic, complex systems associated with the disposition and discharge of soldiers that require and demand urgent simplification, and I am committed to getting on with fixing this system. I am dedicated to making sure that soldiers are equitably and fairly cared for, that they reach their full level of care, and that they are returned to the force or retired in a manner that shows respect and dignity for them.

As you have heard, we have taken immediate actions. The chief has listed some of those.

Building 18 is empty as of today, and within weeks we will begin repair of that building. We have got teams out around our installations checking to make sure that the quality of life, communications, command and control, and infrastructure are in good shape at our other installations.

You know, a soldier won't attack an objective in combat out of the sight of a medic. And our 68W medics are the best in the history of our Army. And they are connected inexorably to Landstuhl Regional Medical Center and to the great facility at Walter Reed Army Medical Center, which I think you know provides absolutely outstanding inpatient and, I would suggest to you, outpatient care.

The doctors, nurses and administrators that are doing that are doing a superb job. There are clearly questions about our handling of the soldiers' quality of life and the processing through the disability system that I would be happy to answer your questions on.

It is a very complex disability system. It is confusing and, frankly, we realize it is adversarial and confrontational. And we have got to fix that. Soldiers tell us it is as though we don't respect them because of the way that they have to work their way through the disability system.

Secretary Gates is expecting decisive action, and he and our soldiers will get it.

The Walter Reed Army Medical Center has got a magnificent reputation. The care for soldiers on the battlefield is second to none. That is a combination of the skill of the staff at our facilities, who prepare themselves and deploy; the technology that we bring to bear—new technologies almost every year; and the unwavering support of the Congress and the American people. We want to reestablish that trust.

It is regrettable that *The Washington Post* had to bring this to our attention, but since they have, we are taking immediate action, as we have already said, to fix the problems.

I have been a physician and a soldier for 30 years. It is an honor to lead the Army Medical Department, and it is an honor to serve our soldiers and the nation.

And I look forward to your questions.

[The prepared statement of General Kiley can be found in the Appendix on page 97.]

Dr. CHU. Mr. Chairman, we recognize, as my colleagues have underscored, that we have a special responsibility to those who have suffered severe injury in the service of their nation. That is one of the reasons that we opened, two years ago, a Defense medical injured center as a back-stop to the service programs.

In this arena, you need, really, a layered effort to ensure that you have dealt with all cases adequately. It is the place we bring together our sister Federal agencies—the Department of Labor, the Transportation Security Administration and the Veterans Affairs Department—so we can provide the kinds of services that ought to be available to our people. And I am pleased to say that the Department of Veterans Affairs has placed representatives in our major hospitals to help with the disability evaluation process.

It is also the reason that we are proud to partner with others. Heroes to Hometown is one of those examples, where we are working with the American Legion, with the state Veterans Affairs De-

partments, to ensure that, when the individual comes back to his or her hometown, that they are greeted appropriately and the kind of support they should expect is indeed there.

And we are appreciative that the Congress last year gave us the statute authority to expand the computer electronics accommodations program in which we can provide those who need assistance in order to carry out their tasks, particularly as they seek re-employment, have the equipment that they indeed deserve.

As General Schoomaker emphasized, I think one of the central issues as we move forward here is this question: Do we have the right paradigm for providing for those who have suffered grievous injuries in the service of their Nation?

As he indicated, and as you appreciate, we have really three different programs in the Federal Government that provide support, assistance—especially monetary assistance—to those who have been injured in the service to the Nation.

There is, of course, the defense disability system, but there is also the disability payments system in the Department of Veterans Affairs, and there is the Social Security Administration, which, in some cases, will also make payments.

As General Schoomaker suggested, Title 38, which covers the VA, and Chapter 61 of Title 10 take fundamentally different approaches to the basis on which you should rate the individual. It is, therefore, not surprising that we reach different answers in that regard.

But from the individual's perspective, this is surely complex, indeed, as the reports suggest, frustrating in its character.

Pending that large debate, the Department is indeed revitalizing its own system. We will soon be issuing new instructions for the governance of that system. The services, in their areas of responsibility, are relooking at their processes. The Army has its transformation initiative for its disability evaluation system.

I am confident that with this energy, this level of attention, and your support for necessary, statutory stages, that we can replicate, in the way we administer and the way we run the disability evaluation system, the success we have enjoyed in the clinical area and that is so properly and widely celebrated in our country.

Thank you, Mr. Chairman.

[The prepared statement of Dr. Chu can be found in the Appendix on page 72.]

Dr. SNYDER. Thank you all for your testimony.

I am going to ask unanimous consent also to have admitted to the record the committee memo that the staffs worked together on. And I think it is a good summary of some of the challenges.

[The information referred to can be found in the Appendix on page 111.]

And for anyone out there who would love to have a copy of it before the transcript of the hearing is made publicly available, just holler at the staff members, because I think it gives a good summary of the history of some of the problems, but also some of the involvement of this committee.

The second point I wanted to make—and Mr. Spratt came in here in a very timely fashion.

Dr. Winkenwerder, you specifically stated in your written statement, I think in your oral statement also, that you don't think it is a money problem. That conflicts a little bit with what General Schoomaker says in his written statement, which he thinks there may be some military construction (MILCON) needs that would take congressional action.

But I would encourage you all—I mean, the fire is hot right now. We have got trains revved up and ready to go that can carry some money in your direction to help solve this problem. And if you think that there are areas there that some additional funds in specific areas would be helpful, please let us know. Because I think that this is something the American people want to get solved.

Obviously, we don't want to put money out there and not have it be helpful. But if you think there are money problems, then this is the time to deal with it.

The third point or comment I wanted to make: When I first heard the interview with Dana Priest, who was one of the reporters in *The Washington Post*, she made this comment that when members of Congress would go out there, as a lot of members do just to see what is going on and visit with families and be supportive—I can't speak for everyone on this committee, but we don't have a formal notification process when there are—when our constituents are wounded, or when they are admitted to any of the military treatment facilities or when they are in a medical hold status.

Now, some of us have made some informal arrangements. I think it has been a couple years or so since my office has been notified of any wounded. I think there are some privacy issues, some Health Insurance Portability and Accountability Act of 1996 (HIPAA) issues.

But the point I want to make is one of the things that Dana Priest said is that when a member of Congress found out that an individual was having a problem—I mean, her comment was a lot of times it would get taken care of. We would get ahold of your staff and work through these issues.

Now, what I am trying to say is I think you have got about close to 900 people in a medical holdover status at Walter Reed. That averages out about two per member of Congress who would be advocates for those people if we can work around some of these privacy issues.

I don't say that—I thought of that last night to myself, almost facetiously. I thought about it more today. I thought, "No, that is the way this system works." And you all know that is how it works.

We hear things from families and constituents and we get ahold of your folks, and a lot of times there are legitimate concerns that you all get straightened out. But we do not get formal notification because of privacy issues. Any comment on that?

Who should I direct this to? Maybe General Kiley. How many people today do we think systemwide—or maybe Dr. Winkenwerder—are in a medical hold or holdover status?

General KILEY. Mr. Chairman, I can take the exact answer for the record. But in a rounding figure——

Dr. SNYDER. Yes.

General KILEY [continuing]. About 900 MedHold, which are active duty, and about 3,200 MedHold Over, which are reserve and National Guard, across our installations.

And also, in that 3,200 are about 1,800 that are in our CBHCOs, our community-based health care. So they are living at home, getting care in the community, reporting to their National Guard armories.

Dr. SNYDER. And so how many today are in the Walter Reed status?

General KILEY. At Walter Reed, I believe the number is around 600.

Dr. SNYDER. Around 600 today. Those are about the numbers I have.

General KILEY. Yes, sir, I can get you exact numbers.

[The information referred to can be found in the Appendix beginning on page 166.]

Dr. SNYDER. Dr. Winkenwerder, do you have——

Dr. WINKENWERDER. And let me add to that, there is another—again, I don't have the exact number, but rough order of magnitude 1,000 or so that are Navy, Marine, or a smattering of Air Force. The bulk is the Army.

Dr. SNYDER. And I think it is important we keep these numbers in mind, because this is a well-defined universe. It is not a large group of people for this country to deal with. And there has got to be a way for us to get a better handle on this.

I am told that you all—that somebody sits down in a weekly manner with you all, and you can pull up and have a list of everyone on medical hold, hold over status. Is that correct?

General KILEY. Yes, sir, I believe that is correct.

Dr. SNYDER. That doesn't necessarily mean that you know where they are at, but you actually have a list of them.

General KILEY. We know where they are at, too.

Dr. SNYDER. You know where they are assigned to. That is not the same as knowing where they are at, because they may have walked away on you, or their case managers may have lost track of them, correct?

General KILEY. Well, I wouldn't say that it never happens. But our intent is for us to know where they are, if they are at home in the CBHCOs. We are keeping contact with them.

Dr. SNYDER. Okay, I understand that.

General KILEY. If they are assigned to the MedHold or MedHold Over at their installations, they have case managers who are keeping track of them.

Dr. SNYDER. But your formal system doesn't say that, "They were last seen by a medical facility on February 7."

General KILEY. No, sir. No.

Dr. SNYDER. Which gets to the case managers. Who pays the case managers? Are they military personnel, civilian personnel, or both?

General KILEY. I believe they are a combination of both. Most of them are civilian, a combination of nurses and social workers.

Dr. SNYDER. Who do they work for? Who pays their check?

General KILEY. Well, if they are civilians, I pay their check through MEDCOM.

So if they are working at our facilities as case managers, they work for the commander of the hospital in managing the cases. And as I understand it, I would pay through the hospital's finances for their salaries as contractor general schedule (GS) employees.

Dr. SNYDER. If I ask these 3,000-plus people today, "Do you consider your case manager your advocate?" what do you think the answer would be?

General KILEY. I think their answer would be that in general they are. We have surveyed MedHold Over soldiers and directly asked them the questions about how they feel about the case managers. We are just standing this up. I have just gotten some responses back, and they seem to be very pleased with their case managers in general.

Dr. SNYDER. Well, "in general" may speak to the heart of the problem, because—what do you see the job as case managers to be, Dr. Winkenwerder and General Kiley? Do you see their job as to be advocates?

General KILEY. Absolutely.

Dr. WINKENWERDER. Yes. Yes, sir.

Dr. SNYDER. You don't see their job as trying to explain to them why they are not going to get their appointment for 60 days; you see their job as to have them get their appointment in 5 days. Is that correct?

Because that is not anecdotally what we have heard from some of these warriors. They have not seen their case managers as being their advocate.

Dr. WINKENWERDER. I think that is unfortunate, where that has happened. They should be——

Dr. SNYDER. Do you agree that it has happened?

Dr. WINKENWERDER. Well, the reports—I have read about the same ones that you have, and I think of a case manager, case worker, social worker, nurse as someone who cares about that individual; is trying to do the best for them, get them in, help them with their appointments, make sure they are followed up, if they are not certain or clear about what they need to do next.

They are there to help them. That is the job. It is really personalized attention.

Dr. SNYDER. Mr. Hunter.

Mr. HUNTER. Mr. Chairman, thank you.

And, Mr. Chairman, this is a problem which is especially, I think, both devastating and significant, because it is one that occurred in a place where there are lots of eyes and lots of folks and are close to a center of power.

And I can tell you that, in fact, I was at Walter Reed I believe the same day that this story started to come out, visiting some of our wounded folks in the inpatient area. All of us have been down there a lot.

You know, this is one of those things that doesn't lend itself to statute and legislation and regulation, because we have got a lot of that. It lends itself to an answer that focuses on the military families, that focuses on the ability of a Marine wife, whose husband is severely injured and has two kids in school and just drove 300 miles to get here and doesn't understand the situation, to be able to easily find out what the program is and to be able to easily

access that program and to have a program that is simple enough that folks that aren't experts on military medical law can get taken care of.

And I think it is important for our committee to know that we have had a great oversight team, Democrat and Republican, with Ms. Wada on the Democrat side and Ms. James on the Republican side, visiting literally dozens and dozens of medical facilities throughout the country, as well as Walter Reed and Bethesda.

And one thing we did several years ago that we have never done as a committee, is I appointed one of our professional staff members, Mr. Godwin, to be an ombudsman for the families and for the people who wear the uniform of the United States who are the patients at Walter Reed and Bethesda.

Mr. Godwin undertook more than 80 visits to Walter Reed, a couple fewer visits to Bethesda. And his job was to go in, sit down with military families, but almost exclusively in the inpatient area; talk to them, find out what their problems were, direct them to the right place, try to make sure that they had housing, that they had transportation and that the wounded soldiers and Marines were taken care of.

Now, while we were doing that, we thought that we would do another thing, and that is to start getting jobs for guys that were transitioning out, and ladies who were transitioning out, who were going to be moving out into the private sector.

And so we started to have jobs fairs in a couple of the hospitals, one in California. And I attended one that we put together here at Walter Reed, where members could come down into the day room, tell us a little bit about what they did, what their professions were, and see if we couldn't hook them up with folks in the government but also folks in the private sector.

So we started doing that. After we had done that for about a week and we had actually landed some jobs for a couple of our wounded folks, I was informed that I was on the verge of breaking the law because there might be an ethics problem with a member of Congress or professional staff members helping to get jobs for wounded soldiers and Marines with the private sector, on the basis that the private sector would then expect a quid pro quo from the committee.

So to handle that, we then offered a resolution before the full House which passed—and I think almost every member of this committee voted for it—essentially laying the groundwork for the Ethics Committee and the Administration Committee to approve us having professional staff members on the committee who would assist wounded people, wounded personnel, who were separating from the service with getting jobs in the private sector without having an ethics ramification.

That resolution passed the full House. It is awaiting action by the Ethics Committee, which hasn't been forthcoming.

So I would just recommend to my colleagues that one great thing that you can do for folks who are wounded is to make sure that when they get that transition, if a guy is a generator mechanic and he is going to go back to Maine, we should be able to contact the companies in that location and see if we can't get a good job inter-

view perhaps put together while he is in Walter Reed or while he is in Bethesda.

So I thought, Mr. Chairman, it is important for our committee members to know that we have had a strong oversight team going throughout the United States, conducting also sensing sessions with over 1,000 personnel and their families with no brass present and with no administrators present so they could talk candidly to us.

Nonetheless, this problem has occurred basically right under our noses, right here in the center of power.

And I would offer that the key to this thing is to have a system which is consumer- and customer-friendly. And that means when that young wife of a wounded Marine comes in and she has got two kids that she has left with her mom while she drove 300 miles down here to see her husband, perhaps for the first time, that she not only has a path of things that she has to do with respect to applications and filling our forms and waiting, but that she is given very important person (VIP) treatment—that is, preferential treatment, that she has somebody who leads her through this path that she has never had to walk down before.

We need to have a system that is customer-friendly, because there is no family that is more vulnerable, nor in more of a state of anxiety and, to some degree, confusion, than a military family whose loved one has been injured. And in 99 percent of the times of the cases, that means that they have got to travel some distance so they are away from home. They have major expenses.

Now, I think it is important to note that we have a number of great organizations, like the Semper Fi organization and a number of others, that will provide cash and will provide help. And we also have great on-hospital facilities like the Fisher House and others where families can put up without paying that 120 bucks a day in the Washington area for hotel rooms while you are here.

But this a problem, I would just say to my colleagues.

And, you know, if the buck stops here, General Schoomaker, my gosh, all of us have been down to Walter Reed numerous times. I think I was there visiting a patient when the story broke. So the buck stops here also.

But I think that the answer to this question is not going to be regulations. Regulations got us here. It is the same regulation that means, when a soldier is carried off the field on a stretcher and gets to Walter Reed, he ends up receiving a bill for the equipment that he lost when he was hit with the improvised explosive device (IED).

It is a bureaucratic system, and you have to keep mowing the grass to make sure that you keep that from developing a system that is very unfriendly to the customer. And the customer is the men and women who wear the uniform of the United States who are receiving the medical care.

So I think that the answer to this has to start with the people. It has got to start with the soldier, and it has got to start with the family. And what we have to have is a simple system.

Now, before you fix all the regulations, or we try to fix something structurally so that this doesn't happen again, there is one way to get through this early.

And that is to assign lots of people to the families and to the wounded personnel, so that when you have that 18-step program somebody has to go through before they get their compensation or before they get the next booking for therapy, you have got somebody standing next to them saying, "I will take care of this," and they take care of it. And that wife who has driven 300 miles has the answer and the solution, rather than simply a direction as to what the second of 35 different steps is going to be.

So I think if we start with the personnel, with the wounded soldier, sailor, airman, Marine, and his family, start with them—let's fix them up first, make sure we have got somebody that takes care of them, just like there is somebody if a VIP comes to Bethesda or Walter Reed; there is somebody there to walk them through that system, to get them through the bureaucracy. We need to have a VIP system attached to every single person that wears the uniform.

Let's undertake that, because that will give us a result a lot earlier than a series of legislative steps.

And I think largely this is not a solution that requires as much legislation as it requires a cultural change.

So if we could do that, if we could focus on the wounded American service member and the family first, attach lots of people to them to get them through this cumbersome system, then fix the system, I think that will expedite things.

Thank you, Mr. Chairman.

And I am glad that you put into the record the oversight activities that the Democrat and professional staff members have undertaken.

And you know we have a great system. We have all seen the incredible wounds that would not have been survived 10 or 15 or 20 years ago that now are survived because of excellent care, literally, from that medic on the battlefield right through to the skilled hands of the surgeons and the medical providers.

What we have to do is match that capability with a streamlined bureaucracy that is soldier- and Marine- and airmen- and sailor-friendly. If we do that, we will retrieve this great system.

Thank you, Mr. Chairman.

Dr. SNYDER. Thank you, Mr. Hunter.

I think Duncan had such wisdom there that I would like each of you to respond to what he was talking about in terms of having a consumer-friendly system.

Because my guess is if we asked you a month ago, "Do you think you have a consumer-friendly system?" you all would have said, "Yes, we have been really working at it and we get good feedback." But it is apparent that we don't.

So starting with you, General Kiley, how do you see where we are at today and where we are going to get with regard to having the kind of consumer-friendly—help families and the soldiers walk through that system.

I suspect this is going to get to what two or three of you said in your written statement—working on the training and numbers of case managers as a part of that—but would each of you respond to what——

General KILEY. Yes, Mr. Chairman.

Dr. SNYDER [continuing]. Mr. Hunter talked about?

General KILEY. I think Congressman Hunter is exactly correct. My assessment is we have come a ways in customer-friendly activity, but I don't think we are totally there.

I think the turnover of personnel in our facilities is a constant training program. And I think it only takes one person not being customer-friendly to potentially ruin the reputation of an organization, even something as big as Walter Reed.

I think we just need to redouble our efforts and refocus on exactly those issues. An ombudsman program is clearly something that would be of benefit in our installations.

And I think, clearly, if we can put more people helping soldiers and sailors and their families now, which we can do—we can hire, and we can call for volunteers. There are several different ways we can do to take this on. It will clearly expedite some of these stories we have heard of soldiers being left without knowing what the next step is.

We have had more than 6,000 combat soldiers come through Walter Reed since the start of the war, and we have learned a lot of lessons and made it better. But it still needs more work, needs to be further improved.

Dr. SNYDER. General Schoomaker.

General SCHOOMAKER. Well, I will probably say something heretical here, but I think that what we need to do is focus on output, focus on results.

And, you know, in government and in the military, a lot of people take a lot of pride in complying with processes, checklists, procedures, working real hard, getting up real early, going to bed real late. And as far as I am concerned, you don't get any credit for all that stuff. What we get credit for is what comes out the other end of the pipe.

And so if we want a customer-friendly system, which we all do, we need to measure it at the customer end and make sure that what we are doing is satisfying that.

And, unfortunately, part of our problem here is that as we have been touching the customer and asking them, we have not been getting the kind of feedback that we need. And so we got to figure out why.

And my view is it probably comes down to trust and some other kinds of things that we need to regenerate. And if we can do that, get the communications, then I think we will be able to measure what we need to measure.

Dr. SNYDER. Dr. Winkenwerder.

Dr. WINKENWERDER. Oh, I agree with what Congressman Hunter had to say. I totally agree with it. I think it is right on their mark, and I would concur completely with General Kiley and General Schoomaker.

And, to me, you know, if you have done what you need to do when the people you are caring for, your customers, tell you that you have done a good job. And if they don't, that is your best indication.

So I think it is that communication, and there are tools—surveys help, but sometimes it is just talking to people. It is focus groups. It is talking to people, and it is listening. And it is not saying, "Why can't you do something?" It is turning back to the bureauc-

racy and saying, "Why can't we do this? Why can't we do this to make it easier on the person?"

That has got to be the mentality. And I agree. Sometimes, in the military—and even outside the military, with my experience—people get into, "Well, this is the way we do it. This is the checklist, you know, and this is supposed to be the right way."

Well, if it is not meeting the needs of the customer, it is not getting the job done. And that is the outcome. That is the result. And that is what we ought to be focused on.

Dr. SNYDER. Dr. Chu.

Dr. CHU. First, I hope Congressman Hunter gets a favorable ruling from the Ethics Committee. Otherwise, we may be in trouble, too, because we have held a half a dozen of these job fairs, as you know, Congressman, last year. We are committed to at least half a dozen this year. I think the most recent was at Fort Dix, if I recall correctly.

On a more serious note, I could not agree more. I do think we need to look at the structure within which the advocate works. Let's come back to case workers for a moment: I think that is the source of some of the situations described most recently.

From the early days of the conflict, we had too few case workers. We have beefed it up considerably; I think the Army is now to a point where the case worker-to-cases ratio is at approximately the right level.

But the system in which they work is one in which these decisions are all sequential. And one of the things we are looking at with the new energy, attention that has been focused on this challenge is, why is it sequential? Why can we not gather up all the decisions in a package for the soldier, sailor, et cetera, to confront at one time, as opposed to going through this one step at a time?

We are committed to the standard that you advocated. I think the issue ahead is, how do you get there? How do you get there quickly? And how do we start making at least the major improvements in the next few weeks and months?

Dr. SNYDER. Thank you, Dr. Chu.

We will now go and start our questions for the committee members. Dr. Winkenwerder has a mid-afternoon plane, but I think everyone else is committed to being here for some distance from now. So we should get to everyone.

Mr. Ortiz.

Mr. ORTIZ. Thank you, Mr. Chairman.

Welcome to our hearing this morning.

A few years ago, we took a tour, a group of Republicans and Democrats, because we wanted to see the worst facilities of our military. And we took a tour. Fort Sill, we saw a new facility, a big facility, where the young soldiers were taking a shower and the water was dripping out the walls.

I think that we did that, and I know we did that, because sometimes we feel that the budget is not patient-driven or soldier-driven; it is budget-driven.

Sometimes we give you a bunch of money. We don't know the size of the facility if we go. I visited Walter Reed and Bethesda many times. But unless we know what are the worst facilities that you have, we won't be able to fix them for you.

Now, when I was touring Building 18 about three, four days ago, we looked around and I asked some of the people working there, "What happened here?" They said, "A–76."

What happened with A–76? There was a contract, and even though the civilian workers submitted a better bid, they gave it to the contractor. Now, correct me if I am wrong. And he says, "You know what happened, Congressman? A lot of experienced, knowledgeable workers walked out the door."

Now, if I am correct, this facility won't shut down on 2011. Am I correct? When is it supposed to—2011?

General SCHOOMAKER. The installation is to close in 2011 under the BRAC realignment.

Mr. ORTIZ. In the meantime, we have a surge. More soldiers are going to Iraq and Afghanistan. More wounded soldiers will be coming back. I wanted to ask, General Kiley, do you think that you can give us a list of your worst facilities so that a group of members here can go see it so that we can be in a position where we can help you fix those facilities?

A lot of members might say, "You know what? We are shutting it down. Why do we put any more money here?" But those lives are very precious. They are soldiers. They are young sons and daughters.

And at the time, I want to know, did A–76 have an impact as to what happened in Walter Reed?

General KILEY. Congressman, I will take for the record your request and work with General Wilson to look at worst facilities across our Army facilities. And I would defer to the chief if he wants to talk about the larger barracks MILCON issue.

We clearly are looking at the A–76 study. I think the garrison commander was challenged as the contract was getting ready to stand up, and some of this workforce was leaving for that exact reason—probably more about A–76 than BRAC.

There were other issues. We have identified some of those, and we are fixing them.

[The information referred to can be found in the Appendix beginning on page 164.]

Mr. ORTIZ. Do you think that we might be able, for the committee, to get a list of the facilities so that we know exactly how much money you need and what we need to fix?

I mean, we are at war. And as much as we would like to have a budget-driven budget, we have got to think about our soldiers and our families. And I think that this Congress would be willing to give you the money to fix what is wrong.

And if any of you would like to elaborate on my question——

General SCHOOMAKER. Well, Congressman Ortiz, I couldn't agree with you more, and we would be glad to give you a list of what we consider to be our worst facilities.

With your help, you might remember that over the last three years, what we have been doing is putting enormous amounts of money to not only upgrade existing facilities, but to build new facilities where we have languished so long.

You know that our SRM, our sustainment, repair, and maintenance funds, traditionally have always taken a hit, because of priorities and money has had to shift.

And I can remember times in my career past where installations were being funded at less than 50 percent of requirement, which means that you are fixing things that break, not fixing and staying ahead of the power curve.

So Secretary Harvey and I made it a priority. And we came to you and asked for money, and we put hundreds of millions of dollars into both barracks upgrade and the new thing.

On the other hand—and I am going to say this, and this is not a criticism, but I think we all recognize how difficult it is, through the budget process.

This year we still don't have a veterans, MILCON, BRAC budget. We are six months into the fiscal year and we do not have a bill.

And the amount of energy that this committee and we and everybody else has spent trying to get that through is indicative of how much energy that senior levels has taken, trying to get things to come together, that would be better spent, quite frankly, getting things done, you know, with the resources.

Now, there is no question we are going to get these resources. But again, we are into this business of half the fiscal year is gone before we get going on it.

As you know, at Fort Bliss, the MILCON, BRAC business has called a stall out there in building facilities for the growth of the Army and for the repositioning of the Army globally. And we have discussed it, and you have helped us with that.

But I just think that we—you know, it is bigger, and we would be glad to give you a list, and you can go look, but I think that, again, what we have to do is systemically look at things and recognize the fact that we are a Nation at war, yet we are trying to overcome what I have testified here many times in the past is the historic underfunding of the United States Army—a significant underfunding and investment in the United States Army.

And we are trying to fill that underinvestment, at the same time that we are consuming ourselves, at the same time that we are trying to grow. And that is a big challenge. And we need a lot of help to get that done.

Dr. SNYDER. Mr. Saxton.

Mr. ORTIZ. Let me just say one thing, Mr. Chairman.

We are not here to point fingers at anybody. We are here because we want to help you. Because these are our soldiers. And we are not here to point fingers. We want to help you.

Dr. SNYDER. Mr. Saxton.

Mr. SAXTON. Thank you, Mr. Chairman.

Let me just do a couple of things. Let me say a couple of things.

First of all, let me commend you, Mr. Chairman, as chairman of the Personnel Subcommittee, and Mr. McHugh, as the Ranking Members of that subcommittee, for the very serious, studious, bipartisan, substantive job you are doing in looking at this issue.

This is an issue that could be fraught with politics and a whole bunch of stuff that wouldn't be productive. And your leadership on this issue is very much appreciated. So, thank you very much.

Second, you know, to listen to this conversation, you would think the whole system is broke. And I have got to tell you it is not.

I have had some great experiences in observing how this system works, from Fort Bragg, where medics are highly trained in lifesav-

ing procedures that have kept soldiers alive time after time after time.

I have seen the results of that training in the field. I have been able to experience the great job that is done in field hospitals in-country, particularly in Iraq. I have been able to visit wounded soldiers in Landstuhl and the great job that is done there, and the nurse getting me by the arm and saying, "We need to make this place bigger." And I have seen the care that is offered here in this town.

And I am very proud, by the way—Dr. Chu, earlier this week, I had a conversation with the commander up at Fort Dix, and he was so proud because Lieutenant General Wilson, the installation management commander, recently commended him on having one of the best facilities in the Army to take care of soldiers.

And so, there are good things to be said along with some problems to be pointed out with this system.

And I know that we have tried to fix things as we go along. I visited Fort Dix I guess two years ago, or three years ago, and I found out that we didn't have specialists there to take care of some of the problems and that soldiers had to be loaded in a van at 5 o'clock in the morning, driven to Walter Reed, wait there to be treated, and be treated, and drive back to Fort Dix that evening. I called General Schoomaker and he fixed it.

Still a couple of specialties that we have to use that process, but the number of soldiers that have to go through that process from Fort Dix to Walter Reed is a fraction of what it used to be, because General Schoomaker fixed it.

And so there are good things.

And currently at Fort Dix we don't have enough space, so the Army has decided to take a barracks, gut it, remodel it. And that process is under way as we speak.

So for members who are experiencing this conversation, maybe in the early stages of their experience with this—need to know that it is not all negative. There are a lot of very positive things, from one end of this process to the other.

So I guess that is not a question, but I just wanted to point that out.

I guess the question that I would ask is, within this system of, I think, mostly good, what are the things that you need us to concentrate on to help you fix those problems?

Dr. Chu, why don't we start with you?

Dr. CHU. First of all, sir, thank you for your kind words about the things that are going right. I do agree with you there are a lot going right in this system, and I think we do see, back to the earlier issue raised, a large number of satisfied personnel, particularly with the quality of their clinical care.

I think there are two major areas where you can help. And General Schoomaker has already touched on one: that is, the timely appropriation of funds we need.

I do think the fact that we don't have the full MILCON appropriation completed is a problem, particularly given the statutory deadlines for the base realignment and closure actions.

We need to move forward. We need to get those new facilities built. The Army is expanding. We need to make sure the right fa-

cilities are in place, or we will have more nominations for Congressman Ortiz's list in two years, with people at the expanded installations not able to enjoy the facilities they ought to have.

So I really would hope that when the supplemental is enacted—I recognize that is not this committee's lane—but when it is enacted, that there is the full restoration of the BRAC money that was originally requested.

I think the second place where you can help us—and this is a little bit further down the road, I don't think we are ready yet to make a proposal, but I do think, back to Congressman Hunter's standard, if we can streamline this process so that the complexity that now exists is no longer a problem for the beneficiary, that we will substantially improve the customer-friendliness of the system.

And that may take some statutory change, because the two major disability systems, VA and DOD, are operating on different purpose foundations in the underlying statute that come out of history. Indeed, I think if you look at our major conflicts in American history, late in or after every conflict there has been great controversy about what is the right place for the Nation in terms of veterans' benefits. It was true right after World War II.

But the basic regulations in this regard, the basic statutes in this regard, really date to 1949. And I do think it is time for a reconsideration, particularly in light—as you have all emphasized, these are relatively small numbers. We ought to be able to manage this problem as a nation.

Now, the Department will do everything in the next few weeks and months within its statutory limitations to get to the goal I have outlined. But I believe that at the end of the day we will need some statutory assistance.

Dr. SNYDER. Mr. Smith.

Or does anyone else have a comment in response to Mr. Saxton?

Dr. WINKENWERDER. I will echo—since you asked for a response from everybody—I would agree exactly with those things. The timeliness of funding is really important. That is particularly relevant with the base realignment and closure and being able to move forward to do things that we need to do.

I think in addition to that, we can and we will take a look at medical facilities and come back to you and see if we have any needs. By and large, from all the feedback we have gotten, our facilities are very good facilities. But I think it is a time to take a look and to make sure that you and we both agree.

And we really appreciate your offer to help us on this. So thank you.

General SCHOOMAKER. I would like to reinforce what Congressman Saxton said.

First of all, we have, undoubtedly, the best military health care system in the world. Everybody else looks at what we have and they marvel. We have treated Canadians, Brits, Romanians, Poles, El Salvadoreans, all kinds of folks and soldiers, and they marvel at it.

Other nations have others solutions. But the issue is not comparing against what others have, but are we as good as we should be and could be in terms of what we do?

And that is why I made that statement up front that I hope that we recognize the fact that we do have a very good system and we have a lot of very dedicated professionals in it, but there is a lot of room for improvement, and we need to look at it, I believe, from a comprehensive view.

Second, it is not just battlefield medicine we are talking about. This is an integrated system, from the combat lifesaver, the soldier on the battlefield; through the medic; through the medevac system, into the definitive care of the combat surgical hospitals that we have forward; through the system that regulates them to Landstuhl; into the Walter Reeds and the Brooke Army Medical Centers (BAMCs) and all these kinds of places. And everybody is focused on that.

But we also have a huge mission in providing military medicine for readiness purposes to the active, guard, and reserve soldiers and their families. And it is a huge piece of our recruiting and retention of these families and a huge piece of how we compensate soldiers and families for their service.

And so, I think, you know, as Congressman Hunter said and as everybody else has talked about, this is very important that we take a look at this comprehensively and recognize that there is more than just a battlefield medicine piece of it is important.

And I would remind you that my view in this world today, the most dangerous world, I believe, that we have faced in a long time, that our military capacity in the health care business is going to be important for homeland security, homeland defense; and that there are unique capabilities inside of military medicine that are not resident out there in the civilian sector, especially in the area of chemical, biological, radiological kinds of issues.

And so that is, kind of, how I would come at it. I mean, this is something. We have an opportunity here to look at this very broadly and to not try to patch things together, but to really make this and pull it into the 21st century in a way that it should be.

General KILEY. Congressman, I would echo all the other presenters' comments and simply say that we need to get on with it as quickly as we can. This can't be a six-month or one-year solution set. We have got some opportunity right now to make some of these changes almost immediately.

STATEMENT OF HON. IKE SKELTON, A REPRESENTATIVE FROM MISSOURI, CHAIRMAN, COMMITTEE ON ARMED SERVICES

The CHAIRMAN [presiding]. I thank the gentleman.

Before I call on Mr. Smith, let me thank Dr. Snyder for assuming the chair for me. I was unavoidably detained, working on funding you folks in the supplemental.

And it appears from my observation that the battlefield through the acute care gets rave reviews, and from there it seems to be going downhill. I think we will be discussing that as we go along in this hearing.

Mr. Smith.

Mr. SMITH. Thank you, Mr. Chairman.

A couple points and a couple of questions.

First of all, I think your budget point is outstanding, and we have got to change the way we do things in Congress. It is not even really contemplated by members of Congress that we are going to have our appropriations process done on October 1st, okay? And we have, sort of, institutionalized and accepted that. The last couple of Congresses, it is not even contemplated that it was going to be ready by January 1st.

But October 1st is a huge day, for you guys certainly, but for everybody that we fund and they just, sort of, hang out for two or three months waiting to see what is going to happen.

And I appreciate you making that point, because I think we need to change the way we do our structure around here to try, as much as possible, to get as many of our appropriations bills as possible done on October 1st because that is when things get really complicated if we don't do it.

And, now, like I said, it is to the point where we don't even think about doing it by that timeframe—maybe by the end of the month, maybe by November. But we have got to do better on that.

I also will say that I think—you know, I take the point about it is not necessarily a money issue, and I think in any given situation, you can look at the resources that you have and figure out how to use them better. No doubt about that, and that has got to be the first piece.

But based on what I have worked on, it seems like there is at least a little bit of a dollar issue. I mean, we have had a massive influx of veterans in the last few years because of Iraq, because of Afghanistan. I know out in my area, in the Seattle-Tacoma area, we have waiting lists for the VA. And that is money. That is facilities.

You know, I will tell you a money issue. You can't park most of the time at the Seattle VA, okay? So you are obviously injured and you have got to park blocks away. Building a parking lot: money issue.

So let's not go too far down the road of, you know, "We are fine; we have got the money we need." Because it sure as heck isn't the case out where I come from. And I doubt that that is somehow unique.

The other piece of this: The casework is critical. And I don't know what the numbers are, in terms of what—you need an advocate. Because no matter who you are—I mean, my wife and I are both lawyers; you know, very attention-to-detail people. And whenever we have to go through a health care situation, it is a nightmare trying to figure out, you know, what forms do you fill out; you know, what are you covered for; what aren't you covered for; you know, let alone an injured service man.

I mean, you need to have case workers who are advocates. And if, you know, 30 cases for one person isn't getting it done, then we have got to figure out a way to cut that in half so that that case worker is taking care of all that bureaucratic B.S. that is necessary. You can't just go giving the money away, but you have got to somebody fighting for that, so the soldier and the family aren't going through that.

So, again, I think that, too, is a money issue.

A couple question areas.

Guard and reserve, a totally different situation because they are not active duty. There is the complaint about the level of services; they have to get services on base. We have had that complaint. On base isn't where they live most of the time. It sets up a different situation.

So I want to hear what you are doing for the challenges for guard and reserve, particularly on the mental health piece, if they don't necessarily get the same care, don't have the same community, making sure that they are drawn in.

I know, out at Fort Lewis, there is a program, now, where everyone who goes in-theater, when they come back, they have to go in for a mental health review—I think it is 30 days after they come back; it is whatever window the psychiatrists think is the best one to do it—so that they don't have to volunteer and say, "Hey, I have got mental problems; help me out." Because, as you know, most people, let alone most soldiers, aren't going to do that. You need to reach out to them. So I want to know if we are doing that.

And for the record, maybe, if you can't answer this, I am very interested in electronic medical records. As part of this, also as you are moving patients around the system, do the records follow them? Do we have electronic medical records (EMRs) within the military, so that we are not losing track of records?

And last, just to make it really complicated, how system-wide is this?

This was what we have heard. There has been a lot of focus, in my neck of the woods, on Madigan and what kind of job they are doing out there.

Is Walter Reed uniquely problematic, or is it more system-wide, and what is your judgment on that?

And we are down to 30 seconds, so what you can't answer for me, if you could—you know, we will submit these questions for the record and try to get them back. Thank you.

General KILEY. I can attempt to answer.

Congressman, we will take your questions for the record, to include some discussion of guard and reserve and to include some discussion of mental health. I agree with you completely.

I would like to say one—I have sent teams out with Bob Wilson, General Wilson, to look at our other installations, to see if there is any replication there of the issues we found with living conditions at Walter Reed.

I do think that, systemically—we have already alluded to this—there are issues of the complexity and confusion about the medical board process.

Even if case manager ratios are low, the medical community attempts to document all the health care. And then the physical disability DOD process has to determine the disability. And therein is a problem that is systemic in nature and which we are going to attempt to address here in short order.

So that is a short answer. The rest of those questions, we can take——

[The information referred to can be found in the Appendix beginning on page 166.]

Mr. SMITH. A quick stab at the EMR thing. How is your——

General KILEY. We do have one in the DOD. It is ALTA. It is worldwide. A doctor can pull up a record of a soldier that was cared for at Landstuhl. But it doesn't talk yet with the VA system. And we are working pretty aggressively to get the two, ALTA and Veterans Integrated System Technology Architecture (VISTA), together.

I would defer to——

General SCHOOMAKER. Congressman——

General KILEY. Excuse me, sir.

General SCHOOMAKER. No, go ahead.

General KILEY. No, I was just going to say I would defer to Dr. Winkenwerder at the DOD level for that.

General SCHOOMAKER. I would like to make just one comment on the guard and reserve. Because I think we clearly have our emphasis—I mean, our focus right now on the back-side, once they have served, and going through the process that we are talking about.

But there is huge opportunity, up front, with the guard and reserve, to improve medical readiness. Part of our challenge has been—during this particular conflict—has been the unreadiness of guard and reserve, medically, in terms of—because many of them don't have health care in their civilian life; there isn't money in the system to provide them health care prior to mobilization.

And so we find, once we mobilize them, we are having to deal with dental issues, things like diabetes, and all kinds of things that we should have been able to detect and deal with prior to mobilization. Because once they are mobilized, we then must return them corrected, when they demobilize.

And therefore that is why you see the numbers of guard and reserve in the system that are, right now, compared to active, because we are dealing with that issue and what is required there.

So, again, looking at this comprehensively, this really is a readiness issue, and it really does have to do with how we resource guard and reserve and prevent some of this stuff, you know, then we have to deal with in a catastrophic way once they are mobilized.

The CHAIRMAN. Dr. Kiley, when do you think you can get back to Mr. Smith on that answer?

General KILEY. Sir, within a week, if that is soon enough, Mr. Chairman.

The CHAIRMAN. That would be fine.

Mr. McHugh.

Mr. MCHUGH. Thank you, Mr. Chairman.

Gentlemen, proper manner suggests I should say how happy I am you are here. Honesty demands that I tell you I am not. I suspect you are not particularly happy to be here either. It is hard to tell what the greater emotion is: that of yell in anger or cry in sorrow.

But we all understand the great challenge we have here. And I want to associate myself with the comments of the gentleman from New Jersey, my friend Mr. Saxton.

At the point of care—the point of the hypodermic, if you will, rather than the spear—this is a great system. The doctors, the nurses, the physician assistants, those folks providing that care on the hospital floors and the field hospitals that we have all visited are outstanding, and we are so grateful for their service.

But this is a system in its structure is broken. It has turned what should be a support system, where soldiers view it as a place of shelter and hope and help, into one of adversaries. And you have said it yourselves.

And, frankly, it is not a surprise. Dr. Chu mentioned the GAO report that this committee placed into the 2006 authorization bill, dealing with the Medical and Physical Evaluation Boards.

Dr. Snyder and I, back when I had the chance to chair the Personnel Subcommittee, had not one but two hearings on medical holds and medical holdovers.

General Kiley, you sent your deputy; the surgeon general for the Navy was there. We had soldiers, sailors, Marines in, talking about their frustrations.

We knew this. We knew it. And yet somehow the kinds of problems we have been reading about and we have been hearing about in the media came about in any event.

I trust the services, and we are going to watch very carefully—we are going to find those responsible and take the necessary action. Frankly, I think, you know, companies and military units tend to do what commanders inspect, so there are command problems here.

But on the broader issues, as I have heard many of my colleagues on both sides of the aisle here this morning say, we as Congress have to be a productive part of that.

Budgets—let's talk a little bit about budgets.

Dr. Winkenwerder, I believe I heard you say that in your judgment, resourcing has not been a problem. I am concerned about it nevertheless.

We have a little factor in budgets now called efficiency wedges. That is a nice way to say, "You will find savings somewhere. And we are not going tell you where. The only thing we are going to tell you is they are going to come out of the medical treatment facilities, the MTFs."

And if we go back to when this started, back in 2006, we had an efficiency wedge of $94 million spread across the Army and the Navy and the Air Force against the medical treatment facilities. Then again in 2007, it was $167 million—$167.3 million. In 2008, $212.3 million has been inserted as an efficiency wedge against the medical treatment facilities.

Roughly added, that is over $473 million.

Now, we have talked to some folks who are concerned because these efficiency wedges by the Administration's budget are documented out through the fiscal year 2013. We have been told that if the efficiency wedge in 2009 is implemented, the only savings that are going to be available to probably both the Army and the Navy will be the actual closure of facilities, a facility in each.

General Kiley, do you have any opinion on where that efficiency wedge might take us by 2009 and that statement that others have unofficially told us?

General KILEY. I am concerned by 2008 and 2009 we will have efficiency wedge that, at least as I sit here now, I cannot see efficiencies gained to recover that.

I think the number in 2008 of $140 million is about equivalent to a MEDACS annual operation, and in 2009 it is equivalent to one

of our medical centers' operations at the $200 million to $240 million.

So I have grave concern if we are going to be able to meet those budgetary cuts in those out-years.

Dr. WINKENWERDER. Let me respond——

Mr. MCHUGH. Yes, Dr. Winkenwerder.

Dr. WINKENWERDER [continuing]. And separate some things out and try to take a crack at explaining here.

With respect to the matter of Building 18, I think many have said—and to clarify there—that resources to have avoided that having happened were not an issue; resources were there. There is no question about that. Those were judgments——

Mr. MCHUGH. If I may, that probably makes it worse.

Dr. WINKENWERDER. Right.

Mr. MCHUGH. But I understand your point. Thank you.

Dr. WINKENWERDER. With respect to the broader issue about the so-called efficiency wedge, that was determined as an approach forward three years ago, and planned and agreed upon by the three services and our office and Dr. Chu and others. It was premised on the notion that there were ways to be more efficient and more effective with delivering care, but it was also caveated by saying that we would look at this every year to ensure that this was something that was achievable.

I believe, no question, that at this point we have got to look at it. We will look at it. I think that if there is anywhere—and I have said this many times—that we do not want to stress the system, it is on the direct care of our beneficiaries, of our soldiers, sailors and their families—airmen and their families.

So we will look at this. And I think it is a timely point to do that.

If you look from this point backward, I think the dollar amounts are relatively insignificant, such that they have not had any effect that we would be concerned about.

In fact, we have returned dollars last year because we didn't fully execute our budget. We returned dollars to the services to be used for whatever was needed. So we really didn't have an issue this past year.

Mr. MCHUGH. It was nearly a quarter of a billion dollars.

The CHAIRMAN. Gentlelady from California, Ms. Sanchez.

Ms. SANCHEZ. Thank you, Mr. Chairman.

And thank you, gentlemen, for being before us today.

And I just want to back up the comments that Mr. McHugh just made with respect to the fact that, sitting on the Personnel Subcommittee, we have been very concerned. And also our current chairman, Mr. Snyder, being a doctor, I think the medical issues are really something that we have delved into as a subcommittee on this overall committee. And it is a real concern. It is a real concern.

As you know Dr. Winkenwerder, when you came before us just a few—maybe about a month ago and we talked about the $2 billion or $1.8 billion plus $236 million of efficiency costs that you were trying to shave off of the budget, that when we look at a normal business plan, most businesses anticipate anywhere between 5 and 8 or 10 percent increase in their medical costs for their em-

ployees. And, unfortunately, and what has been the case with spiraling costs, can sometimes be 15, 17, 18 percent a year.

So it is a real issue for us when you are telling that you are holding down costs. And we want to hear that, but the fact of the matter is, there may not be enough money there.

General Kiley, I want to take the opportunity—you were the commander of Walter Reed between 2002 and 2004. Is that correct?

General KILEY. Yes, ma'am.

Ms. SANCHEZ. During your tenure, were you aware of the problems with the adequacy of the housing for the patients at Walter Reed?

General KILEY. When I was the commander at Walter Reed, all the patients were on the installation. There were no patients in Building 18.

Ms. SANCHEZ. Were you aware of the problems with losing paperwork?

General KILEY. I was aware that the process of doing medical boards, particularly for reserve and National Guard, was complex; that there were 22 different forms.

Ms. SANCHEZ. But you didn't know that your staff was losing it there, the paperwork?

General KILEY. I was not aware of an individual case, no.

Ms. SANCHEZ. Were you aware that there were problems with the lack of bilingual staff?

General KILEY. I think we recognized that we needed bilingual support. We didn't have a robust bilingual staff when I was there to assist, but we did have cases where we had to find someone to assist a patient or their family.

Ms. SANCHEZ. So you didn't think it was a problem? You thought you could just grab a ten-year-old child who happens to be the son who could speak English or something like that? I mean——

General KILEY. No, I just—I didn't address that issue.

Ms. SANCHEZ. And that is what happens in some of the clinics that we have. I mean, the child, for example, becomes the interpreter between the doctor and the patient which, unfortunately, is not a very good one, as you can imagine.

General KILEY. That is not typical.

Ms. SANCHEZ. So you knew there was a problem but you didn't address it?

General KILEY. I don't remember that I specifically gave directions to increase bilingual staff. But it is an issue that we are going to take on and we are fixing.

Ms. SANCHEZ. Were you aware of the problems patients described with having access to their case workers and access to care?

General KILEY. We have recognized that we needed more case workers. We had social workers on the staff of the hospital, but it became obvious, as we have talked about earlier, the value of case workers. I think what I failed to realize was that a ratio of one case worker to, say, 50 soldiers was too much. They were attempting to do too much.

We have taken that on. We have lowered those ratios. And we are going to reexamine that and probably lower them again.

Ms. SANCHEZ. Gentlemen, I just returned from leading a Congressional Delegation (CODEL) in Iraq this past Monday. And

when I spoke with my soldiers, many of them from California, they had just learned that they were going to be extended—maybe about a week ago they learned. They were supposed to be going home actually this week. Their morale was, as you can imagine, incredibly low. And, in fact, most of them, or all of them, said, "Get us out of here."

Now, we have asked our active duty and our reservists and our National Guardsmen to sacrifice a lot and we send them on these multiple tours. Many of them are extended, in particular. Many are going to find themselves extended because of the President's surge.

And while our troops haven't been to Walter Reed, they are reading the newspaper and they are finding out that their buddies who are returning home are being treated this way: lack of case workers to help them through the process, lack of bilingual staff, lack of paperwork, losing paperwork, being housed in slum tenant conditions.

What do you think the neglect at Walter Reed and the publicity of this is going to have on the morale of our troops out there?

General KILEY. I think if we don't fix it right away it has the potential to negatively impact on the morale, which is why I am committed to fixing it.

Ms. SANCHEZ. And how do we tell our families? Because I know I am going to go home this weekend and I am going to meet the families and they are going to tell me, "How could you have let this occur?"

What is the answer? Can someone on the board tell me how could we have let this occur?

General KILEY. I think we have been very busy across the Army Medical Department. I think, in this case, we just lost sight of some of the issues that some of these soldiers were dealing with, didn't respond quickly enough. And we have got to fix it.

We understand what the problems are. We are going to redouble our efforts not just at Walter Reed, but at bases and posts around the nation.

Ms. SANCHEZ. Thank you, Mr. Chairman. And I see my time has expired.

The CHAIRMAN. Thank you.

Before we go on, as I understand it, Dr. Kiley, you say the $140 million is the Army's military hospitals' efficiency wedge, which means that the Army has to find another $140 million in the budget. Am I correct?

General KILEY. I believe that is correct.

The CHAIRMAN. All right.

Now, as I understand, Dr. Winkenwerder said that he returns money that was not needed. Now, it is not needed, then why don't we give that money to the military hospitals and eliminate the so-called efficiency wedge? This country lawyer has a hard time understand that. Would somebody like to explain that to me?

Dr. Winkenwerder? Anybody? Dr. Chu?

Dr. CHU. Let me, if I may, sir.

I think Dr. Winkenwerder's statement about returning funds applied to fiscal 2006, the fiscal year already concluded. The numbers that you cited, the $147 million, that is fiscal 2007. It is different.

The CHAIRMAN. Was money returned in 2007?

Dr. CHU. We haven't finished executing 2007——

The CHAIRMAN. Will money be coming back? Or do you know?

Dr. CHU. I think it depends on execution.

Let me, however, explain how these numbers were derived. We looked in detail at the efficacy of all our military treatment facilities. In other words, if we pay them on the basis that we pay our private sector providers, could they cover their costs?

Many of our facilities do very well on that kind of metric. There are some facilities that perform very poorly. In other words, they are not doing the level of work they need to do given the level of resources we have.

So these figures came from a decision to challenge the poor-performing facilities to come up not to the top, but to the average over a period of years.

The CHAIRMAN. All right.

Dr. CHU. Now, as Dr. Winkenwerder said, it is something we are going to look at year by year. This is relatively small in the overall defense health program. I don't think we ought to overdo it. And if these are not achievable, we will reverse course.

The CHAIRMAN. Of course, the ones you need to explain all this to—which is very difficult for this country boy to understand—I am not sure that the patients sitting out there in Building 18 would understand it.

Dr. CHU. It should be invisible to the patient. The standard for the patient should be the same everywhere.

The CHAIRMAN. Thank you.

Mr. Jones.

Mr. JONES. Thank you, Mr. Chairman.

I guess my question is going to be to General Kiley, and also to you, Dr. Chu.

Along the lines of Ms. Sanchez, what has amazed me, I do not understand—General Kiley, I guess you would be called the governor or the mayor of Walter Reed, because of your position.

Is there not some ongoing process of some individual or some committee that goes through these facilities on a regular basis to make sure that the maintenance is current and do the things that normally people do around universities—they do it around big businesses, they do it at homes?

I mean, there are people constantly—know, with any facility, you have got to have an ongoing process to keep it current. I mean, meaning the repairs, the paint, whatever it is.

And I want to ask you this question. If it had not been for Dana Priest and the article in *The Washington Post*, would you have known there was a problem? I will ask General Kiley, I will ask Dr. Chu, because time is limited: Would you have known there was a problem with the substandard living conditions if there were going to be heroes put in those conditions?

General KILEY. I would not. In my position as the commander of MEDCOM and the surgeon general, I would not have.

And when I commanded Walter Reed, I had a colonel who was the city mayor; I had a colonel who was the brigade commander; I had a colonel who commanded the hospital facility, who reported to me daily. They had subordinates that were charged with the

day-to-day maintenance of buildings. And, of course, I did not have patients there.

But my successors also had those same command relationships. I don't know if that answers your question.

Mr. JONES. Well, it does somewhat.

I guess, again, my question is, if these facilities are so substandard, it just didn't happen overnight. It has been an existing problem. Whether you had left the command at that time, I don't know, and it doesn't really matter.

I am just trying to better understand the process that is not working.

General KILEY. I think there are two factors, quickly.

I think that is an old building. We had renovated it several times, had put in carpets, et cetera.

And then what I believe may have been part of the problem is we failed to reprioritize the maintenance of that building as a patient care area versus a standard administrative building. And so the repairs that the NCO was requesting weren't put into the queue like all the other repairs, and it was just an error. We fixed that.

Of course, the building is empty now, but in retrospect, we could have done a better job of that.

Mr. JONES. Dr. Chu, when did the Department of Defense make a decision to privatize this construction work?

Dr. CHU. It wasn't Department of Defense. This was an Army proposal within the larger effort to look at who should do what.

I think you are speaking to the A–76 contract at Walter Reed. Am I correct, sir?

Mr. JONES. I think this is right. My question is, can you tell me who the IAP construction—who that business is that won the contract?

Dr. CHU. Sir, could you repeat that? I couldn't hear over the bells.

Mr. JONES. IAP is the group, the management group, that got the contract. Do you know anything about them?

Dr. CHU. I would have to defer to the Army on the specific contract.

Mr. JONES. Okay. When you put this out for private bid, then I assume that the parameter is anyone that can do the work can bid on the process. Is that right?

Dr. CHU. Again, I would have to turn to the Army on this issue of the contract.

If you are referring to the A–76 process, as you know, sir, it first starts as a comparison between in-house best organization, which allows the in-house entity to reorganize itself and rethink how it does business. And they receive, actually, an edge in the competition in terms of the calculation. So they are allowed to come in certain higher because we do value the continuity that is there.

And then, yes, sir, under Federal contracting regulation procedures, outside elements are allowed to bid, and the decision is made which is the better value answer.

I can't speak to the specifics in this particular competition. We will have to take that question for the record.

[The information referred to can be found in the Appendix beginning on page 167.]

Mr. JONES. Mr. Chairman, could I submit a letter for the record asking a couple more detailed questions about the contractor process?

The CHAIRMAN. Certainly do it for the record, and hopefully you get back to us within a week.

Mr. JONES. Thank you, sir.

The CHAIRMAN. Mr. Andrews from New Jersey.

Mr. ANDREWS. Thank you, Mr. Chairman.

General Kiley——

The CHAIRMAN. Excuse me. Just a second, Mr. Andrews.

There are two votes, and we will break shortly. We will ask the witnesses to stay because this is terribly important that we get through all of this. So bear with us, gentlemen.

Mr. Andrews.

Mr. ANDREWS. Thank you, Mr. Chairman.

General Kiley, I think I think I heard you just say a minute ago to Congressman Jones that you would not have known about some of the reports and conditions had you not read it in *The Washington Post*. Is that what you said?

General KILEY. What I thought I was answering to Congressman Jones was that I would not have been aware of some of the maintenance challenges—specifically the mold, the holes in the roof—if I hadn't seen that in *The Washington Post*.

Mr. ANDREWS. How about the rodents? Same——

General KILEY. Same thing.

Mr. ANDREWS. Okay.

Who down the line from you would have been aware of that? If a soldier who is in that facility says, "Hey, there was a rat in my bathroom this morning," who does he tell? Where is that person in the chain of command? How come you didn't know that?

I have got to tell you, if I were managing a college—if I were a college president, and one of my students said to me that there are rats in the infirmary, and if my subordinates did not know—A, know that, and B, tell me that was the case, they wouldn't be my subordinates much longer.

Who is it that would know that? And why didn't they tell you that? What was missing here?

General KILEY. There is a chain of command starting with General Weightman, who manages that installation. There is a colonel, the garrison commander, city manager, and a brigade commander. Those soldiers answer to the brigade commander through company commanders and first sergeants, who are charged with the day-to-day health and safety of the soldiers, to include inspecting their rooms. They should have known.

Certainly, any soldier that came to me and said, "Hey, sir, you know, you are the commanding general MEDCOM, and there are rats in my rooms"—I would have acted on that immediately, as would have General Weightman.

Mr. ANDREWS. And I take it on faith that you did not know, or I am sure you would have done——

General KILEY. I did not know.

Mr. ANDREWS [continuing]. I know that is the case. I am just deeply concerned that you didn't. And I am not suggesting that that is necessarily your fault.

But based upon what you know here, where did the information stop flowing upward? When someone found that there were rodents in these rooms, where did that information stop so it did not reach you?

General KILEY. Congressman, that is under investigation as we speak, in a formal investigation, 15–6. I can tell you that the commanding general relieved two first sergeants and a company commander that were involved in MedHold and that holdover. And that investigation should be closed soon.

Mr. ANDREWS. Okay.

General, I am not sure you are the right person to answer this question. My information is that there are 1,055 soldiers Army-wide who remain in medical hold-over (MHO) for more than 360 days at this point. I would like to know how many of them are in the community-based program.

[The information referred to can be found in the Appendix beginning on page 167.]

Mr. ANDREWS. With respect to those in the community-based program, what quality assurances, provisions are in place now so we can be sure that their treatment is appropriate and their conditions are appropriate?

And then second, for those who are not in CBHCO—if someone who is not in CBHCO was my constituent, and he or she called me today and said, "I am living in a facility here that is subhuman," whom do I call to fix that?

General KILEY. You would call me right now, Congressman, but——

Mr. ANDREWS. If I can just say, that doesn't work—and I would call you—but not everyone has access to their congressman to ask that question.

If this soldier told his or her spouse that problem, who would he or she go to? And who would fix the problem?

General KILEY. Those soldiers that are not in the CBHCO are still on our Army installations. And they have command and control; they have a company commander and a first sergeant; they have a MedHold Over commander; there is a hospital commander, the Inspector General (IG). They could talk to a lot of people if they had an issue that was not being answered.

Mr. ANDREWS. I want to go back to Mr. Smith's question of a few minutes ago. Do you they have an ombudsman or an advocate that is there for them that is not part of the chain of command, but is their advocate? Do they have such a person?

General KILEY. I don't believe we have a formal ombudsman program yet that is separate and distinct from either the garrison or the Medical Command, but——

Mr. ANDREWS. Do you think that we should?

General KILEY. Yes, sir, I do. And we are going to.

Mr. ANDREWS. Thank you, Mr. Chairman. I appreciate it. I would also appreciate an answer to my first question for the record when it becomes available.

General KILEY. Yes, sir.

Mr. ANDREWS. Thank you.

The CHAIRMAN. We will take a few minutes' break. We have two votes, and we will be back. I appreciate the witnesses staying.

[Recess.]

The CHAIRMAN [presiding]. The committee will come back to order.

Mr. Miller from Florida.

Mr. MILLER OF FLORIDA. Thank you, Mr. Chairman.

Good afternoon, gentlemen. Thanks for being here and staying through the extended delay for the votes.

Got several questions and issues that I am going to be submitting to the acting secretary of the Army. And I will also be asking some of the questions, particularly to General Kiley today.

And we have talked about a wide variety of things, but one of the things that is most important to me is traumatic brain injury. I know it is to most everyone else in the health care world. And the proper care and monitoring of those who suffer from it is of particular concern, from ensuring our possible traumatic brain injury (TBI) patients receive proper initial cognitive screening to crafting legislation that changes the International Statistical Classification of Diseases and Related Health Problems (ICD) codes associated with TBI and psychiatric disorders.

We as a government need to do all we can, and we need to do it quick.

General Kiley, as many members say to our men and women in uniform, I appreciate your service, certainly your patriotism, and in no way do I doubt your dedication to the Army or to our wounded soldiers.

However, it is important that we have trust and confidence in our leaders. And I, along with many of my colleagues, have lost that trust and confidence in you, sir.

And I think it is only fair before I begin questioning that I inform you that I have written a letter to the secretary of defense asking that he know my wishes that you should be relieved of your command.

And, Mr. Chairman, with your permission, I would like to enter that letter into the record.

The CHAIRMAN. Without objection.

[The information referred to can be found in the Appendix on page 156.]

Mr. MILLER OF FLORIDA. Frankly, I have been amazed even at your public comments prior to this hearing and even some of them here today.

And I want to associate myself with my colleague Congressman Bill Young's comments and frustrations that he made. I know in a hearing yesterday—I believe Mr. Young and his wife are uniquely qualified to talk about the issues as they relate particularly to Walter Reed.

And also, one of things you said in your opening statement, that we had failed in the last few weeks—actually I know you probably meant we failed for quite some time. I think it is the last few weeks that it has actually been brought to our attention by *The Post*.

Some of the questions that I have are, again, about the codes that are currently being used. And I know you are familiar—I think it is ICD–9 that is currently being used.

And please correct me if I am wrong, but it is my understanding that that designation, without any other description going along with it, medically translates to an organic, psychiatric disorder, and that an IED victim who suffers TBI and has obvious brain damage and neurological issues is actually assigned that particular code.

My question is, is that true, and why are we still using ICD–9? I understand that it may also be congressionally required, but should we go to the ICD–11 that the private medical fields are going to?

General KILEY. Congressman, to my knowledge, the ICD–9 codes for diagnosis—you are correct, as I understand it, sitting here today. There is no specific code number for traumatic brain injury, and so our medical personnel, as they codify the health care that we are delivering, have to find a code that is close.

And, frankly, that is not acceptable. I don't control ICD–9 coding. We have to find a solution to that right away.

Our TBI task force, which I launched last fall, I am sure will be making recommendations to me in that regard.

Mr. MILLER OF FLORIDA. Any other comments from anybody?

Dr. Winkenwerder.

Dr. WINKENWERDER. I agree that that is a concern. As I understand it, the ICD–9 and ICD–11 is managed by the American Medical Association. I think we and others should be and will be working with them to look at this issue.

You know, the whole matter of traumatic brain injury, whether it is occurring in the context of our kinds of experiences with warriors or in athletics or other, is really a new, emerging field, underrecognized in the past.

And I just want to assure you, because I know that is probably on the minds of others, that we are moving very aggressively on that area. We have a field screening tool that has been in place since last fall to screen people out on the field when these events happen. We are beefing up our screening afterwards. We are increasing our research. And I think the overall awareness has gone way up, as it should.

But we need to do more. And there is just no question about that. And we will be.

Mr. MILLER OF FLORIDA. And certainly there are field tests and other tests that are given to determine whether a person suffers from a traumatic brain injury.

Is it true that if a person takes these cognitive tests and receives anything in the average range, whether being above average or below average in cognitive function, that they, in fact, do not get designated as TBI, if they are still within that average range? So if you are below average, you still don't get told you have TBI?

Dr. WINKENWERDER. Again, I am learning about this because the disability system, again, is something that is driven out of the personnel community, but from what I have learned it sounds like that system is behind the times, so to speak, with respect to how it looks at people with these kinds of injuries, which are not—you

know, they are not visible, and they are subtle sometimes, and they may be varying in terms of their symptoms.

And so I think—and Dr. Chu and I were just talking about this recently—that we may need a new paradigm; we may need a different way to think about how to look at disability for somebody who has that kind of injury.

The CHAIRMAN. I thank the gentleman.

The subcommittee chairman of Personnel has a couple of inquiries at this moment.

Dr. SNYDER. Thank you, Mr. Chairman.

Mr. McHugh had to leave, but we still got a little confused about case manager and case manager ratios.

General Kiley, maybe you can answer these questions here, and then one for the record, if you need a bit more detail.

What is the current case manager ratio, system-wide, in the Army? What is the current case manager ratio at Walter Reed? And what should the case manager ratio be? And when I asked you before about who paid the case managers, are they all employees, or are any of those contracted out?

General KILEY. I believe the case ratio at Walter Reed is approximately 1:30—25 to 30. And I will take all these questions for the record.

I can't give you, as I sit here, a case manager-to-soldier ratio across the MEDCOM. I do believe it varies, that some of the data I have looked at—it can be as low as 1:17 to 1:35, depending on the installation.

I will come back. I can give you those numbers.

[The information referred to can be found in the Appendix beginning on page 166.]

Dr. SNYDER. And what is your goal? What do you think it ought to be?

General KILEY. Well, we thought our goal was 1:30, 1:25. We are reassessing that now. It may be 1:15.

And at some point, you reach a point of potential diminishing returns, in the sense that you are expending resources and then, all of a sudden, the case managers don't have much to do because they have taken care of the 10 or 15 soldiers. But we are not there yet. We don't have an answer for that yet.

They are made up of GS employees. There are activated reservists, case managers that work for us, also, at our installations. I will take it for the record, to give you a lay-down, across every installation.

Dr. SNYDER. Thank you. If you can share that with——

General KILEY. And it would not surprise me, although I do not know, sitting here, now, do I have some nurse case managers at one of my installations that we have brought on board under a contract? It could be all three combinations.

Dr. SNYDER. If we could have that within a week, two?

General KILEY. Yes.

Dr. SNYDER. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Ms. Bordallo, please.

Ms. BORDALLO. Thank you very much, Mr. Chairman.

Mr. Secretary Winkenwerder and also Dr. Chu, I spoke to you briefly during the recess. I want to thank you all for your testimony.

Like my colleagues, I am concerned to learn that service members who have been wounded as a result of their service in Iraq and Afghanistan or elsewhere may not be receiving the quality of care they need. And I trust that the DOD shares this committee's concern and desire for prompt action to fix the problems at Walter Reed.

I want to make sure that the Department is aware that problems at Walter Reed are indicative of problems that exist across the Department's entire health care system.

For example, many times in the past, including in committee hearings and in meetings at my office, I have raised with you, Mr. Secretary, and others in the Department—I have some of the correspondence here with me here that I have inquired about this, and you have written back—the health care needs of retirees who are reliant on the TRICARE system for health care. That is, a U.S., 20-year, military retiree who lives on Guam, who are referred off-island for specialty care or emergency care, are forced to travel to those locations at their own expense.

These trips to access referred specialty care in Hawaii or California cost in the thousands of dollars, unless, of course, they are going military air travel. In 2005, the Department suddenly changed policy to no longer reimburse retirees for travel expenses.

On Guam, Mr. Secretary, and to the other witnesses here, we cannot travel across the states to another hospital. We are the only U.S. jurisdiction in the Pacific, thousands of miles away from specialty care. So as a result, these costs are born solely by the retiree.

Mr. Secretary, I have met with you, and I have written to you, as I have said. And I have addressed this issue more than once in hearings. The committee included report language on this matter in 2005. The retirees deserve resolution. From what I can gather, no measurable action has been taken by you or anyone else on this matter since we met and discussed this issue last year.

If my proposed legislative remedies continue to be unacceptable to you or the Administration, then I respectfully request that you propose alternative solutions for the committee to consider if a fix cannot be made administratively.

So during this hearing, I will ask, once again, will you work to rectify this problem to reassess your policy of discontinuing reimbursement of travel for these 20-year U.S. veterans?

Dr. CHU. Congresswoman, yes, we will look at it. And I will take another look at it. And as I have said, I am sensitive to that concern. We are sensitive to that concern.

It wasn't a discontinuance of payment for that. It related to the fact that there had been, in the prior years, flights that had occurred where people could go on those flights and that it is no longer possible because of the flight schedules and so forth.

But I think that deserves another look, and I promise that we will do that and get back to you promptly.

Ms. BORDALLO. Thank you. Thank you, Mr. Secretary.

And, Dr. Chu, I thank you for listening to me, as well, this morning. I want to work together. I want to help our veterans. Just re-

cently I had a town hall meeting on Guam, and this was a major concern among our veterans. And I hope that we can come to some solution.

Dr. CHU. Thank you, ma'am.

Ms. BORDALLO. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. LoBiondo.

Mr. LOBIONDO. Thank you, Mr. Chairman.

I want to thank the panel for being here today.

And, General Schoomaker, I had the opportunity to visit earlier in the week. And I have to tell you I was very impressed by the hands-on your brother demonstrated with where we are with this.

But as a number of my colleagues have indicated, I am having a hard time grasping how this came about.

In my visit, I listened to the frustration of a couple of our soldiers who repeatedly attempted through their case worker and then up the chain of command to have something done. Now, whether there was frustration about the bureaucracy of the paperwork that was a part of this, as was indicated—but the reality is that those conditions were horrific, deplorable. And repeatedly, over a long period of time, we had soldiers trying to point this out.

I don't understand how this breakdown in the chain of command could have happened. And I am concerned that there are other situations where this chain of command is broken down in other areas that we don't know about yet.

So I would like one more time to try to understand. Because having been on this committee for a few years, there have been isolated incidents—and I will say isolated—where I sense when members of Congress ask questions we are almost dismissed from just some level of the chain of command—the higher chain of command that doesn't want to be asked any questions. And then we have a situation like this where we are held responsible. Yes, you are being held responsible, but we are being held responsible.

So I am still failing to understand that through the whole chain of command this thing was broken down. I mean, whoever was in charge didn't have officers underneath that understood the plight of the veterans who were in their care. The case workers couldn't do anything about it. These rooms were on the list and kept getting bumped off the list.

And what assurances do we have that there isn't something else wrong in the system somewhere along the line? I am really trying to understand this to work with you, but it is very difficult.

I don't know who wants to take a stab at that.

General SCHOOMAKER. Congressman, are you addressing me on the issue? I assume by the end of your question you were talking about Building 18 and how that occurred.

Mr. LOBIONDO. Building 18 and how that occurred.

General SCHOOMAKER. But, of course, there are also obvious breakdowns in outpatient care in general and the medical evaluation board (MEB)/physical evaluation board (PEB) process. We have had reports of inpatient care concerns and all the rest of it.

And the Building 18—those soldiers that were in there were outpatients going through this process. Noncommissioned officers were assigned over them. There was a company commander over them, a first sergeant. And it goes on up through the, you know, brigade

that is there on Walter Reed that answers to the commander of Walter Reed.

So that is precisely what we are investigating right now, is how did we get to this? With all of the leadership present that was at Walter Reed, how is it that something as simple as this—when we were not constrained in resources to fix this, and where we are fixing it throughout the Army in a very aggressive way—why would this be a surprise to anybody? And why would we be where we are today on it?

I think that—and so we are investigating it. As you know, a couple of first sergeants and a company commander have been relieved, and we have put in place a more robust structure with a better span of control on it. And there is very aggressive action being taken in making sure that the housing for the barracks for soldiers are adequate. But we need to find out.

And, you know, the assurance is we have to reinforce the chain of command. And the chain of command is based upon trust and confidence in the people that are in that chain of command, and it requires them to take action—of all of us.

So, you know, the assurance is that we are aggressively pursuing, you know, what happened. We are going to fix whatever the root causes of it are. And we are putting energy in the system, putting the right leaders in place to make sure that, you know, that it has continued to be an aggressive program and we move onward.

There is no excuse. And I have consistently said that. There is absolutely no excuse. But there are some reasons, and we need to figure out what the reasons are and address them properly.

Mr. LOBIONDO. Mr. Chairman, can we on the committee expect that we will have a follow-up to this to hear some of these reasons or conclusions at some point in the future?

The CHAIRMAN. We could very well do that. It hasn't been determined yet, but we could very well do that.

Mr. LOBIONDO. And what about other facilities across that country? I mean, I am assuming there is some aggressive action being taken to make sure that nothing like this is taking place anywhere else.

General SCHOOMAKER. Well, you are correct, and at various levels. We have a tiger team that is going out and looking at it. Immediately upon learning this, we have asked everybody to—the mission commanders out there, as well as the hospitals and other facilities—it is not just limited, you know, to the Medical Command. We have asked all of our commanders out there to take a look at what they have and make sure that we know what the challenges are, because we have been aggressively working these issues.

And that is what is so frustrating. What angers me so much is—I mean, we have been working now for at least three years very aggressively, and have pursued the resources to do it, have gotten the resources, have been applying the resources. And there is really no reason for it.

Mr. LOBIONDO. Well, that is the way we feel. And obviously, over the last three years, with what you have done, some folks below you on the chain of command don't quite understand it, and I hope they do get the message.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Ms. Castor from Florida.

Ms. CASTOR. Thank you.

Gentlemen, let me start by saying that I am compelled to convey to you the moral outrage of the folks I represent in the treatment of our soldiers.

I represent a community that truly values the contribution of our young, brave men and women. I represent the Tampa Bay area. We have the largest VA hospital in Tampa, the Haley Center. It also is one of the very unique polytrauma centers that focuses on the critical brain injuries and spinal cord injuries. And just across the bay, we have the great Bay Pines veterans' center.

So, in our community, we truly value the service of these young men and women and many veterans. In Florida, we have the second highest number of veterans.

And, General, I agree with you. It is time for a comprehensive solution, and I just wanted to point out a couple of cases, in talking with soldiers there over the past few weeks and, really, over the past few years, that you can build into your comprehensive solution.

First is information provided to families. Before I was elected to Congress, I served as a county commissioner, and I was very surprised a year and a half ago to receive a call from a family that could not get any information on an injured soldier.

He was an Army specialist that was—his unit was attacked. There were IEDs in the roadway outside Fallujah. He was caught up in a firefight, shot in the neck, and could not communicate himself. And, of course, flown to—provided excellent care, flown to Germany and then to Walter Reed.

And very surprised as a local government official to get a call, as a county commissioner. They didn't have anywhere else to turn. You know, I was the closest elected official to them. And, fortunately, Senator Bob Graham was on the Veterans Committee then and provided entree.

And I happened to be going to Washington, just happenstance, to be able to go to Walter Reed with folks from Senator Graham's office, and we had to go to the hospital to get information. We could not get information by calling anyone in the chain of command, by calling doctors at Walter Reed.

And at that time, I believe, Senator Graham was a Ranking Member on the Veterans' Committee.

We had to go to the hospital and track down the doctor and find out what this soldier's condition and then phone the family back home.

Now, I know since that time there have been improved efforts to communicate with families, but that is a travesty that you have to rely on those kind of efforts to get the information back to the family.

And finally the soldier returned back home, and we had said, "If you need anything else, you know, don't hesitate to call," thinking that certainly there would be no other issues that they would have to call a county commissioner to get through to the Army and to military health.

But sure enough, a few weeks later, this soldier called. And I know it took a lot for him to call again and said, "I can't get my rehab appointments scheduled." He was shot through the neck, injured his spinal cord, and he was back at home but could not access the rehab system.

So this information, information-sharing to the families, and being sure that these soldiers don't have to go through that rigmarole to get their rehab appointments—another story: Visiting a soldier just a couple of weeks ago at the Bay Pines inpatient center, where they deal with drug rehabilitation and post-traumatic stress disorder, a young soldier said, "You know, when we come back and we are going through discharge, we are in such a hurry to get out that we get in the screening that is done—the medical screening, especially psychological, they hand us a checklist, and we go through, and we check it off. And we are tough guys, and we don't have any physical wounds, but we know something is not right, but we are in such a hurry to get out, we just check all the boxes and then go."

And he did that. And then all of the PTSD set in, and his marriage went on the rocks. In discharge, did not have any other prospects for employment. Eventually became homeless, started drinking.

And he said, "You know, if they had just been a little more proactive with us upon discharge, that would have made all the difference in the world."

So being more active at the time of discharge.

And then let me also mention quickly: Dr. Scott at the polytrauma center at the VA in Tampa said they are having a lot of difficulty with residents in training—bringing in the residents for these type of brain injuries and training the rehab doctors. And this is at a place where we have a college of medicine right across the street.

Thank you.

The CHAIRMAN. Thank the gentlelady.

Mr. Kline.

Mr. KLINE. Thank you, Mr. Chairman.

Thank you, gentlemen, for being here. I know all of us wish the circumstances were a little bit different.

I, like everybody else, find it unexplainable and inexcusable that we could have the kind of conditions that we did have in Building 18. And I know that action is being taken. We have seen some of it already pretty visibly. And I know that you are working vigorously to get to the bottom of it and make sure it doesn't exist elsewhere.

Having said that, I want to identify myself with the remarks that some of my colleagues have already made—Mr. Saxton, Mr. McHugh among them—and that is about the terrific soldiers who work at Walter Reed.

One of my very, very best friends retired from the Marine Corps about the same time I did, another Marine colonel. He goes out to Walter Reed with his wife about three times a week. They have gotten extensive care out there: vascular surgery and other things.

And he called me day before yesterday in a rage, not about the deplorable conditions, but about what the impact of all of this cov-

erage was on the morale of the personnel at Walter Reed. My wife's last duty station as an Army nurse was in Walter Reed. And I know not just because she worked there—but I know that these are soldiers too and they care. And they give their all.

And I know that this kind of publicity is damaging to the morale. And as one of the doctors said to my friend, it is just not fair because this looks to the world like we are a Third World dump out here with substandard care and substandard facilities everywhere. And we know that not to be the case.

So I just think it is important as we go through this that we remember that it is not just the soldiers who are being treated there that we need to care about, but it is those working, in many cases very selflessly.

I am going to get to a question here, Dr. Chu.

The commandant of the Marine Corps was here testifying last week or so, and we had a discussion about something that he calls the wounded warrior regiment, a sort of formalized way of making sure that Marines aren't falling through the cracks as they go through this recovery process.

Some of them are being treated at Camp Lejeune or at Camp Pendleton or something, and then some of them are being discharged, they have being picked by the VA. And we know many, many cases where we have had soldiers and Marines who have dropped through the cracks as they go from defense care to veterans care.

And to most of this country, gentlemen, let's face it, it is all the same: It is how are we taking care of our wounded soldiers, whether they are active duty or guard or been discharged.

So my question, I guess to you, General Schoomaker, is, are you looking at a wounded warrior—I know you have something, sort of, called a wounded warrior program. But are you looking at this concept that the Marine Corps has to, sort of, formalize this? They have a regiment, a regimental commander. They have brought an active duty colonel back from Hawaii to command it. They have two separate battalions.

Are you looking at something like that to help keep soldiers from falling through the cracks and taking care of some of these case management questions we have been talking about?

General SCHOOMAKER. Well, we have, as you correctly stated, in the Army the Wounded Warrior Program that we started in 2003. And it really got formalized in early 2004 for exactly this purpose.

And we have had tremendous success with it. We have integrated industry and jobs and the whole idea that this is a soldier-for-life approach to things. And the purpose of it was to ensure that soldiers didn't fall through the cracks on the thing.

As you know, the load on this program has increased significantly since 2003. And, you know, that approach that you are talking about there may very well be something that we ought to institute, you know, so that we distribute—kind of, expand the control over it.

But the purpose of both programs is the same. And that is that we have got a lifelong commitment to these young men and women that have worn the Nation's uniform. And it is our intention—our true intention to be dedicated to lifelong support of them.

Mr. KLINE. Well, I hope that the Army and the Marine Corps—and it would be a model for other services—we kick those programs into very high gear, so we have somebody serving in uniform that the soldiers and marines know how to get in touch with—you know how to get in touch with them and we know how to get in touch with them—that is making sure we are not losing these terrific young men and women.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much.

Ms. Davis.

Ms. DAVIS OF CALIFORNIA. Thank you, Mr. Chairman.

Thank you to all of you for being here. I know this is not of your choosing, but on the other hand, we have to all be accountable. And I think it is so important that we get to the heart of this.

As you know, I represent also a great military community. And we have some of the finest examples of patient care and support for our service members there. But we also share in those problems as well.

A number of people have discussed contracting out. And part of that is for operations and maintenance at Walter Reed.

But I want you to take a look and help me understand the impact of what some people would call the military-to-civilian conversions, where you have service providers have to be bought, really, in the civilian marketplace, and what impact that is having on our service members and the care that they receive.

One of the concerns, of course, is that there is not the kind of continuity that we would hope for. Perhaps someone is an advocate for many service members at one time, but we can't keep those people in that job. And so, in fact, there are some changes that occur.

If you could address that, I would appreciate it.

Dr. CHU. I think this is an opportunity for the Department to ensure that there is the best possible care for our service members.

The United States, as you appreciate, has a medical care establishment second to none. People come from overseas to the United States. This is a long tradition in the Department. Let me take an example from a different military service, at Newport, Rhode Island.

For some years, the Navy tried to operate its own inpatient facility; decided that really wasn't the best way to provide first-class care. The Navy continues to maintain a clinical staff—internists, et cetera—at the Newport Naval Station.

But for inpatient care, they place the patients in the civilian hospitals in that community. The military physicians attend on those patients.

So mil-civ conversion, that bumper sticker, in my judgment, is an opportunity, through the Department, and through each military service, to rethink how it does business, to make sure we have got the best possible set of ingredients.

So we use military personnel where it is essential.

The Department has been through a major review of what is the military content we must have to deal with deployed medicine, on the battlefield, bring the patients home for the kind of care they get at Walter Reed. That does not mean we have to staff everyplace else the same way.

There are examples all across the military that have been used in the past. Take radiology as an example. It is not necessarily the case that at a smaller installation we should try to have our own radiologist. It is not professionally satisfying for that person. And so many installations we have gone to agreeing with a local radiology group, they will read the films, we will reimburse them for the read, et cetera.

So this is an opportunity, in my judgment, to get it right, to make sure that we are delivering care in a way that is most effective.

Ms. DAVIS OF CALIFORNIA. And if I can interrupt, Dr. Chu, in what areas, Secretary Chu, are these not working very well?

And let me just quickly—because we talked about the advocate issue earlier, and one of the things that was said—and ordinarily I would certainly support having volunteers in positions, but we all know that we can't solve this problem with short-term—whether it is short-term employment or volunteers for that matter. I mean, if we are really going to attack it, professionally and in the best way, we need to do it right.

And so part of my concern is that perhaps there are some areas in which this hasn't worked very well.

Dr. CHU. I am sure there are instances where people have tried new arrangements where they have fallen short. And our policy would be, let's back up and rethink those areas and do it differently.

To your question about using volunteers as caseworkers, the caseworkers that we are talking about here today are paid personnel. These are professional staff members.

At the military injured center, we basically staffed at the master's degree level, for example, to be sure we have the right kind of backstop there for the service program. So we understand you need a high level of professional competence to do this job well. This is not straightforward.

Ms. DAVIS OF CALIFORNIA. Thank you. And if we can follow up with that in the future and make sure that those people are highly qualified and well trained, that would be helpful.

One very quick thing: In San Diego, they have developed a one-stop center, which essentially provides employment opportunities not just for the service member, but also for the family member as well, housed with the California DOD and educational opportunity center.

Is that a model that we should duplicate elsewhere, or are there other models that you think are best practices?

Dr. CHU. On employment for both the member and the family, we are experimenting with a wide variety of models, ma'am. Let me send you something separately on that front.

Ms. DAVIS OF CALIFORNIA. Okay. Thank you.

The CHAIRMAN. Before I call on Ms. Drake, General Kiley, General Weightman was recently in charge of Walter Reed.

General KILEY. Yes, sir.

The CHAIRMAN. Prior to him was a General Farmer.

General KILEY. Yes, sir.

The CHAIRMAN. Prior to that was you.

General KILEY. Yes, sir.

The CHAIRMAN. Did you have knowledge of any of the shortcomings that have been reported regarding Building 18 when you were there?

General KILEY. No, sir.

The CHAIRMAN. Was Building 18 being used when you were there?

General KILEY. Yes, sir. We housed a permanent party and transient student detachment, students that were soldiers that came in for training at Walter Reed, some for short periods of time.

The CHAIRMAN. So when you were there it was not being used for patients?

General KILEY. That is correct.

The CHAIRMAN. And when did it begin being used for patients?

General KILEY. If my memory serves me correctly, Mr. Chairman, after about a $270,000 renovation to Building 18, General Farmer in 2005 began using that, carefully selecting patients who were ambulatory, getting toward the end of their stay at Walter Reed, and began assigning them there, as I am told.

The CHAIRMAN. Ms. Drake.

Mrs. DRAKE. Thank you, Mr. Chairman.

Gentlemen, thank you for being here. I am just going to get all my questions out at once, and then we can get as many answered as possible.

But I think we have heard overwhelmingly today that truly we have a wonderful health care system within the military, that it truly is quality. The problem is the long-term care.

And one of my questions for Secretary Chu and Dr. Winkenwerder: Is there any process in place that you are having discussions with the VA? Because, of course, these men and women, some will be returned to active duty, some won't.

So what are doing? And can we use what has happened now to make sure it is not happening over in the VA system just as well?

I will tell you, I have never had a complaint in my office about Walter Reed. I have had many complaints abut the VA system. So if we can use this with all of you working together, that could be helpful.

And I know I was encouraged in 2005, when we put the money in for the seamless transition; we called it for better information technology (IT) between VA and DOD.

And maybe, Mr. Chairman, we could do a joint hearing, if that would be appropriate, with the Veterans Committee to look at the VA system, as well.

The CHAIRMAN. The chairman of that committee and I have already discussed this possibility.

Mrs. DRAKE. Good.

The CHAIRMAN. Thank you for mentioning it.

Mrs. DRAKE. Thank you.

And I think it is really good today to hear that we are going to redefine the job of case managers, but I would also encourage you—I know Duncan Hunter just called it a VIP system. Maybe even if we had a hotline; that if they felt that case manager wasn't listening to what they were saying—and, obviously, they are overworked, as well, but not just for our military men and women, but for their families.

If their families felt they had a way to communicate and say, "Something isn't right here."

And, General Kiley, you have said it: It is complex. It is confusing. And, you know, we are the hotline. When people call us as their member of Congress, that is exactly the role that we play. And, fortunately, we know who to call and are able to get through.

But I would also like to ask specifically about Walter Reed. Since that decision was made some time ago in the studies that were done on Walter Reed and with a number of injured men and women who are returning now from a global war on terror, does it make sense to relook at Walter Reed, or is this just a done deal?

And is it going to be BRACed? And if it is going to be BRACed—we have talked a lot about uncertainty of funding. Chairman Smith talked about it, not having our bills done by October 1st.

And just an aside on that, two paralyzed veterans came to see me yesterday. The only request they had of me was we get our bills done by October 1st. And I thought, "Boy, that is not a lot for us. It doesn't cost us anything to do that." And they were stressing what it meant to them that we don't get those done on time.

But I am also curious about what is the uncertainty—if we are BRACing Walter Reed, and we have just reduced, in the 2007 bill, the $3 billion for BRAC—what the uncertainty is for you now. Are we moving ahead with Bethesda or do you have to wait to see how we are going to address that issue?

So thank you for being there. And I know that was a lot, but—thank you.

Dr. CHU. Let me try to answer them quickly within the allotted time.

On your first question, yes, we have tried, in this Administration, to try a new construct. We have a joint executive council where I and the deputy secretary of the VA and all the affected leaders meet once a quarter. We have had a special meeting just this last week or so to start dealing with these issues. We see it as an opportunity to do exactly what you suggested.

On the hotline front, we do have a hotline that is at the severely injured center. We do field calls there and we open case files on those cases, just as you suggest——

Mrs. DRAKE. Well, maybe that needs to be more widely public.

Dr. CHU. I think I am hearing you say it does need to be widely publicized.

Mrs. DRAKE. Okay.

Dr. CHU. Although we do get lots of calls, so it is——

Mrs. DRAKE. And family members as well, because that is——

Dr. CHU. Anybody may call.

Mrs. DRAKE. Okay.

Dr. CHU. And we do not restrict what is "severely injured." If, in your perception, you are severely injured, that is good enough for us; we will take that case. And as I said, we have master's level counselors to work that system.

We fully support getting money by October 1st. You have identified a very serious problem for the Department. This is a game of large-scale musical chairs, unfortunately. If we do not get the $2.3 billion that is at stake in the BRAC shortfall, we have a big problem on our hands because those are statutory deadlines.

In the specific case of Walter Reed, Bethesda—also Brooke and Wilford Hall—the Department is aiming to put at these two premier locations a first-class, 21st-century facility.

Both Walter Reed and, on a slightly longer timescale, Bethesda as buildings need to be replaced. We should not wait on this issue. In fact, I was pleased, in the hearing on the Senate, Tuesday, that Senator Warner urged us to go faster, not slower.

But we do need the funding. And I would urge that members of this committee join their colleagues in ensuring that funding is in the supplemental, so we correct this issue as quickly as possible.

So we would like to get on with it. We would like to make sure it is first-class; it has the capacity and the modernity of facilities to serve our people well.

Mrs. DRAKE. And do we think that we will re-look at Walter Reed, or is it going to remain BRACed by 2011?

Dr. CHU. Well, it is a statutory decision, as I—I am not a lawyer, but I understand the statutory decision. We have no real desire to reopen this decision.

We want a first-class facility. I don't think anyone would argue, though, two tertiary care facilities within five miles of each other—we should have one first-class space.

The advantage of the Bethesda location is it is the same campus as our medical school. And it is, as you know, across the street from the National Institutes of Health (NIH).

And Bill Winkenwerder and I have charged the medical school dean, as a prelude to this event, to build a stronger relationship between DOD and NIH, so we bring to bear on our problems the talent in that institution.

Mrs. DRAKE. Thank you.

And, Mr. Chairman, I would just like to reiterate what Chairman Snyder said. If you could tell us if we have a constituent that is there. I think even just contacting them and letting them know we know that they were injured and thank them for what they have done for our country.

Dr. CHU. Thank you, ma'am.

Mr. LARSEN [presiding]. Thank you, Ms. Drake.

Actually, I am next in line, so I will—I don't know that I have a question, but just a comment. Sometimes I show up at these hearings with a set of questions I really need to ask. Sometimes I need to come and listen in and hear what I need to hear and develop some thoughts.

I first just want to underscore Mr. Miller from Florida's comments earlier about traumatic brain injury, combat traumatic brain injury. That is something of great importance who have contacted my office—ensuring that we don't wait too long before we try to screen some of these folks—not wait till something shows up. But if, you know, the science needs to advance faster than it has, let us know what we can do to help out with that so we can screen faster and catch it sooner.

As you leave at some point today, I do not want you to think that the morale issue at Walter Reed is a function of media exposure, okay? It is a function of, from my perspective, a disastrous and horrendous failure in leadership; not because it got covered in some newspaper and is being covered all over the country now. It

wouldn't have happened—it wouldn't be covered unless things weren't getting taken care of. And so I really have to emphasize that from my perspective.

Let me tell you a fun story, a high school football story. We got shellacked one game. And we didn't get beat by a lot, but we had done pretty well all year except this one game. Our defense—all the gaps showed up, all the weaknesses showed up. We hung in there, but all the weaknesses showed up. We ended up losing the game.

And our football coaches asked after the game, he said, "What do you think of the execution of your defense?" He said, "Well, I think it might be a little too early for that extreme of an action. We will see how they do next week."

The point I am making is that—and Dr. Chu, you talked about execution, how things were done—the execution on this has been terrible as well. And not just how you have handled it since it has been covered, but we are here because we need to ask: Why did this happen in the first place? Why did this occur in the first place?

Now, Secretary Gates, to his credit, has come down like a ton of bricks on this issue. And, frankly, I hope he has a few more tons of bricks to bring on this issue as well—before, during or after the independent review group is done. Because this is a problem that is going to—it is costing us now.

But we debate about Iraq. We debate about Afghanistan. If we lose hearts and minds of the folks who are coming home, people who are active duty and become veterans, if we lose hearts and minds of the families because we aren't treating those folks well when they come home, that is when we lose, in the minds of the American people, what we are doing overseas. And that is a great frustration of mine.

If we aren't taking care of these folks when they are coming home, if we aren't taking care of these folks as active duty in our military health care system, and then—as they become veterans—then it doesn't matter how well we do sometimes overseas, because the people who have fought are going to be critical of how they were treated when they got home.

So on the positive side, we want to help improve that. We have to. We can't be fighting this one 30 years from now. We can't be fighting how we treated our veterans today 30 years from now like we are fighting another war 30 years ago because how we treated veterans then. We got to get it right.

And that is why we are here today. And if we are frustrated, if I am frustrated, if some of us are frustrated, it is because we have got enough work ahead of us. We have enough work ahead of us. We have to get this right.

So with that, I will end my comments.

And Mr. Turner from Ohio.

Mr. TURNER. Thank you, Mr. Chairman.

General Schoomaker, General Kiley, as you will recall, I participated in the Government Reform hearing on Monday at Walter Reed. General Kiley, at that point you were asked several questions that were similar to Ms. Sanchez's questions of how could this happen.

Today you answered, "We have been busy." Monday you answered—because I wrote it down, and I asked you about it later, and I asked General Schoomaker—you said, "The complexity of the injuries of these soldiers was not fully realized."

And my question to you, General Schoomaker, was: Did you find that an acceptable answer? Because it wasn't an acceptable answer to me or the Government Reform, Subcommittee of National Security.

Because I think we could easily have anticipated the type and level of injuries that were described to us in the hearing or that were described to the patients. I understand you have 371 outpatient rooms at Walter Reed. That was part of the testimony on Monday.

And, General Schoomaker, you told me that you were not aware of General Kiley having made that statement and that you would check on that statement and what he meant by it and get back to me.

And now I am back in front of you, and you are back in front of us, so I would like to know your comments on whether or not you think that General Kiley's statement is an acceptable answer of, "The complexities of these soldiers' injuries were not fully realized," as an answer to how this could have happened.

General SCHOOMAKER. Well, I am not sure I remember the context in which this was—as I listened to this, what you just described, I take it we are talking about the complexity of the injuries that we are seeing come off the battlefield today.

Mr. TURNER. We were asking the question as to how this could have happened. And just like General Kiley today said to Congresswoman Sanchez, "We have been busy," his answer on Monday was, "The complexities of these soldiers' injuries were not fully realized."

And what I asked you on Monday was, it would seem to me and the other members of the Committee of Government Reform that when we heard that, that that was not acceptable; that in fact the injuries could easily be anticipated and the complexity of their injuries would have been very easily anticipated. And we asked General Kiley, "Well, what type of injuries did you prepare for then, if it wasn't these?"

Because what we saw in that hearing, the three individuals we had testify, a family member and two soldiers, we had a machinegun wound, an explosion and a vehicular accident, which don't seem to me to be very unexpected in a conflict.

And you indicated when I asked you the question that you would check with General Kiley about that answer and get back to me. I wonder what your thoughts were today.

General SCHOOMAKER. My thoughts today are that I think we are seeing soldiers survive injuries in combat we haven't seen before. And I think things like TBI and PTSD and the multiple things that we had, that is the context in which I understood the question.

Mr. TURNER. Okay. They are surviving, though, as a result—General, they are surviving, though, as a result of the actions that you have taken and others have taken——

General SCHOOMAKER. That is correct.

Mr. TURNER [continuing]. On the battlefield that clearly—I mean, it is not an unexpected result—if you are taking action to increase the survivability, certainly your expectation would be that the medical system would be receiving these individuals and be required to step to the plate for their care.

General SCHOOMAKER. As a non-medical person, my understanding is that what we are seeing, though, are injuries that aren't visible injuries; that we understand differently today than we understood even two or three years ago in terms of TBI, PTSD, some of these kinds of things that—yes, soldiers survive an IED attack and they may not even be wounded in the typical sense——

Mr. TURNER. General, I understand that. My time is just expiring soon, so I want to ask you—because I asked you that then. I understand your further explanation of that, that it has taken a while for you guys to understand what you are going to be receiving.

But this problem arose in the past couple weeks. It came to light in the last couple weeks, but it has been ongoing.

So at what point was it—because it wouldn't have been just when *The Washington Post* started the article of the difficulty that soldiers are having. At what point was it that the complexities of these injuries were fully realized? Because it wouldn't have been two weeks ago.

General SCHOOMAKER. From my standpoint, I think we have been learning every day. Every day we learn something different—I certainly do—in the soldiers that I visit and the things that I hear on this. And so I don't know. I think it has been a learning process, a process of adaptation all along.

And, again, I am not a medical professional. I think that the complexity that I am talking about is the results of survivability rates and unseen injuries that we are starting to understand now that are a lot different than anything I have experienced in my career.

Mr. TURNER. Thank you, Mr. Chairman.

The CHAIRMAN [presiding]. Thank the gentleman.

Before I call Ms. Shea-Porter, do I understand correctly, Dr. Winkenwerder, that you must leave? We have three——

Dr. WINKENWERDER. Yes, sir——

The CHAIRMAN [continuing]. Four members——

Dr. WINKENWERDER. Yes, sir. I am going to try to stay another 15 or so minutes——

The CHAIRMAN. I think we will get everybody in if we stick by the five-minute rule well.

Ms. Shea-Porter.

Ms. SHEA-PORTER. Thank you, Mr. Chairman.

I have several questions. At first I want to preface those questions by telling you that I was at Fitzsimons Army Medical Center with my husband during the 1970's. And it is so discouraging to see the same kinds of issues and the same problems and the same surprise that things aren't going so well.

And I wonder where the breakdown is. And it is hard for me to buy into any of this, because my feeling is that you know that these soldiers are going into combat. You know that some of them are going to have their bodies and their spirits broken. And who

has been looking out for them? And I can't answer that. And I am going to ask you a couple questions to see if you could answer that for me.

The first one I wanted to ask was General Kiley, please.

I have it that you said when you did the initial review of Walter Reed, "I do not consider Building 18 to be substandard. We needed to do a better job on some of those rooms, and those of you that got in today saw that we, frankly, fixed all those problems. They weren't serious and there weren't a lot of them."

Is that accurate?

General KILEY. Well, obviously, the rooms that had the mold and the holes in them were clearly below standard. And subsequent to those comments, I have said that.

It is an old building. It requires constant maintenance. We have failed to do that. So, as an organization, we have failed, but recognize that and we are fixing that now.

Ms. SHEA-PORTER. Well, I even want to get past the buildings, although I do believe that any time you are in command of anything for anyone, part of your responsibility is to make sure that you talk to people on the bottom of the rung and not just on the top, and that you walk around your facilities and you look for yourselves.

You must never, ever lose that hands-on, have-a-look touch. Because this is what happens when we do this.

But what about the people in those rooms? Even if the rooms looked okay to you, at that point, you must have heard something about the people who were occupying those rooms, and the problems they were having?

General KILEY. No, ma'am. When I made rounds and talked to soldiers at Walter Reed, I was never approached that there was a problem in Building 18—"Hey, sir, you should see my room; it has mold." I would have taken immediate action.

And subsequently to that, talking to soldiers, the ones that were in those rooms were asking to get those repaired, and we failed to do that. We screwed that up, and we need to fix it.

And it is not just Building 18. I take your point. We need to make sure that is not happening anywhere else in MEDCOM.

Ms. SHEA-PORTER. Well, you know, when my husband was a lowly lieutenant, I am not sure that I would have walked up to a four-star general—although I might have—or a three-star general or even a colonel and said anything about it. It is really your responsibility to have a look, instead of expecting that.

Now I would like to talk to Secretary Chu for a moment, please.

You are the undersecretary of defense for personnel and readiness. Did you ever go out to visit any of these facilities? Have you talked to any of those who have these brain injuries and other horrific injuries? Who do you depend on to find out if we are doing what we need to do for these troops?

Dr. CHU. I depend both on the top and the bottom. Wherever possible, I do try to visit our various facilities, although I have not been to Building 18, I should acknowledge. But I also depend on the Department's various reporting sources to look at, overall, how are we doing on this front.

And I do think, as several members have said, the clinical care that the Department delivers to these individuals is first-rate. And I do think we do want to make sure we thank the commissions and the clinical staff at places like Walter Reed for what they are doing.

As General Kiley has testified, the Department did not do a good enough job in terms of the billeting for these troops. We accept that responsibility.

We accept the responsibility for the complexity of the Disability Evaluation System. I think this debate is a terrific opportunity to reconsider that entire system.

And we are at the beginning stages of doing that. I think we would like to have a different kind of system for the future; one that, from the family's perspective, from the injured's perspective, is simple to use, even if the back office elements, the statutory foundations, are complex.

Let's let the specialists deal with that; present the family with a simpler and more easily explained set of choices so that they understand what their selection might be and how they might best proceed in the next stages of their lives.

So, yes, ma'am, we do understand that we did not perform well, in terms of how we cared for some of these troops. We do set a higher standard for our people. I accept my responsibility in that regard.

What we are dedicated to is changing the system, changing the outcomes that we get for these individuals. These are terrific Americans, and they deserve good outcomes.

Ms. SHEA-PORTER. I would like to say that I have nothing but admiration for those clinicians and others who work to help our troops. And this has absolutely nothing to do with them, but it really has a lot to do with the leadership right here.

And so I want to ask you again, where have you gone to visit the troops that are injured?

And do you have plans, now—because you are relying on layers and layers and layers of bureaucracy, whereas, since it is your job, how are you going to reach out and actually—I realize you are very busy, but at some point during the year, you have to go out and actually talk to a couple of families to get the stories.

Have you done that, and do you have any plans to do that?

Dr. CHU. When I visit an installation, I make it a point to visit a barracks, to visit the housing for families, to sit down, if possible, and have lunch with a few of our soldiers or sailors or airmen or Marines, or junior officers, whatever the case might be——

Ms. SHEA-PORTER. Injured ones—have you gone and——

Dr. CHU. And I have, in my career, ma'am, visited, I think, every major military medical installation in this Department.

Now, have I done every one in the last week? No, of course not. But I do make it a point to visit the bottom as well. Because I agree with you: It is up to us to take a look, on a random basis, as to how the program is actually working, as the Navy would phrase it, at the deck-plate level.

Ms. SHEA-PORTER. Well, I think the only way you are ever going to really know is to actually talk to those—is that it? I thank you.

The CHAIRMAN. Thank you very much.

Mr. Wilson.

Mr. WILSON. Thank you, Mr. Chairman.

And, Secretaries, Generals, thank you for being here today.

I have actually seen the good. I have visited the casualty hospital in Baghdad. I have been to Landstuhl, seen the dedicated people there. I have been to Bethesda, seen the dedicated personnel. I am really grateful we have the highest survivability rate in history.

There have been advances in prosthetics that are history-making. In fact, I have got two sons that were born at Bethesda National Hospital. So I know the military medical system. But that makes it even more of a disappointment that people could fall through the cracks.

The Washington Post article was actually pretty explanatory that—in terms of a military unit—that there are two companies, one for active duty and one for reserve components. And then it is divided into platoons, with sergeants. And, indeed, I have such faith in the NCOs of our military, it was described that sergeants know everything about soldiers: vices and talents, moods and bad habits, even family stresses.

Then I was reading about the military supervisors and case managers, and that there has been an extraordinary increase in the number of these. How do the case managers and the sergeants and the military structure and the civilian structure—how do they work together, or do they not? Because it seems like people have fallen through the crack, through this system.

General KILEY. Sir, the relationship between the case managers and platoon sergeants is an important one. The platoon sergeants have official military accountability for the soldiers, know where they are, make sure—or should be making sure that their health and safety on a day-to-day basis is met to include the condition of their rooms. And the case managers worry about the medical conditions, the recovery from medical conditions, the coordination for examinations and for appointments.

There is a third piece of this that closes out the episode of a soldier being at Walter Reed, which is the medical board process. And in some cases it appears that records have been lost. That is totally unacceptable—very frustrating, both to the case managers and the soldiers. And that is a Patient Administration Division and a Physical Evaluation Board liaison responsibility.

And all of those are being very vigorously examined under another AR 15–6 investigation at Walter Reed to try to determine exactly where the breakdowns were.

It is a very complex process, as I was asked a little earlier. And working your way through the medical board process with these complex, multiple, often unseen injuries—TBI, PTSD—sometimes the PTSD starts to manifest itself a month or two after some of the other injuries have started to heal. In a MEB and PEB system that goes back not only to the 1970's, but to the 1950's, it can be very trying and very daunting for the soldiers.

Mr. WILSON. And I am glad you brought up about the paperwork, because that seems to be the next step: how these different layers of persons work together. But Secretary Chu has identified the complexity in med boards; I am familiar how difficult that can be.

I indeed am happy to hear that this is being studied, because the thought that young people would be lost in some kind of bureaucratic system——

General KILEY. Yes, sir.

Mr. WILSON [continuing]. For month after month is just really not at all what we as veterans, as members of Congress, as parents would anticipate for the treatment of our young people.

General KILEY. Yes, sir.

And given the complexity of the medical board process, as the chief has referenced, we have made iterative improvements, attempted to improve it; for example, designating physicians whose only job is to do the MEB for soldiers rather than have 10 or 15 or 20 physicians in a facility all trying to figure out how to do the one medical board they are going to do this year.

We learned the hard way years ago in this process that that wasn't working. And so, for example, Walter Reed, there are, I am told, three and a half fully dedicated physicians in the med board process. That is the physician piece.

But we have got to keep getting at this. We need to reduce the paper work. If we could make the entire process an electronic process, we are looking for these kinds of solutions right now. No lanes or boundaries on getting this thing fixed.

Mr. WILSON. Well, I, again, just have to tell you that those of us who so much support our troops and so much support our military are deeply concerned.

General KILEY. Yes, sir.

Mr. WILSON. We appreciate your efforts very, very much.

And I know we have the best in the world, but we want to make sure our troops do understand that. I want our families to understand that.

General KILEY. So do I.

Mr. WILSON. Thank you.

General KILEY. Yes, sir, thank you. So do I.

The CHAIRMAN. Doctor.

Dr. WINKENWERDER. Yes, sir.

I was just going to say if you would allow—it would be possible to excuse myself. I am glad to take any question for me for the record or even call back personally if that would be better for the member.

The CHAIRMAN. We appreciate you being with us. We noticed you have stretched your deadline 15 minutes, and thank you——

Dr. WINKENWERDER. Thank you very much. Thank you.

The CHAIRMAN. Mr. Hayes.

Mr. HAYES. Thank you, Mr. Chairman.

General Schoomaker, it pains me a great deal to ask the following question—a lot of criticism leveled. You have got a management problem: Should not General Kiley be relieved from duty because of what has happened here?

General SCHOOMAKER. Well, I will make my recommendations as appropriate to the authority that has that deal. And I prefer not to say it here.

As you know, I have officially been recused from dealing with this because my brother is in the mix. But I can promise you that this is being investigated, and I can assure you that the proper ac-

tion will be taken as a result of this investigation in terms of accountability.

Mr. HAYES. And, again, that is not a question I want to ask, but as a manager in the private sector, it all ends up in my lap.

At Fort Bragg we have a very active town hall, kind of, a format to air these kinds of concerns. There is a very aggressive action plan that has been outlined for Walter Reed. Is that a part of, again, gathering information to make sure that this doesn't happen?

General SCHOOMAKER. Well, actually, I had a meeting with other General Schoomaker and General Kiley this week out at Walter Reed, addressing and listening to what some of their thoughts are on how to approach this. And that is clearly part of not only town hall meetings, but selective meetings with people at various levels in a personal setting to really have very candid discussions and get their buy-in and understanding of where we might best improve things.

But I will tell you, it is very distressing to me that with the amount of direct contact, hundreds and hundreds of visits all over our medical facilities, from Landstuhl to Brooke to Walter Reed to Tripler and everywhere out there, talking to families and talking to soldiers—which I truly believe are candid discussions where people are not afraid to walk up to a four-star general, where we are sitting in their room, talking to families, "Are you being cared for properly? What are your concerns? What do you think about things?" unanimously, without question, it has been thumbs up on the kind of care that they are been receiving.

General SCHOOMAKER. Yes, there have been issues that have been raised, and we fixed them, because they raised the issues.

But to have something like this occur with all of this truly is a surprise to me, and we are going to find out why. And when we find out why, we will hold those accountable that are the problem.

Mr. HAYES. Thank you.

Again, to reiterate, Walter Reed is a premier institution. The good that has been provided is incredible. My brother-in-law 35 years ago went there for some—he was a Marine; even let a Marine in—for serious cancer surgery.

So, again, hopefully we are past the turning point and we can get back to focusing on care for the soldiers, which is what we do day-in and day-out.

But, again, I thank you for your efforts, and sorry we are here. But, as you say, anybody that didn't get the job done, make sure that that is taken care of.

Mr. Chairman, thank you. I yield back.

The CHAIRMAN. Thank you so much.

General Kiley, how many rooms are there in Building 18?

General KILEY. Mr. Chairman, I believe there are 54.

The CHAIRMAN. How many rooms are we talking about that are subject to the inquiry?

General KILEY. Sir, I believe there were a total of seven rooms that had evidence of mold. Two of them had mold on the walls. The other four or five had mold around the bathtub and the sinks. And then there were another 19 or 20 that had some other issue: They

had a leaky faucet, a leaking toilet, a switch that didn't work, as I understand.

The CHAIRMAN. Mice?

General KILEY. Sir?

The CHAIRMAN. Mice?

General KILEY. Sir, there had been a problem with some mice and cockroaches last year, in 2006. This was brought to the attention of the command at Walter Reed. The preventive medicine teams went in. They did an assessment of the extent of it.

The CHAIRMAN. Did they assess cockroaches and mice?

General KILEY. Sir, what they did was take a look through the rooms and take a look at the condition of the building and determined that they could, one, set mouse traps and roach traps. They asked——

The CHAIRMAN. They catch them all?

General KILEY [continuing]. Asked the soldiers to clean up any food that might be in their rooms.

The CHAIRMAN. Did they catch them all?

General KILEY. Sir?

The CHAIRMAN. Did they catch them all?

General KILEY. Sir, as far as I know, they did. They haven't seen mice, I am told, for months. I think they policed that up, yes, sir, in an area where you are in a city, urban area, yes, sir.

The CHAIRMAN. What else, besides the mice, cockroaches and mold?

General KILEY. Well, some leaky toilets, a leaking faucet here or there, a couple switches that didn't work, as I understand it. I can take that for the record and give you a whole list of the findings.

The CHAIRMAN. No, no. I just want to know, were complaints made?

General KILEY. Sir, I believe the process at the time was that soldiers would make their concerns——

The CHAIRMAN. No, no, no. Just answer the question: Were complaints made?

General KILEY. Yes, sir.

The CHAIRMAN. To whom?

General KILEY. To the barracks noncommissioned officer.

The CHAIRMAN. And then what happened after that?

General KILEY. He would submit work orders to repair them.

The CHAIRMAN. And were they done?

General KILEY. Some were done last year. I am told that up to 200 of these were fixed over last year. But there were repair work orders outstanding.

The CHAIRMAN. Are there conditions such as this in hospitals elsewhere in the United States?

General KILEY. Inside the hospitals, it is a challenge with some of our older facilities.

The CHAIRMAN. The answer to your question is yes?

General KILEY. I think it is. Yes, sir.

The CHAIRMAN. Now the answer to your question is yes. Would you then explain where they are, if you know?

General KILEY. Sir, I have to take that for the record. I have got an SRM project list of things to fix and improve across all of our hospitals.

[The information referred to can be found in the Appendix beginning on page 161.]

The CHAIRMAN. Right.

Dr. Gingrey.

Dr. GINGREY. Mr. Chairman, thank you.

And I want to thank the witnesses, Secretary Chu, General Schoomaker, General Kiley. I am sorry that Dr. Winkenwerder had to leave, but I appreciate you being here for so long.

And, you know, I want to say for the record, Mr. Chairman, that I have been to Building 18, I have been to Walter Reed on a number of occasions. But specifically in regard to this issue I went to take a look firsthand, having grown up in a motel when I was going to medical school and living in one of the rooms.

When I saw this old Walter Reed Motor Inn, it really reminded me a lot, Mr. Chairman, of the motel that my parents had in Augusta, Georgia. It is not a five-star hotel, make no mistake about it, but it is not a flop house. It is not a dump. It is not a dive. It needs some work, no question about it. I am not making excuses, of course.

And when I read *The Washington Post* report, I was glad to know that those cockroaches were belly up. It suggested to me that at least somebody was spraying for them, Mr. Chairman.

And, of course, if you leave food around in a motel room or a dorm room at a college, you are going to get some mice to show up at some point in time.

But there is no question that there is a problem. I have heard some of my colleagues on both sides of the aisle suggest that specific heads should roll. I was a little bit shocked, quite honestly, that the secretary of the Army was relieved of his command, and the commander at Walter Reed, General Weightman, was relieved of his command, and a change has been made there.

I don't know what comes next, but I would guess if you ask—since General Schoomaker has had to recuse himself—ask *The Washington Post* whose head should roll, I think it probably would be the commander in chief—would be the only satisfaction. And that would be President Bush.

But here again—and let's try to take the politics aside, and some of the rhetoric, and try to solve the problem.

As a physician member, I think that we need a lot of things that would help in regard to, let's say, going to a complete electronic medical records system, where these soldiers that are injured, and the families where they have traumatic brain injury or missing limbs don't have to worry about filling out 22 forms and repeating it four times because somebody has lost it.

I think the impression that I get—and hopefully I won't use my entire 5 minutes so you can respond—is that when you have a soldier recovering, whether he or she is at the Mologne House on the main campus or just across the street at Walter Reed Motor Inn, Building 18, and they have no mobility problems at that point, wherever you have them, if you keep them too long—and 360 days is too long—at some point they are going to be so frustrated over a missed appointment or a long queue or lost paperwork, maybe a little unhappy about adjudicating their disability claim, either getting back with their troops or rotating back into civilian life, that

they are going to start noticing the mold and the cobwebs and the dead cockroaches and the rats. And that is part of the problem.

So I would like to suggest to the witnesses that maybe if we can move in that direction, we will go a long way toward solving this problem.

Dr. CHU. Let me speak to——

The CHAIRMAN. Does someone have an answer to that—Secretary?

Dr. CHU. Delighted to, sir.

To the electronic record challenge, that is where we are. We have deployed—I am sorry Dr. Winkenwerder had to leave because I think he was very proud of it—we have deployed ALTA, as I think you are aware, which is an electronic outpatient record system, worldwide availability, so basically your records on a server—actually, more than one—and you can call it up wherever you are.

We have agreed with the Veterans Affairs Department that, for the future, we should have a common inpatient electronic record.

We have already started what we call bi-directional electronic exchange at certain installations, but that is with the existing systems. And as you appreciate, we have got two different systems designed from different I.T. perspectives for the future, which will take some years. I don't want to mislead you.

We are aiming at a common system for the two enterprises, which will facilitate the long-term care of those who have significant injuries.

I take your point about the length of time that is involved here. I do think part of it is that the Army, specifically, tries very hard to allow those soldiers who can continue to serve and wish to continue to serve to recuperate.

And that does take some time, given the nature of these injuries, as you appreciate—a considerable period of time. And that may lead to some of the frustrations that you have described.

And I accept your advice that, if we can find ways to shorten that, consistent with the medical situation, we would be importantly advantaged.

General SCHOOMAKER. Mr. Chair, I would like to say just a couple things here.

First of all, I am no expert at all in the system, but I have had explained to me—and I have some experience from previous commands and frustrations—with the length of time it takes to process people through this MEB/PEB process.

And I think a lot of people get confused at the recuperation period, which can go on for as much as a year for some of these soldiers—is not part of the MEB/PEB process.

And it is until the healing is done that the process of going through the evaluation—there is no use to do it.

If you assume that somebody took an entire year to heal and then went through the rest of the process as fast as, administratively, you can go through it, it would take another 180 days.

If they never missed an appointment, never appealed a decision, never did anything, it would take another 140 days plus—180 days plus 40 days—so 220 more days on top of the healing thing.

And I am exactly in your camp. I think that the bureaucracy and the length of time it takes to go through this thing is a huge factor

in terms of the frustration level and the opportunity for misunderstanding and all of the stuff that we are so frustrated about on this.

And I really do believe that we have got to figure out a way that we can, kind of, multi-task and figure out how to get this kind of a process to appropriately move at a speed that protects the soldiers' interests, which is what this is about, as well as the institution's interests, in terms of reconciling what they have.

Second, as I said earlier in the hearing, in my opening statement, I am concerned that we have different public laws that regulate what DOD does in terms of disability ratings, which are different—you know, Title 10 is different than Title 38, which the VA goes under. And then I guess Social Security has got a different one.

And so part of the distrust in the system is the fact that somebody may get 40 percent in DOD and turn right around and VA gives them 70 percent.

And so there is a fundamental inconsistency in it that tends to lead one to believe that there are some shenanigans in the deal, combined with the frustration of length of time.

So I think, again, as we have been talking about all day, there is an opportunity here to come down comprehensively and reconcile this system. Because this is not going to go away. We are in a long war. We are going to continue to see and learn more about what we are doing. And we must fix this thing comprehensively. And I think that is the opportunity we have.

Dr. GINGREY. Mr. Chairman, thank you. You have been most generous with allowing me extra time, and I really appreciate your allowing——

The CHAIRMAN. I thank the gentleman. Let me follow through on your inquiry.

Regarding electronic medical records—I am not sure who to address the question to, probably Dr. Kiley.

General KILEY. I will take a stab at it, Mr. Chairman.

The CHAIRMAN. We funded this some years ago. Is that correct?

General KILEY. Yes, sir. This has actually been going since 1983.

The CHAIRMAN. Since when?

General KILEY. Sir, since I was a physician at William Beaumont, on the hospital information system in 1983, we were building new prototypes.

The CHAIRMAN. The outpatient care has been complete. Am I correct? Medical records for outpatient care has been complete.

General KILEY. It is close. There are still some modules we would like to put in, but it is pretty close, yes, Mr. Chairman.

The CHAIRMAN. The inpatient care has just begun——

General KILEY. That is correct.

The CHAIRMAN [continuing]. With the exception of some specialized cases, as I understand it.

General KILEY. There are some specialized——

The CHAIRMAN. What in the world has taken so long, since 1983?

General KILEY. Well, sir, that was a prototype back in 1983. I think Dr. Winkenwerder——

The CHAIRMAN. When was it funded?

General KILEY. Sir?

The CHAIRMAN. When was it fully funded?

General KILEY. I will have to take that for the record. I don't know. It has been 10 to 12 years, Mr. Chairman——

The CHAIRMAN. Dr. Chu, do you know?

Dr. CHU. If I could, Mr. Chairman. This is actually the second generation. ALTA is the second-generation system the Department has deployed in this regard.

The CHAIRMAN. When was it funded?

Dr. CHU. Over the last several years. I would have to get you the numbers for the record.

[The information referred to can be found in the Appendix beginning on page 161.]

The CHAIRMAN. Would you be kind enough to do that——

Dr. CHU. Delighted to.

The CHAIRMAN [continuing]. As to how much and at what dates?

Dr. CHU. Yes, sir.

The CHAIRMAN. Or at least what years?

Dr. CHU. Yes, sir.

The CHAIRMAN. That would help.

Dr. Chu, the other day, during the Navy presentation, the Navy is proposing to cut an additional 900 medical providers out in 2008, 100 of which are doctors. And as I understand it, the Navy medical system is being challenged quite a bit.

At what point was this approved in the Pentagon?

Dr. CHU. Sir, I presume you are referring to the Navy's military-civilian conversion plan.

The CHAIRMAN. No, no, no.

Dr. CHU. I am sorry.

The CHAIRMAN. No. It is just old-fashioned Navy—it was spelled out for us: Navy medical providers.

Dr. CHU. The Navy as a whole is shrinking in terms of personnel.

The CHAIRMAN. We know that. We know that.

Dr. CHU. The Navy medical establishment is taking significant steps to rebalance its staffing between uniform personnel and civil personnel; the issue that Congresswoman Davis raised.

That came out of a broad-scale review for the Department as a whole as to what is the size of the uniformed establishment we need to have in order to sustain deployed operations now and in the future.

But beyond that, I am not familiar with the specific numbers that you just read.

The CHAIRMAN. Those are the Navy numbers that were provided to us recently.

Without objection, my statement at the beginning, which I was unable to deliver, will be put—Dr. Kiley, does the Army inform members of Congress when there is a wounded soldier from his or her district?

[The prepared statement of Mr. Skelton can be found in the Appendix on page 67.]

General KILEY. Mr. Chairman, I am going to have to take the question for the record.

But if my memory serves me, we ask each soldier if they would like their representative to be notified. And I believe that we pull

a roster together once a week to notify. But I will have to double-check that; I don't want to go on the record incorrectly.

The CHAIRMAN. We would appreciate that. I know full well that we are notified if there is a death or a casualty——

General KILEY. Yes, sir.

The CHAIRMAN [continuing]. Like that.

Yes?

General SCHOOMAKER. Sir, I believe that there is a weekly notification made to Congress on soldiers——

The CHAIRMAN. On wounding?

General SCHOOMAKER. On wounded soldiers. But the soldier must agree to have his name——

The CHAIRMAN. Oh, I see.

General KILEY. Right. Yes, sir, that is the privacy thing.

The CHAIRMAN. Yes, I understand. Thank you.

I might mention, it has been a little while ago, but I was able to see one of your medical facilities from the inside out. Congressman Tim Murphy and I were in a vehicle mishap just outside Baghdad and we were taken by ambulance to the Baghdad Army hospital, where we received excellent treatment and then medevaced to Landstuhl hospital.

And I cannot say—I know Congressman Murphy would agree with me—I cannot say enough good things about the people who treated us there.

As a matter of fact, with Speaker Pelosi—it has been about a month ago, Secretary Chu, six of us were in the Middle East. We came back. But we were at Ramstein and Landstuhl hospital.

And I was able to thank, in an upright position, the four nurses who were so kind to me there. It is a first-class facility, and I can't do anything but brag about them.

Dr. CHU. Well, thank you, sir, for saying that. And I know they deeply appreciate it.

General KILEY. Yes, sir, very much.

The CHAIRMAN. And you went by room number seven in the ICU unit, where I lingered for over three days. [Laughter.]

Well, gentlemen, thank you.

Dr. Gingrey, do you have any further questions?

Thank you so much for being with us.

This is a major challenge for us. I believe there will be a follow-through hearing at the subcommittee level. That is my understanding, in visiting with these subcommittee chairmen.

Thank you for being with us. And do your best to fix it.

General KILEY. Yes, sir.

The CHAIRMAN. Thank you.

Dr. CHU. Thank you, Mr. Chairman.

General KILEY. Thank you, sir.

[Whereupon, at 1:37 p.m., the committee was adjourned.]

A P P E N D I X

MARCH 8, 2007

PREPARED STATEMENTS SUBMITTED FOR THE RECORD

MARCH 8, 2007

Statement of the Honorable Ike Skelton
Chairman, House Armed Services Committee

Challenges and Obstacles Wounded and Injured Service Members Face During Recovery
March 8, 2007

The Committee will come to order.

Today, the full committee will review the challenges and obstacles wounded and injured service members face during recovery. This hearing continues the committee's effort to ensure that wounded and injured service members and their families have the support and care that is needed.

Let me welcome Dr. David Chu, the Under Secretary of Defense for Personnel and Readiness; Dr. William Winkenwerder, Assistant Secretary of Defense for Health Affairs; General Peter Schoomaker, Chief of Staff of the United States Army, and General Kevin Kiley, the Army Surgeon General. Thank you for coming.

Gentlemen, we are here today not just because of the recent articles in the Washington Post that highlighted the challenges that wounded and injured soldiers experience at Walter Reed. We are here today because these challenges are being experienced by soldiers, sailors, and Marines across this country. For the last several days, the committee has received phone calls and letters from service members and their families detailing the challenges that they are facing in obtaining health care and navigating the unknown and complex disability process.

Sadly, the articles in the Post are eerily similar to the articles that first surfaced early in the 108th Congress. Press reports at that time highlighted the challenges that injured reserve component soldiers were facing at Fort Stewart, Georgia and Fort Knox, Kentucky. In response, this committee undertook numerous initiatives to improve the situation. However, it is clear that these continued and persistent problems require closer inspection and

may demand a significant and comprehensive overhaul of the process.

What happened at Walter Reed is greater than just leadership failure in the Army. It is symptomatic of the extensive and complex factors that affect military medicine and, ultimately, our injured and wounded service members and their families. In the last several years the Department and the Services have moved aggressively in converting military medical positions to civilian positions. While it may make fiscal sense, the unintended consequences of these decisions have ultimately reduced access to care for wounded and injured service members and their families.

Fewer military medical providers mean fewer providers left in military hospitals back home treating injured and wounded service members. It also means that those who do remain continue to face a high and sustained operational tempo—greater deployments and more time away from home. These are

individuals whose talents and skills are in great demand in civilian communities. Yet, the Navy, for example, has proposed for fiscal year 2008 to cut an additional 900 medical providers, including 100 doctors that provide needed health care to service members and their families. This is nonsense. The Marine Corps is proposing to increase its end strength, the President is pushing forward with a troop increase in Iraq. Yet, it seems that these decisions are being made in isolated bubble and the people who are getting the short end of the stick are our sick, wounded and injured service members. This is unacceptable.

That is why we are here. These problems, gentlemen, need to be fixed--Period. This is not just a leadership failure in the Services; this is a system-wide failure that desperately needs to be a priority for both the Services and the Department of Defense.

Let me recognize the committee's ranking Republican, Mr. Hunter, for any remarks he may wish to make.

[Following Mr. Hunter's remarks]

Without objection, the entirety of your prepared statements will be entered into the record. Dr. Chu, let's begin with you.

Prepared Statement

of

The Honorable David S. C. Chu

Under Secretary of Defense (Personnel and Readiness)

Before the

House Armed Services Committee

Hearing on

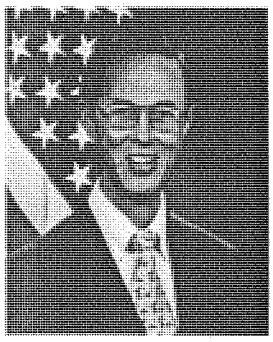
"Challenges and Obstacles Wounded and Injured Service Members Face During Recovery"

March 8, 2007

Not for publication until released by the committee

Under Secretary of Defense for Personnel and Readiness

The Honorable David S. C. Chu



David S. C. Chu was sworn in as the Under Secretary of Defense for Personnel and Readiness on June 1, 2001. A Presidential appointee confirmed by the Senate, he is the Secretary's senior policy advisor on recruitment, career development, pay and benefits for 1.4 million active duty military personnel, 1.1 million Guard and Reserve personnel and 700,000 DoD civilians and is responsible for overseeing the state of military readiness.

The Under Secretary of Defense for Personnel and Readiness also oversees the $21 billion Defense Health Program, Defense Commissaries and Exchanges with $17 billion in annual sales, the Defense Education Activity which supports approximately 96,000 students, and the Defense Equal Opportunity Management Institute, the nation's largest equal opportunity training program.

Dr. Chu began his service to the nation in 1968 when he was commissioned in the Army and became an instructor at the U.S. Army Logistics Management Center, Fort Lee VA. He later served a tour of duty in the Republic of Vietnam, working in the Office of the Comptroller, Headquarters, 1st Logistical Command. He obtained the rank of captain and completed his service with the Army in 1970.

Dr. Chu earlier served in government as the Director and then Assistant Secretary of Defense (Program Analysis and Evaluation) from May 1981 to January 1993. In that capacity, he advised the Secretary of Defense on the future size and structure of the armed forces, their equipment, and their preparation for crisis or conflict.

From 1978 to 1981, Dr. Chu served as the Assistant Director for National Security and International Affairs, Congressional Budget Office, providing advice to the Congress on the full range of national security and international economic issues.

Prior to rejoining the Department of Defense, Dr. Chu served in several senior executive positions with RAND, including Director of the Arroyo Center, the Army's federally funded research and development center for studies and analysis and Director of RAND's Washington Office.

Dr. Chu received a Bachelor of Arts Degree, magna cum laude, in Economics and Mathematics from Yale University in 1964 and a Doctorate in Economics, also from Yale, in 1972. He is a fellow of the National Academy of Public Administration and a recipient of its National Public Service Award. He holds the Department of Defense Medal for Distinguished Public service with silver palm.

Mr. Chairman and distinguished members of this committee, thank you for this opportunity to discuss care for injured Service members and the administrative processes for restoration to duty or separation from military service.

We provide extraordinary medical services, on the battlefield, in transport to facilities outside of the theater, and in clinical centers here in the United States. With the advent of operations in Afghanistan and Iraq, our medical care systems mounted an enormously effective trauma treatment response. More of those suffering traumatic injuries were saved; in years past they might have succumbed to their wounds instead.

I will defer to Dr. Winkenwerder's discussion of the specifics of medical care, but I wish to underscore that I share his distress with the significant administrative problems at Walter Reed. On behalf of the Department, I apologize to the service members and to the American public.

We did not meet our standards as we should. The various review panels now being organized will help establish what occurred and the adequacy of remedial actions. Permit me to turn to the other issues of interest to the committee, starting with the Department's disability system.

DEPARTMENT OF DEFENSE DISABILITY SYSTEM

The Right Paradigm? Does this Nation have the right paradigm in place military disability compensation? We have diverse approaches in the public sector to problems that have much in common. Social Security's disability payments, the Department of Labor, Workmen's Compensation, the Department of Veterans Affairs' and the Department of Defense's Disability Evaluation System are carried out in different ways, against different standards, to achieve

different ends. Perhaps foreseeing this issue, the Congress in 2003 directed the establishment of the Veterans Affairs (VA) Disability Benefits Commission. Its report is expected October 2007, and it may help us understand how to achieve unity of effort and purpose.

DoD Disability Evaluation System. The citizens of the United States have a long and proud history of compensating Service members whose opportunity to complete a military career has been cut short as the result of injuries or illnesses incurred in the line of duty. Congress mandated the development of a system of rating military disabilities in 1917 and over time that system has been further refined to the benefit of Service members and their families. The Career Compensation Act of 1949 formalized the code the Military Departments utilize today. In addition to DoD disability compensation, former Service members may be eligible for disability compensation benefits through the VA. A key difference between the DoD and VA disability systems is that the Services only award disability ratings for medical conditions that make the individual unfit for continued military service, whereas the VA may rate any change in health status that can be linked to the time the member was in Service regardless of whether it was disabling enough to preclude continued service. Military disability ratings are fixed upon final disposition, while VA ratings can increase over time when the condition worsens.

Now, as in the past, the Department of Defense remains committed to providing a comprehensive, fair and timely medical and administrative processing system to evaluate our injured or ill Service members' fitness for continued service using the Disability Evaluation System (DES). The overarching legislative guidance for the DoD DES is set forth in statute in Chapter 61 of Title 10 of the United States Code. Since the inception of Chapter 61 in 1949, the Department has provided additional policy guidance. Ultimately, Secretaries of the Military Departments have exercised this title 10 authority consistent with their roles and missions.

However, the Department does mandate Military Department DES include four elements: medical/physical evaluation, appellate review, counseling and final disposition.

Title 10 mandates that each Service member determined to be unfit be afforded the right to a full and fair personal appearance and hearing. To ensure due process, Department policy requires Secretaries concerned to utilize a series of medical and administrative boards.

The evaluation process begins with the Medical Evaluation Board (MEB). The MEB is typically generated by a physician when a Service member has an unresolved medical condition or injury which precludes him or her from being classified as fit for full duty. The MEB documents the medical diagnosis(es), course of treatment, prognosis and any duty limitations of the Service member. The MEB process serves to protect the health of the Service member. But it may be the basis for referral to the Physical Evaluation Board process if the MEB calls into question the individual's fitness for continued military service.

The Physical Evaluation Board (PEB) is a performance-based process composed of two board types referred to as Informal and Formal PEBs. Formal PEBs typically consist of three board members but Board composition and membership is established by the individual Service Secretaries. The PEBs review a variety of medical evidence and performance information to adjudicate the impact of the Service member's medical condition his ability to reasonably perform the duties of his or her office, grade, rank, or rating. The Informal Board is a record review process without representation whereas the Formal Board provides a personal appearance opportunity with legal representation. If the Service member's case proceeds to a formal hearing, he or she is encouraged to utilize legal assistance, provided by the Service or retained by the Service member at personal expense. The formal hearing is a non-adversarial proceeding designed to ensure fairness, equity, and due process.

PEB Adjudication. On the basis of a preponderance of the evidence, the PEB determines whether the individual is fit or unfit (i.e., does not meet medical retention standards) for continued military service with one of four possible disposition recommendations: return to duty, separate from the Service, placement on the temporary disability retired list, or permanent disability retirement. As a product of the PEB process and according to title 10, Service members found unfit for continued military service will be awarded a disability rating percentage, for the military unfitting condition, in accordance with the rating guidance established in the Veterans Administration Schedule for Rating Disabilities (VASRD). This disability rating determines entitlement to separation or retirement benefits.

Timely DES Adjudication. The Department's DES timeliness standards were established in 1996 based on a 1992 DOD Inspector General recommendation. When a physician initiates a MEB, the processing time should normally not exceed 30 days from the date the MEB report is dictated to the date it is received by the PEB. Upon receipt of the MEB or physical examination report by the PEB, the processing time to the date of the determination of the final reviewing authority as prescribed by the Secretary of the Military Department should normally be no more than 40 days. One can easily see that the timeliness of the adjudication of each DES case is dependent upon a myriad of factors, e.g. the severity of the injury, the recovery process, administrative documentation, and due process concerns.

According to the Military Departments, the average adjudication period for MEB/PEB cases is now longer because the cases are more complicated as a result of the types of injuries Service members are sustaining in current combat operations. In 2004, in order to mitigate this formal board phenomenon, the Army Physical Disability Agency established a mobile PEB to

augment its capacity to conduct formal boards at their three fixed PEB sites. This has helped the Army accommodate its increased case load.

Reserve component Service members' cases occasionally take longer because private practitioners are involved in documenting the cases. The Army reports that its overall timeliness rates are above the DoD goal; this is attributed to the complexity of injuries and the challenges in collating case files for RC soldiers.

It may be difficult for the individual service member to differentiate between the medical inpatient/outpatient recovery phase and the administrative MEB/PEB processes. This creates the impression of long processing times caused by MEBs/PEBs when, actually, the Service members could still be receiving medical and convalescing care for their injuries.

Let me also emphasize that during this process of health care, convalescent care, rehabilitation, and MEB/PEB review, Service members are in receipt of full pay and allowances. The system is designed not to rush a decision. I assure you our Service members' best interests are at the heart of the system. But we need to communicate better the purposeful and deliberate intent of the DES to our Service members and their families.

Update on the GAO findings. The 2006 GAO report, "Military Disability System: Improved Oversight Needed to Ensure Consistent and Timely Outcomes for Reserve and Active Duty Service Members" concluded that disability ratings are consistent between active and Reserve components. The report could not determine if dispositions were consistent, and lacking data on preexisting conditions, it called for stronger oversight. In response, the Department revitalized its Disability Advisory Council so that it plays an active and strengthened role in molding Department DES policy.

Revitalization Efforts. In a self-policing effort, the Military Departments' Personnel Chiefs and Surgeons General recommended we charge the DAC with updating the set of DoD directives/instructions that promulgate disability policies. The Department has also tasked this group with strengthening oversight processes and making recommendations on program effectiveness measures. The Department has established working groups, under the Disability Advisory Council, consisting of senior human resource and medical subject matter experts from the Military Departments and OSD agencies to address the GAO recommendations on training, oversight and consistency of application. We anticipate revised DoD instructions will be completed in May 2007.

In addition to our DoD-level initiatives, the Military Departments are also continually reviewing their processes to make them more effective. For example, Army leadership recently established a Physical Disability Evaluation System Transformation Initiative which integrates multiple major commands and the Department of Veterans Affairs. This combined effort targets improving process efficiency and timeliness in areas such as: MEB and PEB processes, automation of disability data, counseling and training, and transition assistance. Additionally, in November 2006, the Army directed an internal Inspector General review of its DES process. I understand that the report is due out this fall.

QUALITY OF LIFE PROGRAMS FOR SEVERELY INJURED

Military Severely Injured Center. The Department is committed to providing the assistance and support required to meet the challenges that confront our severely injured and wounded Service members and their families during the difficult time of transition. Each Service has programs to serve severely wounded from the war: the Army Wounded Warrior

Program (AW2), the Navy SAFE HARBOR program, the Air Force Helping Airmen Recover Together (Palace HART) program, and the Marine4Life (M4L) Injured Support Program. DoD's Military Severely Injured Center augments the support provided by the Services. It reaches beyond the DoD to coordinate with other agencies, to the nonprofit world, and to corporate America.

It serves as a fusion point for four federal agencies - DoD, the VA, the Department of Homeland Security's Transportation Security Administration, and the Department of Labor.

Federal Partners. The Military Severely Injured Center unites federal agencies through a common mission: to assist the severely injured and their families.

- The VA Office of Seamless Transition has a full-time liaison assigned to the Center to address VA benefits issues ranging from expediting claims, facilitating VA ratings, connecting Service members to local VA offices, and coordinating the transition between the Military and the VA systems.
- The Department of Labor has assigned three liaisons from its REALifelines program which offers personalized employment assistance to injured Service members to find careers in the field and geographic area of their choice. REALifelines works closely with the VA's Vocational Rehabilitation program to ensure Service members have the skills, training, and education required to pursue their desired career field.
- The Department of Homeland Security's Transportation Security Administration has a transportation specialist assigned to the Center to facilitate travel of severely injured members and their families through our nation's airports. The Center's TSA liaison coordinates with local airport TSA officials to ensure that each member is assisted

throughout the airport and given a facilitated (or private) security screening that takes into account the member's individual injuries.

Non-Profit Coordination. The MSI Center has coordinated with over 40 non-profit organizations, all of which have a mission is to assist injured Service members and their families. These non-profits offer assistance in a number of areas from financial to employment to transportation to goods and services. Many are national organizations, but some are local, serving Service men and women in a specific region or at a specific Military Treatment Facility. Some of the many organizations that are providing assistance are the Wounded Warrior Project, the Injured Marine Semper Fi Fund, the VFW, the American Legion, Disabled American Veterans, the Coalition to Salute America's Heroes, and, of course, the Service Relief Societies. There are hundreds of other non-profits who offer assistance to military families in general that are part of the America Supports You network (www.americasupportsyou.mil).

Operation Warfighter. The Department of Defense sponsors Operation Warfighter (OWF), a temporary assignment or internship program for Service members who are convalescing at military treatment facilities in the National Capital Region. This program is designed to provide recuperating Service members with meaningful activity outside of the hospital environment that assists in their wellness and offers a formal means of transition back to the military or civilian workforce. The program's goal is to match Service members with opportunities that consider their interests and utilize both their military and non-military skills, thereby creating productive assignments that are beneficial to the recuperation of the Service member and their views of the future. Service members must be medically cleared to participate in Operation Warfighter, and work schedules need to be flexible and considerate of the candidate's medical appointments. *Under no circumstance will any Operation Warfighter*

assignment interfere with a Service member's medical treatment or adversely affect the well-being and recuperation of OWF participants.

In 2006, 140 participants were successfully placed in OWF. Through this program, these Service members were able to build their resumes, explore employment interests, develop job skills, and gain valuable federal government work experience to help prepare them for the future. The 80 federal agencies and sub-components acting as employers in the program were able to benefit from the considerable talent and dedication of these recuperating Service members. Approximately 20 permanent job placements resulted from Operation Warfighter assignments upon the Service member's medical retirement and separation from military service.

The core of Operation Warfighter is not about employment, however; placing Service members in supportive work settings that positively assist their recuperation is the underlying purpose of the program.

Heroes to Hometowns. The American public's strong support for our troops shows especially in their willingness to help Service members who are severely injured in the war and their ever-supportive families, as they transition from the hospital environment and return to civilian life. Heroes to Hometowns' focus is on reintegration back home, with networks established at the national and state levels to better identify the extraordinary needs of returning families before they return home. They work with local communities to coordinate government and *non-government* resources necessary for long term success.

The Department has partnered with the National Guard Bureau and the American Legion, and most recently the National Association of State Directors of Veterans Affairs, to tap into their national, state, and local support systems to provide essential links to government, corporate, and non-profit resources at all levels and to garner community support. Support has

included help with paying the bills, adapting homes, finding jobs, arranging welcome home celebrations, help working through bureaucracy, holiday dinners, entertainment options, mentoring, and very importantly, coordinated hometown support. Currently, Heroes to Hometowns assistance has been provided to 156 families in 37 states and 2 territories.

Many private and non-profit organizations have set their primary mission to support severely injured veterans. The Sentinels of Freedom in San Ramon, California, for example, recruits qualifying severely injured to their community with "scholarships" that include free housing for four years, an adaptive vehicle, a career enhancing job, educational opportunities, and comprehensive community mentoring. Through a coordinated effort among local governments, corporations, businesses, non-profits, and the general public, six scholarships have already been provided in the San Ramon Valley and plans are to expand the program nationwide.

Paralympics. The ability of injured Service members to engage in recreational activities is a very important component of recovery. We continue to work with the United States Paralympics Committee and other organizations so that our severely injured have opportunities to participate in adaptive sports programs, whether those are skiing, running, hiking, horseback riding, rafting, or kayaking. We are also mindful of the need to ensure installation Morale Welfare and Recreation (MWR) fitness and sports programs can accommodate the recreational needs of our severely injured Service members. At Congressional request, we are studying current capabilities of MWR programs to provide access and accommodate eligible disabled personnel.

The United States Olympic Committee Paralympics organization is also coordinating with key Military Treatment Facilities to see how severely injured sports and recreational opportunities can be expanded and incorporated into all aspects of the recovery, rehabilitation,

and reintegration process. The Department is coordinating with other organizations such as the Armed Forces Recreation Society to provide similar opportunities to severely injured veterans on the municipal and local levels, even possibly partnering with colleges and universities to take advantage of those facilities and recreational programs.

THE WAY AHEAD

Earlier I requested the Department of Defense Inspector General perform an independent review, evaluating our policies and processes for injured OIF/OEF Service members. The objective is to ensure they are provided effective, transparent, and expeditious access to health care and other benefits when identified for separation or retirement due to their injuries. I expect to receive the IG report by July 2007.

In compliance with the Fiscal Year 2005 National Defense Authorization Act, the Joint Medical Readiness Oversight Committee (JMROC) was established to improve medical readiness throughout the Department of Defense and enhance Service member health status tracking before, during, and after military operations. The JMROC oversees medical readiness issues by using a Comprehensive Medical Readiness Plan. Initially consisting of the 22 actions required by the FY 2005 National Defense Authorization Act, the Department is expanding that list to include readiness initiatives emanating from FY 2006 and FY 2007 National Defense Authorization Acts. I believe the JMROC can assist the Department in implementing improvements to support our injured service members.

As the various reviews reach their conclusions, I hope that we can reach a national consensus on the integration of Federal disability systems affecting our Nation's veterans and how they can be improved. I look forward to working with you to develop the best way to

provide for the men and women who stepped forward to defend this Nation and were injured in its Service.

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STATEMENT ON

CHALLENGES AND OBSTACLES WOUNDED AND INJURED

SERVICE MEMBERS FACE DURING RECOVERY

BY THE HONORABLE WILLIAM WINKENWERDER, JR, MD, MBA

ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS

BEFORE THE

HOUSE ARMED SERVICES COMMITTEE

UNITED STATES HOUSE OF REPRESENTATIVES

MARCH 8, 2007

NOT FOR PUBLIC RELEASE UNTIL

RELEASED BY COMMITTEE

Mr. Chairman, distinguished members of this committee, thank you for the opportunity to discuss the Military Health System, and in particular to address the concerns raised in recent news media reports regarding treatment of Service members at Walter Reed Army Medical Center.

Our wounded Service members and their families deserve coordinated professional health care services – both clinical and administrative – together with quality housing and family member support. In the case of the incidents cited at Walter Reed, The Department did not meet our patients' expectations, and we did not meet our own expectations.

I want to address the events associated with the media reports and internal findings regarding substandard housing for some of the service members receiving outpatient, long-term rehabilitative care, and the administrative delays and hassles associated with the military's disability process.

I would first like to outline the principles that underlie the Department's approach in addressing this problem.

- We welcome public scrutiny, even when it is critical. Perhaps especially when it is critical. In this case, the Department accepts the fundamental premise of the reports by the Washington Post that unacceptable conditions existed at Walter Reed for some of our service members.
- Where change is required, the Department will make it. The focus will be on understanding and fixing the problems using a systems approach. As Secretary Gates has stated, persons who allowed these conditions to persist will be held accountable. Yet, several of the issues identified cut across organizational boundaries, and our greatest attention will be to introduce change to the processes by which we support our service members and families.
- Our military health system is a unique, national asset. It must be preserved. As we engage on this issue using the skills and talents of our people to solve the problems, we must act carefully to preserve the morale and trust of our dedicated caregivers.

Context Within the Larger Military Health System: Medical Support to Service Members

We serve over 2.2 million members in the Active, Reserve, and Guard components, to include over 251 thousand service members deployed overseas, and another 7 million families, and retirees. Over 9 million Americans are entrusted to our care – and in both battlefield medicine and traditional health care delivery here at home, we are excelling in our mission. Based on data, measures, and independent assessments by health care organizations around the country, the performance of our military medical personnel on the battlefield and in our medical facilities in the United States has been extraordinary. We have established new standards in virtually every major category of wartime medicine, and many areas of peacetime medicine:

- Lowest Disease, Non Battle Injury (DNBI) Rate. A testament to our medical readiness and preparedness, our preventive medicine approaches and our occupational health capabilities, we are successfully addressing the single largest contributor to loss of forces – disease.

- Lowest Death to Wounded Ratio. Our agility in reaching wounded service members, and capability in treating them, has altered our perspective on what constitutes timeliness in life-saving care from the "golden hour" to the "platinum fifteen minutes." We are saving service members with grievous wounds that were likely not survivable even ten years ago.

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

- Our medical professional have provided high quality medical care, and indicators of quality compare very favorably with national benchmarks. The DoD Patient Safety Program is a national model, and efforts to reduce and eliminate medical errors have achieved ground breaking results.

We are also ensuring our service members are assessed before deployments, upon return and then again 90-180 days after deployment. These health assessments provide a comprehensive picture of the fitness of our forces, and highlight areas where intervention is indicated. For example, we've learned that service members do not always recognize or voice health concerns at the time they return from deployment. By checking with them three to six months later, we've found that about half of them report physical concerns, such as back or joint pain, and a third of them have mental health concerns. As of January 31, 2007, 212,498 Service members have completed a post-deployment health reassessment with 31% of these individuals receiving at least one referral for additional evaluation.

We have introduced an Individual Medical Readiness (IMR) measure that provides commanders with a picture of the medical readiness of their soldier, sailor, airman and marine down to the individual level.

We have worked closely with our partners in the VA, in our shared commitment to provide our service members a seamless transition from the MHS to the Department of Veterans Affairs. DoD implemented a policy entitled "Expediting Veterans Benefits to Members with Serious Injuries and Illness," which provides guidance on the collection and transmission of critical data elements for service members involved in a medical or physical evaluation board. DoD began electronically transmitting pertinent data to the VA in October 2005 and continues to provide monthly updates, allowing the VA to better project future workload and resource needs. Receiving this data directly from DoD before these service members separate eliminates potential delays in developing a claim

for benefits by ensuring that VA has all the necessary information to award all appropriate benefits and services at the earliest possible time.

Here in the United States, our beneficiaries continue to give the TRICARE program high marks in satisfaction. Military health system beneficiaries' overall satisfaction with medical care in the outpatient and inpatient settings compares very favorably against national civilian benchmarks. The quality of our medical care is further attested to by such organizations as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) that has recognized the excellence in our medical treatment facilities with ratings well above civilian averages.

Internationally, our medical forces have deployed with great speed, skill and compassion. Their accomplishments in responding to international disasters has furthered our national security objectives; allowed us to constructively engage with a number of foreign nations; and saved civilian lives throughout the world.

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

Identifying the Way Forward

The set of issues addressed recently in the Washington Post deserve our immediate and focused attention. The Army and the Department have taken swift action to improve existing conditions, and enhance services provided at Walter Reed, and identify areas meriting further study and improvement. Army leadership initiated immediate steps to control security, improve access, and complete repairs at identified facilities and sought to hold accountable those personnel responsible to provide for the health and welfare of our nation's heroes.

Most recently, Secretary Gates commissioned an independent review group (IRG) on 1 March 2007 to evaluate and make recommendations on this matter. The IRG shall conduct its work and report its findings to the Secretary of the Army, the Secretary of the Navy, and the Assistant Secretary of Defense for Health Affairs NLT 16 April 2007. The Report will include:

- Findings of an assessment of current procedures involved in the rehabilitative care, administrative processes, and quality of life for injured and ill members, including analysis of what these heroes and their families consider essential for a high quality experience during recovery, rehabilitation and transition.

- Alternatives and recommendations, as appropriate to correct deficiencies and prevent them from occurring in the future.

The Department will be relentless in its actions – engaged, action-oriented and focused on making measurable improvements. Goals will be clear and milestones will be established. We will regularly inform the people we serve – the soldiers, the families,

military leaders, the Congress, the Secretary and President -- on our progress. Findings and actions will be shared with the public.

We know that this approach works. It has been successfully employed in attacking other issues over the past – the development and implementation of pre and post-deployment health assessments; clinical guidelines for psychiatric care; the development of stringent health information security measures and reporting processes; and the electronic collection of deployment health data.

An Assessment of the Issues

There are a number of disturbing elements to the conditions at Walter Reed, yet I am confident that each of these items is fixable with sustained leadership and oversight. The Department, with the assistance of the Secretary's independent review group (IRG), will come forward with revised approaches to addressing the more complex personnel and medical issues. I would categorize and assess the problems before us as follows:

Physical Facility Issues. In the case of substandard housing, the Army has been able to quickly implement a corrective action plan. Some of those actions have already occurred with facility repair and improvements. Clearly, other facility improvements may require more comprehensive repairs that may take longer. I am confident the Army and the Navy are taking steps to ensure that any needed improvements will be made.

Process of Disability Determinations. The critical first step in assessing this process will be to identify the desired outcome. We know that there are expectations that both the service member and the Department want:

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

The fundamental problems did not result from a lack of available resources.. The main effort here must be focused on the processes being analyzed and assessed for their value and alternatives. The processes must be redrawn with the outcomes we have in mind, with as much simplicity and timeliness as possible.

Process of Care Coordination. Again, the quality of medical care delivered to our service members is exceptional. This assertion is supported by independent review. Yet, the process of coordinating delivery of services members in long-term outpatient, residential rehabilitation needs attention. The Army will assess, and my office will review, the proper ratio of case managers to wounded service members. The administrative and information systems in place to properly manage workload in support of the soldiers will also be assessed.

The planned consolidation of health services and facilities in the National Capital Region will enable the Department to best address the changing nature of inpatient and outpatient health care requirements, specifically the unique health needs of our wounded servicemembers and the needs of our population in this community. The BRAC decision also preserves a precious national asset by sustaining a high quality, world-class military medical center with a robust graduate medical education program in the Nation's Capital. The plan is to open this facility by 2011. In the interim, we will not deprive Walter Reed of resources to function as the premier medical center it is. In fact, in 2005 we funded $10 million in capital improvements at Walter Reed's Amputee Center – recognizing the immediate needs of our warrior population. We are proud of that investment in capacity and technology. We simply will not allow the plans for a new medical center to interfere with the ongoing facility improvements needed in the current hospital.

The Legacy of Military Medicine

Sustaining a medically ready military force and providing world-class health services for those injured and wounded in combat remains our primary mission.

In the current spate of news reports on Walter Reed, the trust that we have earned through our other many medical achievements has been damaged. Everyone's efforts will be focused on repairing and re-earning that trust.

Our civilian and military leaders have remained steadfast in both their support of what we have accomplished, and their belief that these matters can be fixed. U.S. military medicine and our medical personnel are a national asset, representing a readiness capability that does not exist anywhere else, and – if allowed to dwindle – could not be easily reconstituted. We must preserve this asset.

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

After more than five and one-half years of service as the Assistant Secretary of Defense for Health Affairs, I look forward to working together with you and with the leaders within the Services and DoD in the remaining weeks of my tenure to begin this effort at rebuilding this important part of our system that needs attention. And I remain grateful for the opportunity to have worked with such selfless servants that comprise the military health system.

RECORD VERSION

STATEMENT BY

GENERAL PETER J. SCHOOMAKER
CHIEF OF STAFF
UNITED STATES ARMY

BEFORE THE

COMMITTEE ON ARMED SERVICES
UNITED STATES HOUSE OF REPRESENTATIVES

FIRST SESSION, 110TH CONGRESS

ON WALTER REED ARMY MEDICAL CENTER OUTPATIENT CARE

8 MARCH 2007

NOT FOR PUBLICATION
UNTIL RELEASED BY THE
COMMITTEE ON ARMED SERVICES

STATEMENT BY
GENERAL PETER J. SCHOOMAKER

Mr. Chairman, Mr. Hunter, and distinguished members of the committee, thank you for this opportunity to discuss the outpatient care of our Nation's wounded warriors at Walter Reed Army Medical Center, and throughout our Army. Every leader in our force is committed to ensuring that Army healthcare for America's Soldiers is the best this Nation can provide. From the battlefield through a Soldier's return home, our priority is the expedient delivery of compassionate and comprehensive world class medical care.

I am here today as the Chief of Staff of the US Army. And I can tell you, I have never been prouder than I am today to serve with our incredible Soldiers, who motivate me every day and who remain the focus of everything we do as an Army.

As Americans, we treasure the members of our All Volunteer Force who have raised their right hand to say, "America, in your time of need, send me. I will serve." We instinctively understand that in return for their service and sacrifice, especially in a time of war and demanding operational tempo, we owe them a quality of care that is at least equal to the quality of service they have provided to us.

I have visited Army medical facilities around the world, and I have met with Soldiers, staff, and patients in Iraq and Afghanistan; at Landstuhl, Germany; at installations across the United States, to include Walter Reed and Brooke Army Medical Centers. Without exception, the people I encounter inevitably remind me that the United States is a special Nation, blessed with incredible sons and daughters who are willing to serve. From the wounded Soldiers I meet, whose bodies have been hurt, but whose spirits remain strong, to loved ones whose tender attention and tireless dedication are easing our warriors' path to recovery, to the medical staff who have devoted themselves to fulfilling the promise of our Army's Warrior Ethos that we will never leave a fallen Soldier; I have witnessed

unparalleled strength, resilience, and generosity, and I am humbled by their bravery. Even if all of our facilities were the best in the world, and every process, policy, and system were streamlined perfectly, our Solders and families would still deserve better. And without a doubt, they deserve better than we have been providing to date.

Today we have 248,000 Soldiers deployed in more than 80 countries around the world. When injured or wounded, every one of those Soldiers begins a journey through our medical treatment facilities with the top-notch care delivered by Army medics, surgeons, nurses, and civilians in the forward operating facilities. There, our Soldiers receive extraordinary acute care that has drastically lowered our died-of-wounds rate, and is regularly cited as being without peer.

But it is after the incredible life-saving work has been done, and the recovery process begins, that our Soldiers are subjected to medical processes that can be difficult to negotiate and manage. Due to a patchwork of regulations, policies, and rules – many of which need updating -- Soldiers and staff alike are faced with the confusing and frequently demoralizing task of sifting through too much information and too many interdependent decisions. To compound this challenge, we have not optimally managed Army human and capital resources to assist wounded Soldiers and their families. Some of our counselors and case managers are overworked and have not received enough training yet. At times, we do not adequately communicate necessary information. We must make better progress in improving our administrative processes. Some of our medical holding units are not manned to the proper level and some of our leaders have failed to ensure accountability, discipline, and the well-being of our wounded Soldiers. And we need to improve our maintenance of some of our facilities. Most of these issues we can repair ourselves, and we are working aggressively to do so. Some others may require your support and assistance to resolve.

We have identified and fixed a number of problems, but there is still much to do. The Army has launched a wide-ranging and aggressive action plan to address current shortfalls, both at Walter Reed and across our Army. We are committed to rapidly fixing these problems, and are focusing our efforts in four key areas: Soldier welfare, infrastructure, medical administrative processing, and information dissemination.

At Walter Reed, we have made significant progress in repairing and improving conditions at Building 18. We have also accelerated improvements to the medical hold organizations and medical processes and are expediting the identification and implementation of ways to improve the Physical Disability Evaluation System across the force.

We are re-organizing the Walter Reed medical hold unit by establishing a wounded warrior transition brigade, creating an additional medical hold company, and increasing its permanent party personnel to ensure we have the right numbers of leaders with the right skills to properly take care of our outpatient wounded Soldiers and their families. We have selected a command-experienced, promotable lieutenant colonel and command sergeant major who will lead this organization. We are assigning more platoon sergeants who possess greater tactical leadership experience and are re-establishing the Walter Reed Garrison Command Sergeant Major position to provide the right level of skilled, caring leadership our wounded Soldiers and their families deserve.

To assist with outpatient care and reduce the delays in the medical and physical evaluation process, we are adding more personnel, improving their training, and adjusting our medical and administrative processes. We are expediting the re-assignment and hiring of an additional 34 case managers and 10 physical evaluation board liaison officers to handle the increased patient load at Walter Reed. We have improved the physical, administrative, and medical transition of patients between the hospital and the medical-hold task force, and have implemented a revamped clinic appointment system for our outpatient

wounded warriors. Additionally, a complete review of the medical and physical evaluation process is underway.

Addressing the emotional, physical, and administrative challenges our wounded warriors and their families face is a major area of emphasis. In addition to the improvements to our outpatient care and administrative processes, we have assigned Army officers to meet and escort the families of our wounded warriors from local airports to Walter Reed. To assist with their needs at Walter Reed, we are creating a streamlined "one-stop shop" Soldier and Family Assistance Center, have hired additional bilingual staff, and have increased counselor availability at the Mologne House. Finally, the Army has implemented the U.S. Army Wounded Warrior Program, which provides long-term support of our seriously wounded Soldiers to help them be self-sufficient, contributing members of their communities.

Let me conclude by reiterating that Army Medical care is the best in the world. Each day selfless, dedicated Army doctors, nurses, and support staff perform miracles to save lives and limbs, and provide the best possible care for our wounded warriors and their families. We will do what is right for our Soldiers and their families. They can be assured that the Army Leadership is committed and dedicated to ensuring that their quality of life and the quality of their medical care is equal to the quality of their service and sacrifice.

On behalf of the nearly 1,000,000 Soldiers that comprise our Army – and our wounded warriors and their families in particular – I appreciate the Committee's concern for these critical issues, and for Congress' continuing support of Soldiers and their families. Army Strong!

UNCLASSIFIED

RECORD VERSION

STATEMENT BY
LIEUTENANT GENERAL KEVIN C. KILEY
THE SURGEON GENERAL

HOUSE ARMED SERVICES COMMITTEE
UNITED STATES HOUSE OF REPRESENTATIVES

FIRST SESSION, 110TH CONGRESS

WALTER REED ARMY MEDICAL CENTER OUTPATIENT CARE

8 MARCH 2007

NOT FOR PUBLICATION
UNTIL RELEASED BY THE
COMMITTEE ON ARMED SERVICES

Statement By
Lieutenant General Kevin C. Kiley

Mr. Chairman, Congressman Hunter, and distinguished members of the subcommittee, thank you for the opportunity to discuss recent media reports about the living conditions, accountability procedures, medical care, and administrative processing of Soldier-patients receiving recuperative or rehabilitative care at Walter Reed Army Medical Center (WRAMC) as outpatients. The leadership and staff of WRAMC are committed to providing world class care for our wounded warriors and we are all upset by the problems detailed in the Washington Post series.

Let me begin by informing you that in the past two weeks I have directed three separate investigations into various problems raised by the Washington Post articles. First, prior to the articles being published, I asked the US Army Criminal Investigation Division to open an investigation into allegations of improper conduct by Dr. Michael Wagner, the former Director of WRAMC's Medical and Family Assistance Center (MEDFAC). The Washington Post published these allegations on Tuesday, 21 February 2007. In addition, I directed two more investigations. The second investigation will look specifically at the execution of command responsibility by the WRAMC Medical Center Brigade and the WRAMC Garrison Command to ensure safe, healthy living conditions for our recovering Warriors. The final investigation will look into WRAMC's internal Medical Evaluation Board (MEB)/Physical Evaluation Board (PEB) processing. The intent of these investigations is to uncover systemic breakdowns in our processes and to improve our system of care for wounded warriors. Once these investigations are complete, we will report back to you on our findings and our actions.

Since 2002, WRAMC has provided highly personalized health care by treating more than 6,000 Soldiers from Operation Enduring Freedom and Operation Iraqi Freedom. Nearly 2,000 of these Soldiers suffered battle injuries, more than 1,650 of whom started their care at WRAMC as inpatients – receiving life-saving medical treatments, needed surgeries and physical therapy – then progressed to outpatient status living near the hospital. A team of 4,200 medical professionals treat these

wounded warriors and dedicate their lives and hearts to helping our Soldiers. On average, more than 200 family members also join them to help with recovery, provide emotional support, and offer a strong hand or a warm hug to carry them through difficult days.

The requirement to assign Soldiers to Medical Holding Units (MHU) is dictated by internal Department of Defense regulations. The Army policy for assigning Soldiers to MHUs is intended to support the needs of the individual Soldier and his/her family. Soldiers with long-term debilitating conditions such as spinal cord and brain injuries or terminal cancer fall into this category and require intensive medical and administrative management only available at the MHU. In certain circumstances a Soldier may be assigned to a MHU while undergoing outpatient treatment when the Military Treatment Facility Commander determines that continuous treatment is required and that the Soldier cannot be managed by his or her unit, i.e., is unable to perform even limited duty at the unit.

Army military treatment facilities have two types of MHU. Active component Soldiers whose medical condition prevents them from performing even limited duty within their unit are assigned to a medical hold company. Each Army hospital with inpatient capability is authorized a medical hold company. Generally speaking, a majority of Soldiers assigned to medical hold companies have medical conditions that will eventually lead to separation from service or medical retirement. Since 2003, reserve component Soldiers who cannot deploy, are evacuated back to the US during their units' deployment, or return home with a medical condition are assigned to a medical holdover company. At WRAMC, both companies are organized under the Medical Center Brigade, which also has command responsibility for permanent party and students assigned or attached to WRAMC.

The current conflict is the longest in US history fought by volunteers since the Revolution Two dozen Soldiers arrive each week and remain on the campus an average of 297 days for active duty, and 317 days for Reserve and National Guard. Often the very first thing they ask when they are able to speak is "When can I get back to my guys?"

The rehabilitation process at Walter Reed is also unique in its focus to restore these wounded Soldiers not just to a functioning level in society, but to return them to the high level of athletic performance they had before they were wounded for continued service in

the US military if possible. This is the stated goal of the WRAMC program, as well as the newer program at the Center for the Intrepid which was modeled after the Walter Reed successes.

The amputee population deserves special note as an example of these initiatives. There have been a total of 552 Soldier members who have suffered major limb amputation in the war. Of these, 432 of the patients were cared for at WRAMC: 394 service members from OIF (68 with multiple amputations) and 38 service members from OEF (6 with multiple amputations). There have been 35 amputee patients with major limb loss who were found fit for duty (17 that are Continuation on Active Duty/Continuation on Active Reserve and 18 remaining to complete the Medical Board process). Five of the 17 Soldiers have returned to serve on the front lines in CENTCOM. All of the Soldiers were monitored and supported by MH or MHO companies during their rehabilitation at Walter Reed.

It is important to note that, with the exception of burn patients, WRAMC cares for most of the critically injured Soldiers. Our Brooke Army Medical Center and its new state-of-the–art rehabilitation center, cares for many critically injured Soldiers with units or home-of record in the South West. The complexity of the injuries and illnesses suffered by these Soldiers often results in a recovery period that is longer and more challenging than those cared for at most other Department of Defense facilities. This places significant stress on the Soldier-patient, their families, and the staff providing care. The media reports about inadequate living conditions brought to light frustrations with billeting and the administrative processes necessary to return these warriors to duty or to expeditiously and compassionately transition them to civilian life. I would like to address three problem areas reported in the Washington Post series: Living conditions in Building 18; accountability management of outpatient-Soldiers; and, administrative processing of medical evaluation boards (MEB) and physical evaluation boards (PEB).

Billeting Issues and Living Conditions in Building 18

As Soldiers are discharged from inpatient status, many need to remain at WRAMC for continued care. Historically, the combination of permanent party Soldier barracks, off-post lodging, and three Fisher Houses have been sufficient to meet the

normal demand for billeting Soldiers assigned to the MHU at WRAMC. Beginning in 2003 the population of active and reserve component Soldiers assigned to WRAMC's MHU increased from 100-120 before the war to a high of 874 in the summer of 2005. To accommodate this increase in outpatient-Soldiers, WRAMC made use of all 199 rooms in the Mologne House – a non-appropriated fund hotel on the installation opened in 1996; 86 rooms in two buildings operated by the Mologne House; 30 rooms in three Fisher Houses; and, 15 contract hotel rooms in the Silver Spring Hilton. With the exception of building 18, all of these facilities have had extensive renovations performed over the last 10 years and have amenities similar to many modern hotels.

In the summer of 2005, WRAMC began housing the healthiest of the outpatient-Soldiers in Building 18 – a former civilian hotel across the street from the main WRAMC campus. Building 18 was constructed in 1969 and leased periodically by WRAMC until the government acquired the building in 1984. Between 2001 and 2005, more than $400,000 in renovations were made to Building 18. In 2005, a $269,000 renovation project made various improvements in all 54 rooms to include replacing carpeting and vinyl flooring. Additional upgrades to the central day room included a donation of a pool table and the command purchase of couches and a large flat screen TV.

The healthiest of our outpatient-Soldiers are assigned rooms in Building 18 after careful screening by the chain of command, case managers, and treating physicians. Patients who have trouble walking distances, have PTSD, or have TBI are not allowed to live in Building 18.

Building 18 has 54 rooms. Whenever a new Soldier was assigned a room, the building manager directed the Soldier and his/her supervisor to identify any deficiencies or damage in the room and initiates work orders to repair identified problems. Additionally, residents and their chain of command may submited work orders through the building manager at any time. This entire process is being reassessed to ensure proper accountability. Since February 2006, more than 200 repairs were completed on rooms in Building 18, repairs continue to be made, and a rapid renovation is planned.

In spite of efforts to maintain Building 18, the building will require extensive repairs if it is going to continue to remain in service. Upon reading the Washington Post articles, I personally inspected Building 18. As noted in the article, the elevator and

security gate to the parking garage are not operational. Twenty-six rooms had one or more deficiencies which require repair. Two of these rooms had mold growth on walls. Thirty outstanding work orders have been prioritized and our Base Operations contractor has already completed a number of repairs. We are also working closely with US Army Installation Management Command, the Army Corps of Engineers, and our Health Facility planners to replace the roof and renovate each room.

There are currently no signs of rodents or cockroaches in any rooms. In October 2006, the hospital started an aggressive campaign to deal with a mice infestation after complaints from Soldiers. Preventive medicine specialists inspected the building and found rooms with exposed food that attracted vermin. Removing the food sources and increased oversight by the chain of command has since brought this problem under control, although such problems require vigilant monitoring, which is on-going.

Accountability and Information Flow to Outpatient-Soldiers

As of 16 February 2007 WRAMC had a total of 652 active and reserve component Soldiers assigned or attached to two MHUs. Currently there are 450 active component Soldiers assigned or attached to WRAMC's Medical Center Brigade. There are 202 reserve component Soldiers assigned or attached. Platoon sergeants and care managers are key to accounting for, tracking, and assisting Soldiers as they rehabilitate, recuperate, and process through the disability evaluation system. Prior to January 2006, WRAMC only had a single medical-hold company to provide command and control, and accountability for all of those Soldiers. Since January 2006, the hospital created new organizational structures to decrease the Soldier-to-platoon sergeant and Soldier-to-case manager ratio from one staff member for every 125 Soldiers to 1 platoon sergeant and 1 case manager for approximately 30 Soldiers.

Platoon sergeants and case managers attend staff training every Thursday. The training consists of various topics ranging from resource availability to Soldier services. Weekly Thursday training is supplemented with a platoon sergeant/case manager orientation program. Departing platoon sergeants work along side their replacement for approximately one week. Reserve component case managers attend a one week training program at Fort Sam Houston Texas for an overview of the Medical Holdover

Program, MEB/PEB process, customer service training and the duties of a case manager. Upon arrival at WRAMC, these case managers undergo a month-long preceptor program. Once hired by WRAMC, these case managers undergo a one-week training program to address organizational structure, MEB/PEB process, case manager roles and responsibilities, use of data systems, administrative documentation, convalescent leave and available resources in the hospital and on the installation, as well as expectations and standards. There is also a weekly clinical meeting held with physician advisory board and case managers for chart reviews and recommendation for the medical evaluation board process. Where ever possible we are working to streamline and merge platoon sergeant and case manager training to make it identical for all new personnel such as incorporating the preceptor concept for both Medical Hold and Medical Holdover units. We will also enhance the weekly training to introduce topics that are not only important to the platoon sergeant and case manager but address recurring issues/concerns raised by Soldiers and family members.

We are conducting a 100% review of the discharge planning and handoff process to ensure the transition from inpatient to outpatient is seamless and patients understand the next step in their recovery. This discharge will now include a battle handoff to a platoon sergeant. We are also in the process of hiring additional case managers and will submit plans to increase other critical positions in the Medical Center Brigade, which will reduce the current staff to outpatient ratio to more manageable levels, allowing more personalized service to the recovering soldier and family member in making appointments, completing necessary paperwork and navigating the complex disability evaluation systems.

The Medical Family Assistance Center (MEDFAC) will co-locate functions performed by Human Resources Command, Finance, and Casualty Assistance into the Medical Family Assistance Center allowing service in one location. In the near term, WRAMC will expand the staff to support the family members and relocate the operations to a more centralized 3,000 SF space in the hospital providing an improved environment for the families to obtain assistance.

The Medical Center Brigade recently established a Soldier and Family Member Liaison Cell to receive feedback from Soldiers and family members. A recent survey of

Soldiers and family members in January 2007 indicated that less than 3% of the outpatient-Soldier population voiced complaints about administrative processes. The command will continue to enhance the structure of the Soldier and Family Member Liaison Cell. We have requested three Family Life Consultants from the Family Support Branch of the Community and Family Support Center, Installation Management Command (IMCOM) to expand the resources available to identify areas of interest as well as provide counseling support to Soldiers and family members. We also will expand the current survey feedback process to include an intake survey for Soldiers and family members, a monthly Town Hall meeting and survey for ongoing issues, and an outtake survey upon the departure of Soldiers and family members. This feedback will be reviewed by the WRAMC Commander and other key leaders.

The Mologne House has approximately 30 personnel on staff that speak Spanish. These personnel work in all departments and a number of them are in management positions. These personnel have been assisting the Spanish speaking Soldiers and their families since the hotel opened. The Mologne House is taking steps to ensure the desk has a Spanish speaking staff member on call 24 hours a day to assist those in need of translation services.

Patients arrive at WRAMC by aero-medical evacuation flights three times a week, (Tuesday, Friday and Sunday). Additionally, some patients arrive at WRAMC on commercial flights for medical care. Family members may arrive with the Soldier or through their own travel itinerary. Soldiers and family members who arrive on MEDEVAC flights are met by an integrated team of clinical staff, MEDFAC, Red Cross, Patient Administration, Unit Liaison NCOs, and Medical Center Brigade representatives. Inpatients are triaged for further evaluation and disposition. Outpatients remain on the ambulance bus and are sent to the Mologne House with a representative from the Medical Center Brigade for billeting. Family members are met by MEDFAC and Red Cross and are escorted to the Mologne House for lodging.

Currently, there are 51 GWOT inpatient casualties. Our census ranges between 30 and 50 depending on the volume of air evacuations (high of 359 in July 2003 to low since OIF began of 64 in November 2005). Roughly half of the patients come as inpatients, and half as outpatients. Outpatients are processed through the Medical

Center Brigade for accountability and billeting when they arrive. Inpatients are accounted for by the hospital's patient administration office. We believe as many as one in five patients may be at risk to miss some of the administrative in processing at the Medical Center Brigade when they are discharged from the hospital, because of the timing of their discharge, their underlying medical condition, or miscommunication. I have directed a complete review of the discharge planning and the development of a new handoff process between the hospital and the Medical Center Brigade. This will include the development of a "GWOT Discharge Validation Inventory" that will be completed by the attending physician, discharging nurse, discharging pharmacist, social worker, brigade staff and hospital patient administration. The checklist will be validated by the Nursing Supervisor, Attending Physician, Deputy Commander for Clinical Services (DCCS) or Deputy Commander for Nursing (DCN).

Each Soldier receives a handbook upon assignment or attachment to Med Hold or Med Holdover. The Med Hold handbook is provided to Soldiers when they are assigned or attached by their respective PLT SGT. Newly arriving family members receive a Hero Handbook as well as a newcomer's orientation binder. Family members attend weekly new arrival meeting and a weekly town hall meeting where information is exchanged to answer questions or discuss ideas. Physical Evaluation Board Liaison Officers conduct monthly training sessions on the MEB/ PEB process for Soldiers and family members. A Case Management booklet with frequently asked questions is also provided to Soldiers.

Administrative processing of MEBs and PEBs

The MEB/PEB process is designed with two goals in mind – (1) to ensure the Army has a medically fit and ready force and (2) to protect the rights of Soldiers who may not be deemed medically fit for continued service. This process was designed to support a volunteer Army with routine health occurrences and it is essentially a paper process. We can and will improve this process in order to ensure that it can support a wartime Army experiencing large numbers of serious casualties.

The average reserve component Soldier assigned to Medical Holdover at WRAMC has been with us for approximately 289 days. We know from past experience

they will be with us, on average, for 317 days from the time they are assigned to the Medical Holdover Company. The primary reason for this lengthy stay is the requirement that each Soldier be allowed to achieve "optimal medical benefit" – in other words, heal to the point that further medical care will not improve the Soldier's condition. All humans heal at different rates and this accounts for the longest part of the process.

Once the treating provider determines the Soldier has reached the point of optimal medical benefit the provider will initiate an MEB. This is a thorough documentation of all medical conditions incurred or aggravated by military service and ultimately concludes with a determination of whether the Soldier meets medical fitness standard for retention. If the treating provider and the hospital's Deputy Commander for Clinical Services agree the Soldier does not meet medical fitness standards, the case is referred to the PEB.

The PEB is managed by US Army Human Resources Command and is comprised of a board of officers, including physicians, who review each MEB. The role of the PEB is to evaluate each medical condition, determine if the Soldier can be retained in service, and, if not retainable, assign a disability percentage to each condition. The total disability percentage assigned determines the amount of military compensation received upon separation. It is important to note that the MEB/PEB process has no bearing on disability ratings assigned by the Department of Veterans Affairs (DVA), but thorough and complete documentation of medical conditions is essential for expeditious review by the PEB and will also aid the Soldier in completing DVA documentation requirements.

The Washington Post articles provide anecdotal experiences of Soldiers and families who have had medical records and other paperwork lost during the MEB/PEB process. All medical records at WRAMC are generated electronically. However, paper copies must be printed since the PEB cannot access the electronic medical record used by Department of Defense hospitals.

There are currently 376 active MEB/PEB cases being processed by the WRAMC PEBLOs. The average time from initiation of a permanent profile to the PEB is 156 days. The MEB is processed through the PEB and Physical Disability Agency for an average of 52 days (including the ~15% of cases returned to the hospital for further

information). Thus, the total time from permanent profile to final disability rating is currently 208 days. At present, WRAMC has 12 trained PEBLO counselors. We are hiring an additional 10 counselors and 4 MEB review physicians to expedite the medical board process. It takes at least 3 months to train a PEBLO counselor and these employees are the main interface between the Soldier and the MEB/PEB system. As you might imagine, PEBLO counselors need to have excellent interpersonal and communication skills to perform well in a system that can be very stressful for the Soldier, family, and counselor.

In closing, let me again emphasize my appreciation for your continued support of WRAMC and Army Medicine. The failures highlighted in the Washington Post articles are not due to a lack of funding or support from Congress, the Administration, or the Department of Defense. Nor are they indicative of the standards I have set for my command. Walter Reed represents a legacy of excellence in patient care, medical research and medical education. I can assure you that the quality of medical care and the compassion of our staff continue to uphold Walter Reed's legacy. But it is also evident that we must improve our facilities, accountability, and administrative processes to ensure these systems meet the high standards of excellence that our men and women in uniform so richly deserve. Thank you again for your concern regarding this series of articles.

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March 7, 2007

MEMORANDUM FOR ARMED SERVICES COMMITTEE MEMBERS

Subject: Full Committee Hearing—Challenges and Obstacles Wounded and Injured Service Members Face During Recovery

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On Thursday, March 8, 2007, at 10:00 am in room 2118 Rayburn, the full committee will meet in open session to receive testimony on the challenges and obstacles wounded and injured service members face during their recovery and subsequent transition to civilian life.

Should you have any questions, please contact Debra Wada (6-5662) or Mike Higgins (5-7560) on the committee staff.

WITNESSES (biographies attached)

Dr. David S.C. Chu
Under Secretary of Defense for Personnel and Readiness

Dr. William Winkenwerder
Assistant Secretary of Defense for Health Affairs

General Peter J. Schoomaker, USA
Chief of Staff, U. S. Army

Lieutenant General Kevin C. Kiley, USA
The Surgeon General, U.S. Army

OBJECTIVES

The committee's hearing will focus on the adequacy of the medical treatment, quality of life, and administrative support for wounded and injured military personnel with special attention to:

- The effectiveness and efficiency of the medical hold and medical holdover system*.
- The quality of care and access to care within the military health care system including TRICARE.
- The environment and facilities in which wounded and injured service members are housed.
- The administrative processes for managing the outpatient population, assessing disability levels, and transitioning to Department of Veterans Affairs programs.

The hearing will also provide an opportunity for the Army to address specific failures and plans for improvement at Walter Reed Army Medical Center (WRAMC).

**An individual in medical holdover (also referred to as medical hold) status is defined as a reserve component (RC) service member, pre or post-deployment, separated from his/her unit in need of definitive medical care or processing through medical and physical evaluation boards, based on medical conditions identified while on active duty status, in support of the Global War on Terrorism.*

BACKGROUND

The recent articles in the Washington Post highlighting the challenges that wounded and injured service members are facing (See Tab A) in their recovery process are not the first press accounts documenting the challenges that wounded service members' face. The first media articles surfaced early in the 108th Congress and reported the problems injured soldiers were experiencing in the Army Medical Holdover (MHO) system at Fort Stewart, Georgia and Fort Knox, Kentucky. Similar concerns were raised by sailors about the Naval Reserve Medical Holdover to the Military Personnel Subcommittee. While the Air Force has a process which sends the injured or wounded airman (reserve or active) back to their home station, the subcommittee did not delve further into the Air Force unique system because the number of wounded has been nominal and no complaints with the system has been raised to date.

In response, on January 21, 2004, the Subcommittee on Military Personnel held a hearing to assess Army and Navy efforts to provide sufficient and appropriate health care services, housing, and command and control for reserve component (RC) members in a medical holdover status who have been activated in support of the Global War on Terrorism. The subcommittee was particularly interested in preventing a reoccurrence of the problems encountered at Fort Stewart and Fort Knox during the massive deployment and re-deployment of forces to Iraq and Afghanistan in the January through May 2004 period and all subsequent troop rotations.

During the course of the hearing, witnesses testified that RC MHO soldiers were experiencing excessive waiting times for medical care, insufficient housing and substandard living conditions, and had an overall feeling of being treated like "second-class citizens" receiving "sub-standard treatment" because they were RC rather than regular Army soldiers. In addition, results from a Navy Inspector General investigation reported during the hearing indicated that RC sailors with medical issues were rushed through the demobilization process without understanding their follow-on plan for care, how to access the necessary care, and who was responsible for providing the care.

Throughout the remainder of 2004, the Committee monitored the medical care, quality of life, and administrative management and processing of all outpatients at military treatment facilities with specific attention on the problems confronting wounded warriors. Beginning in 2004, the committee pursued two closely aligned oversight projects involving the care and support provided to wounded and injured military personnel and their families (1) during their active duty service and (2) during their transition from active duty into their post separation lives.

The two teams began their examination of the issues with over 40 formal meetings in the months just preceding and following the inauguration of the 109th Congress and remained actively engaged throughout the 109th Congress. The Military Personnel Subcommittee held another hearing on the care of injured and wounded service members on March 3, 2005. The oversight process involved extensive travel to DOD and other governmental activities, in-office research, and informational briefings from DOD, other governmental agencies, and private sector organizations. The teams examined the following issues:

- Adequacy of medical treatment and support with special attention paid to mental health services.
- Effectiveness and efficiency of the medical holdover system.
- Identification and resolution of problems encountered by wounded and injured members and their families with particular attention paid to reservists.
- Effectiveness of new programs operated by the military services to assist severely disabled service members and their families.
- Fairness and effectiveness of physical disability evaluation system.
- Effectiveness and efficiency of Department of Defense, Department of Veterans Affairs, and Department of Labor programs intended to provide a seamless transition for wounded and injured service members and families and survivors of deceased members.
- Scope and nature of the services and resources available to wounded and injured service members and families and survivors of deceased members from the Department of Defense, other governmental agencies, and the private sector and the ability of the Department of Defense to integrate and coordinate access to those services and resources.

The Army and the Navy identified several initiatives undertaken to improve the MHO process including:

ARMY

- Increased medical infrastructure—more physicians, case managers and diagnostic capabilities.
- Upgraded billets for soldiers in MHO to accommodate medical conditions and make them commensurate with active duty billets.
- Outsourced administrative support for medical evaluation boards.
- Implemented a new policy in which RC soldiers mobilized after October 25, 2003, may be released from active duty if found medically unfit to deploy within the first 25 days of mobilization.
- Established the Community Based Health Care Organization (CBHCO) which affords soldiers with less severe health issues the opportunity to receive medical care closer to their home.

NAVY

- Established a single point of contact at each Navy military treatment facility to coordinate demobilization of RC personnel with local processing sites.
- Implemented a new policy in which every MHO reservist will demobilize with a written, easy to understand, personalized medical care plan and points of contact for additional assistance after returning home.
- MHO sailors receive a briefing on TRICARE and VA benefits prior to demobilizing.

The continuing oversight initiatives of the committee highlighted the needs of wounded warriors and medical patients in general and contributed to the following legislation being enacted during the 108th and 109th Congresses:

- The National Defense Authorization Act for Fiscal Year 2004.
  - Establishment of a Veterans' Disability Benefits Commission to comprehensively examine disability benefits provided to service members.
  - Expansion of travel entitlements for family members to attend wounded and injured service members and retirees.
- The National Defense Authorization Act for Fiscal Year 2005.
  - Authority to provide $250 in civilian clothing to service members while traveling in connect with medical evacuation.
  - Repeal of requirement for service members to pay the cost of food while hospitalized.
  - Increased the number of family members that may travel to visit seriously injured service members and authorized reimbursement for daily expenses.
  - Requirements for studies by DOD and the Government Accountability Office on the adequacy of disability benefits and the disability benefits made available to other government employees, respectively.
- Emergency Supplemental Appropriations Act for Defense, the Global War on Terror, and Tsunami Relief Act, 2005.

- Authority for automatic insurance coverage for traumatic injury as a rider on the Servicemember's Group Life Insurance (SGLI) program. The policy pays from $25,000 to $100,000 for the loss the physical capability resulting from a traumatic injury incurred while insured under the SGLI program.
- Expanded travel benefits for family members to visit combat wounded service members with less than serious wounds.

- The National Defense Authorization Act for Fiscal Year 2006.
  - Authority for members to participate in the Paralympic Games.
  - Assessment and standardization of policy and procedures involved in providing assistance to severely wounded service members.
  - Prohibition against charging the cost of meals to hospitalized wounded and injured members.
  - Transitional pay for hospitalized wounded and injured members of $430 each month to ensure that family fiscal security was maintained during recovery.
  - Authority to provide travel and transportation allowances to families visiting hospitalized members.
- The John Warner National Defense Authorization Act for Fiscal Year 2007.
  - Authority for members to retain assistive technology and devices after separation from active duty.
  - Standards and guidelines for the establishment of a severely injured center by the Secretary of Defense.
  - Reform of Physical Evaluation Board policy and procedures to improve fairness and efficiency.
  - Inclusion of military members in the policy to provide travel and transportation allowances to family members visiting wounded and injured service members.

In addition to the above legislative initiatives, the committee staff devoted considerable effort to enhancing the support provided wounded and injured service members and their families during more than 150 visits to Walter Reed Army Medical Center (WRAMC), the National Naval Medical Center, Bethesda, and other medical facilities. The effort focused not only on the overall functioning of the patient support systems, but also in resolving the specific problems related to housing, pay, benefits, and medical care. Legislation requiring a comprehensive policy for providing assistance to members of the Armed Forces who incur severe wounds or injuries in the line of duty was adopted to ensure procedures and standards for providing such assistance are uniform across the military departments and that such members are tracked in a central database. A Military Severely Injured Center was authorized to augment and support the programs operated by the military departments to provide personalized assistance and support services to severely injured and wounded service members and their families. The programs operated by the services have steadily improved in coverage and effectiveness. These programs include the Army's "Wounded Warrior Program", the

Navy's "Safe Harbor", the Marine Corps' "Marine for Life", and the Air Force's "Palace HART".

The recent press accounts of problems involving the medical care, quality of life, and administrative management provided for our wounded warriors at WRAMC highlights the importance of continuing oversight even at one of the military's most prestigious medical facilities. Notwithstanding the substantial improvements in compensation, family support benefits, military construction, medical benefits, and management practices, problems have continued. In the case of WRAMC, the problems that occurred resulted in the commanding general, Major General George W. Weightman, being relieved of command. Additionally, Lieutenant General Kevin Kiley, who was the commander at WRAMC prior to becoming the Army Surgeon General, has been removed as the interim commander at WRAMC and his continued service in his current position as the Army's Surgeon General is reported to be under review. Ultimately, the first hand accounts of substandard housing and unacceptable bureaucratic delays in outpatient care at WRAMC resulted in the resignation of the Secretary of the Army, Francis J. Harvey.

ACCESS AND QUALITY OF CARE IN MILITARY HEALTH CARE SYSTEM/TRICARE

While there have been many positive improvements and systemic fixes to the care and treatment of reserve component soldiers returning home after deployment to Iraq and Afghanistan, media reports of about the care of soldiers continued. Injured reserve members continued to express their frustration of having to stay on a military base to get medical treatment, often times away from their families and support network, unlike active component (AC) soldiers who go back to their home station and are able to be with their families. Service members reported that they had to wait weeks and months for medical appointments, surgery or other specialty treatments.

The reports of ongoing dissatisfaction with the MHO process from injured and wounded RC soldiers continue to generate significant congressional attention. The staff of the Military Personnel subcommittee visited Army installations (Fort Hood, TX; Fort Carson, CO; Fort Sam Houston, TX, Fort Lewis, WA, Fort Benning, GA, Fort Stewart, GA, Fort Bragg, NC, and Fort Gordon, GA), two Navy installations (Norfolk, VA and San Diego, CA), and three Marine installations (Camp Pendleton, San Diego, Camp Le Lejeune, North Carolina, and Marine Corp Base, Hawaii) with large MHO populations. In addition, the staff visited three CBHCOs (Little Rock, AR; Riverside, CA; Los Alamedas, CA and Plant City, FL). They reviewed MHO and CBHCO policies, met with the installation, medical treatment facility and MHO and CBHCO leadership and met with over 500 RC soldiers and their families in sensing sessions open to current and past MHO and CBHCO members only.

Despite the Army's commitment to finding solutions to the MHO problems, discussions with MHO soldiers during the sensing sessions revealed problems continued to exist.

For example:

- The perception of substandard treatment and being treated like second class citizens.
- Difficulty accessing medical care.
- Substandard housing.
- Lack of housing and transportation appropriate for soldiers with physical disabilities.
- Different administrative policies that affect reserve and National Guard versus AC.
- Concerns were also raised about the perceived disparity in the outcome of the physical disability rating system for AC and RC soldiers.

Discussions with the installation and military treatment facility leadership suggest that the policies implemented by the Services seemed to be working. Overall, the MHO population across the Army has been reduced considerably with approximately 3205 in MHO today and 21,581 having processed through since November 2003. The reduction has been attributed in part to the 25-day medical assessment process for mobilizing RC soldiers, the increase in resources to treat injured and wounded RC soldiers and the implementation of the CBHCO program. The average time spent in MHO is currently 291 days, however, there are still approximately 1055 soldiers remaining in MHO greater than 360 days, the majority of which are in the CBHCO program which requires longer term rehabilitation. The long administrative process for separating injured and wounded soldiers is cited as the primary reason for extended stays in MHO.

The Navy also seems to continue to have challenges even with improved MHO processes in place. While the Navy has implemented a new policy in which every MHO reservist will demobilize with a written, easy to understand, personalized medical care plan and points of contact for additional assistance after returning home, Naval RC personnel continue to contact the Military Personnel Subcommittee to express their dissatisfaction with the Navy MHO process. These sites currently have a population of 134 MHO sailors and under current policy case managers are assigned to sailors based on the severity of their injuries.

Sailors continue to express their concerns with the coordination among the various activities involved in demobilizing RC personnel.

For example:

- The perception of being treated like second class citizens.
- Access standards for medical care are not being met.
- The perception that the success of a Naval Mobilization Processing Station is measured by how quickly RC sailors can be demobilized regardless of their medical condition.
- RC sailors with medical conditions are found fit for duty, demobilized and told to seek care from the Veterans Administration.

The Marine Corps has made a number of improvements in the system to support MHO Marines, including enhancing their Marine for Life program for severely injured

Marines, and consolidating injured and wounded Marines at Camp Le Jeune in renovated facilities. However, other challenges still remain for MHO Marines as well, such as access standards for medical care. There are currently 624 MHO Marines and 7,853 have been demobilized since October 2001.

Key questions: What oversight process is in place for Service and Department leadership to ensure that policies and programs are being carried out as intended?

Community Based Health Care Organizations

In response to the concerns raised by RC soldiers, the Army established a Community Based Health Care Organization (CBHCO), which currently operates in Arkansas, California, Florida, Massachusetts, and Wisconsin. Discussions with soldiers assigned to the CBHCO appear to indicate that the CBHCO is a positive step toward providing injured and wounded RC soldiers a more positive experience during the treatment, recovery and separation process. Soldiers and spouses appreciated having a case manager who is well versed in all aspects of the process and provides a sense of personal commitment through constant contact and flow of information. Living at or close to home appears to be the most positive feature of the CBHCO.

Key question: The establishment of CBHCOs that allow wounded soldiers to continue their outpatient care closer to their homes seems to be successful in providing the necessary medical and family support for wounded and injured service members. However, this program is only available to soldiers, should this program be expanded to include the other services, particularly for RC sailors and Marines?

Inadequate Access to Medical Appointments Resulting in Delayed Treatment

In discussions with service members and case managers, access to specialty medical care continues to be an issue. A number of facilities visited by committee staff indicated that service members were not afforded care in the private sector, even though access to care within the military system was not available in a timely manner. The staff found that the operational tempo for medical providers from many of the military medical facilities was having an adverse impact on access to care for service members, particularly injured and wounded service members.

In order to manage the MHO populations, there is both a military command and control structure and a medical case management system that must work together to ensure that proper care and support are being provided to wounded and injured service members. They are important to ensure that members are being tracked, obtain the necessary medical services, and assist service member and their families through the administrative process. As Walter Reed has shown though, service polices are not always followed and there needs to be a system in which leadership is able to ensure that such policies are being implemented and maintained.

Key questions: Access to medical care continues to a concern for the Army, Navy and Marine Corps, particularly access to specialty care in the private sector if such care is not being provided in a timely manner in the military hospitals. What effort has the Department taken to ensure that the current access to care policy for reservists is being implemented by the Services? What is the oversight mechanism that Service leadership has to ensure the DOD policy is being met? Should there be a similar policy for specialty care for combat wounded and injured active duty members? Should there be a Department policy on the maximum number of patients a case worker should be responsible for regardless of service policies?

Support for Families of Injured and Wounded Service Members

DOD has seen an unprecedented response from family members desiring to visit and in many cases remain with services members recovering in military treatment facilities. The therapeutic effect of families assisting with care of hospitalized patients is well documented and military medical professionals often encourage families to participate in the treatment of injured and wounded service members. The volume of family members has taxed both the Service sponsored transient accommodations and the private and contractor provided facilities such as the Fisher Houses and local commercial lodging. Families remaining with hospitalized service members for protracted periods of time require more support than temporary services were designed to provide such as child care, schooling and transportation.

In addition, there are small numbers of service members who require highly specialized care for injuries such as traumatic brain injury who are receiving treatment at four Veterans Affairs (VAMC) Medical Centers across the United States (Palo Alto, CA; Richmond, VA; Minneapolis, MN and Tampa, FL). Often these injuries require lengthy hospitalization and rehabilitative care. The VA Medical Centers are not located near military facilities; consequently families accompanying these service members do not have access to the same level of support available on military posts.

Key questions: Should there be advocates to assist service members and their families through this process?

Retaining Disabled Service Members

Until recently, the conventional wisdom has been that when a service member suffers a physically disabling injury, such as the amputation of an arm or leg, they are no longer able to remain in the military. Over the years there have been some exceptions, but the numbers are small. New surgical techniques, high-tech artificial limbs and service members driven by duty, professionalism and a devotion to their comrades are changing the notion of a disability.

To date, over 560 service members have suffered a traumatic or surgical amputation of at least one limb from injuries and wounds sustained in Iraq and

Afghanistan. Many of these service members have expressed a desire to remain in the military and are challenging DOD and the Services to allow them to stay. It appears that DOD and the Services are exploring ways to accommodate these injured warriors but are having difficulty. From discussions with the Services, each Service currently has different standards for retaining amputees and would welcome new policies that ensure consistency and fairness across DOD.

The War on Terror has produced in excess of 39,000 injured and wounded service members. Advances in combat casualty care and personal soldier protection have significantly increased the survivability of the injured and wounded. As a result, the military health system is providing care to thousands of very seriously ill and injured service men and women. These service members and their families present unique challenges to a system that has been significantly downsized and must use both military treatment facilities and private sector care. Advances in medical technology have reduced the limiting effects of physical disabilities. Policies that may have been applicable as recent as five years ago may not be relevant to the emerging needs of injured and wounded service members and their families today.

ENVIRONMENT AND FACILITIES

Military Medical Facilities

Direct military medical care is centrally managed by the Assistant Secretary of Defense (Health Affairs). In direct collaboration with the Service Surgeon Generals, ASD(HA) is responsible for the programming, planning and budgeting for the Facilities Sustainment, Restoration and Modernization (SRM) of all military treatment facilities to include Inpatient facilities, medical clinics, dental clinics and veterinary clinics. In general, the Services are responsible to provide a number of collateral base operating services to most military treatment facilities including berthing, security, dining facilities, child development care and other related services. Certain exceptions to this model exist especially when the military treatment facility is a stand alone installation and include Walter Reed Army Medical Center, Fort Detrick, and Bethesda National Naval Medical Center. These stand alone installations and the associated base operating support are entirely funded by ASD(HA).

Facility Sustainment is funding that maintains the infrastructure in good working order. OSD has adopted a model that compiles a number of metrics to determine a programmatic funding basis. According to DOD, fully funding Sustainment is the most cost effective approach to managing facilities because it provides the most performance over the longest period of time for the least investment. In the case of the Defense Health Programs, a percentile comparison is provided against commercial medical standards. Below is a compilation of the Defense Health Program budget submission for FY08:

Defense Health Programs Facilities Sustainment, Restoration and Modernization ($M)				
	FY2006	FY2007	FY2008	FY2009
Restoration/Modernization CONUS	391	157	160	140
Restoration/Modernization OCONUS	28	26	29	28
R&M Subtotal	419	183	189	168
Sustainment CONUS	442	291	276	238
Sustainment OCONUS	70	51	59	76
Sustainment Subtotal	512	342	335	314
Department Sustainment Rate	145.7%	96.0%	87.0%	77.3%
Grand Total	931*	525	524	482

*FY06 estimate included $90M in FSM funding to address Global War on Terrorism, Hurricane and Pandemic Influenza supplemental funding.

As can be seen in the above table, SRM funding has dropped precipitously for medical treatment facilities since FY06. Even by excluding the FY06 supplemental funding, ASD(HA) has significantly reduced funding for FY07 and this will be further exacerbated in FY08/09 if the presidential budget submission is adopted with the proposed additional SRM reductions. The proposed 87% Sustainment budget for FY08 is under funded as compared to commercial hospital requirements. An additional $50M to the proposed budget will be required to meet commercial hospital Sustainment requirements.

As to the Service SRM support to barracks, administrative space, classrooms, dining facilities and other facilities, this account is also under funded as compared to comparable commercial standards. A total of $6.7B has been allocated for this effort. The Services have elected to take risk in these areas in FY08 and have funded the overall Sustainment requirement at 88.5%. Further reductions in the SRM account are typically seen in the year of execution. This chronic under funding of the Sustainment accounts will lead to an accelerated deterioration of the facilities and is the subject of a GAO report (FEB 2003). An additional $875M is required to optimally fund the long term Sustainment of the facilities.

Key Questions: What is the long term impact of the medical infrastructure if the FY08 presidential budget submission for SRM is accepted? What is the decision to accept additional risk in Sustainment funding below commercial medical standards? How does the Surgeon General ensure the correct funding is provided to the appropriate facility? Does the Army support maintaining their facilities to the standards available in the commercial sector?

Current Facility Conditions

Walter Reed Army Medical Center

In January 2000, the Army initiated an A-76 study leading to a public-private competition for certain "commercial activities" work at Walter Reed Medical Center. A

complicated and extended appeals process followed the Army's September 2004 decision to award in the contract to the in-house federal workforce. As a result, the contract was not awarded until 2006 to a private contractor when a five-year contract was awarded to cover the following services:

- Public works maintenance of WRAMC and Forest Glen infrastructure outside of the hospital.
- Transportation support (e.g., receipt and distribution of freight, operation of the motor pool, personnel travel services and storage of household goods).
- Logistics functions and non-medical communications and electronics repair.
- Military personnel support, including general clerical tasks related to in/out-processing.
- Garrison safety/environmental policy implementation.
- Community activities support (e.g., operation of the library, auto skills shop, and arts and craft at Forest Glen).
- Headquarters Garrison administrative support.

According to a September 2006 Army memo from the Walter Reed garrison commander, "as a direct result of the A-76 study, its associated proposed RIF, and the eventual Base Realignment and Closure (BRAC) of WRAMC's Main Post, we face the critical issues of retaining skilled clinical personnel for the hospital and the diverse professionals for the Garrison, while confronted with increased difficulties in hiring." These personnel shortfalls, the garrison commander noted, came at a time when the garrison and hospital workload had grown significantly – and well beyond the workloads assumed in the A-76 study – because of the Operation Enduring Freedom and Operation Iraqi Freedom. The garrison commander concluded in the memo that if certain measures were not adopted, "WRAMC Base Operations and patient care services [were] at risk of mission failure."

Since 2002, Walter Reed has treated more than 6,000 wounded Soldiers from combat operations in Afghanistan and Iraq. As they approach the end of their care, these Soldiers are placed at a variety of housing sites, including Building 18, the facility recently highlighted by the Washington Post. Building 18 was constructed in 1969. During the summer 2005, it received a $270K repair project that included new carpet and vinyl flooring throughout the facility, new ceiling tiles and light fixtures in parts of the facility. It began housing Soldier patients in October 2005. The building's capacity is 108 Soldiers and in January 2007, there were currently 84 Soldiers residing there. The House Armed Services Committee Professional Staff visited Walter Reed Army Medical Center (including Building 18) in 2006 and did not note any serious facility deficiencies that required immediate attention.

In February 2007, numerous facility deficiencies were noted in Building 18 by the Washington Post series that included mold, soiled carpets and a variety of other facility deficiencies in the building. Lt Gen Kiley's initial review and characterization of the facility revealed the following, "I do not consider Building 18 to be substandard...We needed to do a better job on some of those rooms, and those of you that got in today saw that we frankly have fixed all of those problems. They weren't serious, and there weren't a

lot of them." Subsequent to this review, former Army Secretary Harvey indicated that conditions at the facility were "inexcusable". Facility repairs have commenced but have raised a series of questions as to how the Services manage medical hold personnel and the facilities that are used to support these wounded Soldiers.

Bethesda National Naval Medical Center (NNMC)

Bethesda NNMC principally houses their long term medical hold personnel at Building 50 and other barracks that support the permanent party. After discussing facility conditions for medical hold personnel at Camp Lejeune, the House Armed Services Committee Professional Staff visited Building 50 in summer 2006 and found significant facility degradation. To address these concerns, NNMC developed a scope of work and a $4.3M contract was awarded in September 2006 to make Building 50 Americans with Disabilities Act (ADA) compliant. Construction is ongoing with a scheduled completion in October 2007.

Key Questions: Are the conditions at Walter Reed examples of a systematic facility problem across the medical enterprise? As a policy, are long term medical hold personnel assigned to barracks that are substandard or below the standards available to other Soldiers at Army installations? What is the policy to ensure high living standards are maintained on a daily basis? Are building deficiencies promptly reported and remedied?

Facility Initiatives

Army Wounded Warrior Program

The Chief of Staff of the Army has announced his intent to complete a wide range and aggressive action plan to address current shortfalls, both at Walter Reed and across the Army. Infrastructure represents one of the four key areas of improvement. Current billeting standards and construction practices are expected to be reviewed. The Army expects to provide rapid improvements to identify deficiencies and to promptly correct programmatic concerns.

Marine Corps Wounded Warrior Program

As was discussed during Department of Navy posture hearing, General Conway, Commandant of the Marine Corps, indicated that he believed this Walter Reed problems were isolated to the Army and he cited a "Wounded Warrior" program as to the method that Marine Corps was planning to address similar issues. In general, Marine Corps intends to build wounded warrior support into existing barracks. This includes modifying first-floor rooms to be wheelchair accessible and providing increased privacy space. Camp Lejeune and Camp Pendleton have taken two different approaches that include consolidating wounded marines into a single complex (Camp Lejeune) or decentralizing the wounded marines into their associated divisions and retaining unit integrity (Camp Pendleton).

As to family housing, Americans with Disabilities Act (ADA) requires 5% of all family housing to be built to ADA standards. After reviewing the requirements associated with Marine Corps family housing, the Marine Corps has increased their requirements to 8-10% of renovated/new construction to meet ADA compliance. This decision will significant benefit elderly assisted living and Wounded Warrior requirements. With the ongoing family housing privatization efforts, the ability to meet this standard in Marine Corps housing should be rather expeditious.

Air Force Interests

A worldwide review of all billeting for outpatients, hospitals and Aeromedical Staging Facilities was recently completed. No problems were identified for their medical hold personnel. Both independent walk throughs and Line of the Air Force evaluations reached same conclusion - no issues to report.

Key Questions: How is the Army managing the unique facility concerns associated with long term medical holds in the existing barracks infrastructure? Does the Army believe that unit integrity should be maintained with these wounded warriors or is a centralized approach a better method? Has the Army modified their family housing standards to accommodate assisted living requirements?

MILITARY DISABILITY BENEFITS SYSTEM

The military disability benefits system consists of three phases: (1) rehabilitation; (2) assessment; and (3) transition and separation. During the rehabilitation phase the member is either in a hospital, in a medical holdover or medical hold status receiving treatment and rehabilitative services. After the medical condition or injury stabilizes, an assessment of the member's fitness is made based upon the Department of Defense (DOD) Disability Evaluation System (DES), consistent with DOD regulations.

The DOD DES consists of four elements: (1) medical evaluation by Medical Evaluation Boards (MEB); (2) physical disability evaluation by the Physical Disability Evaluation Board (PEB), to include appellate review; (3) service member counseling; and (4) final disposition by appropriate personnel authorities.

During both the rehabilitation and assessment phases the member continues to receive full pay and allowances pending final disposition. Assessment outcomes include continuing the member on active duty or in active status in a permanent limited duty status, or separation or retirement for physical disability.

Any condition that appears to significantly interfere with performance of duties appropriate to the member's office, grade, rank, and rating will be considered by an MEB. The MEB is conducted by medical authorities and are comprised of physicians or other medical professionals. The MEB records a complete physical examination of the

member; confirms any medical diagnosis; and documents the member's current medical condition, to include treatment status and potential for medical recovery.

The PEB determines the fitness and disability percentage ratings. PEBs are conducted by personnel activities and are generally comprised of line officers, nonmedical civilian employees, and either civilian or military medical professionals. Members have the ability to request to personally attend formal PEBs, but only after the member appeals an initial informal PEB that reviews records only. PEBs grant limited numbers of members the privilege of attending a formal PEB. Members may appeal formal PEBs. PEB consider the MEB report, the assessment of the commanding officer, a line of duty investigation, all medical records, and any rebuttals/appeals that may accompany the case.

The counseling element of the DES affords members undergoing disability evaluation the opportunity to be advised of the significance and consequences of the resulting determination by the PEB and the associated rights, benefits and entitlements. This counseling is conducted by a PEB Liaison Officer or PEBLO.

A condition that renders a member unfit for that person's military duty will be considered for determining the compensable disability rating. The assignment of disability ratings are based on the Department of Veterans' Affairs (VA) Schedule for Rating Disabilities (VASRD), but are applied only to the extent that the condition interferes with the member's ability to perform his or her duties. VASRD translates specific medical conditions into disability percentages in 10 percentage point intervals and specifies the medical criteria to be used in determining the ratings. With regard to some select medical conditions, DOD replaces the VASRD criteria with criteria that are more suitable to the military work environment.

The military DES is separate from the disability rating system operated by the VA. The differences between the systems center on the objective of the military DES to apply disability criteria only to the extent that the condition interferes with the member's ability to perform duties. This relatively narrow objective is contrasted with the VA objective of recognizing the total reduction in earning capacity over the lifetime of the member.

A member determined unfit for duty due to a permanent and stable condition may be retired with a monthly annuity if the member's disability is rated 30 percent or higher or the member is already retirement eligible by virtue of having served for over 20 years. Members who do not meet the criteria for retirement are separated with separation pay, unless the member is approved for permanent limited duty. If the member's condition is not determined to be permanent and stable, the member may be temporarily retired on the temporary duty retired list for up to five years so that the member's condition can be evaluated over time and an appropriate decision reached on whether the member should be retired, separated, or returned to active service.

Concerns About the Disability Evaluation System (DES)

Wounded warriors and other service members receiving outpatient care have expressed concern about aspects of the DOD DES. These concerns include:

- The awarding of lower disability ratings than the VA disability system for similar conditions.
- The awarding of inconsistent disability ratings for similar conditions among the Physical Evaluation Boards (PEBs) operated by the military departments.
- Extensive delays in completing PEB actions, particularly for reserve component members.
- PEBs are awarding fewer permanent disabilities due to the higher cost associated with the greater number of wounded service members.
- Reserve component members receiving consistently lower disability ratings than their active duty counterparts for the same conditions.
- The PEBs not using the precise criteria published in the Department of Veterans' Affairs (VA) Schedule for Rating Disabilities (VASRD) to rate disabilities as required by law.

The Government Accountability Office in their report "Military Disability System: Improved Oversight Needed to Ensure Consistent and Timely Outcomes for Reserve and Active Duty Service Members (GAO-06-362) confirmed that:

- The DOD DES regulations were not sufficiently robust to preclude each of the services from implementing the DES differently.
- Neither DOD nor the services systematically determine the consistency of disability decision making.
- DOD has issued timeliness goals, but is not collecting the data necessary to manage the program successfully.
- DOD is not exercising oversight over training for staff in the disability system and is therefore forfeiting the opportunity to train workers to be consistent and timely.
- Army statistics confirmed that from fiscal year 2001 through fiscal year 2005, cases addressing reserve component members took longer than their active duty counterparts.
- After controlling for differences between reserve and active, ratings of reservists were comparable to those of active duty with similar conditions.

The Congress responded to the GAO report with the following initiatives in the National Defense Authorization Act for Fiscal Year 2007:

- Require the secretaries of the military departments to ensure that documents announcing decisions of PEBs convey the findings and conclusions of the board in an orderly and itemized fashion with specific attention to each issue presented by the member in regard to that member's case.
- Require the Secretary of Defense to publish regulations establishing requirements and training standards for Physical Evaluation Board liaison officers and to assess the compliance of the secretaries of the military departments with those regulations at least once every three years; and

- Require the Secretary of Defense to publish regulations establishing standards and guidelines concerning PEB assignment and training of staff, operating procedures, and consistency and timeliness of board decisions and to assess the compliance of the secretaries of the military departments with those regulations at least once every three years.

The Army Times from March 5, 2007 included an article that indicated the number of soldiers approved for permanent disability retirement had plunged by more than two-thirds from 642 in 2001 to 209 in 2005. This may seem to confirm the complaint that the Army PEB is awarding fewer permanent disabilities in order to save money.

Key Questions: What is the current status of DOD efforts to implement the PEB initiatives included in the National Defense Authorization Act for Fiscal Year 2007? Why do PEB cases involving members of the reserve components take so much longer than cases involving their active duty counterparts? Why did the Army PEB approve fewer permanent disabilities during 2005 than it did during 2001 before the emergence of increased numbers of wounded warriors?

Compensation and Benefits

Shortly after the increase in medical evacuations that accompanied the start of Operation Iraqi Freedom in 2003, a series of concerns surfaced concerning the fiscal welfare of wounded service members and their families, to include:

- Reduced monthly income after losing special pays and allowances associated with duty in a combat zone.
- General fiscal insecurity for the service member's family as they transitioned from active duty compensation levels to VA benefits programs.
- Financial stress on families attempting to finance travel and daily expenses associated with visiting seriously injured members and, in some cases, giving up employment to permanent move to join service members at locations where they were receiving medical treatment.
- Pay system failures that left medically extended Army reserve component members with pay errors and inadequate means to correct their pay levels.

The Congress responded to these concerns with a number of legislative provisions as listed in the background material. The following were three provisions that were critical to protecting the fiscal welfare of wounded members and their families:

- The authority for automatic insurance coverage for traumatic injury as a rider on the Servicemember's Group Life Insurance (SGLI) program. The policy pays from $25,000 to $100,000 for the loss the physical capability resulting from a traumatic injury incurred while insured under the SGLI program.
- The provision to pay $430 each month to compensate hospitalized members who had been medically evacuated from the combat theater.
- The series of initiatives to improve and expanded travel benefits for family members to visit combat wounded service members.

The Congress also took action to increase oversight of reserve pay programs to insure that reserve wounded warriors received the compensation they were due. The GAO reported in February 2007 that the Army had corrected the reserve component pay problems that had plagued reservists that had been held over for medical treatment that they had identified in 2005.

> **Key Questions:** Are family members who visit wounded service members receiving adequate compensation to reimburse them for travel and daily living expenses and, if not, what more needs to be done for these families? Has the traumatic injury rider on the SGLI insurance coverage been effective in helping severely injured members transition to VA benefits and their new lives? What feedback have you received from families about the adequacy of transitional compensation for wounded warriors? Has the Army fully resolved reserve component pay problems that plagued service members who had been retained on active duty to receive medical treatment?

Procedures to Transition Wounded Warriors from Military Health Care and Benefits to VA Heath Care and Benefits

While there is no Department-wide formal process today to transition wounded warriors from the DOD programs to VA programs, each of the Services' transition programs remain varied. Many of the larger military medical treatment facilities are supposed to have a liaison officer from the Department of Veterans Affairs; however, not all facilities that treat wounded and injured service members have full-time VA liaisons. In those cases, service members are often responsible for making the arrangements for their own transition. A DOD-wide process that involves a formal physical handoff may be required to fulfill the obligations of the nation to wounded veterans. Additionally, continuation of active duty service may be required to ensure that members do not suffer a gap in income.

> **Key Questions:** Isn't a more formal process required to insure that wounded warriors are properly transitioned from DOD health care and benefits to VA programs? What would be your perspective on a proposal to retain wounded members on active duty until their VA benefits are approved and operating?

Military Supervision and Case Managers

Military supervisors and case managers are keys to accountability, member tracking, and assisting service members and families in navigating administrative procedures. For example, the outpatient population at WRAMC increased from pre-war levels of 100-120 to a peak of more than 874 soldiers in the summer of 2005. Prior to January 2006, WRAMC had only one medical-hold company to provide command and control and accountability for those soldiers. Since January 2006, WRAMC has added new units and personnel to decrease the ratio of military supervisors to outpatient from 1 to 125 to 1 to 25 or 30, and are hiring additional case managers to reduce the case load.

Key Questions: What is the status of the Army effort to increase the number of platoon sergeants and case managers to ensure that solders' cases are being correctly managed? What is the status of efforts to improve the staff to outpatient ratios in the Navy? What is the process for ensuring that senior leadership has the visibility of problems identified at all levels in the chain of command and by case managers?

Establishment of the Independent Review Group

The Assistant Secretary of Defense for Health Affairs in cooperation with the Secretaries of the Army and the Navy has established an Independent Review Group (IRG) to review and provide recommendations regarding any shortcomings and opportunities to improve rehabilitative care, administrative processes, and quality of life at WRAMC and the National Naval Medical Center in Bethesda, Maryland. The IRG is tasked to report on their findings and recommendations through the Defense Health Board not later than April 16, 2007.

The specific objectives of the IRG are:

- Determine what services and support are most important to injured and sick members and their families during the process of recovery, rehabilitation and transition, and how the Military Services and DOD should ensure they are properly delivered.
- Identify what improvements are needed in the maintenance and management of housing facilities for injured and sick members.
- Ascertain what improvements are needed in the administration of the Disability Evaluation System.
- Address what improvements are needed in the provision and coordination of rehabilitative care for ambulatory injured and sick members.
- Find what command climate issues are impacting the rehabilitative care, administrative processes, and quality of life for injured and sick members.

Key Question: Given that the Independent Review Group established by the Department is scheduled to report their findings and recommendation not later than April 16, just 39 days from today, how do you expect a credible report on long list of specific objectives that include such complex issues as the Disability Evaluation System?

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The Hotel Aftermath

Inside Mologne House, the Survivors of War Wrestle With Military Bureaucracy and Personal Demons

By Anne Hull and Dana Priest
Washington Post Staff Writers
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The guests of Mologne House have been blown up, shot, crushed and shaken, and now their convalescence takes place among the chandeliers and wingback chairs of the 200-room hotel on the grounds of Walter Reed Army Medical Center.

Oil paintings hang in the lobby of this strange outpost in the war on terrorism, where combat's urgency has been replaced by a trickling fountain in the garden courtyard. The maimed and the newly legless sit in wheelchairs next to a pond, watching goldfish turn lazily through the water.

But the wounded of Mologne House are still soldiers -- Hooah! -- so their lives are ruled by platoon sergeants. Each morning they must rise at dawn for formation, though many are half-snowed on pain meds and sleeping pills.

In Room 323 the alarm goes off at 5 a.m., but Cpl. Dell McLeod slumbers on. His wife, Annette, gets up and fixes him a bowl of instant oatmeal before going over to the massive figure curled in the bed. An Army counselor taught her that a soldier back from war can wake up swinging, so she approaches from behind.

"Dell," Annette says, tapping her husband. "Dell, get in the shower."

"Dell!" she shouts.

Finally, the yawning hulk sits up in bed. "Okay, baby," he says. An American flag T-shirt is stretched over his chest. He reaches for his dog tags, still the devoted soldier of 19 years, though his life as a warrior has become a paradox. One day he's led on stage at a Toby Keith concert with dozens of other wounded Operation Iraqi Freedom troops from Mologne House, and the next he's sitting in a cluttered cubbyhole at Walter Reed, fighting the Army for every penny of his disability.

McLeod, 41, has lived at Mologne House for a year while the Army figures out what to do with him. He worked in textile and steel mills in rural South Carolina before deploying. Now he takes 23 pills a day, prescribed by various doctors at Walter Reed. Crowds frighten him. He is too anxious to drive. When panic strikes, a soldier friend named Oscar takes him to Baskin-Robbins for vanilla ice cream.

"They find ways to soothe each other," Annette says.

Mostly what the soldiers do together is wait: for appointments, evaluations, signatures and lost paperwork to be found. It's like another wife told Annette McLeod: "If Iraq don't kill you, Walter Reed will."

After Iraq, a New Struggle

The conflict in Iraq has hatched a virtual town of desperation and dysfunction, clinging to the pilings of Walter Reed. The wounded are socked away for months and years in random buildings and barracks in and around this military post.

The luckiest stay at Mologne House, a four-story hotel on a grassy slope behind the hospital. Mologne House opened 10 years ago as a short-term lodging facility for military personnel, retirees and their family members. Then came Sept. 11 and five years of sustained warfare. Now, the silver walkers of retired generals convalescing from hip surgery have been replaced by prosthetics propped against Xbox games and Jessica Simpson posters smiling down on brain-rattled grunts.

Two Washington Post reporters spent hundreds of hours in Mologne House documenting the intimate struggles of the wounded who live there. The reporting was done without the knowledge or permission of Walter Reed officials, but all those directly quoted in this article agreed to be interviewed.

The hotel is built in the Georgian revival style, and inside it offers the usual amenities: daily maid service, front-desk clerks in formal vests and a bar off the lobby that opens every afternoon.

But at this bar, the soldier who orders a vodka tonic one night says to the bartender, "If I had two hands, I'd order two." The customers sitting around the tables are missing limbs, their ears are melted off, and their faces are tattooed purple by shrapnel patterns.

Most everyone has a story about the day they blew up: the sucking silence before immolation, how the mouth filled with tar, the lungs with gas.

"First thing I said was, '[Expletive], that was my *good* eye,' " a soldier with an eye patch tells an amputee in the bar.

The amputee peels his beer label. "I was awake through the whole thing," he says. "It was my first patrol. The second [expletive] day in Iraq and I get blown up."

When a smooth-cheeked soldier with no legs orders a fried chicken dinner and two bottles of grape soda to go, a kitchen worker comes out to his wheelchair and gently places the Styrofoam container on his lap.

A scrawny young soldier sits alone in his wheelchair at a nearby table, his eyes closed and his chin dropped to his chest, an empty Corona bottle in front of him.

Those who aren't old enough to buy a drink at the bar huddle outside near a magnolia tree and smoke cigarettes. Wearing hoodies and furry bedroom slippers, they look like kids at summer camp who've crept out of their rooms, except some have empty pants legs or limbs pinned by medieval-looking hardware. Medication is a favorite topic.

"Dude, [expletive] Paxil saved my life."

"I been on methadone for a year, I'm tryin' to get off it."

"I didn't take my Seroquel last night and I had nightmares of charred bodies, burned crispy like campfire marshmallows."

Mologne House is afloat on a river of painkillers and antipsychotic drugs. One night, a strapping young infantryman loses it with a woman who is high on her son's painkillers. "Quit taking all the soldier medicine!" he screams.

Pill bottles clutter the nightstands: pills for depression or insomnia, to stop nightmares and pain, to calm the nerves.

Here at Hotel Aftermath, a crash of dishes in the cafeteria can induce seizures in the combat-addled. If a taxi arrives and the driver looks Middle Eastern, soldiers refuse to get in. Even among the gazebos and tranquility of the Walter Reed campus in upper Northwest Washington, manhole covers are sidestepped for fear of bombs and rooftops are scanned for snipers.

Bomb blasts are the most common cause of injury in Iraq, and nearly 60 percent of the blast victims also suffer from traumatic brain injury, according to Walter Reed's studies, which explains why some at Mologne House wander the hallways trying to remember their room numbers.

Some soldiers and Marines have been here for 18 months or longer. Doctor's appointments and evaluations are routinely dragged out and difficult to get. A board of physicians must review hundreds of pages of medical records to determine whether a soldier is fit to return to duty. If not, the Physical Evaluation Board must decide whether to assign a rating for disability compensation. For many, this is the start of a new and bitter battle.

Months roll by and life becomes a blue-and-gold hotel room where the bathroom mirror shows the naked disfigurement of war's ravages. There are toys in the lobby of Mologne House because children live here. Domestic disputes occur because wives or girlfriends have moved here. Financial tensions are palpable. After her husband's traumatic injury insurance policy came in, one wife cleared out with the money. Older National Guard members worry about the jobs they can no longer perform back home.

While Mologne House has a full bar, there is not one counselor or psychologist assigned there to assist soldiers and families in crisis -- an idea proposed by Walter Reed social workers but rejected by the military command that runs the post.

After a while, the bizarre becomes routine. On Friday nights, antiwar protesters stand outside the gates of Walter Reed holding signs that say "Love Troops, Hate War, Bring them Home Now." Inside the gates, doctors in white coats wait at the hospital entrance for the incoming bus full of newly wounded soldiers who've just landed at Andrews Air Force Base.

And set back from the gate, up on a hill, Mologne House, with a bowl of red apples on the front desk.

Into the Twilight Zone

Dell McLeod's injury was utterly banal. He was in his 10th month of deployment with the 178th Field Artillery Regiment of the South Carolina National Guard near the Iraqi border when he was smashed in the head by a steel cargo door of an 18-wheeler. The hinges of the door had been tied together with a plastic hamburger-bun bag. Dell was knocked out cold and cracked several vertebrae.

When Annette learned that he was being shipped to Walter Reed, she took a leave from her job on the assembly line at Stanley Tools and packed the car. The Army would pay her $64 a day to help care for her husband and would let her live with him at Mologne House until he recovered.

A year later, they are still camped out in the twilight zone. Dogs are periodically brought in by the Army to search the rooms for contraband or weapons. When the fire alarm goes off, the amputees who live on the upper floors are scooped up and carried down the stairwell, while a brigade of mothers passes down the wheelchairs. One morning Annette opens her door and is told to stay in the room because a soldier down the hall has overdosed.

In between, there are picnics at the home of the chairman of the Joint Chiefs of Staff and a charity-funded dinner cruise on the Potomac for "Today's troops, tomorrow's veterans, always heroes."

Dell and Annette's weekdays are spent making the rounds of medical appointments, physical therapy sessions and evaluations for Dell's discharge from the Army. After 19 years, he is no longer fit for service. He uses a cane to walk. He is unable to count out change in the hospital cafeteria. He takes four Percocets a day for pain and has gained 40 pounds from medication and inactivity. Lumbering and blue-eyed, Dell is a big ox baby.

Annette puts on makeup every morning and does her hair, some semblance of normalcy, but her new job in life is watching Dell.

"I'm worried about how he's gonna fit into society," she says one night, as Dell wanders down the hall to the laundry room.

The more immediate worry concerns his disability rating. Army doctors are disputing that Dell's head injury was the cause of his mental impairment. One report says that he was slow in high school and that his cognitive problems could be linked to his native intelligence rather than to his injury.

"They said, 'Well, he was in Title I math,' like he was retarded," Annette says. "Well, y'all took him, didn't you?"

The same fight is being waged by their friends, who aren't the young warriors in Army posters but middle-age men who left factory jobs to deploy to Iraq with their Guard units. They were fit enough for war, but now they are facing teams of Army doctors scrutinizing their injuries for signs of preexisting conditions, lessening their chance for disability benefits.

Dell and Annette's closest friend at Mologne House is a 47-year-old Guard member who was driving an Army vehicle through the Iraqi night when a flash of light blinded him and he crashed into a ditch with an eight-foot drop. Among his many injuries was a broken foot that didn't heal properly. Army doctors decided that "late life atrophy" was responsible for the foot, not the truck wreck in Iraq.

When Dell sees his medical records, he explodes. "Special ed is for the mentally retarded, and I'm not mentally retarded, right, babe?" he asks Annette. "I graduated from high school. I did some college. I worked in a steel mill."

It's after 9 one night and Dell and Annette are both exhausted, but Dell still needs to practice using voice-recognition software. Reluctantly, he mutes "The Ultimate Fighting Challenge" on TV and sits next to Annette in bed with a laptop.

"My name is Wendell," he says. "Wendell Woodward McLeod Jr."

Annette tells him to sit up. "Spell 'dog,' " she says, softly.

"Spell 'dog,' " he repeats.

"Listen to me," she says.

"Listen to me." He slumps on the pillow. His eyes drift toward the wrestlers on TV.

"You are not working hard enough, Dell," Annette says, pleading. "Wake up."

"Wake up," he says.

"Dell, come on now!"

For Some, a Grim Kind of Fame

No one questions Sgt. Bryan Anderson's sacrifice. One floor above Dell and Annette's room at Mologne House, he holds the gruesome honor of being one of the war's five triple amputees. Bryan, 25, lost both legs and his left arm when a roadside bomb exploded next to the Humvee he was driving with the 411th Military Police Company. Modern medicine saved him and now he's the pride of the prosthetics team at Walter Reed. Tenacious and wisecracking, he wrote "[Expletive] Iraq" on his left leg socket.

Amputees are the first to receive celebrity visitors, job offers and extravagant trips, but Bryan is in a league of his own. Johnny Depp's people want to hook up in London or Paris. The actor Gary Sinise, who played an angry Vietnam amputee in "Forrest Gump," sends his regards. And Esquire magazine is setting up a photo shoot.

Bryan's room at Mologne House is stuffed with gifts from corporate America and private citizens: $350 Bose noise-canceling headphones, nearly a thousand DVDs sent by well-wishers and quilts made by church grannies. The door prizes of war. Two flesh-colored legs are stacked on the floor. A computerized hand sprouting blond hair is on the table.

One Saturday afternoon, Bryan is on his bed downloading music. Without his prosthetics, he weighs less than 100 pounds. "Mom, what time is our plane?" he asks his mother, Janet Waswo, who lives in the room with him. A movie company is flying them to Boston for the premiere of a documentary about amputee hand-cyclers in which Bryan appears.

Representing the indomitable spirit of the American warrior sometimes becomes too much, and Bryan turns off his phone.

Perks and stardom do not come to every amputee. Sgt. David Thomas, a gunner with the Tennessee National Guard, spent his first three months at Walter Reed with no decent clothes; medics in Samarra had cut off his uniform. Heavily drugged, missing one leg and suffering from traumatic brain injury, David, 42, was finally told by a physical therapist to go to the Red Cross office, where he was given a T-shirt and sweat pants. He was awarded a Purple Heart but had no underwear.

David tangled with Walter Reed's image machine when he wanted to attend a ceremony for a fellow amputee, a Mexican national who was being granted U.S. citizenship by President Bush. A case worker quizzed him about what he would wear. It was summer, so David said shorts. The case manager said the media would be there and shorts were not advisable because the amputees would be seated in the front row.

" 'Are you telling me that I can't go to the ceremony 'cause I'm an amputee?' " David recalled asking. "She said, 'No, I'm saying you need to wear pants.' "

David told the case worker, "I'm not ashamed of what I did, and y'all shouldn't be neither." When the guest list came out for the ceremony, his name was not on it.

Still, for all its careful choreography of the amputees, Walter Reed offers protection from a staring world. On warm nights at the picnic tables behind Mologne House, someone fires up the barbecue grill and someone else makes a beer run to Georgia Avenue.

Bryan Anderson is out here one Friday. "Hey, Bry, what time should we leave in the morning?" asks his best friend, a female soldier also injured in Iraq. The next day is Veterans Day, and Bryan wants to go to Arlington National Cemetery. His pal Gary Sinise will be there, and Bryan wants to give him a signed photo.

Thousands of spectators are already at Arlington the next morning when Bryan and his friend join the surge toward the ceremony at the Tomb of the Unknowns. The sunshine dazzles. Bryan is in his wheelchair. If loss and sacrifice are theoretical to some on this day, here is living proof -- three stumps and a crooked boyish smile. Even the acres of tombstones can't compete. Spectators cut their eyes toward him and look away.

Suddenly, the thunder of cannons shakes the sky. The last time Bryan heard this sound, his legs were severed and he was nearly bleeding to death in a fiery Humvee.

Boom. Boom. Boom. Bryan pushes his wheelchair harder, trying to get away from the noise. "Damn it," he says, "when are they gonna stop?"

Bryan's friend walks off by herself and holds her head. The cannon thunder has unglued her, too, and she is crying.

Friends From Ward 54

An old friend comes to visit Dell and Annette. Sgt. Oscar Fernandez spent 14 months at Walter Reed after having a heart attack in Afghanistan. Oscar also had post-traumatic stress disorder, PTSD, a condition that worsened at Walter Reed and landed the 45-year-old soldier in the hospital's psychiatric unit, Ward 54.

Oscar belonged to a tight-knit group of soldiers who were dealing with combat stress and other psychological issues. They would hang out in each other's rooms at night, venting their fury at the Army's Cuckoo's Nest. On weekends they escaped Walter Reed to a Chinese buffet or went shopping for bootleg Spanish DVDs in nearby Takoma Park. They once made a road trip to a casino near the New Jersey border.

They abided each other's frailties. Sgt. Steve Justi would get the slightest cut on his skin and drop to his knees, his face full of anguish, apologizing over and over. For what, Oscar did not know. Steve was the college boy who went to Iraq, and Oscar figured something terrible had happened over there.

Sgt. Mike Smith was the insomniac. He'd stay up till 2 or 3 in the morning, smoking on the back porch by himself. Doctors had put steel rods in his neck after a truck accident in Iraq. To turn his head, the 41-year-old Guard member from Iowa had to rotate his entire body. He was fighting with the Army over his

disability rating, too, and in frustration had recently called a congressional investigator for help.

"They try in all their power to have you get well, but it reverses itself," Oscar liked to say.

Dell was not a psych patient, but he and Oscar bonded. They were an unlikely pair -- the dark-haired Cuban American with a penchant for polo shirts and salsa, and the molasses earnestness of Dell.

Oscar would say things like "I'm trying to better myself through my own recognizance," and Dell would nod in appreciation.

To celebrate Oscar's return visit to Walter Reed, they decide to have dinner in Silver Spring.

Annette tells Oscar that a soldier was arrested at Walter Reed for waving a gun around.

"A soldier, coming from war?" Oscar asks.

Annette doesn't know. She mentions that another soldier was kicked out of Mologne House for selling his painkillers.

The talk turns to their friend Steve Justi. A few days earlier, Steve was discharged from the Army and given a zero percent disability rating for his mental condition.

Oscar is visibly angry. "They gave him nothing," he says. "They said his bipolar was preexisting."

Annette is quiet. "Poor Steve," she says.

After dinner, they return through the gates of Walter Reed in Annette's car, a John 3:16 decal on the bumper and the Dixie Chicks in the CD player. Annette sees a flier in the lobby of Mologne House announcing a free trip to see Toby Keith in concert.

A week later, it is a wonderful night at the Nissan Pavilion. About 70 wounded soldiers from Walter Reed attend the show. Toby invites them up on stage and brings the house down when he sings his monster wartime hit "American Soldier." Dell stands on stage in his uniform while Annette snaps pictures.

"Give a hand clap for the soldiers," Annette hears Toby tell the audience, "then give a hand for the U.S.A."

A Soldier Snaps

Deep into deer-hunting country and fields of withered corn, past the Pennsylvania Turnpike in the rural town of Ellwood City, Steve Justi sits in his parents' living room, fighting off the afternoon's lethargy.

A photo on a shelf shows a chiseled soldier, but the one in the chair is 35 pounds heavier. Antipsychotic drugs give him tremors and cloud his mind. Still, he is deliberate and thoughtful as he explains his path from soldier to psychiatric patient in the war on terrorism.

After receiving a history degree from Mercyhurst College, Steve was motivated by the attacks of Sept. 11, 2001, to join the National Guard. He landed in Iraq in 2003 with the First Battalion, 107th Field Artillery, helping the Marines in Fallujah.

"It was just the normal stuff," Steve says, describing the violence he witnessed in Iraq. His voice is oddly flat as he recalls the day his friend died in a Humvee accident. The friend was driving with another soldier when they flipped off the road into a swamp. They were trapped upside down and submerged. Steve helped pull them out and gave CPR, but it was too late. The swamp water kept pushing back into his own mouth. He rode in the helicopter with the wet bodies.

After he finished his tour, everything was fine back home in Pennsylvania for about 10 months, and then a strange bout of insomnia started. After four days without sleep, he burst into full-out mania and was hospitalized in restraints.

Did anything trigger the insomnia? "Not really," Steve says calmly, sitting in his chair.

His mother overhears this from the kitchen and comes into the living room. "His sergeant had called saying that the unit was looking for volunteers to go back to Iraq," Cindy Justi says. "This is what triggered his snap."

Steve woke up in the psychiatric unit at Walter Reed and spent the next six months going back and forth between there and a room at Mologne House. He was diagnosed with bipolar disorder. He denied to doctors that he was suffering from PTSD, yet he called home once from Ward 54 and shouted into the phone, "Mom, can't you hear all the shooting in the background?"

He was on the ward for the sixth time when he was notified that he was being discharged from the Army, with only a few days to clear out and a disability rating of zero percent.

On some level, Steve expected the zero rating. During his senior year of college, he suffered a nervous breakdown and for several months was treated with antidepressants. He disclosed this to the National Guard recruiter, who said it was a nonissue. It became an issue when he told doctors at Walter Reed. The Army decided that his condition was not aggravated by his time in Iraq. The only help he would get would come from Veterans Affairs.

"We have no idea if what he endured over there had a worsening effect on him," says his mother.

His father gets home from the office. Ron Justi sits on the couch across from his son. "He was okay to sacrifice his body, but now that it's time he needs some help, they are not here," Ron says.

Outside the Gates

The Army gives Dell McLeod a discharge date. His days at Mologne House are numbered. The cramped hotel room has become home, and now he is afraid to leave it. His anxiety worsens. "Shut up!" he screams at Annette one night, his face red with rage, when she tells him to stop fiddling with his wedding ring.

Later, Annette says: "I am exhausted. He doesn't understand that I've been fighting the Army."

Doctors have concluded that Dell was slow as a child and that his head injury on the Iraqi border did not cause brain damage. "It is possible that pre-morbid emotional difficulties and/or pre-morbid intellectual functioning may be contributing factors to his reported symptoms," a doctor wrote, withholding a diagnosis of traumatic brain injury.

Annette pushes for more brain testing and gets nowhere until someone gives her the name of a staffer for

the House Committee on Oversight and Government Reform. A few days later, Annette is called to a meeting with the command at Walter Reed. Dell is given a higher disability rating than expected -- 50 percent, which means he will receive half of his base pay until he is evaluated again in 18 months. He signs the papers.

Dell wears his uniform for the last time, somber and careful as he dresses for formation. Annette packs up the room and loads their Chevy Cavalier to the brim. Finally the gates of Walter Reed are behind them. They are southbound on I-95 just past the Virginia line when Dell begins to cry, Annette would later recall. She pulls over and they both weep.

Not long after, Bryan Anderson also leaves Mologne House. When the triple amputee gets off the plane in Chicago, American Airlines greets him on the tarmac with hoses spraying arches of water, and cheering citizens line the roads that lead to his home town, Rolling Meadows.

Bryan makes the January cover of Esquire. He is wearing his beat-up cargo shorts and an Army T-shirt, legless and holding his Purple Heart in his robot hand. The headline says "The Meaning of Life."

A month after Bryan leaves, Mike Smith, the insomniac soldier, is found dead in his room. Mike had just received the good news that the Army was raising his disability rating after a congressional staff member intervened on his behalf. It was the week before Christmas, and he was set to leave Walter Reed to go home to his wife and kids in Iowa when his body was found. The Army told his wife that he died of an apparent heart attack, according to her father.

Distraught, Oscar Fernandez calls Dell and Annette in South Carolina with the news. "It's the constant assault of the Army," he says.

Life with Dell is worsening. He can't be left alone. The closest VA hospital is two hours away. Doctors say he has liver problems because of all the medications. He is also being examined for PTSD. "I don't even know this man anymore," Annette says.

At Mologne House, the rooms empty and fill, empty and fill. The lobby chandelier glows and the bowl of red apples waits on the front desk. An announcement goes up for Texas Hold 'Em poker in the bar.

One cold night an exhausted mother with two suitcases tied together with rope shows up at the front desk and says, "I am here for my son." And so it begins.

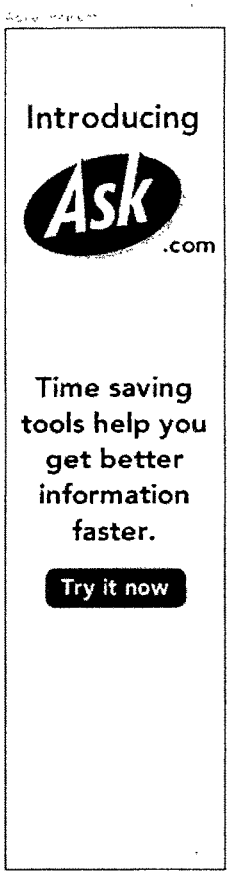
Staff researcher Julie Tate contributed to this report.

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Soldiers Face Neglect, Frustration At Army's Top Medical Facility

By Dana Priest and Anne Hull
Washington Post Staff Writers
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Behind the door of Army Spec. Jeremy Duncan's room, part of the wall is torn and hangs in the air, weighted down with black mold. When the wounded combat engineer stands in his shower and looks up, he can see the bathtub on the floor above through a rotted hole. The entire building, constructed between the world wars, often smells like greasy carry-out. Signs of neglect are everywhere: mouse droppings, belly-up cockroaches, stained carpets, cheap mattresses.

This is the world of Building 18, not the kind of place where Duncan expected to recover when he was evacuated to Walter Reed Army Medical Center from Iraq last February with a broken neck and a shredded left ear, nearly dead from blood loss. But the old lodge, just outside the gates of the hospital and five miles up the road from the White House, has housed hundreds of maimed soldiers recuperating from injuries suffered in the wars in Iraq and Afghanistan.

The common perception of Walter Reed is of a surgical hospital that shines as the crown jewel of military medicine. But 5 1/2 years of sustained combat have transformed the venerable 113-acre institution into something else entirely -- a holding ground for physically and psychologically damaged outpatients. Almost 700 of them -- the majority soldiers, with some Marines -- have been released from hospital beds but still need treatment or are awaiting bureaucratic decisions before being discharged or returned to active duty.

They suffer from brain injuries, severed arms and legs, organ and back damage, and various degrees of post-traumatic stress. Their legions have grown so exponentially -- they outnumber hospital patients at Walter Reed 17 to 1 -- that they take up every available bed on post and spill into dozens of nearby hotels and apartments leased by the Army. The average stay is 10 months, but some have been stuck there for as long as two years.

Not all of the quarters are as bleak as Duncan's, but the despair of Building 18 symbolizes a larger problem in Walter Reed's treatment of the wounded, according to dozens of soldiers, family members, veterans aid groups, and current and former Walter Reed staff members interviewed by two Washington Post reporters, who spent more than four months visiting the outpatient world without the knowledge or permission of Walter Reed officials. Many agreed to be quoted by name; others said they feared Army retribution if they complained publicly.

While the hospital is a place of scrubbed-down order and daily miracles, with medical advances saving more soldiers than ever, the outpatients in the Other Walter Reed encounter a messy bureaucratic battlefield nearly as chaotic as the real battlefields they faced overseas.

On the worst days, soldiers say they feel like they are living a chapter of "Catch-22." The wounded manage other wounded. Soldiers dealing with psychological disorders of their own have been put in charge of others at risk of suicide.

Disengaged clerks, unqualified platoon sergeants and overworked case managers fumble with simple needs: feeding soldiers' families who are close to poverty, replacing a uniform ripped off by medics in the desert sand or helping a brain-damaged soldier remember his next appointment.

"We've done our duty. We fought the war. We came home wounded. Fine. But whoever the people are back here who are supposed to give us the easy transition should be doing it," said Marine Sgt. Ryan Groves, 26, an amputee who lived at Walter Reed for 16 months. "We don't know what to do. The people who are supposed to know don't have the answers. It's a nonstop process of stalling."

Soldiers, family members, volunteers and caregivers who have tried to fix the system say each mishap seems trivial by itself, but the cumulative effect wears down the spirits of the wounded and can stall their recovery.

"It creates resentment and disenfranchisement," said Joe Wilson, a clinical social worker at Walter Reed. "These soldiers will withdraw and stay in their rooms. They will actively avoid the very treatment and services that are meant to be helpful."

Danny Soto, a national service officer for Disabled American Veterans who helps dozens of wounded service members each week at Walter Reed, said soldiers "get awesome medical care and their lives are being saved," but, "Then they get into the administrative part of it and they are like, 'You saved me for what?' The soldiers feel like they are not getting proper respect. This leads to anger."

This world is invisible to outsiders. Walter Reed occasionally showcases the heroism of these wounded soldiers and emphasizes that all is well under the circumstances. President Bush, former defense secretary Donald H. Rumsfeld and members of Congress have promised the best care during their regular visits to the hospital's spit-polished amputee unit, Ward 57.

"We owe them all we can give them," Bush said during his last visit, a few days before Christmas. "Not only for when they're in harm's way, but when they come home to help them adjust if they have wounds, or help them adjust after their time in service."

Along with the government promises, the American public, determined not to repeat the divisive Vietnam experience, has embraced the soldiers even as the war grows more controversial at home. Walter Reed is awash in the generosity of volunteers, businesses and celebrities who donate money, plane tickets, telephone cards and steak dinners.

Yet at a deeper level, the soldiers say they feel alone and frustrated. Seventy-five percent of the troops polled by Walter Reed last March said their experience was "stressful." Suicide attempts and unintentional overdoses from prescription drugs and alcohol, which is sold on post, are part of the narrative here.

Vera Heron spent 15 frustrating months living on post to help care for her son. "It just absolutely took forever to get anything done," Heron said. "They do the paperwork, they lose the paperwork. Then they have to redo the paperwork. You are talking about guys and girls whose lives are disrupted for the rest of their lives, and they don't put any priority on it."

Family members who speak only Spanish have had to rely on Salvadoran housekeepers, a Cuban bus driver, the Panamanian bartender and a Mexican floor cleaner for help. Walter Reed maintains a list of bilingual staffers, but they are rarely called on, according to soldiers and families and Walter Reed staff members.

Evis Morales's severely wounded son was transferred to the National Naval Medical Center in Bethesda for surgery shortly after she arrived at Walter Reed. She had checked into her government-paid room on post, but she slept in the lobby of the Bethesda hospital for two weeks because no one told her there is a free shuttle between the two facilities. "They just let me off the bus and said 'Bye-bye,' " recalled Morales, a Puerto Rico resident.

Morales found help after she ran out of money, when she called a hotline number and a Spanish-speaking operator happened to answer.

"If they can have Spanish-speaking recruits to convince my son to go into the Army, why can't they have Spanish-speaking translators when he's injured?" Morales asked. "It's so confusing, so disorienting."

Soldiers, wives, mothers, social workers and the heads of volunteer organizations have complained repeatedly to the military command about what one called "The Handbook No One Gets" that would explain life as an outpatient. Most soldiers polled in the March survey said they got their information from friends. Only 12 percent said any Army literature had been helpful.

"They've been behind from Day One," said Rep. Thomas M. Davis III (R-Va.), who headed the House Government Reform Committee, which investigated problems at Walter Reed and other Army facilities. "Even the stuff they've fixed has only been patched."

Among the public, Davis said, "there's vast appreciation for soldiers, but there's a lack of focus on what happens to them" when they return. "It's awful."

Maj. Gen. George W. Weightman, commander at Walter Reed, said in an interview last week that a major reason outpatients stay so long, a change from the days when injured soldiers were discharged as quickly as possible, is that the Army wants to be able to hang on to as many soldiers as it can, "because this is the first time this country has fought a war for so long with an all-volunteer force since the Revolution."

Acknowledging the problems with outpatient care, Weightman said Walter Reed has taken steps over the past year to improve conditions for the outpatient army, which at its peak in summer 2005 numbered nearly 900, not to mention the hundreds of family members who come to care for them. One platoon sergeant used to be in charge of 125 patients; now each one manages 30. Platoon sergeants with psychological problems are more carefully screened. And officials have increased the numbers of case managers and patient advocates to help with the complex disability benefit process, which Weightman called "one of the biggest sources of delay."

And to help steer the wounded and their families through the complicated bureaucracy, Weightman said, Walter Reed has recently begun holding twice-weekly informational meetings. "We felt we were pushing information out before, but the reality is, it was overwhelming," he said. "Is it fail-proof? No. But we've put more resources on it."

He said a 21,500-troop increase in Iraq has Walter Reed bracing for "potentially a lot more" casualties.

Bureaucratic Battles

The best known of the Army's medical centers, Walter Reed opened in 1909 with 10 patients. It has treated the wounded from every war since, and nearly one of every four service members injured in Iraq and Afghanistan.

The outpatients are assigned to one of five buildings attached to the post, including Building 18, just across from the front gates on Georgia Avenue. To accommodate the overflow, some are sent to nearby hotels and apartments. Living conditions range from the disrepair of Building 18 to the relative elegance of Mologne House, a hotel that opened on the post in 1998, when the typical guest was a visiting family member or a retiree on vacation.

The Pentagon has announced plans to close Walter Reed by 2011, but that hasn't stopped the flow of casualties. Three times a week, school buses painted white and fitted with stretchers and blackened windows stream down Georgia Avenue. Sirens blaring, they deliver soldiers groggy from a pain-relief cocktail at the end of their long trip from Iraq via Landstuhl Regional Medical Center in Germany and Andrews Air Force Base.

Staff Sgt. John Daniel Shannon, 43, came in on one of those buses in November 2004 and spent several weeks on the fifth floor of Walter Reed's hospital. His eye and skull were shattered by an AK-47 round. His odyssey in the Other Walter Reed has lasted more than two years, but it began when someone handed him a map of the grounds and told him to find his room across post.

A reconnaissance and land-navigation expert, Shannon was so disoriented that he couldn't even find north. Holding the map, he stumbled around outside the hospital, sliding against walls and trying to keep himself upright, he said. He asked anyone he found for directions.

Shannon had led the 2nd Infantry Division's Ghost Recon Platoon until he was felled in a gun battle in Ramadi. He liked the solitary work of a sniper; "Lone Wolf" was his call name. But he did not expect to be left alone by the Army after such serious surgery and a diagnosis of post-traumatic stress disorder. He had appointments during his first two weeks as an outpatient, then nothing.

"I thought, 'Shouldn't they contact me?' " he said. "I didn't understand the paperwork. I'd start calling phone numbers, asking if I had appointments. I finally ran across someone who said: 'I'm your case manager. Where have you been?'

"Well, I've been here! Jeez Louise, people, I'm your hospital patient!"

Like Shannon, many soldiers with impaired memory from brain injuries sat for weeks with no appointments and no help from the staff to arrange them. Many disappeared even longer. Some simply left for home.

One outpatient, a 57-year-old staff sergeant who had a heart attack in Afghanistan, was given 200 rooms to supervise at the end of 2005. He quickly discovered that some outpatients had left the post months earlier and would check in by phone. "We called them 'call-in patients,' " said Staff Sgt. Mike McCauley, whose dormant PTSD from Vietnam was triggered by what he saw on the job: so many young and wounded, and three bodies being carried from the hospital.

Life beyond the hospital bed is a frustrating mountain of paperwork. The typical soldier is required to file 22 documents with eight different commands -- most of them off-post -- to

enter and exit the medical processing world, according to government investigators. Sixteen different information systems are used to process the forms, but few of them can communicate with one another. The Army's three personnel databases cannot read each other's files and can't interact with the separate pay system or the medical recordkeeping databases.

The disappearance of necessary forms and records is the most common reason soldiers languish at Walter Reed longer than they should, according to soldiers, family members and staffers. Sometimes the Army has no record that a soldier even served in Iraq. A combat medic who did three tours had to bring in letters and photos of herself in Iraq to show she that had been there, after a clerk couldn't find a record of her service.

Shannon, who wears an eye patch and a visible skull implant, said he had to prove he had served in Iraq when he tried to get a free uniform to replace the bloody one left behind on a medic's stretcher. When he finally tracked down the supply clerk, he discovered the problem: His name was mistakenly left off the "GWOT list" -- the list of "Global War on Terrorism" patients with priority funding from the Defense Department.

He brought his Purple Heart to the clerk to prove he was in Iraq.

Lost paperwork for new uniforms has forced some soldiers to attend their own Purple Heart ceremonies and the official birthday party for the Army in gym clothes, only to be chewed out by superiors.

The Army has tried to re-create the organization of a typical military unit at Walter Reed. Soldiers are assigned to one of two companies while they are outpatients -- the Medical Holding Company (Medhold) for active-duty soldiers and the Medical Holdover Company for Reserve and National Guard soldiers. The companies are broken into platoons that are led by platoon sergeants, the Army equivalent of a parent.

Under normal circumstances, good sergeants know everything about the soldiers under their charge: vices and talents, moods and bad habits, even family stresses.

At Walter Reed, however, outpatients have been drafted to serve as platoon sergeants and have struggled with their responsibilities. Sgt. David Thomas, a 42-year-old amputee with the Tennessee National Guard, said his platoon sergeant couldn't remember his name. "We wondered if he had mental problems," Thomas said. "Sometimes I'd wear my leg, other times I'd take my wheelchair. He would think I was a different person. We thought, 'My God, has this man lost it?' "

Civilian care coordinators and case managers are supposed to track injured soldiers and help them with appointments, but government investigators and soldiers complain that they are poorly trained and often do not understand the system.

One amputee, a senior enlisted man who asked not to be identified because he is back on active duty, said he received orders to report to a base in Germany as he sat drooling in his wheelchair in a haze of medication. "I went to Medhold many times in my wheelchair to fix it, but no one there could help me," he said.

Finally, his wife met an aide to then-Deputy Defense Secretary Paul D. Wolfowitz, who got the erroneous paperwork corrected with one phone call. When the aide called with the news, he told the soldier, "They don't even know you exist."

"They didn't know who I was or where I was," the soldier said. "And I was in contact with my platoon sergeant every day."

The lack of accountability weighed on Shannon. He hated the isolation of the younger troops. The Army's failure to account for them each day wore on him. When a 19-year-old soldier down the hall died, Shannon knew he had to take action.

The soldier, Cpl. Jeremy Harper, returned from Iraq with PTSD after seeing three buddies die. He kept his room dark, refused his combat medals and always seemed heavily medicated, said people who knew him. According to his mother, Harper was drunkenly wandering the lobby of the Mologne House on New Year's Eve 2004, looking for a ride home to West Virginia. The next morning he was found dead in his room. An autopsy showed alcohol poisoning, she said.

"I can't understand how they could have let kids under the age of 21 have liquor," said Victoria Harper, crying. "He was supposed to be right there at Walter Reed hospital. . . . I feel that they didn't take care of him or watch him as close as they should have."

The Army posthumously awarded Harper a Bronze Star for his actions in Iraq.

Shannon viewed Harper's death as symptomatic of a larger tragedy -- the Army had broken its covenant with its troops. "Somebody didn't take care of him," he would later say. "It makes me want to cry. "

Shannon and another soldier decided to keep tabs on the brain injury ward. "I'm a staff sergeant in the U.S. Army, and I take care of people," he said. The two soldiers walked the ward every day with a list of names. If a name dropped off the large white board at the nurses' station, Shannon would hound the nurses to check their files and figure out where the soldier had gone.

Sometimes the patients had been transferred to another hospital. If they had been released to one of the residences on post, Shannon and his buddy would pester the front desk managers to make sure the new charges were indeed there. "But two out of 10, when I asked where they were, they'd just say, 'They're gone,' " Shannon said.

Even after Weightman and his commanders instituted new measures to keep better track of soldiers, two young men left post one night in November and died in a high-speed car crash in Virginia. The driver was supposed to be restricted to Walter Reed because he had tested positive for illegal drugs, Weightman said.

Part of the tension at Walter Reed comes from a setting that is both military and medical. Marine Sgt. Ryan Groves, the squad leader who lost one leg and the use of his other in a grenade attack, said his recovery was made more difficult by a Marine liaison officer who had never seen combat but dogged him about having his mother in his room on post. The rules allowed her to be there, but the officer said she was taking up valuable bed space.

"When you join the Marine Corps, they tell you, you can forget about your mama. 'You have no mama. We are your mama,' " Groves said. "That training works in combat. It doesn't work when you are wounded."

Frustration at Every Turn

The frustrations of an outpatient's day begin before dawn. On a dark, rain-soaked morning

this winter, Sgt. Archie Benware, 53, hobbled over to his National Guard platoon office at Walter Reed. Benware had done two tours in Iraq. His head had been crushed between two 2,100-pound concrete barriers in Ramadi, and now it was dented like a tin can. His legs were stiff from knee surgery. But here he was, trying to take care of business.

At the platoon office, he scanned the white board on the wall. Six soldiers were listed as AWOL. The platoon sergeant was nowhere to be found, leaving several soldiers stranded with their requests.

Benware walked around the corner to arrange a dental appointment -- his teeth were knocked out in the accident. He was told by a case manager that another case worker, not his doctor, would have to approve the procedure.

"Goddamn it, that's unbelievable!" snapped his wife, Barb, who accompanied him because he can no longer remember all of his appointments.

Not as unbelievable as the time he received a manila envelope containing the gynecological report of a young female soldier.

Next came 7 a.m. formation, one way Walter Reed tries to keep track of hundreds of wounded. Formation is also held to maintain some discipline. Soldiers limp to the old Red Cross building in rain, ice and snow. Army regulations say they can't use umbrellas, even here. A triple amputee has mastered the art of putting on his uniform by himself and rolling in just in time. Others are so gorked out on pills that they seem on the verge of nodding off.

"Fall in!" a platoon sergeant shouted at Friday formation. The noisy room of soldiers turned silent.

An Army chaplain opened with a verse from the Bible. "Why are we here?" she asked. She talked about heroes and service to country. "We were injured in many ways."

Someone announced free tickets to hockey games, a Ravens game, a movie screening, a dinner at McCormick and Schmick's, all compliments of local businesses.

Every formation includes a safety briefing. Usually it is a warning about mixing alcohol with meds, or driving too fast, or domestic abuse. "Do not beat your spouse or children. Do not let your spouse or children beat you," a sergeant said, to laughter. This morning's briefing included a warning about black ice, a particular menace to the amputees.

Dress warm, the sergeant said. "I see some guys rolling around in their wheelchairs in 30 degrees in T-shirts."

Soldiers hate formation for its petty condescension. They gutted out a year in the desert, and now they are being treated like children.

"I'm trying to think outside the box here, maybe moving formation to Wagner Gym," the commander said, addressing concerns that formation was too far from soldiers' quarters in the cold weather. "But guess what? Those are nice wood floors. They have to be covered by a tarp. There's a tarp that's got to be rolled out over the wooden floors. Then it has to be cleaned, with 400 soldiers stepping all over it. Then it's got to be rolled up."

"Now, who thinks Wagner Gym is a good idea?"

Explaining this strange world to family members is not easy. At an orientation for new arrivals, a staff sergeant walked them through the idiosyncrasies of Army financing. He said one relative could receive a 15-day advance on the $64 per diem either in cash or as an electronic transfer: "I highly recommend that you take the cash," he said. "There's no guarantee the transfer will get to your bank." The audience yawned.

Actually, he went on, relatives can collect only 80 percent of this advance, which comes to $51.20 a day. "The cashier has no change, so we drop to $50. We give you the rest" -- the $1.20 a day -- "when you leave."

The crowd was anxious, exhausted. A child crawled on the floor. The sergeant plowed on. "You need to figure out how long your loved one is going to be an inpatient," he said, something even the doctors can't accurately predict from day to day. "Because if you sign up for the lodging advance," which is $150 a day, "and they get out the next day, you owe the government the advance back of $150 a day."

A case manager took the floor to remind everyone that soldiers are required to be in uniform most of the time, though some of the wounded are amputees or their legs are pinned together by bulky braces. "We have break-away clothing with Velcro!" she announced with a smile. "Welcome to Walter Reed!"

A Bleak Life in Building 18

"Building 18! There is a rodent infestation issue!" bellowed the commander to his troops one morning at formation. "It doesn't help when you live like a rodent! I can't believe people live like that! I was appalled by some of your rooms!"

Life in Building 18 is the bleakest homecoming for men and women whose government promised them good care in return for their sacrifices.

One case manager was so disgusted, she bought roach bombs for the rooms. Mouse traps are handed out. It doesn't help that soldiers there subsist on carry-out food because the hospital cafeteria is such a hike on cold nights. They make do with microwaves and hot plates.

Army officials say they "started an aggressive campaign to deal with the mice infestation" last October and that the problem is now at a "manageable level." They also say they will "review all outstanding work orders" in the next 30 days.

Soldiers discharged from the psychiatric ward are often assigned to Building 18. Buses and ambulances blare all night. While injured soldiers pull guard duty in the foyer, a broken garage door allows unmonitored entry from the rear. Struggling with schizophrenia, PTSD, paranoid delusional disorder and traumatic brain injury, soldiers feel especially vulnerable in that setting, just outside the post gates, on a street where drug dealers work the corner at night.

"I've been close to mortars. I've held my own pretty good," said Spec. George Romero, 25, who came back from Iraq with a psychological disorder. "But here . . . I think it has affected my ability to get over it . . . dealing with potential threats every day."

After Spec. Jeremy Duncan, 30, got out of the hospital and was assigned to Building 18, he had to navigate across the traffic of Georgia Avenue for appointments. Even after knee surgery, he had to limp back and forth on crutches and in pain. Over time, black mold invaded his room.

But Duncan would rather suffer with the mold than move to another room and share his convalescence in tight quarters with a wounded stranger. "I have mold on the walls, a hole in the shower ceiling, but . . . I don't want someone waking me up coming in."

Wilson, the clinical social worker at Walter Reed, was part of a staff team that recognized Building 18's toll on the wounded. He mapped out a plan and, in September, was given a $30,000 grant from the Commander's Initiative Account for improvements. He ordered some equipment, including a pool table and air hockey table, which have not yet arrived. A Psychiatry Department functionary held up the rest of the money because she feared that buying a lot of recreational equipment close to Christmas would trigger an audit, Wilson said.

In January, Wilson was told that the funds were no longer available and that he would have to submit a new request. "It's absurd," he said. "Seven months of work down the drain. I have nothing to show for this project. It's a great example of what we're up against."

A pool table and two flat-screen TVs were eventually donated from elsewhere.

But Wilson had had enough. Three weeks ago he turned in his resignation. "It's too difficult to get anything done with this broken-down bureaucracy," he said.

At town hall meetings, the soldiers of Building 18 keep pushing commanders to improve conditions. But some things have gotten worse. In December, a contracting dispute held up building repairs.

"I hate it," said Romero, who stays in his room all day. "There are cockroaches. The elevator doesn't work. The garage door doesn't work. Sometimes there's no heat, no water. . . . I told my platoon sergeant I want to leave. I told the town hall meeting. I talked to the doctors and medical staff. They just said you kind of got to get used to the outside world. . . . My platoon sergeant said, 'Suck it up!' "

Staff researcher Julie Tate contributed to this report.

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DR. DAVID S. C. CHU

Under Secretary of Defense for Personnel and Readiness



David S. C. Chu was sworn in as the Under Secretary of Defense for Personnel and Readiness on June 1, 2001. A Presidential appointee confirmed by the Senate, he is the Secretary's senior policy advisor on recruitment, career development, pay and benefits for 1.4 million active duty military personnel, 1.3 million Guard and Reserve personnel and 680,000 DoD civilians and is responsible for overseeing the state of military readiness. The Under Secretary of Defense for Personnel and Readiness also oversees the $15 billion Defense Health Program, Defense Commissaries and Exchanges with $14.5 billion in annual sales, the Defense Education Activity which supports over 100,000 students, and the Defense Equal Opportunity Management Institute, the nation's largest equal opportunity training program.

Dr. Chu earlier served in government as the Director and then Assistant Secretary of Defense (Program Analysis and Evaluation) from May 1981 to January 1993. In that capacity, he advised the Secretary of Defense on the future size and structure of the armed forces, their equipment, and their preparation for crisis or conflict. From 1978 to 1981, Dr. Chu served as the Assistant Director for National Security and International Affairs, Congressional Budget Office, providing advice to the Congress on the full range of national security and international economic issues.

Dr. Chu began his service to the nation in 1968 when he was commissioned in the Army and became an instructor at the U.S. Army Logistics Management Center, Fort Lee VA. He later served a tour of duty in the Republic of Vietnam, working in the Office of the Comptroller, Headquarters, 1st Logistical Command. He obtained the rank of captain and completed his service with the Army in 1970.

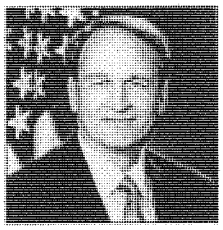
Prior to rejoining the Department of Defense, Dr. Chu served in several senior executive positions with RAND, including Director of the Arroyo Center, the Army's federally funded research and

development center for studies and analysis and Director of RAND's Washington Office.

Dr. Chu received a Bachelor of Arts Degree, magna cum laude, in Economics and Mathematics from Yale University in 1964 and a Doctorate in Economics, also from Yale, in 1972. He is a fellow of the National Academy of Public Administration and a recipient of its National Public Senior Award. He holds the Department of Defense Medal for Distinguished Public service with silver palm.

WILLIAM WINKENWERDER, JR.

Assistant Secretary of Defense for Health Affairs



The Assistant Secretary of Defense for Health Affairs (ASD/HA), is the principal staff assistant and advisor to the Secretary and Deputy Secretary of Defense and the Under Secretary of Defense for Personnel and Readiness for all Department of Defense (DoD) health policies, programs, and activities. The ASD/HA has the responsibility to effectively execute the Department's healthcare mission. This mission is to provide, and to maintain readiness to provide healthcare services and support to members of the Armed Forces during military operations. In addition, the Department's healthcare mission provides healthcare services and support to members of the Armed Forces, their family members, and others entitled to DoD healthcare.

In carrying out the responsibilities of the Office of the Assistant Secretary of Defense for Health Affairs (OASD/HA), the ASD/HA exercises authority, direction, and control over the medical personnel, facilities, programs, funding, and other resources within the DoD. These responsibilities include, but are not limited to:

Establishing policies, procedures, and standards that govern DoD healthcare programs

Serving as program manager for all DoD health and medical resources

Directing DoD financial policies, programs, and activities including unified budget formulations, program analysis, and evaluation

Overseeing TRICARE and the consistent, effective implementation of DoD policy throughout the Military Health System

Directing deployment medicine policies

Leading strategic planning for the Military Health System

Maintaining strong communication with the line, beneficiary representatives and associations, the media and the Congress

Presenting and justifying the unified medical program and budget throughout the planning,

programming, and budgeting system process, including representation before the Congress

Co-chairing with the director, Defense Research and Engineering, the Armed Services Biomedical Research Evaluation and Management Committee, which facilitates consideration of DoD biomedical research

PETER J. SCHOOMAKER

Chief of Staff, U.S. Army



General Schoomaker became the 35th Chief of Staff, United States Army, on August 1, 2003. General Schoomaker graduated from the University of Wyoming in 1969 with a Bachelor of Science Degree. He also holds a Master of Arts Degree in Management from Central Michigan University, and an Honorary Doctorate of Laws from Hampden-Sydney College. General Schoomaker's military education includes the Marine Corps Amphibious Warfare School, the United States Army Command and General Staff College, the National War College, and the John F. Kennedy School of Government Program for Senior Executives in National and International Security Management. Prior to his current assignment, General Schoomaker spent 31 years in a variety of command and staff assignments with both conventional and special operations forces. He participated in numerous deployment operations, including DESERT ONE in Iran, URGENT FURY in Grenada, JUST CAUSE in Panama, DESERT SHIELD/DESERT STORM in Southwest Asia, UPHOLD DEMOCRACY in Haiti, and supported various worldwide joint contingency operations, including those in the Balkans. Early in his career, General Schoomaker was a Reconnaissance Platoon Leader and Rifle Company Commander with 2nd Battalion, 4th Infantry, and a Cavalry Troop Commander with 2nd Armored Cavalry Regiment in Germany. He then served in Korea as the S-3 Operations Officer of 1st Battalion, 73rd Armor, 2nd Infantry Division. From 1978 to 1981, he commanded a Squadron in the 1st Special Forces Operational Detachment - D. Following Army Command and General Staff College, General Schoomaker served as the Squadron Executive Officer, 2nd Squadron, 2nd Armored Cavalry Regiment in Germany. In August 1983, he returned to Fort Bragg, North Carolina, to serve as Special Operations Officer, J-3, Joint Special Operations Command. From August 1985 to August 1988, General Schoomaker commanded another Squadron in the 1st Special Forces Operational Detachment - D. Following the National War College, he returned as the Commander, 1st Special Forces Operational Detachment - D from June 1989 to July 1992. Subsequently, General Schoomaker served as the Assistant Division Commander of the 1st Cavalry Division, Fort Hood, Texas, followed by a tour in the Headquarters, Department of the Army staff as the Deputy Director for Operations,

Readiness and Mobilization. General Schoomaker served as the Commanding General of the Joint Special Operations Command from July 1994 to August 1996, followed by command of the United States Army Special Operations Command at Fort Bragg, North Carolina through October 1997. His most recent assignment prior to assuming duties as the Army Chief of Staff was as Commander in Chief, United States Special Operations Command at MacDill Air Force Base, Florida, from November 1997 to November 2000. General Schoomaker's awards and decorations include the Defense Distinguished Service Medal, two Army Distinguished Service Medals, four Defense Superior Service Medals, three Legions of Merit, two Bronze Star Medals, two Defense Meritorious Service Medals, three Meritorious Service Medals, the Joint Service Commendation Medal, Joint Service Achievement Medal, Combat Infantryman Badge, Master Parachutist Badge and HALO Wings, the Special Forces Tab, and the Ranger Tab.

Maintained by the Army Medical Department, Office of the Surgeon General

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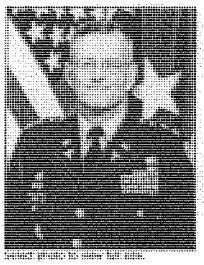
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Lieutenant General Kevin C. Kiley, M.D.

Leaders & Organizations

U.S. Army Surgeon General
Commander, U.S. Army Medical Command



LTG Kevin C. Kiley, M.D., was appointed the 41st surgeon general of the Army and Commander, U.S. Army Medical Command, Fort Sam Houston, Texas, on Sept. 30, 2004.

Kiley is a graduate of the University of Scranton, with a bachelor's degree in biology. He received his medical degree from Georgetown University School of Medicine, Washington D.C. He served a surgical internship and then an obstetrics and gynecology residency at William Beaumont Army Medical Center, El Paso, Texas.

His first tour was with the 121st Evacuation Hospital in Seoul, South Korea, where he was the Chief of OB/GYN services. He returned to the residency training program at William Beaumont Army Medical Center and served as Chief, Family Planning and Counseling Service. He then served as Assistant Chief of the Department of OB/GYN.

He was assigned as the Division Surgeon of the 10th Mountain Division, a new light infantry division in Fort Drum, N.Y. He then assumed command of the newly activated 10th Medical Battalion, 10th Mountain Division, serving concurrently in both assignments. He returned to William Beaumont Army Medical Center, where he first served as the Assistant Chief, then Chairman of the Department of OB/GYN.

In November 1990, he assumed command of the 15th Evacuation Hospital at Fort Polk, La., and in January 1991, he deployed the hospital to Saudi Arabia in support of Operations Desert Shield and Desert Storm. Upon his return, he was assigned as the Deputy Commander for Clinical Services at Womack Army Medical Center, Fort Bragg, N.C.

He is a graduate of the U.S. Army War College, Carlisle Barracks, Pa. He assumed command of the Landstuhl (Germany) Regional Medical Center and what is now the U.S. Army Europe Regional Medical Command at Landstuhl, Germany, serving concurrently as the Command Surgeon, U.S. Army Europe and 7th Army.

LTG Kiley then assumed the duties of Assistant Surgeon General for Force Projection; Deputy Chief of Staff for Operations, Health Policy and Services, U.S. Army Medical Command; and Chief, Medical Corps. His next tour was as Commander of the U.S. Army Medical Department Center and School and Fort Sam Houston, where he continued as Chief of the Medical Corps. Immediately before his current assignment, LTG Kiley was commander of Walter Reed Army Medical Center and North Atlantic Regional Medical Command and Lead Agent for Region I.

He is a board-certified OB/GYN and a fellow of the American College of Obstetricians and Gynecologists.

Among his awards and decorations are the Distinguished Service Medal, Defense Superior Service Medal, Legion of Merit (three oak leaf clusters), Bronze Star Medal, Defense Meritorious Service Medal, Meritorious Service Medal (two oak leaf clusters), Army Commendation Medal, the "A" professional designator, the Order of Military Medical Merit and the Expert Field Medical Badge.

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March 6, 2007

The Honorable Robert Gates
1000 Defense Pentagon
Washington, DC 20301-1000

Dear Secretary Gates,

First let me applaud your strong leadership since assuming your position as the Secretary of Defense earlier this year. I doubt any other Secretary of Defense in our history has had so much asked of him in such a short period of time. Our country is fortunate to have people like you willing to return to public service and endure what may seem at times like a thankless endeavor.

Although Major General George Weightman was the Commander of Walter Reed for a short period of time, I found it proper that he was relieved. I also found it appropriate that former Army Secretary Francis Harvey was relieved. I do not believe he fully understood the implications or seriousness of this issue as evidenced by some of his comments to the press to include his comments that "if that satisfies the populace, maybe this will stop further dismissals." As an unelected political appointee who served at the pleasure of the President, Secretary Harvey had an obligation to the American people to do what was correct and his comments seem to trivialize the lack of attention to wounded service members and blame the media for the Army's lack of supervision and proper leadership at Walter Reed.

This lack of supervision and proper leadership was and is the responsibility of Lieutenant General Kevin Kiley as well. His initial reaction to the Washington Post stories and comments at subsequent congressional hearings were quite possibly the most uninformed comments I have heard from a senior General Officer. General Kiley commented that the Post presented "one-sided representation" of conditions at the facility and that "while we have some issues here, this is not a horrific, catastrophic failure at Walter Reed." Additionally, he said yesterday to a congressional panel that "inspections of barracks were not part of his normal duties" and it is my understanding he tried to blame enlisted soldiers for some of the issues as well.

I find General Kiley's public comments to be unacceptable and believe they speak to his fundamental lack of understanding on this issue and quite frankly I think he no longer deserves the honor of commanding our Army's fine medical professionals during

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a time of war. I strongly recommend General Kiley be removed from his current position and hope you will take my recommendation into consideration.

No matter what mistakes have been made to date in the Iraq or Afghanistan theaters of operations in the Global War on Terror, we must not fail our wounded service members while on active duty or once they transition to the Veterans Affairs' system. The fact this issue was brought to our attention by our media is unacceptable. I wish I had personally discovered this earlier and I am working to ensure we meet our moral and constitutional obligation to our military and the American people.

Thank you for your continued service to our nation during these important times and I look forward to hearing from you.

With warm personal regards, I am

Sincerely,

JEFF MILLER
Member of Congress

AHLTA funding FY 1997-FY 2013*:

($M)	FY 1997	FY 1998	FY 1999	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Operations & Maintenance	4.4	11.4	20.7	30.1	40.5	27.9	34.1	53.5	83.5	75.8	99.251	73.3	128.0	138.4	142.4	156.2	159.6
Procurement	17.0	33.7	42.5	37.9	48.3	37.8	16.6	65.9	40.0	34.3	78.1	3.7	9.2	13.0	0.0	0.0	0.0
Research, Development, Testing & Evaluation	0.0	0.0	0.0	0.0	27.9	53.8	18.5	19.1	5.6	29.8	22.0	7.6	4.9	4.4	4.4	2.7	2.8
Total	**21.4**	**45.1**	**63.2**	**68.0**	**116.7**	**119.5**	**69.2**	**138.5**	**129.1**	**139.9**	**199.4**	**84.6**	**142.1**	**155.8**	**146.8**	**158.9**	**162.4**

*FY 1997-2005 amounts represent actuals. FY 2006-FY 2013 are the budgeted amounts for AHLTA in the FY 2008 President's Budget.

**All funds are Clinical Information Technology Program Office only; this does not include funds supporting infrastructure needs nor Service Medical IM/IT departments.

QUESTIONS AND ANSWERS SUBMITTED FOR THE RECORD

MARCH 8, 2007

QUESTIONS SUBMITTED BY MR. SKELTON

The CHAIRMAN. What else, besides the mice, cockroaches and mold? Are there conditions such as this in hospitals elsewhere in the United States?

General KILEY. US Army Medical Command currently lists $183,832,000 of unfinanced requirements for sustainment, repair and maintenance of medical facilities that directly impact the delivery of healthcare to Army beneficiaries. These projects are listed in the chart below. Additionally, Army Medical Command has unfinanced requirements for non-healthcare delivery projects totaling $42,878,000. Those projects support medical research, force protection, quality of life, and preventive and veterinary medicine across the Army.

State	Location/Installation	Project Title/Description	Cost $000
AZ	Yuma	Renew Yuma Proving Grounds Health Clinic	$1,700
CA	Ft. Irwin	Renovate ER & Main Entrance-Weed ACH	$1,670
CA	Ft. Irwin	Modify Mary Walker Clinic	$400
CA	Monterey	Presidio of Monterey Health Clinic Renewal	$7,500
CO	Ft. Carson	Smith Dental Transition	$3,000
CO	Ft. Carson	Repair Floor Heaving Phase 1	$7,500
DC	Walter Reed Army MEDCEN	Renovate Intensive Care Unit	$2,500
DC	Walter Reed Army MEDCEN	Install HVAC return air system	$350
DC	Walter Reed Army MEDCEN	Repair Lab Pneumatic Tube System in	$210
DC	Walter Reed Army MEDCEN	Repair Non-Compliant Fire Stop/Smoke Barriers	$400
DC	Walter Reed Army MEDCEN	Repair 34 of 38 Hot water converters	$950
DC	Walter Reed Army MEDCEN	Upgrade restrooms to ADA compliance	$2,540
DC	Walter Reed Army MEDCEN	HVAC Controls and Balancing	$450
DC	Walter Reed Army MEDCEN	Signage—Improve patient travel in facility	$1,200
DC	Walter Reed Army MEDCEN	Replace the worn and torn base cove	$120
DC	Walter Reed Army MEDCEN	Paint Interior Stairwells and handrails	$200
DC	Walter Reed Army MEDCEN	Modify sprinklers to meet NFPA Requirements	$275
DC	Walter Reed Army MEDCEN	Repair Chiller Plant Systems and Valves	$1,300
DC	Walter Reed Army MEDCEN	Bldg. 82, Roof Repair	$20
DC	Walter Reed Army MEDCEN	Replace electrical distribution panels	$377
DC	Walter Reed Army MEDCEN	Convert Delano Hall to Barracks	$403
DC	Walter Reed Army MEDCEN	Modify Soldier Family Assistance Center/SFAC	$450

State	Location/Installation	Project Title/Description	Cost $000
DC	Walter Reed Army MEDCEN	Emergency Riser in Heaton Pavilion South	$523
DC	Walter Reed Army MEDCEN	Install revolving door to maintain climate control	$250
DC	Walter Reed Army MEDCEN	Repair/Replace Fire Doors/Frames Phase II	$250
DC	Walter Reed Army MEDCEN	Repair Bldg 178	$920
GA	Ft. Benning	Patient Tower Perimeter Heating	$4,500
GA	Ft. Benning	Repair Roof, Paint Exterior, Replace Windows	$4,200
GA	Ft. Benning	Replace Operating Room Reheat	$450
GA	Ft. Benning	Repair Radioloy Dept	$3,300
GA	Ft. Gordon	Repair Lightning Protection/Grounding System	$500
GA	Ft. Gordon	Modernize Elevators Building 300	$449
GA	Ft. Stewart	Warfighter Refractive Eye Surgery Program	$2,500
German	Hohenfels	Hohenfels Health Clinic Exterior Repair	$604
German	Illsheim	Renovate Illsheim Health Clinic	$200
German	Landstuhl	Install direct digital control in Critical Care Tower	$1,200
German	Landstuhl	Renovate Wing 2A/C of the Medical Center	$2,200
German	Stuttgart	Renew Dental Clinic	$450
German	Stuttgart	Renew Stuttgart Dental Clinic	$3,750
German	Vilseck	Dental Clinic Interior Repair	$1,050
HI	Schofield Barracks	Bldg 681, Repairs and Renovation	$7,300
HI	Tripler Army MEDCEN	Correct boiler deficiencies to ASME standards	$375
HI	Tripler Army MEDCEN	Optimize Optometry Clinic	$575
HI	Tripler Army MEDCEN	Optimize Orthopedic Clinic	$841
HI	Tripler Army MEDCEN	Bldg 137, Repair Emergency Generator	$950
HI	Tripler Army MEDCEN	Bldg 161, Repair Fire Sprinkler System	$350
HI	Tripler Army MEDCEN	Clinic Ergonomics, 10 Areas	$680
HI	Tripler Army MEDCEN	Bldg 161, Install Emergency Generator	$550
HI	Tripler Army MEDCEN	Expand Pathology lab capacity	$1,080
HI	Tripler Army MEDCEN	Combine functions in specialty clinics to reduce need for additional staff	$1,000
HI	Tripler Army MEDCEN	Renovate Neonatal Intensive Care Unit	$700
KS	Ft. Leavenworth	Central Patient Records Area	$1,000
KS	Ft. Leavenworth	Physical Therapy/Ortho Add/Alt	$4,050
KS	Ft. Riley	Riley Same Day Surgery Clinic	$11,000

State	Location/Installation	Project Title/Description	Cost $000
KY	Ft. Campbell	Renovate Bldg 2730 to Satellite Pharmacy	$985
KY	Ft. Campbell	Red and Blue Clinic Renovations	$2,500
KY	Ft. Knox	Repair Jordan Dental Clinic	$9,000
KY	Ft. Knox	Repair deficient Sprinkler System and Standpipe	$1,000
LA	Ft. Polk	Renovate and reconfigure Perioperative Services	$8,000
MD	Aberdeen	E2100 Renewal—Electrical Feasibility Study	$99
MD	Ft. Meade	Renew Patholoy Lab	$5,000
MO	Ft. Leonard Wood	Site Pre for Modular Troop Medical Clinic	$750
NC	Ft. Bragg	Build out Attic Space to free up ward space	$1,700
NC	Ft. Bragg	MASCAL DECON Facility	$1,000
NC	Ft. Bragg	EDIS Building	$1,000
OK	Ft. Sill	Repair Interstitial Lighting	$404
OK	Ft. Sill	Repair Bleak Troop Medical Center	$700
OK	Ft. Sill	Warehouse/Records Conversion for clinical space	$1,300
OK	Ft. Sill	Allen Dental Addition/Alteration	$6,000
SC	Ft. Jackson	Hospital Structural Foundation Repair—East Win	$2,900
SC	Ft. Jackson	Renewal Troop Medical Clinic Optimization	$5,400
TX	Ft. Bliss	Warfighter Refractive Eye Surgery Program	$3,000
TX	Ft. Bliss	Construct Social Work Services Building	$700
TX	Ft. Bliss	Medical Resident Village	$2,800
TX	Ft. Bliss	Repair outlying Building Roof on medical building	$350
TX	Ft. Hood	Upgrade Elevators 1–7	$1209
TX	Ft. Hood	Replace Emergency Generators	$2,900
TX	Ft. Sam Houston	Renew McWethy Troop Medical Clinic	$2,990
TX	Ft. Sam Houston	Construct temp admin facilities so hospital can be used for clinical requirements	$3,750
TX	Ft. Sam Houston	Hospital Orthopedic Clinic Expansion	$350
TX	Ft. Sam Houston	Repair/renovate Budge Dental	$7,500
VA	Ft. Lee	Repair 2nd Floor, ''A'' Wing	$1,186
VA	Ft. Lee	Renew Bull Dental Clinic	$5,000
VA	Ft. Lee	Renew Kenner Clinic	$5,000
VA	Ft. Lee	Site work for interim Troop Medical and Dental Clinics	$1,800
VA	Ft. Myer	Rader Clinic Transition Space	$3,000

State	Location/Installation	Project Title/Description	Cost $000
WA	Ft. Lewis	Construct LDR #8 for Women's Health Program	$750
WA	Ft. Lewis	Expand Madigan Pediatric Clinic	$700
WA	Ft. Lewis	Renew Labor and Delivery area; recovery area	$600
WA	Ft. Lewis	Renovate Wing 2A/C of the Medical Center	$1,000
WA	Ft. Lewis	Renovate Labor & Deliver Nursing Team Center	$450
WA	Ft. Lewis	Addition to Women's Health Clinic	$750
		TOTAL	**$183,832**

The CHAIRMAN. Regarding electronic medical records. We funded this some years ago. The outpatient care has been complete. Medical records for outpatient care has been complete. The inpatient care has just begun with the exception of some specialized cases. What has taken so long, since 1983? When was it fully funded?

Dr. CHU. Funding for the Armed Forces Health Longitudinal Technology Application (AHLTA) covering the period fiscal year (FY) 1997 through FY 2013 is $1.9 billion. This funding includes both acquisition and sustainment costs. The $1.2 billion acquisition costs of AHLTA include the development, integration, initial procurement, and deployment of the system. Sustainment costs include activities such as software maintenance, program management, and information assurance.

This funding chart shows funding by fiscal year covering the period FY 1997 through FY 2013. AHLTA (formerly known as Composite Health Care System II) received Milestone Zero Approval in FY 1997. (In other words, funding to build AHLTA began in FY 1997). Therefore, the FY 1997 through FY 2005 shows actual funds spent on AHLTA by fiscal year.

Each year a budget request (President's Budget) is submitted to Congress. This budget is the biennial budget submission and covers two years. However, the Department of Defense (DoD) builds a budget that is called the Future Years Defense Plan (FYDP). The FYDP for the latest FY 2008 President's Budget covers FY 2006 through FY 2013. The chart shows the funding budgeted for AHLTA in the FY 2008 President's Budget for FY 2006 through FY 2013.

FY 1997 through FY 2005 reflect actual funds spent and the FY 2006 through FY 2013 reflects the budget request (FY 2006 and FY 2007 are years that still have active appropriations and therefore are still considered in the budget submission).

[The chart referred to can be found in the Appendix on page 158.]

QUESTIONS SUBMITTED BY MR. ORTIZ

Mr. ORTIZ. Do you think that you can give us a list of your worst facilities so that a group of members here can go see it so that we can be in a position where we can help you fix those facilities?

General KILEY. At all but one Army installation with Medical Holdover Soldiers, the Army Installation Management Command is responsible for the command and control of Medical Holdover Soldiers, including billeting. The Army Medical Command (MEDCOM) is responsible for providing healthcare at those installations. The sole exception is Walter Reed Army Medical Center, where MEDCOM is responsible for both installation management and healthcare delivery.

From a medical facilities assessment, the hospitals at Fort Knox, Kentucky, Fort Benning, Georgia, Fort Riley, Kansas, and Fort Hood, Texas, are all more than 40 years old and have significant infrastructure concerns. Each of these facilities is in need of replacement. Tripler Army Medical Center, Hawaii, is also in need of significant renovation or replacement. In the next few years, the inpatient tower at Landstuhl Regional Medical Center, Germany, will need replacement as will the health clinic at Fort Rucker, Alabama.

MEDCOM is able to maintain these facilities in accordance with the Life Safety Standards of the Joint Commission on Accreditation of Healthcare Organizations through sustainment, repair and maintenance funds. However, a long-term strategy within the Medical Military Construction appropriation is required to ensure Army medical treatment facilities are capable of supporting the Army into the future.

QUESTIONS SUBMITTED BY MR. MCHUGH

Mr. MCHUGH. As more information comes to light about the widely publicized problems at Walter Reed Army Medical Center, it appears that private-public job competition, referred to by many as the "A–76 process," sapped the facility of needed workers at a time when a demand for their skills, based on inpatient and outpatient population, was growing. Please provide for me the data in a chart form, that (1) shows month by month how the numbers of workers on hand in functions covered by the A–76 process changed over time, and (2) how the WRAMC inpatient and outpatient (medical hold and medical holdover) populations changed month to month over the same period. The period I am interested in begins two months before the A–76 process was announced and continues through the month when the A–76 contractor was awarded the contract and ends with the month of January 2007.

General KILEY. The requested data is provided below. It shows that personnel strength levels remained relatively stable throughout the competition. It also shows that considerable resources continued to be devoted to maintenance during the short transition period.

	Nov 05	Dec 05	Jan 06	Feb 06	Mar 06	Apr 06	May 06	Jun 06	Jul 06	Aug 06	Sep 06	Oct 06	Nov 06	Dec 06	Jan 07
Med Hold/Med Holdover	*	*	*	*	*	*	*	667	*	*	*	*	617	640	625
BASOPS Staff	296	292	292	289	293	294	294	294	250	244	228	228	232	224	209
* Data not available															

Mr. MCHUGH. How many other installations involving medical hold and medical holdovers since 2001 have undergone A–76 competitions? Please provide me with the same trend data from the time the A–76 was awarded through the time a contract may have been awarded versus patient workloads.

General KILEY. Below are the titles and associated sites where the Army Medical Command has conducted A–76 competitions since 2001. None of these competitions had any impact on patient care. All but two of the conversions occurred after the start of Operation Iraqi Freedom. Unlike the Walter Reed A–76 competition, none of these studies involved base operations that effected the sustainment, repair, or maintenance of medical facilities or billeting of patients.

Title	Affected Site(s)	Status	Patient Care Impact
Automation Management	Riley	3 Sep. 01 Contract Award	Pre-OIF
Hospital Housekeeping	Riley	1 Oct. 01 (Government Start Date)	Pre-OIF
Ambulance Services	Polk	1 Nov. 01 Contract Award	Pre-OIF
Hospital Housekeeping	Huachuca	3 Dec. 02 In-House Start Date	Pre-OIF
Hospital Housekeeping	Benning	19 Dec. 03 Contract Award	332 Soldiers in Medical Holdover
Base Support Services	Detrick	25 Jan. 04 In-House Start Date	No patients

QUESTIONS SUBMITTED BY DR. SNYDER

Dr. SNYDER. How many people today do we think systemwide are in a medical hold or holdover status?

General KILEY. On March 8, 2007, there were 901 Active Component Soldiers assigned to Army Medical Treatment Facilities for Medical Hold Care and 670 attached. There were 1,895 Reserve Component Soldiers assigned to installation-based Medical Holdover Units and 1,321 Reserve Component Soldiers assigned to Community Based Healthcare Organizations.

Dr. SNYDER. What is the current case manager ratio, system-wide, in the Army? What is the current case manager ratio at Walter Reed? What should the case manager ratio be? And when I asked you before about who paid the case managers, are they all employees, or are any of those contracted out?

General KILEY. As of March 8, 2007, US Army Medical Command has one Case Manager for every 30 Soldiers across the Army. The ratio varies based on the complexity of patients at any particular location. Currently, the ratio ranges from 1:18 at Walter Reed Army Medical Center to 1:36 at smaller community hospitals. This is 116 case managers for approximately 3,400 Soldiers assigned to Medical Holdover Units. Community Based Health Care Organizations average one case manager for every 16 Soldiers (81 case managers for 1,294 Soldiers assigned). The case manager ratio at Walter Reed Army Medical Center is one case manager per 17 Soldiers. The total number of case managers across the Army includes 158 military and 51 civilian case managers.

QUESTIONS SUBMITTED BY MR. SMITH

Mr. SMITH. I want to hear what you are doing for the challenges for guard and reserve, particularly on the mental health piece, if they don't necessarily get the same care, don't have the same community, making sure that they are drawn in.

I am very interested in electronic medical records. As part of this, also as you are moving patients around the system, do the records follow them? Do we have electronic medical records (EMRs) within the military, so that we are not losing track of records?

And last, just to make it really complicated, how system-wide is this?

General KILEY. For National Guard Soldiers, the Post-Deployment Health Reassessment (PDHRA) tool offers both physical and mental well-being screening. The Army National Guard implementation continues as states and territories incorporate PDHRA into training schedules. On average, there are 20 on-site screening teams available each weekend. Some of the issues facing the PDHRA screening teams include (1) Geographic dispersion of Soldiers impacts utilization of the teams; (2) Mobilizations of National Guard units have not maintained unit integrity resulting in wide dispersal of eligible Soldiers, and (3) Units do not train on every weekend of every month. The Army National Guard will continue to focus on on-site events as the primary method to achieve screening. Call Center processes are being refined to reduce wait time and increase viability of the screening method. The Army National Guard is also advocating for an automated method for tracking referral completion.

For the Army Reserve, there are similar challenges. We determined that the previous method of contacting Soldiers for 100% PDHRA screening, via the Call Center, proved less effective than on-site events. Limited staff availability to schedule PDHRA screening events was problematic. With the hiring of PDHRA Coordinators and scheduling more PDHRA on-site events, the Army Reserve projects meeting its goal of 3,000 monthly screens by March 2007. Funding has been received to hire a PDHRA Coordinator at each Direct Reporting Command. Monitoring of mobilization and demobilization dates is being undertaken to proactively schedule units within the 90–180 day window.

We do have an Electronic Medical Record (EMR) under development within the Military Health System (MHS). Over the past several years, the Army, in conjunction with the MHS, has deployed AHLTA, an outpatient EMR that uses one centralized clinical data repository. By the end of Fiscal Year 2007, AHLTA will make outpatient medical records available across MEDCOM and at combat support hospitals in Iraq and Afghanistan. What the MHS still lacks is an inpatient EMR that enables the same visibility of inpatient information as AHLTA. We also need to develop an updated system for pharmacy, laboratory, and radiology orders and results. These two remaining components are under development, but still several years away. Until they are complete, the Composite Health Care System, originally developed and deployed in the late 1980's remains the backbone of the ancillary and inpatient EMR for the MHS.

Many of the problems with the Physical Disability Evaluation System (PDES) discovered at Walter Reed Army Medical Center exist across the Army. The PDES is clearly an outdated system that does not meet the 21st century needs of the Army or our Soldiers. All too often, this system places the Soldier in an adversarial position with the medical and personnel systems. We are working to streamline this system, improve the Soldier's understanding of the system, and ensure every Soldier receives a thorough and fair evaluation of their disability.

QUESTIONS SUBMITTED BY MR. JONES

Mr. JONES. IAP is the group, the management group, that got the contract. Do you know anything about them?

When you put this out for private bid, then I assume that the parameter is anyone that can do the work can bid on the process. Is that right?

Dr. CHU. There was no decision to "privatize" the base support services at Walter Reed Army Medical Center (WRAMC), nor was there a pre-decision to "privatize." Privatization is a decision to exit a business line, terminate an activity, or sell government-owned assets to the private sector. Public-private competition subjects recurring, commercial activity type work performed by government personnel to competition with the private sector to determine if the government or contractor is the most efficient and cost effective source. The Army made a decision to conduct such a public-private A–76 competition for the base support services at WRAMC under OMB Circular A–76 procedures. The competition was to determine the lowest-cost, technically acceptable service provider that could provide base support services at WRAMC.

The public-private competition was for base support services, not construction. The outcome of the competition was the private sector offeror, International American Products Worldwide Services, Inc. (iAP). The timeline for the public-private competition process of the base support services at WRAMC (functions included all public works-related functions, hospital logistics—hospital warehouse functions, and administrative/logistics functions) follows:

May 19, 2000—the United States Army Medical Command Assistant Chief of Staff for Resource Management notified the Assistant Chief of Staff for Installation Management that the WRAMC Commander intended to compete base support services at WRAMC.

June 13, 2000—WRAMC competition began upon Congressional notification and public announcement.

September 29, 2004—WRAMC made a tentative decision, which provides due process for affected parties to dispute the outcome (e.g., appeals and protests).

June 5, 2006—Congressional notification was made via the Final Decision Report identifying the selected private sector source, iAP.

November 7, 2006—The 90-day transition period (phase-in period) began.

February 4, 2007—iAP contract performance period (first period of full performance) began.

International American Products Worldwide Services, Inc. is one of the largest facility management companies doing business with the Department of Defense (DoD). iAP purchased Johnson Controls World Services, which was the successful offeror during the public-private competition process due to their long and successful history of competing for DoD contracts to provide base support services.

As part of the acquisition process, under Federal Acquisition Regulations, Defense Acquisition Regulations, and Army Acquisition Regulations, private sector offerors are subjected to a source selection process where a government source Selection Evaluation Team evaluates them and the Source Selection Authority determines the lowest-priced, technically qualified private sector offeror to perform the work. Such competitions are performed in accordance with regulations, and, when appropriate, OMB Circular A–76. iAP was selected for the base support services at WRAMC under these regulations.

QUESTIONS SUBMITTED BY MR. ANDREWS

Mr. ANDREWS. My information is that there are 1,055 soldiers Army-wide who remain in MHO for more than 360 days at this point. I would like to know how many of them are in the community-based program.

General KILEY. There are 1,134 Reserve Component Soldiers who had been assigned to installation-based Medical Holdover units and Community Based Healthcare Organizations for longer 360 days as of March 8, 2007. 695 of these Soldiers are assigned the Community Based Healthcare Organizations.

QUESTIONS SUBMITTED BY MR. MILLER

Mr. MILLER. I'm sure you are familiar with the ICD–9 designation. It is my understanding that an ICD–9 designation without any accompanying description medically translates to "an organic psychiatric disorder" and that IED victims who suffer TBI and have obvious brain damage and neurological issues are given this designation.

Dr. WINKENWERDER. The application of the 9th revision of the International Classification of Diseases (ICD)–9 codes to a person's medical situation is an attempt to classify, in a standardized manner, each of the individual's medical conditions or reasons for seeking care. Every ICD–9 code is associated with a text description of the diagnosis. There are no codes without such descriptions. In the context of traumatic brain injury TBI, there are numerous ICD–9 codes which may be appropriate for specifying the patient's condition. They include:

310.2 Post-concussion syndrome
800 Fracture of vault of skull
801 Fracture of base of skull
802 Fracture of face bones
803 Other and unqualified skull fractures
804 Multiple fractures involving skull or face with other bones
850 Concussion

Fourth digits from .0 to .5 and .9 specify whether or not there was loss of consciousness and, if so, the duration of that loss of consciousness.

851 Cerebral laceration and contusion
852 Subarachnoid, subdural, and extradural hemorrhage, following injury
853 Other and unspecified intracranial hemorrhage following injury
854 Intracranial injury of other and unspecified nature
925 Crushing injury of face, scalp, and neck
959.0 Injury, other and unspecified, of the head, face, and neck

Code 310.2 refers to the presence of impaired mental (i.e., intellectual) function following a concussion, not to a psychological disease. It is a mental disorder, not a psychiatric disorder. The category 310 as a whole is specifically for "non-psychotic mental disorders due to organic brain damage."

The list of ICD–9 codes above includes those traditionally used for potential (TBI) cases. They do not cover the full clinical spectrum such as the non-specific symptoms for which the codes are in the 780.xx series. Unique codes for military external causes of injury have been proposed and are being coordinated now with the TRICARE Management Activity coding office for incorporation into Armed Forces Health Longitudinal Technology Application and other systems. These codes, if used consistently and accurately, would add some details and may improve our ability to study TBI from a clinical perspective.

Mr. MILLER. Why would the Army assign a combat wounded TBI patient with a psychiatric disorder? Can we in Congress help you to create a new designation specifically for TBI and one that does not carry the stigma some believe exists with having a "documented psychiatric disorder?"

Dr. WINKENWERDER. The International Classification of Diseases (ICD)–9 refers to the 9th revision of the ICD, a system promulgated by the World Health Organization. It is not a Department of Defense (DoD) or United States Army system. Changes are made to the disease classification codes every year, but it takes time and must reflect international acceptance. Traumatic Brain Injury TBI is a recently introduced medical term that is not used extensively around the world, nor is there full agreement in the scientific community regarding precise definitions for various types of TBI, such as mild, moderate, or severe. Consequently, at this time, there is no specific ICD code for TBI. The closest match is ICD–9 code 310.2, entitled "post-concussion syndrome."

In the ICD rubric, this particular code falls under the major diagnostic classification grouping of "mental disorders," a reference to dysfunction of the brain from any cause, including organic diseases, dysfunction due to injury or chemicals, behavioral issues, and various psychological conditions. Examples of non-psychiatric disorders in the "mental disorders" category include mental disorders induced by drugs (i.e.,

medications), acute alcohol intoxication, tobacco dependence, tension headaches, and dyslexia.

Code 310.2 refers to the presence of impaired mental (i.e., intellectual) function following a concussion, not to psychological disease. Combined with the other specific ICD–9 codes that depict the anatomical extent of head injuries, there should be no stigma associated with 310.2, any more than with the other mental disorders in the list above. Accurate coding of an individual with a post-concussive syndrome (also known as TBI), falls in the mental disorders category of codes, but it is not a code associated with a psychiatric disorder.

Recognizing the limitations of the ICD–9 system, the DoD developed a set of militarily unique codes for external causes of injury related to TBI. This list is in coordination with the TRICARE Management Activity coding office for incorporation into Armed Forces Health Longitudinal Technology Application and other systems. These new codes, if used consistently and accurately, will add some details and should improve our ability to study TBI from a clinical perspective.

Mr. MILLER. Is it true that while waiting for the results of a medical board, a soldier cannot have any needed surgeries because a surgery would change his medical status? If so, what are you doing to remedy this obviously problematic regulation?

Dr. WINKENWERDER. A medical board is the process of gathering the medical testing and evaluation information on a patient that addresses all of the medical symptoms, concerns, complaints or diagnoses the patient has. After an analysis of this medical information, the board decides if the Service member meets medical retention standards.

If a patient develops a new medical problem or has a surgery before the medical analysis is done, then the medical board process is interrupted and the new information needs to be completed and added to the other information.

It is not true that a patient cannot undergo surgery or receive any other needed medical attention. The health of the patient always comes first, and the processing time for the medical board will, of necessity, be extended.

The Department of Defense is working with the Department of Veterans Affairs to re-evaluate the medical disability evaluation systems that are currently in place. Even with improvements in developing a single, overall process, determination of disability cannot be accurately made until the patient's medical condition is fully evaluated and is stable.

Mr. MILLER. Is it true that all outpatients at Walter Reed are bureaucratically and administratively transferred from one system or database to another so that if I were to call the WR switchboard today and ask for a constituent that is an outpatient, the operator would not know if that individual was there or not? Can outpatients receive mail at WR once they are transferred?

Dr. WINKENWERDER. As patients are discharged from inpatient status to outpatient status, the medical center brigade assumes accountability for them. Walter Reed Army Medical Center (WRAMC) personnel located at the information desk and other places at WRAMC do not have a personnel roster or database of outpatients. Outpatients are currently assigned to the medical center brigade and will soon be assigned to the warrior transition brigade. Outpatient rosters are maintained by the brigade and can be made available to the WRAMC personnel. The hospital and brigade are partnering together for an optimal solution to this issue.

Outpatients do receive mail once they are in-processed to WRAMC.

Our newly approved hospitality services will include a much more robust information desk and information system for customer service.

Mr. MILLER. What is currently in Building 40? What are it's future plans and do you believe there is a better way to use this building?

Dr. WINKENWERDER. Building 40 is the old WRAIR building. This building has been vacant since 1998. In October 04, HQDA approved and signed a EUL (Enhanced Use Lease) on this property. The original plan was to renovate this historic structure to create a modern and efficient multiple purpose building capable of providing the Installation adequate and efficient space to support the overall WRAMC mission. The projected end state was 200,000 square feet of modern office, or lodging space. The renovation cost was estimated at $62 million, all funded by a private developer. This plan was suspended after the official BRAC announcement.

Mr. MILLER. I'm sure you are familiar with the ICD–9 designation. It is my understanding that an ICD–9 designation without any accompanying description medically translates to "an organic psychiatric disorder" and that IED victims who suffer TBI and have obvious brain damage and neurological issues are given this designation.

General KILEY. The International Classification of Diseases-9 (ICD) codes all known diseases. There area wide variety of codes which cover different types of head trauma. These include fractures, intracranial injuries, including concussion, and un-

specified head injuries. The ICD codes which cover head trauma are 800.0–801.9, 803.0–804.9, 850–854.1 and 959.0.

It is not true that an ICD–9 designation without any accompanying description medically translates to "an organic psychiatric disorder" and that IED victims who suffer TBI and have obvious brain damage and neurological issues are given this designation. Those patients' conditions should be coded according to the correct diagnosis. However, the term "organic psychiatric disorders" covers a wide range of conditions. Organic psychiatric disorders are those with demonstrable pathology or etiology, or which arise directly from a medical disorder. Therefore a patient with traumatic brain injury could present as an organic psychiatric condition, and could receive several diagnoses. There are also many separate diagnostic codes for organic psychiatric disorders. For example, organic psychotic conditions are coded as 290–294.

Mr. MILLER. Why would the Army assign a combat wounded TBI patient with a psychiatric disorder? Can we in Congress help you to create a new designation specifically for TBI and one that does not carry the stigma some believe exists with having a "documented psychiatric disorder?"

General KILEY. The primary diagnosis for a combat wounded TBI patient should be one of the ICD–9 codes specific for head trauma. These include fractures, intracranial injuries, including concussion, and unspecified head injuries. However, a patient may also have an organic psychiatric disorder, psychiatric symptoms related to his or her injury, or a separate psychiatric disorder. For example: (1) the head trauma may cause depression directly; (2) they may be very depressed and anxious over their injuries, or (3) they may have symptoms of post-traumatic stress disorder or other anxiety unrelated to their injury.

It is part of the task of the clinician to evaluate, diagnose, and treat both the patient's physical and psychological wounds. In some cases, this evaluation may take time as the clinical picture changes.

As the war has progressed and the extent of the head injuries became more apparent, our clinicians have received more training in evaluation and diagnosis of mild traumatic brain injury. Certainly a mild TBI may be confounded with a psychiatric condition. Part of the current challenge is to ensure that civilian practitioners also receive training how to perform this evaluation and diagnosis.

Mr. MILLER. Is it true that while waiting for the results of a medical board, a soldier cannot have any needed surgeries because a surgery would change his medical status? If so, what are you doing to remedy this obviously problematic regulation?

General KILEY. Clearly, if there is a medical consequence (i.e., a threat to life, limb or survival) to the timing of the surgery, it will be done at the right time regardless of the administrative process. In short, medically-necessary surgeries are always performed even if the Medical Evaluation Board (MEB)/Physical Evaluation Board (PEB) processes must be stopped and subsequently reinitiated.

If the surgery is not going to change the ability to meet retention standards, if it is associated with prolonged rehabilitation, and it will not change one's functional status, then a thorough medical review is performed to see which surgeries are "elective". An "elective surgery" is defined is one that is not life-or-limb threatening nor required for survival.

Elective surgeries are not performed during a MEB during which the fitness for duty determination is begun nor during the PEB which is the sole forum within the Army to determine a Soldier's unfitness for duty as a result of a physical impairment.

The MEB's mission is to determine if the physically-impaired Soldier meets retention standards in accordance with AR 40–501, Standards of Medical Fitness. The MEB process documents the Solder's medical history, current physical status and recommended duty limitations. The Solder's Command prepares a memorandum on the Commander's position on the Soldier's physical abilities to perform his/her primary military occupation specialty (PMOS) or officer specialty (OS). If it is found that the Soldier does not meet retention standards, the MEB findings are then forwarded to the PEB for adjudication.

The PEB's underlying mission is to determine whether the Solder can reasonably perform the duties of his/her primary MOS/OS and grade; and, if not, to determine the present severity of the Soldier's physical or mental disability and rate it accordingly.

If the Soldier non-concurs with the decision of the PEB, the case is forwarded to the Physical Disability Agency (PDA) which may modify the PEB's findings and recommendations if it concludes that the PEB made an error.

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Mr. MILLER. What is currently in Building 40? What are it's future plans and do you believe there is a better way to use this building?

General KILEY. Building 40 is the old WRAIR building. This building has been vacant since 1998. In October 04, HQDA approved and signed a EUL (Enhanced Use Lease) on this property. The original plan was to renovate this historic structure to create a modern and efficient multiple purpose building capable of providing the Installation adequate and efficient space to support the overall WRAMC mission. The projected end state was 200,000 square feet of modern office, or lodging space. The renovation cost was estimated at $62 million, all funded by a private developer. This plan was suspended after the official BRAC announcement.

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