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DEPARTMENT OF DEFENSE APPROPRIATIONS FOR 2010

HEARINGS

BEFORE A

SUBCOMMITTEE OF THE

COMMITTEE ON APPROPRIATIONS

HOUSE OF REPRESENTATIVES

ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

SUBCOMMITTEE ON DEFENSE

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PART 4

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PART 4

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DEPARTMENT OF DEFENSE APPROPRIATIONS FOR 2010

THURSDAY, MAY 21, 2009.

DEFENSE HEALTH PLAN

WITNESSES

ELLEN EMBREY, DEPUTY ASSISTANT SECRETARY OF DEFENSE FOR FORCE HEALTH READINESS AND PROTECTION

LIEUTENANT GENERAL ERIC SCHOOMAKER, ARMY SURGEON GENERAL AND COMMANDER, U.S. ARMY MEDICAL COMMAND

VICE ADMIRAL ADAM M. ROBINSON, SURGEON GENERAL OF THE NAVY

LIEUTENANT GENERAL JAMES G. ROUDEBUSH, SURGEON GENERAL OF THE AIR FORCE

VICE ADMIRAL JOHN M. MATECZUN, COMMANDER, JTF CAPMED

BRIGADIER GENERAL PHILIP VOLPE, DEPUTY COMMANDER, JTF CAPMED

INTRODUCTION

Mr. MURTHA. The committee will come to order.

We appreciate this distinguished panel. Mr. Young is caught in traffic. He has a long ways to travel, but there has been nobody more involved than he and his wife. And I assume all three of you have heard from his wife periodically, all four, if there is something wrong. But I appreciate her dedication to the military and dedication to make sure that people are taken care of, and we appreciate what you folks do.

As I said to you privately, lately when I go to the hospitals there are a lot less patients there, but I hear nothing but compliments. In fact, when I stopped at Landstuhl, two patients were having babies, so those were the only two patients that I saw. So that was a real change from the time I went and they didn't have air-conditioning.

But we appreciate—we think you put the money to good use that we have added, and we compliment you on the fact that you have added money this year, and we don't have to make up for that $1 billion that you were short every year.

But with that, I will ask Ms. Embrey to give her opening statement, and any other statements we will put in the record or let you say a few words, and we will put your full statement in the record.

If you will summarize it for us.

SUMMARY STATEMENT OF MS. EMBREY

Ms. EMBREY. Mr. Chairman, Mr. Dicks, Mr. Moran. I am honored to be today to present the priorities of the Military Health System (MHS) in its Fiscal Year 2010 budget.

America's Armed Forces are our country's greatest strategic assets, and apart from defending the Nation, DOD has no higher priority than to provide the highest quality health care and support to our force and its families. Secretary Gates has said that at the heart of the all-volunteer force is a contract between the United States of America and the men and women who serve, a contract that is legal, social, and sacred.

When young Americans step forward of their own free will to serve, he said, they do so with the expectation that they and their families will be properly taken care of. And we wholeheartedly agree.

Indeed, the MHS has one overarching mission: to provide optimal health services in support of our military's mission anytime, anywhere.

Today, the Military Health System serves more than 9.4 million beneficiaries. In addition to ensuring force health protection and delivering the full range of beneficiary health services, the military health system provides world-class medical education, training and research and support to military and humanitarian assistance operations at home and abroad.

In addition to sustaining a fit and healthy protected force, our goals include achieving the lowest possible rate of death, injury and disease during military operations; delivering superior follow-up care that includes smooth transition to the Department of Veterans Affairs; and to build healthy and resilient individual family and communities and improve access to high-quality, cost-effective care.

I want to especially thank this committee and you, Mr. Chairman, for your leadership and support, financially and otherwise, as we strive to provide the best possible care for our forces and their families. Your support for them and especially for our combat wounded, ill, and injured is greatly appreciated.

While there is always much more to be done, I believe we have made significant progress towards our goals. I have provided this information in some detail in my formal statement, which is submitted for the record.

I briefly would like to discuss a broad summary of the Unified Medical Budget request for 2010. DoD's total budget request for health care in 2010 is $47.4 billion. This includes the Defense Health Program; wounded, ill and injured care and rehabilitation; military personnel; military construction and Medicare-eligible retiree health care.

The largest portion of the budget request, $27.9 billion, is requested for the Defense Health Program, which includes $27 billion for operations and maintenance, $300 million for procurement, $600 million for military-relevant medical research and development.

For military personnel, the budget request includes $7.7 billion to support more than 84,000 military personnel who provide health-care services to our forces around the world, including those

involved in air or medical evacuation, shipboard and undersea medicine, and global humanitarian assistance and response.

Funding for military construction includes $1 billion for 23 medical construction projects in 16 locations, including two of the Department's highest construction priorities: Phase 1 of a hospital replacement project in Guam, and Phase 1 of a new ambulatory air care center at Lackland Air Force Base, Texas.

The estimated normal costs for the Medicare-eligible retiree health care fund in the budget request is 10.8 billion, which includes payments for care and Military Treatment Facilities (MTFs), to provide health-care providers, and to reimburse the services for military labor used in the provision of health-care services.

For wounded, ill, and injured service members, the budget request includes $3.3 billion for enhanced care, new infrastructure and research efforts to mitigate the effects of traumatic stress and traumatic brain injuries.

The Secretary funded all Fiscal Year 2010 medical requirements identified by the Service medical departments and the TRICARE Management Activity. It is important to note that the budget does not include any benefit reform savings, and beneficiary enrollment fees and copays remain unchanged.

MTF efficiency savings, previously assumed, have been fully restored to the Services medical departments and previously programmed mil-to-civ conversions are being restored in accordance with the Fiscal Year 2008 National Defense Authorization Act (NDAA). Pursuant to this restoral, the Services have submitted memorandums of agreement to restore 5,443 billets in Fiscal Year 2010.

Mr. Chairman, the MHS is doing the very best we can for the men and women who give everything they have for each one of us. We can never fully repay them for their sacrifices on our behalf. We can and will continue to do all that we can to protect and strengthen their health, heal their wounds, and honor their courage and commitment to our Nation.

I look forward to answering your questions.

[The statement of Ms. Embrey follows:]

STATEMENT BY

MS. ELLEN EMBREY

PERFORMING THE DUTIES OF THE ASSISTANT SECRETARY OF DEFENSE
FOR HEALTH AFFAIRS

REGARDING

THE MILITARY HEALTH SYSTEM: BUDGET OVERVIEW

BEFORE THE

HOUSE COMMITTEE ON APPROPRIATIONS

SUBCOMMITTEE ON DEFENSE

MAY 21, 2009

FOR OFFICIAL USE ONLY
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Mr. Chairman, Members of the Committee, thank you for the opportunity to discuss the priorities of the Military Health System (MHS) and its budget for Fiscal Year 2010. We are pleased to be here.

The men and women of America's Armed Forces are our country's greatest strategic asset. Apart from defending the Nation, the Department has no higher priority than to provide the highest quality care and support to our forces and their families.

As Secretary Gates has said, "At the heart of the all-volunteer force is a contract between the United States of America and the men and women who serve ... A contract that is ... legal, social, and sacred."

"When young Americans step forward of their own free will to serve," he said, "they do so with the expectation that they, and their families, will be properly taken care of ..."[1]

MHS Mission and Strategic Plan

Mr. Chairman, that commitment, which dates back to the Civil War, is engraved in granite on the Lincoln Memorial, along with Lincoln's pledge to care for those who "have borne the battle." We take it seriously. And it encompasses not only the wounded, but all who serve.

Indeed, the MHS has one overarching mission: to provide optimal health services in support of our Nation's military mission – any time, anywhere.

Today, the MHS serves 9.4 million beneficiaries, including retired military personnel and their families.

In addition to force health protection and family support, the MHS provides humanitarian assistance at home and around the world, and supports world class medical education, training and research.

Our strategic plan, developed in concert with the Surgeons General, and the Joint Staff – supports all of these mission components. It also recognizes the outcomes the American people expect from their investment in military medicine.

In addition to a fit, healthy and protected force, our goals include the lowest possible rate of death, injury and disease during military operations; superior follow-up care that includes transition to the Department of Veterans Affairs (VA); healthy and resilient

[1] From speech delivered by Secretary Gates to the Wounded Warriors Family Summit, *Monday, October 20, 2008, Washington, D.C.*

individuals, families and communities; and the highest quality care at the lowest possible cost to the taxpayer.

We appreciate the support the Congress, and especially this Committee, has provided to help us provide the very best health care for our forces and their families, and in particular for the wounded ill and injured. While there is always much more that must be done, I believe we have made significant progress toward each of our goals, and I would like to tell you where we are, and what we have accomplished.

A Fit, Healthy and Protected Force

Mr. Chairman, contrary to common assumption, the single largest contributor to loss of forces is not combat, but disease and non-battle injuries. To keep our forces fit and ready, health assessments are performed on accession, annually, and each Service member prior to deployment, following deployment, and again 90 to 180 days after a Service member has returned to home station.

These health assessments not only provide a comprehensive picture of personal health, but highlight areas of concern, provide an opportunity for additional education, evaluation, or treatment, if necessary; and give commanders a view of force readiness down to the individual level.

Vaccinations are another way to protect force health, particularly against serious illness and disease. Smallpox and anthrax, for example, continue to be viewed as real threats, as well as potential bioterrorism weapons that could be used against our forces. After the Food and Drug Administration (FDA) confirmed the Anthrax Vaccine Absorbed (ABA) safe and effective for individuals at high risk, the Department restarted the anthrax vaccination program. We also implemented FDA-approved changes for a reduced number of doses, which will lower both the number of needed inoculations and the cost.

To date, Department of Defense (DoD) vaccines have protected almost 2.2 million Service members against anthrax, and more than 1.75 million against the smallpox virus. These vaccination programs have an unparalleled safety record, and are setting the standard for the civilian sector.

The Department continues to lead the world in disease surveillance, education and rapid eradication of global epidemics including influenza. Indeed, DoD influenza surveillance assets offer a global perspective of emerging infectious diseases that not only impact the Department but overall national security – and national health.

In the recent H1N1 outbreak, for example, Defense surveillance assets were responsible for identifying the first two cases in California and Texas, and we continue to be actively engaged with other federal agencies to ensure that the Department's response is

consistent with national efforts and guidelines. In addition, the Department has established stockpiles of medications and other materials to ensure its ability to meet mission requirements anywhere, any time.

As a result of these and other measures, the Disease, Non Battle Injury (DNBI) rates for Operation Enduring Freedom and Operation Iraqi Freedom are the lowest ever reported – 5 percent and 4 percent respectively for Operation Enduring Freedom and Operation Iraqi Freedom, as compared with 5.6 percent in Operation Desert Shield/Desert Storm, 7.1 percent in Operation Joint Endeavor (Bosnia), and 8.1 percent in Operation Joint Guardian (Kosovo).

Thanks to the dedication of the men and women who rapidly reach, evacuate, and treat the wounded, the Death to Wounded Ratio has also dropped. In the past, battlefield medicine was a tricky business. Reaching the wounded warfighter in time to impact his chances of recovery was uncertain at best, and most did not survive the process. Today, every U.S. soldier, sailor, airman and Marine – regardless of location– can rely on state-of-the-art treatment and equipment within the first hour of injury. As a result, the battlefield survival rate now stands at 97 percent, as compared with 75 percent in World War II and 81 percent in Vietnam.

Using aeromedical intensive care units (Critical Care Air Transport Teams) and the latest technology, US medics have significantly reduced the amount of time it takes to evacuate the wounded, moving personnel from forward deployed surgical units on the battlefield to the highest quality care in the United States in as little as 48 hours.

With regard to environmental health protection, Service Occupational and Environmental Health (OEH) specialists routinely monitor air, soil, water and other aspects of the environment in theater to detect and prevent hazardous exposures before they occur. To date, more than 11,000 environmental samples from Iraq and Afghanistan have been collected and analyzed, and new samples are constantly reassessed. Findings to date indicate a low risk to our forces for any long-term health effects from environmental exposures.

In addition, through a multinational agreement (Chemical Biological Radiological Memorandum of Understanding) with Australia, Canada, and the United Kingdom, the MHS is now also sharing this data with our allies to increase their situational awareness of OEH threats in deployed locations, reduce redundancy and duplication of effort, and strengthen their ability to protect deployed forces.

Superior Follow-up Care, including Wounded Warrior and Transitional Care

In addition to prevention, follow-up care is also paramount, particularly for Service members with psychological health needs or traumatic brain injuries (TBI).

The Department is committed to ensuring that every wounded or injured Service member, especially those with psychological health or traumatic brain injuries, receives consistently excellent care across the entire continuum of care – from prevention, protection and diagnosis to treatment, recovery and transition from the DoD to the VA.

In 2007, the Department embarked upon a comprehensive plan to transform our system of care for psychological health and TBI. The plan was based on seven strategic goals:

- Building a strong culture of health leadership and advocacy;
- Improving the quality and consistency of care, across the country and around the world;
- Creating easy and timely access to care, regardless of patient location;
- Strengthening individual and family health, wellness, and resilience;
- Ensuring early identification and intervention for individual conditions and concerns;
- Eliminating gaps in care for patients in transition; and
- Building a network in which to leverage and/or direct medical and cross-functional research, including new and innovative treatments, technologies, and alternative medicine techniques.

Throughout 2008, we made significant progress toward achieving each of them.

We established the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) to lead the effort to develop excellence in prevention, diagnosis, practice standards, training, outreach, and direct care for those with psychological health and TBI conditions, and to provide the nexus for research planning and monitoring.

Since its inception, the DCoE has focused its efforts on the development and continuous improvement of a patient-centered network dedicated to all issues related to psychological health and TBI. Approximately $58.2 million was obligated in FY 2008 to establish the DCoE and supporting networks.

To improve the quality and consistency of mental health care, DoD, in full partnership with VA, continue to develop and update clinical standards and guidelines, share lessons learned and best practices, and establish evidence-based care as the enterprise standard for acute stress disorder, posttraumatic stress disorder (PTSD), depression, and substance use disorders. Over the past year, the Clinical Practice Guideline for depression has been revised, and the existing "Guideline" on PTSD is being updated.

A new evaluation tool, the Military Acute Concussion Evaluation tool, was introduced in USCENTCOM to assess the likelihood of mild TBI. Clinical guidelines for its use in operational settings were also published. TBI certification programs in military medical

treatment facilities were established and standardized protocols for determining if a member should return to full duty or to the United States for further treatment were implemented.

The Department also joined with the VA to implement a standardized training curriculum on evidence-based psychotherapy for PTSD, and trained more than 2,700 providers in evidenced-based treatments for PTSD and TBI.

To recognize the challenging diagnoses and unique requirements that can accompany psychological health and TBI wounds, the DCoE worked with the Intrepid Fallen Heroes Foundation to support the design of a new facility, the National Intrepid Center of Excellence (NICoE).

The new Center will provide an interdisciplinary team of clinicians and scientists dedicated to a holistic evaluation and treatment approach for Service members with mental health and TBI conditions, and provide advanced diagnostics and comprehensive treatment planning for those whose mental health conditions or traumatic brain injuries are not responding to traditional methods. When the new Center is complete, we expect that there will be no finer care available in the country, or perhaps the world, for wounded warriors with these conditions.

In a similar manner, the DCoE, the National Institutes of Health (NIH) Office of Research on Women's Health (ORWH), and VA, are working to identify and explore the existing science on trauma spectrum disorders (such as PTSD and TBI) related to military deployment, and the DoD and VA are working together to foster partnerships between suicide prevention experts in government, medicine, and communities.

To improve access to mental health care, regardless of location, we provided funds to the Military Departments to hire additional mental health and other specialty providers, and implemented a policy that requires first appointment access within seven days for mental health concerns.

Approximately $32.6 million was obligated to improve the quality and consistency of mental health and TBI care in FY 2008.

Under DCoE, the Department also initiated a telehealth network for clinical care, medication monitoring, support and follow-up for individuals with TBI or stable mental health conditions, including a number of Web-based applications that deliver real-time mental health services, and telehealth-delivered services – especially important to those in rural and underserved locations – to improve and augment access for those concerned about stigma. A new anti-stigma, pro-resilience campaign entitled "Real Warriors" will be launched nationwide this month. Approximately, $227 million was obligated to improve access to mental health and TBI care in FY 2008.

The Department is working with its federal and private sector partners to eliminate gaps in care as patients transition through the various health systems, or to different duty locations.

For example, we recently established an assisted living pilot program in Johnstown, Pennsylvania to improve functionality and independent living after TBI, and to provide valuable insight for replication in other areas where appropriate. We helped establish the Federal Care Coordination program and stood up a TBI care coordination system to integrate Federal, State and local resources.

A new program, *In Transition*, will be launched early June to maintain the continuity of mental health care for Service members transitioning between military treatment facilities and affiliated healthcare systems such as TRICARE and the VA.

The *In Transition* program proactively facilitates a Service member's transfer from one healthcare system to another, and bridges potential gaps in health service, by assigning each Service member to a Transitional Support Facilitator. The facilitators, licensed behavioral health clinicians who specialize in coaching, remain with the Service member (with a 24/7 network back-up) until the transition to a new provider is complete.

Two studies have been designed to increase the basic knowledge of issues important to the psychological health of Service members. The first, which is currently underway, will identify the various factors that contribute to a mental health professional's decision to either enlist or leave military service. This study will inform the development of policies to successfully mitigate loses in active duty providers. The second is a study to improve deployment-related primary care assessments of PTSD and mental health conditions. Preliminary approval for this study has already been received.

Approximately $6.1 million was obligated to help eliminate transitional gaps in care in FY 2008.

To ensure early identification and intervention of mental health and TBI issues, the Department enhanced post-deployment assessments and reassessments, and in July 2008, also began conducting baseline neuro-cognitive assessments on Active and Reserve personnel prior to deployment.

To facilitate the continuity of care for veterans and Service members, we implemented a common DoD/VA post-deployment TBI assessment protocol, which will allow clinicians across the enterprise to collect and access the same information.

We also designed and implemented the Mental Health Self Assessment Program, which offers Service personnel and their families the opportunity to identify their own symptoms and access assistance before a problem becomes serious. The self-assessments

address PTSD, depression, generalized anxiety disorder, alcohol use, and bipolar disorder, and may be taken anonymously online, over the phone, or at special events held at installations. After completing a self-assessment, individuals receive referral information that includes services provided by TRICARE, Military OneSource, and VA Vet Centers. More than 37,000 military and family members have accessed the anonymous web- and phone-based mental self-assessment program since it was introduced in 2006.

Approximately $59.9 million was obligated for early identification and intervention of mental health issues in FY 2008.

Improving care and outcomes associated with traumatic brain injuries and PTSD requires a commitment to research in funding breakthrough prevention, detection, diagnostic and treatment modalities.

The Department is building a network in which to leverage and/or direct medical and cross-functional research that will enhance outcomes of psychological health and TBI patients.

For example, at the request of the Service Vice Chiefs of Staff and the Surgeons General, the MHS will sponsor an expedited, intramural (DoD facilities), multi-center randomized clinical trial of hyperbaric oxygen (HBO2) therapy in chronic and mild-to-moderate TBI.

The study, which is in the advanced development phase, will answer important questions regarding efficacy in this population, including whether HBO2 therapy should be provided to service members when indicated. Currently, the study is awaiting approval by the Food and Drug Administration (FDA).

We also participated in blast mitigation studies through and with the United States Army Medical Research and Materiel Command, and are working with external groups, such research universities as the Massachusetts Institute of Technology and Virginia Tech, and the National Football League, to explore new ways to mitigate the effect of blast and blunt trauma on our populations.

Together with ongoing research activities supported by the Joint Improvised Explosive Device Defeat Organization, and the Institute of Soldier Nanotechnology, we have learned a great deal about how to keep our Service members safe before, during, and after physically traumatic events.

In addition, in FY 2007 to 2008, the Department executed more than $446.5 million in Research Development, Testing, and Evaluations appropriations to further science in the areas of TBI and psychological health, including:

- Basic research directed toward gaining greater understanding of the brain and how it works;
- Applied research to provide more in-depth knowledge of TBI and psychological health prevention, treatment, diagnosis, and recovery techniques;
- Advanced technology development to create new tools, technologies, pharmaceuticals and devices, and treatment protocols to improve prevention, diagnosis, treatment and recovery;
- Clinical trials to demonstrate the safety, toxicity, and efficacy of candidate pharmaceuticals, prototype medical devices, or protocols benefiting patients diagnosed with TBI or mental health conditions; and
- Complementary and alternative medicine approaches to the treatment of PTSD and TBI, such as yoga or acupuncture.

Of course, despite the significant gains that have been accomplished, more work remains. We will continue to work with our partners to eliminate gaps; ensure the quality and consistency of care; meet the needs of Reserve forces, especially those in underserved areas; improve efforts to recruit and retain high quality mental health providers; reduce the rate of suicide, improve our ability to share and exchange data with the VA; and continually seek new ways to expand our knowledge and improve our ability to care for Service members, veterans and families.

Healthy and Resilient Individuals, Families and Communities

In addition to the measures cited above, the Department is implementing a range of policies to strengthen resilience to psychological stress and traumatic events and create healthy and resilient individuals, families and communities. These policies include removing or mitigating organizational risk factors, bolstering resilience characteristics in our Service personnel, and strengthening family wellness.

To reduce the stigma associated with mental health issues, we mounted a pro-resilience and anti-stigma campaign, and established a number of effective outreach and educational initiatives to increase "psychological fitness" through resilience building programs. We also eliminated the requirement to divulge combat-related mental health history on security clearance forms.

With the assistance of the Service Vice Chiefs, the MHS began development of the *"Real Warriors, Real Battles, Real Strength"* campaign, mentioned earlier[2], which stresses the impact of war on Service personnel, and emphasizes that seeking help for psychological concerns is a sign of strength. Supporting initiatives have been implemented across the Services to target their individual cultures.

[2] Page 6.

The MHS also helped develop educational tools to help families, especially children, cope with deployed parents or loved ones.

One exciting initiative in this area is "SimCoach," a program currently under development that will allow warriors and families to electronically query top experts in psychological health and TBI, and discuss their injuries with their peers.

Specifically targeted to the Armed Forces younger population, SimCoach will combine the best of simulation, advanced gaming technology, artificial intelligence, and avatar-based computer interaction to encourage warriors and their families to initiate treatment or access educational resources, and to reduce the stigma associated with seeking psychological health care.

Approximately $32.2 million was obligated to strengthen resilience to psychological stress and traumatic events, and to reduce the stigma associated with mental health issues in FY 2008.

The Department has also initiated a number of programs that address the adverse effects of tobacco, alcohol, obesity, and inactive lifestyles on health.

For example, the "Healthy Lifestyles Initiatives" are evidence-based projects designed to reduce tobacco use, obesity, and alcohol abuse among both active and non active duty beneficiaries.

"Quitline," is a 24/7 telephone-based tobacco cessation counseling program that offers web-based support, educational program, and pharmacotherapy. Both preliminary and final demonstration study results indicated increases in cessation rates at the end of each quarterly milestone.

The Program for Alcohol, Training, Research and Online Learning, or "PATROL," is a promising web-based, alcohol abuse pilot project that targeted young, active duty Service members on eight military installations. One month after rollout, participants in one study reported a significant reduction in heavy and binge drinking – results that were sustained in a six-month follow-up.

To help determine how best to encourage MHS beneficiaries to obtain preventive services, the TRICARE Management Activity (TMA) held a summit with experts from both the civilian and government sectors in early 2008. A variety of different pay for performance/prevention initiatives was discussed, along with strategies to determine their overall effectiveness. The National Defense Authorization Act (NDAA) for Fiscal Year 2009 codified these efforts to improve the health status of active duty members, retirees, and their family members.

- We are within 90 days of fully implementing the change to the TRICARE benefit by removing potential financial barriers to receiving certain preventive services and waiving all copayments for preventive services, including colorectal, breast, cervical, and prostate cancer screening, immunizations and visits for children less than six years of age. This also ensures that non-Medicare eligible beneficiaries pay nothing for preventive services during a year, even if the annual deductible amount has not been met.

- TMA has designed a demonstration project to assess the effects of providing incentives, along with wellness programs and care management, on healthy behaviors and lifestyle practices among non-Medicare eligible retired beneficiaries and their family members.

  This project will be conducted in three geographic area of the United States for non-Medicare eligible, TRICARE Prime retirees. Participants will receive a self-reported health risk assessment (HRA), and physiological and biometric measures, that include assessment of blood pressure, glucose level, lipids, nicotine use and weight determination. As an incentive to full participation in this project, enrollees will be eligible to receive a waiver of 50 percent of their annual TRICARE Prime enrollment fee (a $230/family annual savings).

  Information obtained from the project will be used to provide targeted interventions that help prevent, manage and improve any chronic conditions identified in the enrollee throughout the three year demonstration period. Participants will retake the HRA annually to reassess their health behaviors and outcomes.

- In order to establish a comprehensive Smoking Cessation Program under TRICARE that builds upon initiatives that had already begun, and makes available, at no cost to the beneficiary, pharmaceuticals used for smoking cessation through the mail-order pharmacy (TMOP) program, TMA has drafted a change in regulations to allow TRICARE to dispense over the counter medications from the TMOP, and to waive copayments for these medications. In addition, TMA is working diligently to contract for a 24/7/365 quit line that will be accessible for counseling world-wide, and anticipates this will be operational by the fall of 2009.

  TMA is obligating a demonstration project, through December 31, 2011, to evaluate the efficacy of providing an annual allowance to members of the Armed Forces to determine if this would increase their use of preventive health services for themselves and their family members. In this demonstration up to 1,500 members from each Service are eligible to participate. Half of the Services members are single; half have family members. Each Service will pay a preventive health services allowance of $500 per year to single members, and $1,000 per year to members with families.

AHLTA, DoD's standard global electronic health record and clinical data repository, is also enhancing efforts to build healthy communities by creating a life-long, computer-based patient record and health information to support the entire continuum of health care.

Since the Departments of Defense and Veterans Affairs share a significant amount of health information for patient being treated by both departments, AHLTA also enhances continuity of care, especially for those in transition.

To keep pace with evolving requirements and advances in technology, AHLTA is being deployed in phases or "blocks" of increasing functionality. Block 1, deployed worldwide in December 2006, provides the foundation of system performance through a graphical user interface for real-time ambulatory encounter documentation. Through AHLTA, the electronic medical records of MHS beneficiaries are retrievable at the point of care, whether the care is delivered at one of more than 880 fixed military medical and dental facilities, on board select ships, or in a deployed medical facility. On average, AHLTA processes over 135,000 encounters per workday. As of May 1, 2009, AHLTA had processed and stored over 107 million outpatient encounters.

AHLTA Theater (AHLTA-T) is operational in Iraq, Kuwait and Afghanistan. AHLTA-T collects outpatient encounters which are sent to the Theater Medical Data Store (TMDS) and AHLTA Clinical Data Repository for use in AHLTA worldwide. As of March 31, 2009, 2.2 million theater outpatient clinical encounters had been documented and transferred to AHLTA. Both DoD and VA health care providers use the Bidirectional Health Information Exchange to access theater medical information.

Currently, DoD and VA share a significant amount of health information for common patients including pharmacy data, allergy data, laboratory results, radiology reports, provider notes and procedures, problem lists, vital signs, family and social history, and digital radiology images at some sites. The Departments expect to achieve electronic health record interoperability by September 30, 2009.

Additional improvements and enhancements of AHLTA are planned for the fourth quarter of FY 2009. Key features will include automated clinical practice guidelines; a faster clinical encounter documentation process; electronic signature capabilities, so that patients can sign consents and other forms electronically; health assessment management tools, to allow patients to self-report patient history information online for storage in AHLTA; and multi-site user account access for mobile providers.

AHLTA Block 2 integrates robust dental charting and optometry support capabilities. The MHS is also developing an enterprise-wide document and image management capability, targeted for the 2nd Quarter of FY 2010 that will incorporate non-text information into AHLTA.

Currently, AHLTA's inpatient documentation capability is operational at many of DoD's largest military treatment facilities (MTF), and covers more than 50 percent of DoD's inpatient workload. Within one year, DoD plans to deploy to additional inpatient sites which will cover approximately 90 percent of DoD inpatient beds.

The Department will continue to enhance AHLTA's performance, reliability and usability and work toward our primary goal of creating a virtual lifetime electronic health record to efficiently support the processes and workflow needs of end-users.

Highest Quality and Cost Effective Care

Our final goal – providing the highest quality care and cost effective care at the lowest possible cost to the taxpayer – is every bit as important as the others I've just outlined. Military and civilian leaders, as well as the American people, rightly expect us to simultaneously provide outstanding health care to beneficiaries and efficiently manage the cost of care. While it is impossible to include all of the actions we have taken to reduce the cost of care, I can provide a good overview of the most significant.

BRAC recommendations have improved the use and distribution of military medical facilities nationwide by reducing unnecessary infrastructure, consolidating medical facilities, and providing more robust platforms for Graduate Medical Education.

Other ways we are addressing cost effectiveness include:

- Implementation of Federal Ceiling Pricing of retail pharmaceuticals. This regulation requires manufacturers to refund a portion of the cost pharmaceuticals dispensed in the retail setting. Discounts are approximately 24 percent of the non-Federal average manufacturers' price. The Department will begin receiving these rebates under this provision beginning May 26, 2009.

- Obtaining significant discounts for pharmaceuticals at MTFs and mail-order venue.

- Effective Contracting Strategies. We have reduced administrative costs through effective TRICARE contracting strategies. Efforts to further enhance the next generation of the TRICARE contracts are well underway.

- Additional increases in VA and DoD sharing of facilities, capabilities, and joint procurements.

- Introduction of new prime vendor agreements that will lower the costs of MTF medical and surgical supplies. The MHS has aggressively negotiated preferential pricing with medical-supply vendors across the country, and we project a cost avoidance of $28.3 million.

Using our strategic planning tool, the Balanced Scorecard, we are identifying the most critical mission activities, and then applying the continuous process improvement methodology to create a data-driven, decision-making culture for process improvement. The Service Surgeons General have aggressively incorporated this methodology into their business operations, and we are already witnessing positive results. We have also hired a nationally recognized expert in Lean Six Sigma to help facilitate integration of the National Capital Area and San Antonio under our BRAC work.

In fall 2006, based on recommendations from local-level MHS leaders, we began the Innovations Investment Program, to identify the best practices in place at select MTFs, or best practices utilized by private-sector health care firms and introduce them to DoD on a global scale. The intent of this program is to accelerate the use of best practices, using a joint-service, interdisciplinary team of experts to evaluate, validate and then implement proven approaches to better health care delivery. We are currently evaluating three initiatives under this program.

The 2009-2011 VA/DoD Joint Strategic Plan will improve the quality, efficiency, and effectiveness of benefits and services to veterans, service members, military retirees, and their families. For example, 113 VA medical facilities partner with 137 MTFs for a total of 323 direct sharing agreements in the delivery of 158 unique services. In FY 2008, VA and DoD joint national contracts for pharmaceuticals avoided approximately $115 million in costs.

Another example is the DoD/FDA Shelf Life Extension Program (SLEP) for pharmaceuticals. The VA used the program to extend the expiration dates on products in its Emergency Pharmacy Service program at estimated cost avoidance to VA of more than $214 million in FY 2008.

Beneficiary Satisfaction

Mr. Chairman, we studiously seek feedback from our MHS beneficiaries, and I'm pleased to say that they continue to give the TRICARE program solid marks in satisfaction in all of our key inpatient, outpatient and population-based surveys. These surveys are based on the Consumer Assessment of Healthcare Providers and System surveys to enable us to compare our results to U.S. civilian health care surveys.

We fared well on the 2007 American Customer Satisfaction Index survey produced by the University of Michigan and other groups who rate satisfaction with the federal government. Participants rated satisfaction with inpatient care at DoD medical centers at 89 percent, the second highest satisfaction score by federal agencies/departments surveyed in the benefits-recipients segment.

MHS users' overall satisfaction with the TRICARE health plan rose from 44 percent in 2001 to 59 percent in 2008. Considering that the survey covers the entire period the Nation has been at war, with all of its accompanying stress that is a remarkable achievement.

On the monthly TRICARE Outpatient Satisfaction Survey, the six key metrics of outpatient satisfaction all increased slightly, while a survey of MHS beneficiaries' overall satisfaction with providers was 85 percent, higher than the civilian benchmark at 81 percent.

Other survey results, such as the one for the TRICARE Mail Order Pharmacy (TMOP) show that the military community has been consistently satisfied with the delivery of health care services through our partners, and we will continue to ensure that these private sector providers are rewarded for the outstanding care they deliver to our beneficiaries.

In addition to soliciting general beneficiary feedback regarding use and satisfaction with TRICARE, our surveys are also used to assess specific program performance.

For example, we surveyed National Guard and Reserve members and their families and compared those who purchased the TRICARE Reserve Select (TRS) benefit to those who did not.

We found that TRS enrollees reported the same or better access and satisfaction compared to their Selected Reserve counterparts who use their other health insurance. Specifically, TRS enrollees were more likely to report quick access to care, good communication with providers, and higher levels of satisfaction with overall health plans and health care.

In addition, TRS enrollees who use the TRICARE Standard/Extra benefits option did not differ from regular component Standard and Extra users on most aspects of access and satisfaction.

Despite these positive survey results, the MHS leadership recognizes the continuing challenge of providing timely, consistent access to care at our installations. This is a high priority for the MHS in the year ahead.

Mr. Chairman, these are some of the more significant accomplishments the Military Health System has achieved with the resources already provided by Congress and the American people. I'd like to now highlight the key components of our budget request for FY 2010.

UNIFIED MEDICAL BUDGET REQUEST FOR FY2010

The Military Health System (MHS) is uniquely different from any other health care system. The MHS delivers preventive medicine, disease management, treatment, rehabilitation, public health, dental care, medical research, and a host of other services too numerous to list, in virtually every possible environmental condition around the globe. For many of these services, there is no civilian comparison.

The MHS works to enhance its deployable medical capability, the medical readiness of the force, and homeland defense by effectively focusing on products, processes, and services. We strive to anticipate the needs of Commanders and Service members and respond with innovative solutions, new opportunities, and high performance services and products. We have adopted a renewed emphasis on research and development infrastructure to rapidly design, develop, and deploy solutions for the warfighter, and especially to ensure that wounded warriors receive the best possible care, treatment, and support. Achieving these goals is challenging due to stress on the medical force as a result of continuing operations, a growing and aging patient population, and higher than anticipated medical cost growth.

The MHS augments care at military treatment facilities with the TRICARE health benefit. TRICARE provides eligible beneficiaries with access to a global network of private-sector healthcare providers, hospitals, and pharmacies. The MHS provides a world-class health benefit at a reasonable cost to the Department. We continue to see demand for TRICARE benefits grow, with a commensurate increase in the associated costs.

The Defense Health Program (DHP), the appropriation that supports the MHS, is under mounting financial pressure. As a result of the benefits added but Congress and beneficiaries returning to TRICARE as their primary benefit, the DoD health care financing requirement has more than doubled since 2001 – from $19 billion to $44 billion in FY 2009.

The majority of DoD health spending supports health care benefits for military retirees and their dependents, not the active force. We project that up to 65 percent of DoD health care spending will be going toward retirees in FY 2011 – up from 45 percent in FY 2001. As civilian employers' health costs are shifted to their military retiree employees, TRICARE is seen as a better, less costly option and they are likely to drop their employer's insurance. By 2015, at the current trend, DoD health care costs are projected to reach $64 billion, or 11.3 percent of the DoD budget, versus 8 percent today.

Despite these fiscal challenges, the FY 2010 budget request provides realistic funding for projected health care requirements. I would like to highlight several key attributes of this budget submission. First, the budget does not include any benefit reform savings, and beneficiary enrollment fees and co-pays remain unchanged. Second, Military Treatment Facility efficiency savings previously assumed have been fully restored to the Services Medical Departments. Finally, previously programmed military–to-civilian conversions are being restored in accordance with the provisions of the FY 2008 NDAA. Pursuant to this restoral, the services have submitted memorandums of agreement to restore 5,443 billets in FY 2010.

The FY 2010 Budget Submission reflects several areas of emphasis. While we have achieved outstanding success in managing injuries on the battlefield and preparing wounded Service members to live productive lives, much work remains to be done to help America's injured warriors return to full duty or to move on to the next phase of their lives.

The MHS will continue its efforts to improve diagnosis and provide compassionate care for traumatic brain injury (TBI) and post-traumatic stress disorder (PTSD), illnesses that have presented significant challenges in providing responsive, coordinated, patient-centered healthcare. The FY 2010 budget request includes funding to support organizations, like the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury and Defense Vision Center of Excellence, to overcome these challenges.

The Unified Medical Budget, the Department's total request for health care in FY 2010, is $47.4 billion. This includes the Defense Health Program; Wounded, Ill and Injured Care and Rehabilitation; Military Personnel, Military Construction, and Medicare-Eligible Retiree Healthcare.

Defense Health Program

The largest portion of the request, or $27.9 billion, will be used to fund the Defense Health Program (DHP), which is comprised of Operation & Maintenance (O&M), Procurement and Research, Development, Test & Evaluation (RDT&E).

- $27 billion is for O&M, which funds most day-to-day operational costs of healthcare activities;
- The DHP budget also includes $0.3 billion for equipment and systems procurement; and $0.6 billion for military relevant medical research, double that of last year's request, to advance the state of medical science, and to develop world class medical products and capabilities to improve survivability and quality-of-life.

It is worth noting that we are requesting an additional $0.4 billion (included in the $0.6 billion above) in medical RDT&E funding to be used to advance the state of medical science, technologies, and practices in those areas of most pressing need and relevance to today's battlefield experience. Early emphasis will be on psychological health, TBI, prosthetics and rehabilitation, restorative eye-care, poly-trauma and supporting medical information and training systems. Research projects will be selected for funding using a competitive process where DoD researchers, industry and academia will submit proposals for specific research and development projects. By using this process we believe the most promising and expedient medical solutions will be developed and fielded for the Joint Force.

Military Personnel and Construction

For Military Personnel, the Unified Medical Budget includes $7.7 billion to support the more than 84,000 military personnel who provide healthcare services in military theaters of operations and fixed health care facilities around the world. These services include medical and dental care, global aeromedical evacuation, shipboard and undersea medicine, and global humanitarian assistance and response.

Funding for medical Military Construction includes $1.0 billion for 23 medical construction projects in 16 locations, including two of the Department's highest construction priorities: Phase 1 of a Hospital Replacement Project in Guam, and Phase 1 of a new Ambulatory Care Center at Lackland Air Force Base, Texas.

DoD Medicare-Eligible Retiree Health Care Fund

The estimated normal cost of the Medicare-Eligible Retiree Health Care Fund in FY 2010 is $10.8 billion. This funding includes payments for care in military treatment facilities, to private health care providers, and to reimburse the Services for military labor used in the provision of health care services.

Wounded Ill and Injured

The DoD has, and will continue to provide, world class health and rehabilitative care for all Service members who are wounded, ill or injured as a result of their service to our country.

The FY 2010 DoD budget request includes $3.3 billion for enhanced care for wounded, ill or injured Service members, new infrastructure to house and care for them, and research efforts to mitigate the effect of psychological health and traumatic brain injuries.

The DHP budget request includes $1.7 billion of the total DoD request. A major focus of the budget for FY 2010 is to ensure that all medical requirements associated with wounded warrior health care, to include TBI and psychological health are addressed.

The Service medical departments, along with the TRICARE Management Activity, presented requirements and the Secretary fully funded all medical requirements requested. No additional requirements are anticipated at this time.

CONCLUSION

Mr. Chairman, I began my statement with a quote from the Secretary of Defense that epitomizes the Military Health System's commitment to the health and well-being of our forces and their families. I'd like to end by quoting one of the many wounded warriors who epitomize the will and fighting spirit of the men and women who so proudly and selflessly defend the freedoms we enjoy every day.

Lieutenant Jason Redman is a Navy SEAL who was part of an elite Special Ops team in Iraq last year when he took rounds from a machine-gun in his face and arm. Jason posted a bright orange sign on the door of his hospital room at Bethesda National Naval Medical Center. It read:

"Attention to all who enter here. If you are coming into this room with sorrow, or to feel sorry for my wounds, go elsewhere. The wounds I received I got in a job I love, doing it for people I love, supporting the freedom of a country I deeply love.

"I am incredibly tough and will make a full recovery. What is full? That is the absolute utmost, physically, my body has the ability to recover. Then I will push that about 20 percent further through sheer mental tenacity."

"This room you are about to enter," he wrote, "is a room of fun, optimism, and intense rapid regrowth. If you are not prepared for that, go elsewhere."

Mr. Chairman that is what the Military Health System is all about – Doing the very best we can for these men and women who give everything they have for every one of us. We can never fully repay them for the sacrifices they make for our country and our future as a free people, but we can and will continue to do everything we can to heal their wounds and honor their courage and commitment to the country we all love.
Thank you again, Mr. Chairman, for the opportunity to be with you today. I look forward to your questions.

[END]

SUMMARY STATEMENT OF GENERAL SCHOOMAKER

General SCHOOMAKER. Mr. Chairman, Ranking Member Young, distinguished members of the Defense Subcommittee, thank you for the opportunity to discuss Army medicine and the Defense health program.

Army medicine in the past few years, due in no small measure to this committee and your leadership, sirs, and in general this year, is well funded in fiscal year 2010.

The President has requested sufficient funding to support the growth in Army end strength, wounded, ill, and injured care, traumatic brain injury and psychological health programs, and specialized casualty care.

The medical treatment facility efficiency wedge, as it was called, was fully restored and, as Ms. Embrey has commented, all military-to-civilian conversions were reversed. We received partial rebasing for the workload increases we have achieved since 2003, but expect the balance to come in this year of execution.

Facilities sustainment is funded at 100 percent. We have added significant funding to the human capital programs to include our civilian hiring incentives, our three Rs, recruiting, retention and relocation; our health profession and scholarship program and loan repayment, and continuation of civilian nurse loan repayment and special civilian salary rates.

While the Presidents's budget is adequate, fiscal year 2010 may present some financial challenges for Army medicine as new and expanded missions emerge to meet the increasing health-care requirements of the Army at war.

I strongly believe that we must focus on building health and resilience and in conducting science-driven, evidence-based practices, focusing on the ultimate clinical outcomes when bad things happen to good people and they fall off the balance of good health, such as with combat wounds, injuries, serious illnesses and the like.

Sir, before the meeting, we were talking about the utility, for example, of scanning procedures for, say, colon cancer. And good evidence-based practices would always look at whether that procedure, when applied to patients, truly does extend life and find disease earlier. If it is just technology that has not added value, that is what we talk about when we talk about evidence-based practices and optimal outcomes. I believe that this approach will ultimately lead to the best results for our Army and military community and the most cost-effective system of health and health-care delivery.

I would also like to comment upon the efforts to prevent, to mitigate, to identify, manage and treat behavioral health consequences of service in uniform and those arising from frequent deployments, from long family and community separations, and the exposures to the rigors of combat.

Army leaders at all levels recognize that combat and repeated deployments are difficult for soldiers and stress our families, especially the short dwell times between deployments.

We are making bold, sustained efforts to improve the resilience of the entire Army and family and to reduce the stigma associated with seeking mental health care. We want to provide multidisci-

plinary care that addresses specific behavioral health-care needs, both promptly and expertly.

We are resolved to prevent adverse social outcomes associated with military service in combat, such as driving while intoxicated and family violence.

Suicides are unacceptable losses of our soldiers. Realizing that the loss of even one soldier to suicide is one too many, we are looking closely at the factors involved. Rather than post-traumatic stress disorders, as one might expect, we continue to see that fractured relationships and work-related stressors are the major factors in soldier suicides.

We have numerous coordinated and integrated initiatives in place to help soldiers and their families. Key among them is a new comprehensive soldier fitness initiative which is being led by the Chief of Staff himself and is being implemented by Brigadier General Rhonda Cornum, an Army medical department general officer.

This improves the resilience of the soldier and the whole family, really, by focusing on five areas of fitness and resilience: physical, emotional, spiritual, social and family.

I believe that your leadership has heard about this, and I certainly will expand upon that today if you desire.

In closing, I want to thank one of my colleagues at the table. I mentioned it sir, informally. This is one of our wingmen, Jim Roudebush's last hearings. He has been a terrific partner in military medicine and we certainly admire his service. He is leaving behind a soldier in uniform assigned to and a Stryker brigade in Fort Lewis, for which we are very grateful, and we wish him the very best.

I would thank the committee for their terrific support of the Defense health program and Army medicine. Thank you for holding this hearing and for your continued support of Army medicine and the entire medical force.

Thank you.

[The statement of General Schoomaker follows:]

UNCLASSIFIED

FINAL VERSION

STATEMENT BY

LIEUTENANT GENERAL ERIC B. SCHOOMAKER, MD, PhD
THE SURGEON GENERAL OF THE UNITED STATES ARMY
AND COMMANDER, US ARMY MEDICAL COMMAND

COMMITTEE ON APPROPRIATIONS
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Chairman Murtha, Representative Young, and distinguished members of the Defense Subcommittee, thank you for providing me this forum to discuss Army Medicine and the Defense Health Program. I appreciate this opportunity to talk with you today about some of the very important work being performed by the dedicated men and women—military and civilian—of the U.S. Army Medical Department (AMEDD) who personify the AMEDD value "selfless service." In recognition of 2009 being "The Year of the NCO", throughout my testimony I will highlight the contributions of the AMEDD's Non-Commissioned Officer Corps, the backbone of Army Medicine. Non-Commissioned Officers comprise 18% of the Army Medical Department and play critical roles in every aspect of the organization. I am joined today by the senior enlisted medic in the Army, my Command Sergeant Major Althea Dixon, one of the finest Soldiers and leaders with whom I have had the privilege to serve and an invaluable member of my command team.

As the Commander of the U.S. Army Medical Command (MEDCOM), I oversee with the assistance of Command Sergeant Major Dixon a $10 billion international healthcare organization staffed by 70,000 dedicated Soldiers, civilians, and contractors. We are experts in medical research and development, medical logistics, training and doctrine, the critical elements of public health--health promotion and preventive medicine, dental care, and veterinary care--in addition to delivering industry-leading health care services to 3.5 million beneficiaries around the world. But central to everything we do in Army Medicine is the warfighter—we exist as a military medical department to support the warfighter. I am happy to report that we are accomplishing that mission phenomenally well. I can say this with great confidence after spending the first week of March with the US Central Command (CENTCOM) Surgeon at the Multi-National Force/Multi-National Corps-Iraq Surgeon's Conference in Iraq. Seeing first hand the care and civil-military medical outreach from Brigade and Division to Corps and Theater was a clear demonstration of the Joint Medical Force

providing top-notch medical support across the full-continuum of care and nation building.

To determine how successful we are at executing our mission, Army Medicine uses the Balance Scorecard (BSC) approach developed in the 1990s by Harvard's Doctors Robert Kaplan and David Norton. Simply put, the BSC serves as an organizational strategic management system which can help us improve organizational performance while we remain aligned to our strategy. The MEDCOM began BSC implementation in 2001 under LTG (Ret) James Peake's leadership. Since then, we have continued to refine the BSC to grow and direct our dynamic organization. I use the enclosed Army Medicine Strategy Map (published in April 2008 and revised in January 2009) and Scorecard as the principal tool by which to guide and track the Command as it improves operational and fiscal effectiveness, and better meets the needs of our patients, customers, and stakeholders. The BSC communicates to our MEDCOM workforce; drives top-to-bottom organizational understanding and alignment; and focuses our day-to-day efforts to ensure we execute our Mission successfully.

The Army Medicine BSC measures and improves organizational performance in four "balanced" Strategic Perspectives: "Resources" and "Learning and Growth" which are the "Means"; "Internal Processes" which are the "Ways"; and "Patients, Customers and Stakeholders" which are the "Ends" by which we show best value in products and services. These "Ends" are how I have organized my statement in order to best communicate the significant and varied accomplishments of Army Medicine over the last year.

The Six Army Medicine "Ends"

1.0 Improved Healthy and Protected Families, Beneficiaries, and Army Civilians

2.0 Optimized Care & Transition of Wounded, Ill, and Injured Warriors

3.0 Improved Healthy and Protected Warriors

4.0 Responsive Battlefield Medical Force

5.0 Improved Patient and Customer Satisfaction

6.0 Inspire Trust in Army Medicine

1.0 Improved Healthy and Protected Families, Beneficiaries, and Army Civilians - Improve the health of beneficiaries thru cost-effective evidence-based care, proactive disease management, demand management, and public health programs.

Use of HEDIS^{R} Measures – The Healthcare Effectiveness and Data Information Set (HEDIS^{R}) is a tool used by more than 90% of America's health plans (> 400 plans) to measure performance on important dimensions of care. The measures are very specifically defined, thus permitting comparison across health plans. The Department of Defense (DoD) is not a member of the HEDIS program, but uses the HEDIS methodology to measure and compare its performance to the HEDIS benchmarks. The Military Health System (MHS) Population Health Portal takes administrative data and electronic health record data and provides reports on the status of our beneficiaries on each measure. Currently, we track 9 measures and compare our performance to HEDIS benchmarks. In October 2008, the Army was in the 90th percentile compared to HEDIS health plans for 2 of 9 measures. We are in the 50th to 90th percentile for 6 measures and below the HEDIS 50th percentile for one measure. Marked improvement has been seen in colorectal cancer screening which improved 8.9% from October 2005 to October 2008 and approaches the HEDIS 90th percentile. In addition, the Army has very high compliance with Pneumovax, the vaccine against pneumococcal pneumonia, for our enrolled patients over age 65. Since 2007, we've been providing financial incentives to our hospitals for superior compliance in key HEDIS measures. The Army was the pioneer for what the Assistant Secretary of Defense for Health Affairs is now terming Pay-for-Performance. We have shown that these incentives work to change behavior and achieve desired outcomes in our system.

MEDCOM Reorganization - The MEDCOM is engaged in a phased reorganization designed to optimize the delivery of healthcare to our Army and to support a deploying force. With the support of senior Army leadership, I approved phase one of this reorganization which aligns CONUS Regional

Medical Commands (RMCs) with their supporting TRICARE regions. MEDCOM is restructuring in order to be better aligned and positioned to support our transforming Army. Command Sergeant Major Matthew T. Brady was instrumental in developing the structure and functions for the newly designed Western RMC headquarters, and his contributions are emblematic of the significant role played by NCOs across the MEDCOM in our restructuring efforts.

Healthcare support today is outstanding and it must remain so for our Army to succeed during an era of persistent conflict. As the Army changes its structures, relationships and organizational designs through transformation and other initiatives to better support our Nation in the 21st Century, the AMEDD must adapt to ensure it remains reliable and relevant for our Army. The main restructuring is from 4 CONUS RMCs to 3 CONUS RMCs. While reorganizing RMCs, we intend to further integrate healthcare resources, capabilities and assets to foster greater unity of effort and synergy of our healthcare mission. The restructuring will posture us to better provide the best support for Army Force Generation (ARFORGEN) and improve readiness through enhanced health care services for our Soldiers, their Families, and Army units.

Clinical Information Systems - The AMEDD has long recognized a need for an information system to help us grow as a knowledge-driven organization. The AMEDD energetically assumed service lead for the DoD during the implementation of the Composite Health Care System II (CHCS II), now known as AHLTA. Unfortunately, AHLTA has not always kept pace with expectations at the user-level or at the corporate level for data mining and other uses. The Army has taken significant steps to leverage the data from AHLTA and other clinical information systems to improve clinical quality and outcomes as well as patient safety. To address identified shortcomings with AHLTA at the provider level, the AMEDD has invested in the MEDCOM AHLTA Provider Satisfaction (MAPS) initiative. This includes investment in tools like Dragon Medical™ and As-U-Type®, individualized training and business process re-engineering led by clinical champions, and the use of wireless and desktop virtualization. At the Heidelberg Health Center in Germany, Staff Sergeant Kenneth M. Melick is the workhorse

who took the physicians' vision for business process reengineering from construction to final implementation and ensured success. MAPS is beginning to show significant improvements in provider usability and satisfaction. Direct interviews with providers and staff reveal that MAPS implementation has generated a dramatic change in attitude among our staff.

The most recent version of AHLTA has presented us with challenges, but it is showing improvements and gaining provider acceptance. AHLTA provides significant benefit to beneficiaries, especially in the areas of patient safety, security, improved clinical and readiness outcomes, and global availability of records. In addition, a new enterprise architecture for the MHS will likely result in a significant improvement in managing our information systems. The next update to AHLTA (version 3.3) is being deployed and its additional functionality and improved speed is well-liked by the providers who have tested it.

Force Health Protection and Public Health Programs – The US Army's Center for Health Promotion and Preventive Medicine (CHPPM) is a subordinate command of the MEDCOM that affects the lives of Soldiers and Families everyday. Its mission is to provide worldwide technical support for implementing preventive medicine, public health, and health promotion/wellness services into all aspects of America's Army and the Army community. The CHPPM team supports readiness by keeping Soldiers fit to fight, while also promoting wellness among their Families and the Federal civilian workforce. CHPPM integrates public health efforts to develop and export primary prevention based products by using epidemiologic data of disease and injury to identify the best prevention programs to implement for overall population health improvement. One member of the CHPPM team--Sergeant Kerri Washington--made a notable impact on the health and safety of our US Army and Iraqi Forces in the Multi National Division – Baghdad area of responsibility. Sergeant Washington deployed as a Preventive Medicine (PM) Specialist with the 61st Medical Detachment (PM) and applied his preventive medicine skills, leadership ability, and unique health surveillance training to enhance Soldier health and disease prevention.

CHPPM is establishing a Public Health Management System to evaluate the programs and policies developed to promote optimal health in the Army community. This system will use the public health process to provide metrics indicating the success or lack of success in these endeavors. This will allow leaders to make informed decisions on effective or ineffective public health issues in the Army. Army veterinarians play a key role in public health as well, ensuring the safety of food and water and the prevention of animal-borne diseases. As part of the MEDCOM Reorganization addressed earlier, I have directed my staff to assess the feasibility and benefits of establishing a Public Health Command to better synchronize and integrate the efforts of all AMEDD members who contribute to public health programs. This will enhance comprehensive health and wellness and optimize delivery of public health support to the Army.

2.0 Optimized Care & Transition of Wounded, Ill, and Injured Warriors

Warrior Care and Transition Program - The transformation of U.S. Army Warrior Care began in April 2007 with the development of the Army Medical Action Plan (AMAP), which outlined an organizational and cultural shift in how the Army cares for its wounded, ill, and injured Soldiers. Over the past 23 months, the AMAP has evolved into the Army Warrior Care and Transition Program (WCTP), fully integrating Warrior Care into institutional processes across the Army, and is achieving many of the Army's goals for enhancing care and improving the transition of wounded warriors back to duty or into civilian life as productive veterans. At the heart of the WCTP is the successful establishment of 36 Warrior Transition Units (WTUs) at major Army installations worldwide, and nine Community Based Warrior Transition Units (CBWTUs) located regionally around the U.S. These units replace the Medical Holdover (MHO) system of the past and provide holistic care and leadership to Soldiers who are expected to require six months of rehabilitative treatment and/or need complex medical case management.

Comprehensive Transition Plan – In our first year of Warrior Care and Transition, we heavily invested in the structure of our units and support systems. Now in our second year, we recognize that our focus needs to be on optimizing the transition for our Soldiers. In March 2008, MEDCOM launched the Comprehensive Transition Plan initiative for Warriors in Transition. Instead of focusing solely on the injury or illness, the Comprehensive Transition Plan fosters a holistic approach to a Warrior's rehabilitation and transition. This is accomplished through the collaboration of a multidisciplinary team of physicians, case managers, specialty care providers, and occupational therapists. Together with the Soldier, they develop individually tailored goals that emphasize the transition phase to civilian life or return to duty. Goals are set and the transition plan developed within one month of the Soldier's arrival at the WTU.

Physical Disability Evaluation System - The Medical Evaluation Board (MEB) and Physical Evaluation Board (PEB) processes have been streamlined and paperwork requirements reduced to more efficiently move a Soldier's disability package through the adjudication process. Additionally, collaboration between the DoD and the Department of Veterans Affairs (VA) ensures that claims from Warriors in Transition are processed by the Veterans Health Administration (VHA) and Veterans Benefits Administration (VBA) 60 to180 days prior to separating so that they can receive their VA benefits and health care immediately upon discharge. General Frederick M. Franks, Jr., USA Retired has been leading an Army task force to research and recommend improvements to the MEB/PEB process. His findings, which were recently delivered to the Secretary of the Army, recommended that DoD and VA eliminate dual adjudication from the current system and "transition to a comprehensive process focusing on rehabilitation and transition back to either uniformed service or civilian life that promotes resilience, self-reliance, re-education, and employment, while ensuring enduring benefits for the Soldier and Family." This finding reaffirms the importance of the Comprehensive Transition Plan.

WTU Staff Training – Included in the AMAP was the development of standardized training for the staff of WTUs. The US Army Medical Department

Center and School (AMEDDC&S) quickly developed an online orientation course for distribution to all staff. In October 2008, the first iteration of a 2-week resident course was conducted. As of May 2009, five classes have been conducted with 486 graduates. The course is designed for newly assigned Squad Leaders, Platoon Sergeants, and Nurse Case Managers (NCM). The mission is to provide education, skills, and tools that can enable them to positively affect the healing and transition of the Warriors and their Families through more compassionate leadership and specialized case management. The course is managed and directed by Ms. Sherri Emerich, a passionate education specialist and veteran of Desert Storm, combined with the subject matter expertise of Master Sergeant Brian Thomas, who was dynamic in the conception of the Fort Dix WTU, as well as development of some of the best practices still in use today. A 1-week training workshop is currently under design for the Primary Care Managers.

Warrior Satisfaction - Over the past two years, the Army has made tremendous progress in transforming how it provides health care to its Soldiers, with improvements impacting every aspect of the continuum of care. Over this period, overall Soldier and Family satisfaction with the care and support they have received as a result of the efforts of the WCTP has increased significantly. Two years ago, only 60% of those in the legacy medical hold units were satisfied with the care they received. Today, that number has increased to 80% of Soldiers and Families who now receive the focused and comprehensive care and support provided by WTUs. Considering that over twenty thousand Soldiers, along with their Families, have transitioned through the WCTP over that time, this represents a significant number of "satisfied" customers. A key element of increased satisfaction has been the availability of a robust ombudsman program staffed primarily with retired NCOs. An ombudsman works at each of our WTUs on behalf of the Warriors in Transition and their Families to fix problems and cut through bureaucratic entanglements. It is a great example of our dedicated senior NCOs continuing to serve Soldiers even after they have taken off the uniform.

3.0 Improved Healthy and Protected Warriors - Improve the health of service members through full spectrum health services to optimize mission readiness, health and fitness, and resiliency before, during, and after deployment.

Evidence Based Practices – The theme of evidence based practices runs through everything we do in Army Medicine and is highlighted throughout our Balanced Scorecard. Evidence based practices mean integrating individual clinical expertise with the best available external clinical evidence from systematic research. Typical examples of evidence based practice include implementation of clinical practice guidelines and dissemination of best practices. I encourage my commanders and subordinate leaders to be innovative, but across Army Medicine we must balance that innovation with standardization so that all of our patients are receiving the best care and treatment available.

Comprehensive Soldier Fitness - The Army Chief of Staff has established a vision of an Army comprised of balanced, healthy, and self-confident Soldiers and Families whose resilience and total fitness enable them to thrive in an era of high operational tempo and persistent conflict. To achieve this ambitious vision, he is instituting the Comprehensive Soldier Fitness Program. General Casey identified several shortcomings in his own Army experience. For example, the Army does not routinely assess all the elements of wellness, fitness, and optimal human performance, other than physical. Resilience, life skills, and mental coping techniques are not fully trained across the Army. The Army does not always link available life skills and performance programs and interventions with Soldiers and Families until the need has been demonstrated by a negative behavior. And the Army does not teach Soldiers about the potential for post traumatic growth, nor give Soldiers the opportunity to validate their post traumatic growth during Post Deployment assessments. The intent of the Comprehensive Soldier Fitness Program is to increase the resiliency of Soldiers and Families by developing the five dimensions of strength—physical, emotional, social, spiritual, and family. This program is in early development, but under the leadership of Brigadier General Rhonda Cornum, an AMEDD physician, and with the

commitment of passionate non-commissioned officers like her Non-Commissioned Officer in Charge, Master Sergeant Richard Gonzales, I expect this program to have a profound positive effect on the lives of Soldiers and Families.

Brain Health - Commanders and leaders are responsible for the mental and physical well-being and care of Soldiers. They play a critical role in encouraging Soldiers to seek prompt medical care for traumatic brain injuries (TBI). This responsibility begins on the battlefield, as close as possible in time and space to the injury. The AMEDD is developing the best process to evaluate and treat every Service member involved in an event that may result in TBI. Commanders and medics throughout theater are emphasizing early recognition of brain injuries followed by examinations and care rendered in accordance with clinical practice guidelines developed by the AMEDD in conjunction with the CENTCOM Surgeon. The Army is also working closely with the National Guard to implement a personnel tracking instrument that provides identification of individuals who may have been involved in a blast and require screening.

In coordination with the VA and the Defense Center of Excellence for Psychological Health and Traumatic Brain Injury, the Army continues to expand resources dedicated to TBI research and treatment. The Defense Centers of Excellence (DCoE), directed by Army Brigadier General Loree Sutton, lead a collaborative effort toward optimizing psychological health and TBI treatment for all Service members. The DCoE establishes quality standards for: clinical care; education and training; prevention; patient, family and community outreach; and program excellence. The DCoE mission is to maximize opportunities for Warriors and Families to thrive through a collaborative global network promoting resilience, recovery, and reintegration for psychological health and TBI.

Fort Campbell's Warrior Resiliency and Recovery Center for mild TBI is showing very promising results in the identification and treatment of mild TBI. The post concussive syndrome appears to exist in these Soldiers with a natural clinical history separate from that of Post Traumatic Stress Disorder (PTSD) or other psychiatric conditions. The syndrome is effectively treated with an intensive

and comprehensive interdisciplinary approach. Early data indicate significant improvement in all treated cases and complete return to duty recovery in over 77% of treated Soldiers.

Battlemind Training - One validated evidence-based practice that reduces the impact of post traumatic stress is the Battlemind Training System (BTS). The Battlemind Training System (BTS) reflects a strength-based approach, using buddy aid and focusing on the leader's role in maintaining our Warriors' mental health. The BTS targets all phases of the deployment cycle as well as the Warrior life cycle and medical education system. BTS includes training modules designed for Warriors, Leaders, and military spouses. Key teaching points about PTSD and concussion were recently incorporated into the deployment cycle and life cycle Battlemind modules.

RC Dental Readiness - Maintaining dental readiness in the Reserve Components (RC) has been challenging. During the past year, new program developments have provided an integrated Army solution for RC dental readiness throughout the ARFORGEN cycle. The Army Dental Command (DENCOM) executes First Term Dental Readiness (FTDR) at Initial Entry Training (IET) installations, and focuses on examining and treating dental conditions in recruits that could otherwise render a Soldier non-deployable. Upon graduation from IET, RC Soldiers return to their units where the Army Selected Reserve Dental Readiness System (ASDRS), initiated in September of 2008, maintains RC Soldier dental readiness throughout the three ARFORGEN phases. If the RC Soldier is mobilized, their deployment dental readiness is validated by DENCOM-operated facilities. If they are found to be deficient, they are examined and treated to bring them up to deployable standards by dedicated AC and RC dental personnel such as Sergeant First Class Dexter Leverett, a USAR NCO mobilized since 2004, who has managed RC mobilization and demobilization dental operations at both Fort Hood and Camp Shelby, MS—two sites which have processed over 12,000 RC Soldiers in the past 5 months alone. Upon return from deployment, DENCOM resets RC Soldier dental readiness by conducting a Demobilization Dental Reset (DDR) which provides a dental exam

and readiness care that can prudently be completed during the abbreviated demobilization process. Since July 2008 we have dentally reset 88% of RC Soldiers demobilizing from overseas. I expect this integrated approach to generate improved RC dental readiness.

Armed Forces Health Surveillance Center - The new Armed Forces Health Surveillance Center (AFHSC), a DoD Executive Agency supported by CHPPM, performs comprehensive medical surveillance and reporting of rates of diseases and injuries among DoD service members. AFHSC's main functions are to analyze, interpret, and disseminate information regarding the status, trends, and determinants of the health and fitness of U.S. military (and military-associated) populations and to identify and evaluate obstacles to medical readiness. AFHSC is the central epidemiological resource for the US Armed Forces, and it provides regularly scheduled and customer-requested analyses and reports to policy makers, medical planners, and researchers. It identifies and evaluates obstacles to medical readiness by linking various databases that communicate information relevant to service members' experiences that have the potential to affect their health.

4.0 Responsive Battlefield Medical Force - ensure health service assets of all three components are trained, modular, strategically deployable, and can support full spectrum operations and joint force requirements.

Pre-deployment Trauma Training – Adhering to the policy that no one should be initially exposed to a medical challenge while on deployment or on the battlefield, pre-deployment trauma training is now mandatory for individual providers and medical units to improve survival rates. It is a critical link between standard medical care and the intense battlefield environment Soldiers face in the current conflicts. By recreating the high-stress situations medics will face in Iraq and Afghanistan, this training allows for the refinement of advanced trauma treatment skills and sensitization to hazardous conditions, thereby allowing medics to increase their confidence and proficiency in treatment. This training includes a surgical skills laboratory, the principles of International Humanitarian

Law, and mild TBI and Combat Stress identification. Returning Soldiers cite this as the best training they have ever received.

Medical Simulation Training Centers - The Medical Simulation Training Center (MSTC) grew from an Army Chief of Staff directive to create and quickly implement medical simulation training to prepare combat medics for the battlefield. Command Sergeant Major David Litteral and Sergeant First Class William Pilgrim were active in the early development of the MSTC program, and are two of the many NCOs instrumental in the program's success. In Fiscal Year (FY) 2008 the 14 stateside MSTCs provided training to 27,136 Combat Medics and non-medical Soldiers in the Tactical Combat Casualty Care (TC3) and Medic sustainment courses. Also in FY 2008, at four locations within the CENTCOM Area of Responsibility (AOR), 26,132 Medics and Soldiers validated their TC3 skills and received just in time training. This success has carried into FY 2009 as 20,235 Medics and Soldiers have passed through the now 16 stateside MSTCs and four CENTCOM locations for training and/or validation of critical battlefield lifesaving skills.

Joint Forces Combat Trauma Medical Course (JFCTMC) - This is a five-day trauma training course developed by the AMEDDC&S and designed for providers deploying to Level III (Combat Support Hospital) medical missions. The course is a series of lectures with breakout sessions by specialty, which include laboratory sessions. JFCTMC prepares deploying providers to care for patients with acute war-related wounds and incorporates lessons learned from Operation Iraqi Freedom and Operation Enduring Freedom. Sergeant First Class Theresa Smith, Sergeant First Class Pearell Tyler, Sergeant First Class David Estrada, Sergeant First Class Robert Lopez, and Staff Sergeant Cedric Griggs conduct the much-praised Emergency Surgical Procedures portion of this course and provide Point of Wounding training. That's right—non-commissioned officers are training physicians and other health care providers.

Combat Development - AMEDD NCO Combat Developers, like Master Sergeant (MSG) Christian Reid and Sergeant First Class Raymond Arnold, have been front and center in product improvements to the Mine Resistant Ambush

Protected (MRAP) ambulance, Army Combat Helmet, Combat Arms Ear Plugs, Improved Outer Tactical Vest, and Fire Retardant Army Combat Uniform. Additionally, MSG Reid has been pivotal in the development of the Improved First Aid Kit (IFAK) from concept to fielding in six months as well as the Warrior Aid and Litter Kit (WALK), of which more than 25,000 have been procured to support current combat operations. The MRAP-Ambulance provides increased protection to our crews and patients. To make the MRAP-Ambulance the most capable ground ambulance in the Army today, we integrated "spin-out" technology from the Future Combat System (FCS) Medical Vehicles. The combat medic is now able to leave the Forward Operating Bases to conduct medical evacuation missions and can provide world class en-route care to wounded soldiers. The AMEDD also developed Casualty Evacuation Kits (CASEVAC) for both the MRAP and HMMV ambulances to increase capability. These efforts provided the combat medic with field ambulances built for survivability in the challenging environment of asymmetric warfare.

Fresh Blood Distribution - Recognizing that fresher blood has been associated with increased survival on massively transfused patients, the Armed Services Blood Program Office (for which Army maintains oversight as Executive Agent) has been working with the Services to decrease the time it takes for blood to arrive in theater with the overall goal of getting 80% of the units in theater by day seven. The average age of red blood cells arriving in theater prior to November 2008 was 13.3 days. Sergeant First Class Peter Maas and others in the Blood Program Office identified 13 action items necessary to improve blood collection, manufacture, and distribution to the CENTCOM AOR. Since implementing these action items in November, 2008, the average age of red blood cells arriving in theater has dropped below 9 days. The most recent shipment had an average age of 6.3 days. In the last few months, we have managed to bypass blood delivery to Bagram and are shipping blood directly to Kandahar from Qatar. This has resulted in blood reaching Kandahar that is 2-3 days fresher than before. In addition to delivering fresher blood to theater, we

are actively and aggressively pursuing new blood technologies that should lead to improved warrior care on the battlefield in the near future.

Armed Forces Institute of Regenerative Medicine - The US Army Medical Research and Materiel Command (USAMRMC) in partnership with the Office of Naval Research, the US Air Force, the National Institutes of Health, and the VA established the Armed Forces Institute of Regenerative Medicine (AFIRM) in March 2008. The AFIRM is a multi-institutional, interdisciplinary network working to develop advanced treatment options for our severely wounded servicemen and women. The AFIRM is made up of two civilian research consortia working with the US Army Institute of Surgical Research (USAISR) at Fort Sam Houston, Texas. One consortium is led by Wake Forest University Baptist Medical Center and the McGowan Institute for Regenerative Medicine in Pittsburgh and one is led by Rutgers, the State University of New Jersey, and the Cleveland Clinic. Each of these civilian consortia is itself a multi-institutional network.

Regenerative medicine, which has achieved success in the regeneration of human tissues and organs for repair or replacement, represents great potential for treating military personnel with debilitating, disfiguring, and disabling injuries. Regenerative medicine uses bioengineering techniques to prompt the body to regenerate cells and tissues, often using the patient's own cells combined with degradable biomaterials. Technologies for engineering tissues are developing rapidly, with the ultimate goal of delivering advanced therapies, such as whole organs and engineered fingers and limbs.

Joint Theater Trauma System and Joint Trauma Analysis and Prevention of Injury in Combat – The Joint Medical Force continues to show great improvements in battlefield care as a consequence of linking all information from Level 2 and 3 care through the entire continuum of care via the Joint Theater Trauma System (JTTS). The JTTS, coordinated by the Institute for Surgical Research of the USAMRMC, provides a systematic approach to coordinate trauma care to minimize morbidity and mortality for theater injuries. JTTS integrates processes to record trauma data at all levels of care, which are then analyzed to improve processes, conduct research and development related to

trauma care, and track and analyze data to determine the long term effects of the treatment that we provide. The JTTS also plays an active role as a partner in the Joint Trauma Analysis and Prevention of Injury in Combat (JTAPIC) program, another USAMRMC asset for Blast Injury Research.

The JTAPIC Program links the DoD medical, intelligence, operational, and materiel development communities with a common goal to collect, integrate, and analyze injury and operational data in order to improve our understanding of our vulnerabilities to threats and enable the development of improved tactics, techniques, and procedures (TTPs), and materiel solutions that will prevent or mitigate traumatic injuries. The JTAPIC Program has already made a difference in the way we protect our Warfighters from combat injuries as illustrated in the following key accomplishments:

- Provided actionable information that has led to modifications and upgrades to vehicle equipment and protection systems, such as seat design, blast mitigating armor, and fire suppression systems;

- Established a near-real time process for collecting and analyzing combat incident data that confirmed the presence of threat weapons of interest;

- Analyzed combat incident data to identify vulnerabilities in operational procedures, and rapidly conveyed those vulnerabilities to commanders in theater;

- Established a process for collecting and analyzing damaged personal protective equipment (PPE), such as body armor and combat helmets, to provide PPE developers with the information they need to develop enhanced protection systems.

The JTAPIC Program received the 2008 Department of the Army Research and Development Laboratory of the Year Award for Collaboration Team of the Year in recognition of its accomplishments.

Combat Medic Skills Textbook - Our combat medics (68W) are the best trained battlefield medics in the world. The historically low "died of wounds" rate is evidence of their enhanced skills. The medics of the 68W generation are trained to perform advance airway skills, hemorrhage control techniques, shock management, and evacuation. Sergeant First Class Nadine Kahla and Sergeant

First Class Jason Reisler are 68W NCOs assigned to the AMEDD Center & School. They are representative of the 17 other 68W NCO authors who contributed to the new 68W Advanced Field Craft Combat Medic Skills Textbook, a state of the art training manual for the combat medic. This delineation of combat medic skills is newly published and will be issued to every graduating combat medic beginning this month. We are currently looking at ways to distribute this textbook to every medic in the force--Active, National Guard, and Army Reserve.

5.0 Improved Patient and Customer Satisfaction - Improve stakeholder satisfaction by understanding, managing, and exceeding their expectations.

Improved Infrastructure - On behalf of the Army Medical Department team, I want to thank the Congress for listening to our concerns about military medical infrastructure and taking significant action to help us make needed improvements to our facilities. Funding provided for military hospitals in the FY2008 supplemental bill and in the American Recovery and Reinvestment Act of 2009 will positively impact the quality of life of thousands of Service Members, Family Members, and Retirees as we build new state of the art facilities in places like Fort Benning, Georgia, Fort Riley, Kansas, Fort Hood, Texas, and Fort Sam Houston, Texas. Additional funding provided by Congress for Sustainment, Restoration, and Modernization of our facilities has been put to great use and allowed us to make some valuable improvements that have been noted by our staff and patients.

The Army requires a medical facility infrastructure that provides consistent, world class healing environments that improve clinical outcomes, patient and staff safety, staff recruitment and retention, and operational efficiencies. The quality of our facilities – whether medical treatment, research and development, or support functions - is a tangible demonstration of our commitment to our most valuable assets - our military family and our MHS staff. The environment in which we work is critical to staff recruitment and retention in support of our All Volunteer Force. Not only are these facilities the bedrock of our direct care

mission, they are also the source of our Generating Force that we deploy to perform our operational mission. To support mission success, our current operating environment needs appropriate platforms that support continued delivery of the best health care, both preventive and acute care, to our Warfighters, their Families and to all other authorized beneficiaries. I am currently working closely with the Assistant Secretary of Defense for Health Affairs and the leadership of the DoD to determine the level of investment our medical facilities will need. I respectfully request the continued support of DoD medical construction requirements that will deliver treatment and research facilities that are the pride of the Department.

Access to Care - Army leadership and MEDCOM are decisively engaged in improving access to care for our Soldiers and their Families. These efforts will result in markedly improved access and continuous situational awareness at each medical treatment facility. Access means that patients are seen by the right provider, at the right time, in the right venue, and this applies equally to the Direct Care System & Purchased Care System (TRICARE). Key elements identified for improving access to care include:

- Aligning treatment facility capacity with the number of beneficiaries
- Enhancing provider availability
- Reducing friction at key points of access
- Managing clinic schedules
- Leveraging technology

We have developed a campaign plan to improve access by giving hospital commanders the tools they need along with the responsibility and accountability to generate results.

Sustainable Cost of Operations – While focusing on quality outcomes, the MEDCOM is also concerned with ensuring that we maintain a sustainable cost of operation for the AMEDD. Our efforts to improve access are coupled with initiatives to improve efficiency. Our Performance Based Adjustment Model (PBAM) provides financial incentives for improving efficiency, patient satisfaction, and quality. PBAM and other incentive programs have resulted in the Army

being the only Service to achieve planned workload gains every year since 2003. A key author of PBAM is Master Sergeant (now retired) Richard Meyer.

Disseminating Best Practices – The MEDCOM has embraced the Lean Six Sigma approach to sustaining improved performance. As an example, a Lean Six Sigma project to improve the telephone appointment process was initiated at Carl R. Darnall Army Medical Center (CRDAMC), the largest telephone appointment call center in the MEDCOM. The call center was plagued with high call volume, low patient satisfaction, long process cycle time, and high variation. The project sought to decrease process cycle time and the call abandon rate to improve patient satisfaction. By the conclusion of the project, the overall average hold time was reduced to 33 seconds (a 6-fold improvement); the call abandon rate was reduced to 3% (a 10-fold improvement); calls handled increased from 4,700 to 7,300 per week; and call agent turnover was reduced. Today the mean hold time at CRDAMC is 3 seconds. This project's successful action plan and metrics have been disseminated across the command as a best practice.

6.0 Inspire Trust in Army Medicine - Increase stakeholder support of Army Medicine by inspiring trust, building confidence, and instilling pride.

Improving civilian medical practices - The implementation of tactical combat casualty care (TC3) principals for point of injury treatment on the battlefield has changed long-standing hemorrhage control protocols in the civilian Emergency Medical Services (EMS) community. The nation's EMS community has altered long-standing treatment protocols that formerly considered tourniquet use a last resort. The use of tourniquets, based on the success of their application by military medics in theater, is now not only seen as safe by our nation's healthcare providers, but as the intervention of choice for control of severe hemorrhage. Hemorrhage control is the leading cause of death in trauma. The change in philosophy regarding tourniquet use will result in more lives saved in both urban and rural areas of our country.

Establishing Successful Interservice Partnerships (San Antonio Military Medical Center) - Wilford Hall Medical Center (WHMC) and Brooke Army Medical

Center (BAMC) are quickly evolving towards the San Antonio Military Medical Center (SAMMC), which is an integrated health care platform in which patient care is delivered in two facilities operating under one organizational structure. The SAMMC organizational structure has been operational for over a year. The organizational structures of BAMC and WHMC were both realigned to form a functional organization for delivery of health care, maintenance of our readiness and deployment platforms, sustainment of training of all levels of health care providers, and promotion of research. Many physical moves of medical services have already occurred across the SAMMC platform. SAMMC is planning for the migration of the two military level one trauma centers in San Antonio to one military level one trauma center, capable of handling the same patient care volume that is being delivered today in the two centers. Planning and coordination with the City of San Antonio have been an integral part of this process to ensure continued trauma support in the city. SAMMC enjoys strong collaborations with both the University of Texas Health Science Center, local government leaders, and the Audie Murphy Veterans Memorial Hospital in support of the large tri-service beneficiary population in the San Antonio community.

Establishing Successful Interagency Partnerships (Behavioral and Social Health Outcomes) - CHPPM resources are partnered with civilian academia, the VA and the Department of Health and Human Services (including the Centers for Disease Control and Prevention, and the National Institute of Mental Health) to work in the mitigation of rising rates of suicide, depression, PTSD and other adverse behavioral and social health outcomes in our Active Duty, Reserve and National Guard Soldiers, Families, and Retirees. MEDCOM is working with other key organizations to build a robust public health capability in the area of Behavioral and Social Health outcomes (to include suicides and homicides). This effort includes the construction of an Army-level relational database that draws critical information from numerous sources to enable comprehensive analysis of adverse outcomes in Army organizations and communities.

Establishing Successful Interagency Partnerships (National Interagency Biodefense Campus)- Fort Detrick, Maryland hosts and is intimately involved in the development of the National Interagency Biodefense Campus (NIBC) to fill gaps in national biodefense and integrate agencies for a whole of government approach to national security. As a charter member of the National Interagency Confederation for Biological Research (NICBR), a collaboration of the National Cancer Institute along with the NIBC partners, the Army is breaking ground in building on a model for interagency cooperation at Fort Detrick. During 2008, members of the NICBR/NIBC were involved in developing national policy on biodefense and biotechnology, as well as collaborating on research. Research includes work on developing vaccines, diagnostics, forensics, and therapeutics. While focusing on protecting people from disease and bioterrorism, members of the NICBR/NIBC participated in multiple national assessments to prioritize and focus biodefense missions, all while continuing united scientific discovery. During 2009, the NICBR/NIBC will continue to work with Congress and others to define and scope gaps and seams in our Nation's biodefense posture.

In closing, I want to thank this Committee for their terrific support of the Defense Health Program and Army Medicine. I greatly value the insight of this Committee and look forward to working with you closely over the next year. I also want to salute our non-commissioned officers for their professionalism, competence, and leadership—they are truly the backbone of Army Medicine. Thank you for holding this hearing and thank you for your continued support of the Army Medical Department and the Warriors and Families that we are most honored to serve.

Army Medicine Strategy Map
Mission
- Promote, Sustain and Enhance Soldier Health
- Train, Develop and Equip a Medical Force that Supports Full Spectrum Operations
- Deliver Leading Edge Health Services to Our Warriors and Military Family to Optimize Outcomes
January 2009
Vision
America's Premier Medical Team Saving Lives and Fostering Healthy and Resilient People
Army Medicine...Army Strong!
Strategic Themes
Maximize Value in Health Services
Provide Global Operational Forces
Build the Team
Balance Innovation with Standardization
Optimize Communication and Knowledge Management
SUSTAIN PREPARE RESET TRANSFORM
In Support of
The Army Family Covenant
ENDS
WAYS
MEANS
Patient/Customer/Stakeholder
Internal Process
Learning and Growth
Resource
Feedback Adjusts Resourcing Decisions
This is a dynamic, living document
For more information go to: https://ke2.army.mil/bsc

ARMY MEDICINE
BALANCED SCORECARD (BSC) OVERVIEW

PURPOSE

The Balanced Scorecard strategic management framework has been and continues to serve as the centerpiece of the Army Medicine's enterprise-wide Strategic Management System. The first AMEDD strategy map was approved by LTG James B. Peake on April 2001 and the framework has continued through today with LTG Eric B. Schoomaker's January 2009 strategy map. The BSC is used to drive top-to-bottom organizational understanding and alignment, focus day-to-day efforts, and ensure that we are executing our Mission.

OVERVIEW

The BSC is a concept introduced by Doctors Robert Kaplan and David Norton in 1992. The BSC is a framework to translate the organization's strategy into terms that can be easily understood, communicated, and acted upon (measureable action).

The foundation and main driver of a BSC is the organization's Mission and Vision. Four perspectives then define the organization: Patient/Customer/Stakeholder (Ends), Internal Processes (Ways), Learning and Growth (Means), and Resource (Means). The April 2008 strategy map (one page schematic) describes Army Medicine's strategy via the strategic objectives (located in the bubbles on the strategy map) in each perspective. Behind each strategic objective is a detailed objective statement that clearly defines the meaning of the strategic objective and measure, which will drive behavior to accomplish each objective. Each measure will have a target and supporting initiatives that will drive the change required to allow the organization to move closer to its intended outcomes (ends).

The BSC is a dynamic, living document that will be refined due to mission and priority changes, organizational learning, as well as when targets are met. Periodic reviews are conducted to ensure proactive change.

ORGANIZATIONAL CASCADING and ALIGNMENT

To ensure enterprise-wide alignment to the Army Medicine BSC, Major Subordinate Command Commanders and Corps Chiefs are required to build a supporting BSC and conduct an alignment brief with TSG.

ADDITIONAL INFORMATION

Detailed information, to include the Army Medicine BSC, is located at https://ke2.army.mil/bsc

https://ke2.army.mil/bsc

As of May 09

SUMMARY STATEMENT OF ADMIRAL ROBINSON

Mr. MURTHA. Admiral Robinson.

Admiral ROBINSON. Mr. Murtha, Mr. Young, distinguished members of the Committee, since I testified last year we have seen the emergence of impressive changes and unique challenges to this Nation and the global community.

Navy Medicine continues on course because our focus has been and will always be providing the best health care for our Soldiers, Marines, and their families while supporting the CNO's Maritime Strategy.

Our Navy Medicine team is flexible enough to participate in overseas contingency operations, homeland defense missions, humanitarian civil assistance missions, disaster relief missions, while at the same time providing direct health care to our Nation's heroes and to their families and those who have worn the cloth of the Nation.

In spite of all the missions we are currently prepared to participate in, we are continuously making the necessary changes and improvements to meet the requirements of the biggest consumer of our operational health-support efforts, the Marine Corps.

Currently we are realigning medical capabilities to support operational forces in emerging theaters of operation. Our Navy humanitarian efforts have continued to grow, and this year we will visit sites in the U.S. Pacific and Southern Command's areas of operation.

We will not be deploying the USS DUBUQUE because of an outbreak of H1N1 in the past several weeks. We are, however, working on other alternatives; and in fact, a USNS ship has been named the USS BYRD to replace the USS DUBUQUE. Our Nation's humanitarian efforts serve as a unique opportunity to positively impact the perception of the United States and our allies by other nations, so this is a critical part of of the CNO's strategic initiatives.

We continue to make improvements to meet the needs of Sailors and the Marines who have become injured while serving in theater or training at home. Over the last year, Navy medicine significantly expanded services so that the wounded warriors have access to timely, high-quality care.

In addition, Navy Medicine's concept of care is always patient- and family-focused. We never lose our perspective in caring for our beneficiaries. Everyone is a unique human being in need of individualized, compassionate, and professionally superior health care.

At our military treatment facilities, we recognize and embrace the military culture and incorporate that into the healing process. The Bureau of Medicine and Surgery Wounded Warrior Regiment medical review team and the Returning Warrior Workshop supports Marines and Navy Sailor reservists by focusing on key issues faced by personnel during their transition from deployment to home. Navy and Marine Corps liaisons at medical treatment facilities aggressively ensure that orders and other administrative details such as extending reservists are completed.

Much attention has been focused on ensuring service members' medical conditions are appropriately addressed upon return from

deployment. The predeployment health assessment, PDHA, is one mechanism used to identify physical and psychological health issues prior to deployment. The post-deployment health assessment and the post-deployment health reassesment, PDHRA, help to identify employment-related health-care concerns on return to home station, and 90 to 180 days post-deployment.

Navy Medicine's innovative deployment health centers, currently in 17 high Fleet and Marine Corps concentrations areas, support the health deployment assessment process and serve as easily accessible nonstigmatizing portals for mental-health care. The centers are staffed with primary care and mental-health providers to address deployment-related health issues such as traumatic brain injury, post-traumatic stress and substance misuse.

Navy Medicine's partnership with the Department of Veterans Affairs medical facilities is evolving into a mutually beneficial partnership. This coordinated care for our warriors who transfer to or are receiving care from a Veterans Administration facility ensures their needs are met and their family concerns are addressed.

Working closely with the Chief of Naval Personnel, medical recruiting continues to be one of the top priorities for 2009.

In spite of successes in the HPSP Medical and Dental Corps recruitment, meeting our direct accession missions still remains a challenge. I anticipate increased demand for Medical Service Corps personnel with respect to individual augmentation missions supporting the current mission in Iraq and Afghanistan, and the planned humanitarian assistance and unexpected disaster relief missions that we will certainly have.

These demands will impact the Medical Corps Service specialties linked to mental, behavioral, and rehabilitative health and operational support such as clinical psychiatrists, social workers, occupational therapists, physicians assistants and physical therapists.

For the first time in 5 years Navy Nurse Corps officer gains in 2008 outpaced losses. Despite the growing national nursing shortage and the resistance of the civilian nursing community to the recession, the recruitment and retention of nurses continues to improve.

It is important to recognize the unique challenges before Navy Medicine at this particularly critical time for our Nation. Growing resource constraints for Navy Medicine are real, as is the increasing pressure to operate more efficiently without compromising health-care quality and workload goals.

The Military Health System continues to evolve, and we are taking advantage of opportunities to modernize management processes that will allow us to operate as a stronger innovative partner within the Military Health System.

Chairman Murtha, Ranking Member Young, I want to express my gratitude on behalf of all of Navy Medicine, uniformed, civilian contractor, and volunteer personnel who are committed to meeting and exceeding the health-care needs of our beneficiaries.

I would also like to take a moment to thank General Roudebush, sitting to my left, who has been a wonderful partner. He has been a wonderful professional to work with, and most of all, he has been a great friend to have. And we will miss him, as General Schoomaker has already alluded to.

So happy retirement to you and thank you very much. He has been an excellent wingman.

Thank you again for providing me this opportunity to share with you Navy Medicine's mission and what we are doing today. It has been my pleasure to testify before you and I look forward to answering your questions.

Thank you.

[The statement of Admiral Robinson follows:]

Not for Publication until released by the House Appropriations Committee

Statement of

Vice Admiral Adam M. Robinson, MC, USN

Surgeon General of the Navy

Before the

Subcommittee on Defense

of the

House Appropriations Committee

Subject:

The State of Navy Medicine

21 May 2009

Not for Publication until released by the House Appropriations Committee

Chairman Murtha, Congressman Young, distinguished members of the committee, since I testified last year we have seen the emergence of impressive changes and unique challenges to this nation and the global community. A historic Presidential election which has made significant national and international political impact, a war effort sustained with military troops deploying into hostile areas; and an increasing military medicine presence playing a key role to support the humanitarian civil assistance mission. We are seeing uncertainty, change and fluctuation in our economy that will impact all of us, including military medicine.

Navy Medicine continues on course, because our focus has been, and will always be providing the best healthcare for our Sailors, Marines, and their family members while supporting the CNO's Maritime Strategy. We are focused on strengthening Navy Medicine today, and are proactively planning to meet future healthcare requirements.

Navy Medicine is built on a solid foundation of proud traditions and a remarkable legacy of Force Health Protection. Our focus has not changed and every day in Navy Medicine we are preparing healthy and fit Sailors and Marines to protect our nation and be ready to deploy.

Navy Medicine is playing a major part in supporting the Maritime Strategy. You will find us at home and around the world providing preventive medical care; health maintenance training and education; direct combat medical support; medical intelligence; and operational planning mission support. Our Navy Medicine teams are flexible enough to participate in Overseas Contingency Operations, a homeland defense mission, a humanitarian civic assistance mission, and a disaster relief mission; while at the same time provide direct health care to our nation's heroes and their family members at home and overseas.

In spite of all of the missions we are currently prepared to participate in, we are continuously making the necessary changes and improvements to meet the requirements of the

biggest consumer of our operational support efforts -- the Marine Corps. Currently, we are realigning medical capabilities to support operational forces in emerging theaters of operation. Since the global operations to combat terrorism began, Navy Medicine's combat medical support has proven exceptionally successful at bringing wounded service members home. We hope, through our ability to remain agile and flexible, to sustain those efforts -- like the record-high survivability rates -- and improve them wherever possible.

The Navy's Maritime Strategy calls for proactive humanitarian civic assistance and disaster response efforts. These missions have been taking place since 1847, and have come a long way since then. The Navy's Humanitarian Civil Assistance missions are now pre-planned engagements deployed from sea-based, land-based or expeditionary platforms to meet a great spectrum of medical needs. From basic medical evaluation and treatment, to optometry, to general surgery, and immunizations, our physicians, nurses, dentists, ancillary healthcare professionals, and hospital corpsmen are ready.

Our efforts have continued to grow and this year, the U.S. Southern Command will sponsor four multi-service Medical Readiness Training Exercises (MEDRETEs). These missions will visit Jamaica, Honduras, the Dominican Republic and Guyana and will include a Navy Medicine Reserve Component. These two-week deployments will provide primary care in remote locations in conjunction with the Ministry of Health of each host nation. The medical services provided will include preventive medicine education, pediatrics, primary medical care, immunizations, pharmacy services, and dental care.

Over 400 Navy Medicine personnel are ready to provide humanitarian civil assistance later this year in two ship-based missions. In April, the USNS COMFORT (TAH 20) deployed for a 120-day mission in support of United States Southern Command to South and Central

America as part of Continuing Promise 09. Later in 2009, in support of the United States Pacific Command, USS DUBUQUE (LPD 8) will deploy for a 125-day mission as part of Pacific Partnership 09.

Our nation's humanitarian efforts serve as a unique opportunity to positively impact the perception of the United States and our allies by other nations. These often joint missions serve as examples of how increased collaboration between host nations, the other services, other government agencies, and non-governmental organizations can maximize available resources in order to improve worldwide response capability. From our experience, we have developed a successful model of healthcare education and training for host country providers. This will lead to local sustainable activities that will provide long-lasting benefits to help overcome healthcare barriers in resource poor countries. Furthermore, these missions have become another avenue for improved recruiting and retention of Navy Medicine healthcare providers.

While our humanitarian civil assistance missions provide us with some amazing opportunities as providers of medical care, Navy Medicine is acutely aware and incredibly proud of our operational commitment to the United States Marine Corps. We never stop improving our strategic ability, operational reach, and tactical flexibility. As the Marine Corps forces shift their efforts to Afghanistan, Navy Medicine will be there providing the highest quality combat medical support from the corpsmen who stand by their Marines on the battlefield, to expeditionary medical facilities, to the care provided at a military hospital and world-class restorative and rehabilitative care facilities in the continental U.S.

We continue to make improvements to meet the needs of Sailors and Marines who may become injured – while serving in theater or training at home. Over the last year, Navy Medicine significantly expanded services so that wounded warriors would have access to timely,

high-quality medical care. Our response is two-tiered, first to uncompromisingly increase specialized multidisciplinary teams, and second, to expand sharing with other government agencies and the private sector of clinical resources, research and expertise.

In addition, Navy Medicine's Concept of Care is always patient and family focused. We never lose our perspective in caring for all our beneficiaries – everyone is a unique human being in need of individualized, compassionate, and professionally superior health care. At our military treatment facilities (MTFs), we recognize and embrace the military culture and incorporate that into the healing process. Based on the progress in a patient's care and healing, from initial care to rehabilitation and life long medical needs, we determine the best clinical location and treatment plan for that patient. Families are a critical part of the health care delivery team, and we integrate the family's needs into the healing process as well.

In 2008, the Bureau of Medicine and Surgery (BUMED), Headquarters for Navy Medicine, consolidated all wounded, ill and injured warrior healthcare support, with the goal of establishing global policy, implementation guidance, and oversight in order to deliver the highest quality customer-focused, comprehensive and compassionate care to service members and their families.

As of April 2009, 168 Medical Care Case Managers were assigned to 45 MTFs and ambulatory care clinics caring for approximately 1500 OIF/OEF casualties. The Medical Care Case Managers collaborate with Navy Safe Harbor and Marine Corps Wounded Warrior Regiment in working directly with wounded warriors, family, caregivers and the multi-disciplinary medical team to coordinate the complex services needed for improved health outcomes.

The BUMED Wounded Warrior Regiment Medical Review team and the Returning Warrior Workshop support Marines, and Navy Sailors, Reservists, and their families by focusing on key issues faced by personnel during their transition from deployment to home. Navy and Marine Corps Liaisons at MTFs aggressively ensure that orders and other administrative details, such as extending reservists, are completed.

Traumatic Brain Injury (TBI) is considered the signature wound of OIF/OEF, due to the proliferation of improvised explosive devices (IED). Navy Medicine continues to improve methods to identify and treat TBI. The traumatic stress and brain injury programs at National Naval Medical Center (NNMC) Bethesda, Naval Medical Center San Diego (NMCSD), Naval Hospital Camp Pendleton (NHCP), and Naval Hospital Camp Lejeune (NHCL) are collaborating to identify and treat service members who have suffered blast exposure. Navy Medicine has partnered with the Navy and Marine Corps community to identify specific populations at risk for brain injury such as front line units, SEALS, and Navy Explosive Ordinance disposal units. Navy Medicine also expanded social work assets to provide clinical mental health support in theater, at Navy MTFs and at regional treatment centers.

Much attention has been focused on ensuring service members' medical conditions are appropriately addressed on return from deployment. The Pre-Deployment Health Assessment (Pre-DHA) is one mechanism that is used to identify physical and psychological health issues prior to deployment. The Post Deployment Health Assessment (PDHA) and the Post Deployment Health Re-Assessment (PDHRA) identify deployment related healthcare concerns on return to home station and 90-180 days post deployment.

Navy Medicine's innovative Deployment Health Centers – currently 17 in high Fleet and Marine Corps concentration areas – support the deployment health assessment process and serve

as easily accessible non-stigmatizing portals for mental health care. The centers are staffed with primary care and mental health providers to address deployment-related health issues such as TBI, Post Traumatic Stress Disorder (PTSD), and substance misuse. Since their establishment in FY07, the DHCs have accomplished over 150,000 healthcare encounters, with approximately 23% for psychological health issues. Approximately 15% of Navy and Marine Corps Post Deployment Health Assessments result in a medical referral, while the Post Deployment Health Re-Assessment medical referral rate is approximately 22%.

Navy Medicine's partnership with the Department of Veterans Affairs (VA) medical facilities is evolving into a mutually beneficial partnership. This coordinated care for our warriors who transfer to or are receiving care from a VA facility ensures their needs are met and their families concerns are addressed. Full-time VA staff members are located at several Navy MTFs where they focus on the healthcare needs of service members and their families.

Filling vacancies in the Medical, Dental, Nurse and Medical Service Corps of the Active and Reserve Components is critical in meeting our mission of maintaining medical readiness of the warfighter and providing healthcare to all eligible beneficiaries. My goal is to maintain the right workforce to deliver medical capabilities across the full range of military operations through the appropriate mix of accession, retention, education and training incentives. Working closely with the Chief of Naval Personnel, medical recruiting continues to be one of my top priorities for fiscal year 2009.

Navy Medicine not only equips and trains our current health care professionals; we also prepare the next generation of health care professionals for the challenges ahead. To build the future force for Navy Medicine we must reach out to America's students and young

professionals, inviting them to visit our schoolhouses, hospitals, and research facilities so they can see, firsthand, the great opportunities available within Navy Medicine.

We thank Congress for their generous support of our medical special pay and bonus authorities. Although the Critical Wartime Skills Accession Bonus (CSWAB) achieved limited success attracting physicians and dentists in fiscal year 2008, we have made some adjustments to better position ourselves in fiscal year 2009, including increasing CSWAB and allowing multi-year payouts.

Navy Medicine offers one of the most generous and comprehensive scholarships in the healthcare field. The Armed Forces Health Professions Scholarship Program (HPSP) provides tuition assistance for up to four years of school. In addition all professional school required fees and expenses, books and equipment are paid for by the Navy. The value of this program could be well over $200,000 during the course of a four year professional school program. Graduates joint the Navy's active duty healthcare team as commissioned officers. During fiscal year 2008, the Navy Medical and Dental Corps met its HPSP goal for the first time in several years.

In spite of the successes in HPSP Medical and Dental Corps recruitment, meeting our direct accession mission may remain a challenge. The Medical Services Corps is our most diverse Corps with 31 specialties under three general groupings consisting of clinicians, health care administrators, and research scientists.

I anticipate increased demand for Medical Service Corps personnel with respect to Individual Augmentation missions supporting the current mission in Iraq and the increasing role of the military in Afghanistan, planned Humanitarian Assistance and unexpected disaster relief missions, as well as to meet the needs of Marine Corps manning increases and the many wounded warrior programs they support. These demands will impact Medical Service Corps

specialties linked to mental, behavioral and rehabilitative health and operational support, such as Clinical Psychologists, Social Workers, Occupational Therapists, Physician Assistants and Physical Therapists.

While it is anticipated that the Assistant Secretary of Defense, Health Affairs' guidance for recruiting and retention incentives for Clinical Psychologists, Social Workers, and Physician Assistants will be released this fiscal year, similar incentives may need to be expanded to other specialties where limited incentives currently exist. Consistent with increased operational demand signals, as well as to compensate for prior shortfalls in recruiting, the overall recruiting goals for uniformed Medical Services Corps officers have nearly doubled since fiscal year 2007.

The Navy has been successful during the past year recruiting and retaining Nurse Corps officers using a combination of accession, retention, and loan repayment incentives. Over 4,000 active duty and reserve Navy nurses are serving in operational, humanitarian, and traditional missions at home and overseas. These men and women are essential to Navy Medicine's Force Health Protection mission. Navy nurses, in particular the wartime nursing specialties of mental health, nurse anesthesia, critical care, family nurse practitioners, emergency medicine, preoperative and surgical care, have been exemplary in all theaters of operations and healthcare settings.

For the first time in over five years, Navy Nurse Corps officer gains in 2008 outpaced losses. Despite the growing national nursing shortage and the resistance of the civilian nursing community to the recession, the recruitment and retention of nurses continues to improve. Additional requirements will be placed on the recruiting and retention efforts of the Nurse Corps in the near future as nursing billets are restored due to changes in the Military to Civilian

Conversion program. Future success in the recruitment and retention of nurses will continue to be dependent on incentive packages that are competitive with the civilian sector.

Like recruiting and retention, our Graduate Medical Education (GME) is a critical part of the foundation for Navy Medicine's ongoing success. Navy Medicine provides world-class graduate medical education at nine sites with 60 programs involving over 1000 trainees. Despite the demands on faculty and staff for operational support, our Navy GME programs continue to be highly rated by the Accreditation Council for Graduate Medical Education. Navy program graduates continue to pass their board certification examinations at rates significantly higher than the national average in almost every specialty. More importantly, Navy-trained physicians continue to prove themselves to be exceptionally well prepared to provide care in austere settings ranging from the battle field to humanitarian assistance and disaster relief efforts.

Along with our successes, Navy GME is facing challenges. Advances in medicine and technology are resulting in longer, and in some cases, completely new types of training that stress the fixed number of funded positions available. Additionally, we did not meet medical student accession goals three and four years ago, and this is beginning to impact our current GME programs. The lower number of uniformed graduates will challenge our ability to support our operational health care mission while placing an adequate number of graduates into training to meet our need for specialists in the future.

Navy Medicine scientists conduct basic, clinical, and field research directly related to current and future military requirements and operational needs. In today's unsettled world, we face not only the medical threats associated with conventional warfare, but also the potential use of weapons of mass destruction and terrorism against our military forces and our citizens at home and overseas and our allies. Navy Medicine's research efforts focus on finding solutions

to traditional battlefield medical problems such as bleeding, TBI, combat and operational stress, and naturally occurring infectious diseases; as well as the health problems associated with non-conventional weapons including thermobaric blast, biological agents, and radiation.

The DoD Center for Deployment Health Research at the Naval Health Research Center reported that 8.7 percent of U.S. troops who were deployed and exposed to combat duty in Iraq or Afghanistan reported symptoms of PTSD on a screening survey. We anticipate that this ongoing research will prove helpful in identifying populations at especially increased risk of PTSD from combat, and lead to improved diagnosis and prevention strategies.

The Naval Institute for Dental and Biomedical Research helped to prove the military utility of a new product "Dent Stat," a temporary dental filling material used in treating dental emergencies in all forward deployed settings. This user-friendly temporary restorative material helps stabilize and reduce pain from fractured teeth and lost or broken fillings so warfighters can quickly return to their units.

The Navy Medical Research Center developed an updated vaccine against Japanese encephalitis (JE) allowing for U.S. Food and Drug Administration licensure. The JE vaccine should prevent this mosquito-borne potentially fatal brain infection, and will save lives of military personnel who deploy to the Asia-Pacific region, and also civilian travelers to JE-endemic regions.

These are just a few examples of how Navy Medicine's biomedical and dental research, development, testing and evaluation, including clinical investigations, will protect and improve the health of those under our care.

It is important to recognize the unique challenges before Navy Medicine at this particularly critical time for our nation. Growing resource constraints for Navy Medicine are

real, as is the increasing pressure to operate more efficiently without compromising healthcare quality and workload goals. The Military Healthcare System (HMS) continues to evolve, and we are taking advantage of opportunities to modernize management processes that will allow us to operate as a stronger innovative partner within the MHS.

Integration of care between the military direct care and our civilian network, and across the services, has implications related to both the quality and cost of care. The National Capital Area and the San Antonio military markets have become pilots for a "joint" healthcare system. While the models are different, the end goal is the same: a single approach to healthcare. With the current economic situation driving the need for cost effectiveness, movement toward a Unified Medical Command construct will likely accelerate. Identifying those functions that can be joint -- along with those that need to remain service specific -- is a critical component of the success of the project. Bringing the direct care system and the TRICARE Management Activity under a single command structure offers significant advantages and might be the next best step as military healthcare evolves. Navy Medicine supports and is actively engaged in these efforts.

Chairman Murtha, Ranking Member Young, I want to express my gratitude on behalf of all who work for Navy Medicine – uniformed, civilian, contractor, volunteer personnel – who are committed to meeting and exceeding the health care needs of our beneficiaries. Thank you again for providing me this opportunity to share with you Navy Medicine's mission, what we are doing today, and our plans for the future. It has been my pleasure to testify before you today and I look forward to answering any of your questions.

Mr. MURTHA. General Roudebush.

SUMMARY STATEMENT OF GENERAL ROUDEBUSH

General ROUDEBUSH. Thank you. Chairman Murtha, Ranking Member Young, distinguished members, it is a pleasure to be here before you today. This is my last time. It has been a privilege to be part of this process, to have the opportunity to share issues, concerns, opportunities with you, and to invariably receive your full attention, your full support, and the unflagging intent and vector to assure that every soldier, sailor, airman, and marine has the care that they need, as well as their family members. And we truly thank you for that, sir.

Air Force medicine contributes significant capability to the joint warfight in combat, casualty care, wartime surgery and air and medical evacuation.

On the ground at both the Air Force Theater Hospital at Balad and the Craig Joint Theater Hospital in Bagram, we are leading numerous combat casualty care initiatives that will positively impact combat and peacetime medicine for years to come.

Air Force surgeons have laid the foundation for a state-of-the-art in-the-field vascular operating room at Balad, the only DOD facility of its kind. Their use of innovative technology and surgical techniques has greatly advanced the care of our joint warfighter and coalition casualties. And their work with their Army and Navy brothers and sisters have truly rewritten the book on combat casualty care in our theater of operation.

To bring our wounded warriors safely and rapidly home, our critical care medical transport teams provide unique ICU care in the air, within DOD's joint en route medical care system. We continue to improve the outcomes of the CCAT wounded warrior care by incorporating lessons learned in the clinical practice guidelines and modernizing the equipment to support the mission.

This Air Force unique expertise pays huge dividends back home as well. When Hurricanes Katrina and Rita struck in 2005, Air Force Active Duty, Guard, Reserve and medical American personnel were in place conducting lifesaving operations. Similarly, hundreds of members of this Total Force team were in force in September of 2008 when Hurricane Gustav struck the Louisiana coast and when Hurricane Ike battered Galveston, Texas less than 2 weeks later.

During Hurricane Gustav, Air Mobility Command coordinated the movement of more than 8,000 evacuees, including 600 patients. Air crews transported post-surgical and intensive-care unit patients from Texas area hospitals to Dallas medical facilities. I am truly proud of this incredible team effort.

The success for our Air Force mission directly correlates with our ability to build and maintain a healthy, fit, force at home and in theater. Always working to improve our care, our Family Health Initiative establishes an Air Force medical home. This medical home optimizes health-care practice within our family health-care clinics, positioning a primary care team to better accommodate the enrolled population and streamline the processes for care and disease management. The result is better access, better care and better health.

The psychological health of our airmen is critically important as well. To mitigate their risk for combat stress symptoms and possible mental health problems, our program known as Landing Gear takes a proactive approach with symptom recognition both pre- and post-deployment.

We educate our airmen to recognize risk factors in themselves and others, along with a willingness to seek help, is the key to effectively functioning across the deployment cycle and reuniting and reintegrating with their families.

Likewise, we screen carefully for traumatic brain injury at home and at our forward-deployed medical facilities. To respond to our airmen's needs, we have over 600 Active Duty and 200 civilian and contract mental health providers.

This mental-health workforce has been sufficient to meet the demand signal that we have experienced to date. That said, we do have challenges with respect to Active Duty psychologist and psychiatrist recruiting and retention. And we are pursuing special pays and other initiatives to try to bring us closer to 100% staffing in these two specialties. And we thank you for your support in this critically important endeavor.

For your awareness, over time we have seen an increased number of airmen with post-traumatic stress disorder; 1,758 airmen have been diagnosed with PTSD within 12 months from return of deployment from 2002 to 2008. As a result of our efforts at early PTS identification and treatment, the vast majority of these airmen continue to serve with the benefit of support and treatment.

Understanding that suicide prevention lies within and is integrated into the broader construct of psychological health and fitness, our suicide prevention program, a community-based program, provides the foundation for our efforts.

Rapid recognition, active engagement at all levels, and reducing any stigma associated with help-seeking behavior are the hallmarks of our program. One suicide is too many and we are working hard to prevent the next.

Sustaining the Air Force Medical Service requires the very best in education and training for our professionals. In today's military, that means providing high-quality programs within our system as well as strategically partnering with academia, private sector medicine, and the VA to assure that our students, residents, and fellows have the best training opportunities possible.

While the Air Force continues to attract the finest health professionals in the world, we still have significant challenges in recruiting and retention. We are working closely with our personnel and recruiting communities using accession and retention bonus plans to ensure full and effective staffing with the right specialty mix to perform our mission today and tomorrow.

At the center of our strategy is the Health Profession Scholarship Program. HPSP is our most successful recruiting tool, but we are also seeing positive trends in retention from our other financial assistance programs and pay plans. Again, thank you for your unwavering support in this critical endeavor.

In summary, Air Force medicine is making a difference in the lives of airmen, soldiers, sailors, marines, family members, coalition partners and our Nation's citizens. We are earning their trust

every day. And as we look to the way ahead, I see a great future for the Air Force Medical Service built on a solid foundation of top-notch people, outstanding training programs, and strong partnerships.

It is indeed an exciting, challenging, and rewarding time to be in Air Force medicine and, indeed, in military medicine. I couldn't be more proud of my Air Force and Joint Medical Team. We join our sister services in thanking you for your enduring support, and I look forward to your questions.

[The statement of General Roudebush follows:]

DEPARTMENT OF THE AIR FORCE

PRESENTATION TO THE COMMITTEE ON APPROPRIATIONS

SUBCOMMITTEE ON DEFENSE

UNITED STATES HOUSE OF REPRESENTATIVES

SUBJECT: DEFENSE HEALTH PROGRAM

STATEMENT OF: LIEUTENANT GENERAL (DR.) JAMES G. ROUDEBUSH
AIR FORCE SURGEON GENERAL

May 21, 2009

NOT FOR PUBLICATION UNTIL RELEASED
BY THE COMMITTEE ON APPROPRIATIONS
SUBCOMMITTEE ON DEFENSE
UNITED STATES HOUSE OF REPRESENTATIVES

BIOGRAPHY

UNITED STATES AIR FORCE

LIEUTENANT GENERAL (DR.) JAMES G. ROUDEBUSH

Lt. Gen. (Dr.) James G. Roudebush is the Surgeon General of the Air Force, Headquarters U.S. Air Force, Washington, D.C. General Roudebush serves as functional manager of the U.S. Air Force Medical Service. In this capacity, he advises the Secretary of the Air Force and Air Force Chief of Staff, as well as the Assistant Secretary of Defense for Health Affairs on matters pertaining to the medical aspects of the air expeditionary force and the health of Air Force people. General Roudebush has authority to commit resources worldwide for the Air Force Medical Service, to make decisions affecting the delivery of medical services, and to develop plans, programs and procedures to support worldwide medical service missions. He exercises direction, guidance and technical management of more than 43,100 people assigned to 75 medical facilities worldwide.

The general entered the Air Force in 1975 after receiving a Bachelor of Medicine degree from the University of Nebraska at Lincoln, and a Doctor of Medicine degree from the University of Nebraska College of Medicine. He completed residency training in family practice at the Wright-Patterson Air Force Medical Center, Ohio, in 1978, and aerospace medicine at Brooks Air Force Base, Texas, in 1984. The general commanded a wing clinic and wing hospital before becoming Deputy Commander of the Air Force Materiel Command Human Systems Center. He has served as Command Surgeon for U.S. Central Command, Pacific Air Forces, U.S. Transportation Command and Headquarters Air Mobility Command. Prior to his selection as the 19th Surgeon General, he served as the Deputy Surgeon General of the U.S. Air Force.

EDUCATION

1971 Bachelor of Medicine degree, University of Nebraska at Lincoln
1975 Doctor of Medicine degree, University of Nebraska College of Medicine
1978 Residency training in family practice, Wright-Patterson USAF Medical Center, Wright-Patterson AFB, Ohio
1980 Aerospace Medicine Primary Course, Brooks AFB, Texas
1981 Tri-Service Combat Casualty Care Course, Fort Sam Houston, Texas
1983 Master's degree in public health, University of Texas School of Public Health, San Antonio
1984 Residency in aerospace medicine, Brooks AFB, Texas
1988 Air War College, by seminar
1989 Institute for Federal Health Care Executives, George Washington University, Washington, D.C.
1992 National War College, Fort Lesley J. McNair, Washington, D.C.
1993 Executive Management Course, Defense Systems Management College, Fort Belvoir, Va.

ASSIGNMENTS

1. July 1975 - July 1978, resident in family practice, Wright-Patterson USAF Medical Center, Wright-Patterson AFB, Ohio

2. July 1978 - September 1982, physician in family practice and flight surgeon, USAF Hospital, Francis E. Warren AFB, Wyo.
3. October 1982 - July 1984, resident in aerospace medicine, USAF School of Aerospace Medicine, Brooks AFB, Texas
4. August 1984 - September 1986, Chief of Aerospace Medicine, 81st Tactical Fighter Wing, Royal Air Force Bentwaters, England
5. September 1986 - July 1988, Commander, USAF Clinic, 81st Tactical Fighter Wing, Royal Air Force Bentwaters, England
6. August 1988 - June 1991, Commander, 36th Tactical Fighter Wing Hospital, Bitburg Air Base, Germany
7. August 1991 - July 1992, student, National War College, Fort Lesley J. McNair, Washington, D.C.
8. August 1992 - March 1994, Vice Commander, Human Systems Center, Brooks AFB, Texas
9. March 1994 - January 1997, Command Surgeon, U.S. Central Command, MacDill AFB, Fla.
10. February 1997 - June 1998, Command Surgeon, Pacific Air Forces, Hickam AFB, Hawaii
11. July 1998 - July 2000, Commander, 89th Medical Group, Andrews AFB, Md.
12. July 2000 - June 2001, Command Surgeon, U.S. Transportation Command and Headquarters Air Mobility Command, Scott AFB, Ill.
13. July 2001 - July 2006, Deputy Surgeon General, Headquarters U.S. Air Force, Bolling AFB, Washington D.C.
14. August 2006 - present, Surgeon General, Headquarters U.S. Air Force, Washington, D.C.

FLIGHT INFORMATION
Rating: Chief flight surgeon
Flight hours: More than 1,100
Aircraft flown: C-5, C-9, C-21, C-130, EC-135, F-15, F-16, H-53, KC-135, KC-10, T-37, T-38, UH-1 and UH-60

BADGES
Chief Physician Badge
Chief Flight Surgeon Badge

MAJOR AWARDS AND DECORATIONS
Distinguished Service Medal
Defense Superior Service Medal with oak leaf cluster
Legion of Merit with oak leaf cluster
Meritorious Service Medal with two oak leaf clusters
Air Force Commendation Medal
Joint Meritorious Unit Award
Air Force Outstanding Unit Award with oak leaf cluster
National Defense Service Medal with bronze star
Southwest Asia Service Medal with bronze star
Air Force Overseas Long Tour Ribbon with oak leaf cluster
Air Force Longevity Service Award with silver oak leaf cluster
Small Arms Expert Marksmanship Ribbon
Air Force Training Ribbon

PROFESSIONAL MEMBERSHIPS AND ASSOCIATIONS
Society of USAF Flight Surgeons
Aerospace Medical Association
International Association of Military Flight Surgeon Pilots
Association of Military Surgeons of the United States
Air Force Association
American Medical Association

EFFECTIVE DATES OF PROMOTION
Second Lieutenant May 15, 1972

First Lieutenant May 15, 1974
Captain May 15, 1975
Major Dec. 8, 1979
Lieutenant Colonel Dec. 8, 1985
Colonel Jan. 31, 1991
Brigadier General July 1, 1998
Major General May 24, 2001
Lieutenant General Aug. 4, 2006

(Current as of May 2008)

Mr. Chairman and esteemed members of the Committee, it is my honor and privilege to be here today to talk with you about the Air Force Medical Service. Our Air Force medics work directly for the Line. To that end, we too are focused on reinvigorating the Air Force nuclear enterprise; partnering with the joint and coalition team to win today's fight; developing and caring for Airmen and their families; modernizing our Air and Space inventories, organizations, and training, and, recapturing acquisition excellence.

In support of our Air Force priorities, our Air Force Medical Service (AFMS) is on the cutting edge of protecting the health and well-being of our Service men and women everywhere. Our experience in battlefield medicine is shaping America's health care for the 21st Century and beyond. We are actively enhancing readiness; ensuring a fit, healthy force, and building/sustaining the model health system for DoD. In short, it's a great time to be in Air Force medicine!

ADVANCEMENTS IN READINESS

Air Force medics contribute significant capability to the joint warfight in aeromedical evacuation, combat casualty care and wartime surgery. Our advancements in these areas are unparalleled in previous combat experience.

Our Critical Care Air Transport Teams (CCATTs) provide unique "ICU care in the air" within DoD's joint enroute medical care system. We continue to improve the outcomes of CCATT wounded warrior care by incorporating lessons learned into clinical practice guidelines and modernizing equipment to support the mission. For example, we are developing a joint electronic in-flight patient medical record to ensure effective patient care documentation and record availability. We are working to improve CCATT equipment, such as mobile oxygen storage tanks and airborne wireless communication systems, and continuing to evaluate existing equipment to ensure safety for our patients.

On the ground, at both the Air Force Theater Hospital at Balad, Iraq and Craig Joint Theater Hospital at Bagram, Afghanistan, Air Force medics lead numerous combat casualty care initiatives that will positively impact combat and peacetime medicine for years to come. The Air Force surgeons garnered invaluable experience in the field of vascular surgery that laid the foundation for a state-of-the-art endovascular operating room at Balad--the only DoD facility of its kind. The inaugural use of diagnostic angiography and vena caval filters, along with coil embolization and stent grafts in select vascular surgeries in-theater have truly modernized care of our joint warfighter and coalition casualties. Colonel (Dr.) Jay Johannigman, the 332nd Expeditionary Medical Operations Squadron lead trauma surgeon, said, "Our Joint combat hospitals, be they Army, Navy, or Air Force, are all beginning to think alike and do things similarly. These efforts help us improve and speed the care to the patient."

Working with the Armed Services Blood Program Office, Air Force medics have improved the supply of crucial life-saving blood products in-theater, supplementing fresh blood with a new frozen red blood cell product with an extended shelf life. An in-theater apheresis center was established to collect fresh platelets needed to support aggressive treatment of trauma patients requiring massive transfusions.

The ability to collect and analyze data is critical to our success in combat casualty care. The Joint Theater Trauma Registry (JTTR), established in 2004, has made significant strides in these efforts. Their work led to major changes in battlefield care, including management of extremity compartment syndromes, burn care resuscitation, and blood transfusion practices. Their results are setting military-civilian benchmarking standards. The JTTR is truly a joint effort, with full participation of the Air Force. An Air Force physician is the JTTR system deputy director, and our critical care nurses are key players in the in-theater JTTR team. Through the JTTR we're capturing and implementing best practices for management of the extensive trauma cases seen.

Air Force-unique expertise pays dividends back home, as well as in theater, and is saving lives. Many Americans who have become victims of natural disasters benefited from our humanitarian support. When Hurricanes Katrina and Rita struck in 2005, Air Force Active Duty, Guard, and Reserve medics were in place conducting lifesaving operations. Similarly, hundreds of members of this Total Force team were in place September 1, 2008 when Hurricane Gustav struck the Louisiana coast and when Hurricane Ike battered Galveston, Texas, less than two weeks later. During Hurricane Gustav, Air Mobility Command coordinated the movement of more than 8,000 evacuees, including 600 patients. Aircrews transported post-surgery/post-intensive care unit patients from Galveston area hospitals to Dallas medical facilities. I am extremely proud of this incredible team effort.

ENSURING A FIT AND HEALTHY FORCE

The success of our medical readiness mission directly correlates with our ability to build and maintain a fit and healthy force at home station and in-theater. One way we do this is through optimization of health care delivery. Our Family Health Initiative, our Air Force "medical home," optimizes health care practice within our family health clinics, increasing the number of medical technicians on the family health teams to better accommodate the enrolled population and streamlining the processes for care and disease management.

We achieve a fit and healthy force by measuring our health care outcomes. The AFMS has used the Healthcare Effectiveness Data and Information Set measures for more than eight years to assess the care we deliver. Our outcome measures for childhood immunization delivery, asthma medication management, LDL cholesterol control in diabetics, and screening for Chlamydia all exceed the 90th percentile in comparison to civilian benchmarks. We also compare very highly with civilian hospital care for all 40 of our measures developed by the Agency for Healthcare Research and Quality, which evaluates patient safety, inpatient quality, pediatric care quality, and prevention-related quality for our hospital services. We recently

began measuring 30-day mortality rates for myocardial infarction, pneumonia and congestive heart failure, and found that the AFMS is well below the national benchmark in all three measures. In 2009, we will implement measurement of well-child visits and follow-up after mental health hospitalization. While this is all good news, we must remain vigilant in analyzing and evaluating the effectiveness of our health care delivery – our patients deserve the very best.

The exposure of our Airmen to battlefield trauma puts psychological health at the forefront of our health and fitness mission. To mitigate their risk for combat stress symptoms and possible mental health problems, our Landing Gear program takes a proactive approach with education and symptom recognition, both pre- and post-deployment. We educate our Airmen that recognizing risk factors in themselves and others, along with a willingness to seek help, is the key to effectively functioning across the deployment cycle and reuniting with their families.

We have over 600 Active Duty and over 200 civilian and contract mental health providers. This includes 97 additional contract Mental Health providers we added in 2007 to manage increased workload. This mental health workforce has been sufficient to meet the demand signal that we have experienced to date. That said, we do have challenges with respect to Active Duty psychologist and psychiatrist recruiting and retention, and we are pursuing special pays and other initiatives to try to bring us closer to 100% staffing in those two specialties. We continually assess and reassess the demand based on mission requirements as well as the need for clinical services. We are seeing a gradual increase in the incidence of post-traumatic stress disorder (PTSD) in our Airmen and we are also seeing a persistent demand at the 1:2 dwell rate for mental health providers in the deployed environment. This demand is not likely to decrease, and could well increase over time. We are tracking this demand closely to ensure that we have the resources to meet tomorrow's demand.

With regard to what we are doing about PTSD, we address post-traumatic stress (PTS) in our Airmen by combining resilience training with frequent screening and ready access to

mental health care. Resilience training is conducted via an Air Force developed program Landing Gear, where Airmen learn what to expect while deployed, and when and how to get help for stress symptoms. Screening occurs before deployment, at the end of deployment, 90-180 days post-deployment and annually via the Physical Health Assessment. Each screening asks about PTS and other psychological symptoms. Health care providers fully assess all symptoms noted on the screening, and refer to mental health providers for further care as needed. We also train frontline supervisors and have positioned mental health personnel in our primary care clinics in order to increase access and reduce stigma. Quality health care for our Airmen requires our mental health providers to have the best tools available to treat PTS. To that end, we have sent 490 of our mental health providers to 2 and 3-day workshops conducted by civilian subject matter experts on the two widely recognized methods of PTSD treatment. All our providers, mental health and primary care, are trained and follow nationally/Veterans Affairs (VA) approved clinical practice guidelines to assure that all treatment for PTSD is state of the art and meets the highest standards.

For your awareness, 1,758 Airmen have been diagnosed with PTSD within 12 months of return from deployment (Fiscal Year 2002-Fiscal Year 2008). The vast majority of these Airmen continued to serve with the benefit of treatment and support. Of these Airmen, 255 have been enrolled in our Wounded Warrior program secondary to PTSD, and are not expected to be returned to duty. Our efforts at early PTS identification and treatment strive to maximize the number of Airmen we are able to return to full duty and health. As noted, however, we are seeing an increase over time in the number of our Airmen with diagnosed PTSD.

Understanding suicide prevention lies within and is integrated into the broader construct of psychological health and fitness, we continue to aggressively work our eleven suicide prevention initiatives, which include frontline supervisor training and suicide risk assessment training for mental health providers. We have mental health providers in our family health units to provide the full spectrum of care for both our active duty and family members. This allows us

to approach issues in a way conducive to quick recognition and resolution, while reducing any perceived stigma associated with visits to mental health clinics. Suicide prevention requires a total Air Force community effort, using all tools available. We are expanding our ability to identify, track and treat Airmen dealing with PTSD, Traumatic Brain Injury (TBI), or other mental health problems to ensure no one is left behind who needs help. We have the resources, the opportunity, and clearly the need to better understand, and care for these injuries.

Current treatment/management for TBI is based on Defense and Veterans Brain Injury Center (DVBIC) TBI Clinical Guidance. The Air Force TBI treatment is done by a multidisciplinary team guided by comprehensive brain injury and mental health assessment tools. All TBI patients receive education on TBI symptoms and management as well as appropriate referrals for occupational therapy, physical therapy, speech and language, pharmacy, audiology and optometry. Cognitive rehabilitation is initiated after medical issues have subsided and the patient's pain is managed. In Fiscal Year 2009, video teleconferencing equipment will be installed in all mental health clinics to allow direct consult with the DVBIC.

We have also taken the lead in DoD with diabetes research and community outreach. We have a very productive partnership with the University of Pittsburgh Medical Center (UPMC) and the Army. Wilford Hall Medical Center (WHMC), Lackland AFB, Texas, is designated as the initial DoD roll-out site for diabetes initiatives developed at UPMC. Major Mark True, an endocrinologist, is the WHMC project lead and director for the Air Force diabetes program. He established a Diabetes Center of Excellence (DCOE) program and, in August 2007, introduced several inpatient diabetes protocols and initiatives in the hospital, including an intravenous insulin protocol that substantially improved glucose control in critical care units. We are working to open an outpatient regional DCOE that will impact clinical outcomes across a regional population. This will be supported by the Mobile Diabetes Management with Automated Clinical Support Tools project beginning this year, which will demonstrate improved diabetic management through cell phones and web-based technology use.

BUILDING AND SUSTAINING A PRE-EMINENT AIR FORCE MEDICAL SERVICE

Sustaining the AFMS as a premiere organization requires the very best in education and training for our professionals. In today's military, that means providing high quality programs within our system, as well as strategically partnering with academia, private sector medicine and the VA to assure that our students, residents and fellows have the best training opportunities possible.

With the ongoing demand for well trained surgeons in our trauma care mission, we have focused on Surgical Care Optimization. This initiative identified eleven medical treatment facility (MTF) platforms to provide the capacity necessary to keep critical wartime medics proficient in battlefield trauma care. It also seeks to increase MTF recapture of DoD beneficiary specialty care by optimizing operating room access and efficiency.

Our Graduate Medical Education programs consistently graduate residents fully prepared to provide excellent clinical care in the inpatient, outpatient and deployed settings. The outstanding performance of our residents on board certification exams is just one marker of the success of our numerous training programs, many of which are partnered with leading civilian institutions throughout the country, including Wright State and Cincinnati University in Ohio; Saint Louis University in Missouri, and the Universities of Mississippi, Texas, Nevada and California.

We partner with local civilian medical facilities to support the Sustainment of Trauma And Resuscitation Skills Program, enabling home-station clinical currency rotations in private sector level one trauma centers. Our Centers for Sustainment of Trauma and Resuscitation Skills is an immensely successful partnering endeavor that provides immersion trauma skills training with some of the great trauma centers in the Nation – R. Adams Cowley Shock Trauma Center in Baltimore, Maryland; University Hospital in Cincinnati, Ohio; and St. Louis University Medical Center, Missouri. Nearly 800 physicians, nurses and technicians completed this

training in 2008; many of them deployed soon after and reported being very well prepared for their roles in combat medicine.

Working closely with our Department of Veterans Affairs partners, we continuously strive to streamline the system for all our personnel to include our wounded, ill and injured Airmen. A major success in this partnership is our joint ventures. The Air Force has four of the eight existing DoD/VA joint venture sites – Elmendorf AFB, Alaska; Kirtland AFB, New Mexico; Nellis AFB, Nevada; and Travis AFB, California. Three additional sites are under consideration or in development at Keesler AFB, Mississippi; Buckley AFB, Colorado; and Eglin AFB, Florida. These joint ventures offer optimal health care delivery capabilities for both our patient populations, while also serving to make the most of taxpayer dollars.

The Disability Evaluation System pilot program is a joint effort that resulted from the Commission on Care for America's Returning Wounded Warriors. The goal is to simplify health care and treatment for injured Service members and veterans and to deliver benefits as quickly as possible. Malcolm Grow Medical Center at Andrews AFB, Maryland was one of the initial three military medical treatment facilities in the National Capital Region to participate. The pilot streamlined and increased transparency of both the medical examination board process and the VA disability and compensation processes. In the pilot, both processes now occur concurrently, provide more information for the member during the process, and supply comprehensive information regarding entitlements from both agencies at the time of the separation. Continued evaluation of the study is slated to occur at 19 more military installations, to include Elmendorf AFB, Alaska.

Cutting-edge research and development initiatives are critical to building the future AFMS. The Virtual Medical Trainer is a continuation of existing efforts to develop advanced distributed learning. This project focuses on the development of training for disaster preparedness and medical care contingencies, addressing such areas as equipment, logistics, and war readiness skills training. Extensive work has been done to increase simulation in all of

our hospitals and trauma training centers. Shared simulation with our university partners improves care and patient safety for both civilian and military patients. Virtual or simulation capabilities are a very cost-effective way to train and prepare our medics to do a variety of missions.

Keesler AFB, Mississippi is studying advanced technologies to include robotic microscopy and virtual (whole slide) imaging. Eight MTFs have the robotic microscopes, and efforts are underway to obtain connectivity between MTFs and the VA Medical Center at Omaha, Nebraska. Once fully operational, this system allows general clinicians remote access to expert advice, diagnosis, and mentoring, and provides high quality standard of care independent of location.

Similarly, telemedicine is vastly expanding the capabilities of our existing resources. Wright-Patterson AFB, Ohio radiologists and clinicians are successfully providing consultation services across the Air Force, and this year the project is slated to extend to Landstuhl Army Medical Center, Germany, and RAF Lakenheath, England. Automated Identification and Data Collection, a new business process study at Keesler AFB, Mississippi will identify opportunities for radiofrequency identification and barcode technologies in military medicine. We are exploring how to improve clinical and administrative processes in medical equipment management and repair, patient flow analysis and management, bedside services, medication administration, and surgical tray management.

Successfully building and sustaining the AFMS requires continued focus on the physical plants we occupy to perform our mission. We greatly appreciate the tremendous support you have provided to recapitalize Air Force aging medical infrastructure. We're excited about our plans to improve facility restoration and sustainment and to move forward with sorely needed medical military construction (MILCON) projects.

Green design initiatives and energy conservation continue to be high priorities for the Air Force. We are incorporating these into AFMS MILCON and restoration projects for our MTFs.

We use the nationally accepted benchmark--Leadership in Energy and Environmental Design--to design and construct buildings with sustainable design elements. I'm pleased to share some recent examples, such as exterior solar shading panels used in Keesler AFB's Base Realignment and Closure (BRAC) Tower and Diagnostic Imaging Center projects. A grey water system incorporated into Tinker AFB, Oklahoma MILCON recycles treated wastewater generated from MTF hand-washing for use in toilets or irrigation systems, decreasing or eliminating the amount of fresh water used for those purposes. Our projected Fiscal Year 2010 Air Force MILCON projects will incorporate enhanced day lighting concepts allowing more natural light into buildings and office spaces. Our energy optimization efforts are both environmentally and fiscally beneficial and enable us to better serve military members and their families.

Our most critical building block for the future is our people. With these unprecedented advances in training and research, it is understandable that the Air Force continues to attract many of the finest health professionals in the world. In Fiscal Year 2008, the Air Force Medical and Dental Corps exceeded their Health Professions Scholarship Program (HPSP) recruiting goals. HPSP is our most successful recruiting tool, and we are seeing positive early trends in retention from our other financial assistance programs and pay plans. We are working closely with our personnel and recruiting communities at targeting accession and retention bonus plans to ensure full and effective staffing with the right specialty mix to perform our mission.

BUILDING A JOINT AND EFFECTIVE MILITARY HEALTH SYSTEM

The AFMS is committed to working with our Sister Services to support joint medical capabilities and leverage common operating platforms such as logistics, research and development and information management/information technology. We are well on the way to bringing BRAC plans to fruition. The Joint Task Force National Capital Region Medical, or JTF CapMed, is moving forward with plans to combine the Army, Navy, and Air Force assets into the

new Walter Reed National Military Medical Center. Malcolm Grow Medical Center at Andrews AFB, Maryland is our component to JTF CapMed and serves as an important care delivery platform in the NCR as the east coast hub for aeromedical evacuation. Since late 2001, Andrews AFB has welcomed home and cared for more than 33,000 patients arriving from Operations Enduring Freedom and Iraqi Freedom, U.S. Central Command, U.S. European Command and U.S. African Command.

The BRAC plans are also moving forward in San Antonio, Texas, to integrate Army and Air Force MTFs into the new San Antonio Military Medical Center (SAMMC), creating the largest inpatient facility in DoD. SAMMC has integrated nearly all clinical activities and has led the way in bringing the Air Force and Army together in an integrated platform that meets the Air Force, Army, and joint mission requirements all the while maximizing the use of existing resources.

Also in San Antonio is the Medical Education and Training Campus (METC). This is an important step toward what leaders are calling the largest consolidation of training in the history of the Department of Defense. Upon completion in 2011, the joint campus, led by tri-Service leadership, will centralize all Army, Navy and Air Force basic and specialty enlisted medical training at Fort Sam Houston, Texas. At Wright-Patterson AFB, Ohio, the 711th Human Performance Wing has been activated and will serve as a cutting-edge joint center of excellence for human performance and aerospace medicine.

These are but some of the ways and places we are working toward joint solutions that enhance mission support and benefit the quality of medical care for our warfighters and their families.

BRIGHT FUTURE AND GOOD TIME TO BE IN THE AIR FORCE MEDICAL SERVICE

Air Force medics make a difference in the lives of Airmen, Soldiers, Sailors, Marines, family members, coalition partners and civilians. They take pride in every patient encounter and earn our Nation's trust...everyday!

As we look to the way ahead, I see a great future for the AFMS, built on a solid foundation of top-notch people, outstanding training programs and strong partnerships. It is indeed an exciting, challenging and rewarding time to be in Air Force medicine! I couldn't be more proud.

We join our Sister Services in thanking you for your enduring support.

Mr. MURTHA. Mr. Young.

REMARKS OF MR. YOUNG

Mr. YOUNG. Mr. Chairman, thank you very much. First let me apologize for being late for the beginning of the hearing; but for me to get to work, I have got to travel on probably the heaviest traffic highway in the world, and there were three accidents on that highway this morning.

Mr. Chairman, I want to welcome the Surgeons General. In one of our previous hearings with the Surgeons General, I made the comment that I complimented the witnesses for the really outstanding medical care that our military troops and their families receive in the military hospitals.

And I will tell you, I took a couple of really tough blogger hits, because it was right about the time when there were some negative stories about one of our hospitals. But I will do it again today. I will tell you that Mr. Murtha and I have visited your hospitals so many times, and I think he would agree that we have actually seen miracles take place at your hospitals; miracles, at least from the layman's perspective.

And I just want to compliment you for the military medical care that you provide for our troops and for their families. No one is perfect. We certainly aren't perfect, but you just do a really good job.

But Jim Roudebush, the last time I saw Jim Roudebush, Admiral Robinson, was at your hospital at Bethesda about 3 weeks ago, and he was in his flight suit. I don't know if he was getting ready to fly off somewhere but I tell you what: That flight suit fit him just like it did about 30 years ago when he first put it on.

MILITARY MEDICINE

Jim, I know the Air Force will miss you; military medicine will miss you.

Military Medicine has done a really good job promoting the United States and the generosity of the American people around the world.

And one of the early projects of this committee was the creation of the hospital ships, the USNS MERCY and the USNS COMFORT. But I have learned some interesting information, because we send the USNS MERCY and USNS COMFORT around the world to natural disasters that are not related to any military operations, but we still do it. And I think it speaks well for the United States, but it also helps those who have been injured and who become sick because of those natural disasters.

But I am getting some word that maybe the Navy has to pick up the cost of even those non-Navy, non-military operations. And, Admiral, I wonder if you might explain that to us. In fact, does that come out of your regular budget that you would use for treating military troops?

Admiral ROBINSON. Congressman Young, humanitarian and civil assistance missions are actually funded out of Fleet Forces Command in Norfolk, so the humanitarian missions are funded in that regard. What I have testified before is a nuance of that goes some-

thing like this: As we staff the humanitarian civil assistance missions and over the course of the last year we have done approximately 130,000 outpatient visits and about 1,400 in-patient visits from around the world the workload of those visits isn't captured by any of the data systems that we use in DoD. And so as my men, women, corpsmen, nurses, physicians, and Medical Corps dentists leave the medical treatment facilities to go do those missions, and as we then backfill with contractors—which is also paid for—the workload often doesn't reflect the additional work that those men and women are doing; and therefore, as we get into our pay-for-performance systems, how we will calculate moneys back to the Military Treatment Facilities (MTFs).

Often, I actually end up being taxed for those humanitarian civilian assistance. So I have previously testified to that and that is, I think, what you are alluding to in terms of the impact on the Military Health System and specifically on Navy Medicine.

Mr. YOUNG. Well, that maybe explains the effect of what you are not able to do for our troops in the Navy hospitals.

Admiral ROBINSON. Well, I would say that, in fact, we are not negatively affected by our ability to do the care and do the missions that we have. But I would suggest that as we look at our workload and as we look at metrics that help explain the efficiency of particularly our hospitals, our MTFs, what you will find is that instead of not being as efficient—which often is reflected in the workload data because the workload data, as I said, that is being done on USNS MERCY, USNS COMFORT and other humanitarian assistance missions isn't being captured—instead of being less efficient, I actually think we are more efficient.

But specifically as we look at the inefficiencies that can occur, we only get graded as not being as efficient, but we also get taxed by not being able to participate in the compensation and the pay-for-performance, so the PPS becomes an issue. So we send people, we do missions and we still get taxed for that. And I just bring that up because I think that is a real factor in Navy Medicine.

Mr. YOUNG. Well, let me direct this question to all three of you, or all four of you. The budget, I personally think that the budget is a little—the budget request is lacking in some of the needs for military service-wide. Are there any things that you all need that are not in the budget request that would become an unfunded requirement?

Ms. EMBREY. As you know, sir, I am performing the duties. I am not currently on appointment of the current administration, so I am serving in an acting capacity. They call it performing the duty. I think I won't be performing the duties much longer if I identified anything other than the needs of the President's budget.

Mr. YOUNG. No, I understand that. But we are not going to tell the President what you tell us.

General SCHOOMAKER. Well, sir, I will echo Ms. Embrey's comments. As I said in my opening statement, Army medicine is sufficiently funded in the fiscal year 2010 budget. But I think you are asking us to give you an assessment, our gut check on where we think we are taking risks.

If I would say that probably if there is an area that I am concerned about, it is that you all have been extraordinarily generous

in helping us reverse several decades of undercapitalization of our physical plants, our hospitals, our clinics. You heard the list from all of us of what you have done for us.

But our initial outfitting and transition cost associated with that, we call them IO&T costs, are funded in the budget year.

So with the increased use of—that is, more users coming into our system, more unique Social Security numbers, more unique individual patients, and with our patients who are enrolled in our system using it more frequently, that is a good thing in the sense that people have reduced stigma to get mental health, so they have been coming in and are using it more.

Wounded and ill and injured soldiers, much like Vice Admiral Robinson commented about the military unique missions of the Navy, in Army medicine we are caring for close to 10,000 wounded, ill and, injured soldiers. They take a significantly larger amount of care.

And so with this growth in care competing with initial outfitting, I think there is some risk there, sir. But I would have to say at this point in time we are sufficiently budgeted.

Admiral ROBINSON. I would echo what Ms. Embrey has said already. I would also suggest that and Navy Medicine is fully funded also.

I would suggest that as we look at the DHP, though, the private sector care moneys, I am not suggesting that they are not fully funded, but that is a risk area because we on the MHS, we in the Active Duty side, don't really have visibility of those amounts of funds, so those are types of issues that come into play.

I don't know that that is going to be an issue. It is just that the visibility is lacking from my point of view, so I can't see that.

So that would be my only comment.

General ROUDEBUSH. Sir, I would agree we are adequately funded. But I think it is also going to be challenging this year, challenging next year. We are operating at a very high ops tempo with the mil-to-civ billets coming back on our books. As we work to fill those with military personnel, we are working to be sure that we keep those gaps filled by other means, whether it is just short-term overhires, whatever the methodology.

But we wanted to assure that we maintain ready access and that we are, in fact, able to provide that care. So it does provide a challenge.

I would like to offer an observation, however. I think you and we are especially well-served by your staffers, who really engage with us at a variety of levels, quite often as that early warning radar to pick up the issues as they are emerging and working through.

So we find that as we do deal with items that come about, I believe we are well-served on both sides. But I believe we will get there this year and continue to deliver the care that our beneficiaries, men and women, so richly deserve.

Mr. YOUNG. Again, thank you very much for being here. Thank you very much for the good job that our military medical professionals provide for our troops.

Mr. Chairman, I have additional questions, but I will wait for another turn. Thank you very much.

Mr. MURTHA. Mr. Dicks.

HYPERBARIC OXYGEN THERAPY

Mr. DICKS. I want to compliment you for the incredible job that is being done. I mean, just the survival rate, I think, is an amazing feat, and its improvement over years is quite impressive.

I wanted to go back, this is a question I asked before when we had an earlier hearing, with regard to the hyperbaric oxygen therapy treatment. Ms. Embrey, the text of your testimony is nearly verbatim from your previous testimony before the committee in March.

Has any progress been made in getting this trial underway?

Ms. EMBREY. Yes, sir. I wish Loree Sutton was here so she could give you exactly the details. But we have worked with the Services and with our outside experts to develop a protocol. We have three different sites where we are planning to do that.

Because the Food and Drug Administration (FDA) has identified oxygen in the hyperbaric chamber as an investigational new drug for this kind of treatment, we need to seek their authority to use that in this protocol. When FDA gives us that authority, then we can begin to execute——

Mr. DICKS. Would you tell the committee, again, in what circumstances this would be utilized; or maybe one of the Admirals, Generals, could do it?

Ms. EMBREY. I am sorry, in——

Mr. DICKS. When would you use this? Under what circumstances would this be used?

Ms. EMBREY. Well, the Navy uses it routinely for diving issues. But for the purposes that you are talking about, we are talking about this as a treatment for traumatic brain injuries and other mental health symptoms.

Mr. DICKS. And it has been prescribed. You can do—it has been utilized. It has been quite effective, I am told.

Ms. EMBREY. Doctors have the ability to identify, because of their personal relationship with their patients, anything that they believe in their judgment would assist them in achieving a better outcome.

And so they have the authority to use and prescribe alternative therapies. Even if they are an off-label use, hyperbaric chambers are safe for certain things. The challenge is that we don't know, there is no evidence currently that indicates that putting a person who has had a traumatic brain injury in a hyperbaric chamber may or may not do harm evidence-wise.

The reason we are doing these studies is to make sure that we do no harm.

Mr. DICKS. Are the studies underway yet?

Ms. EMBREY. In one site I believe they are, sir.

General ROUDEBUSH. Sir, if I can comment, we initiated a study at Wilford Hall beginning back in February, which will be completed within a year's time, which uses hyperbaric oxygen with pre- and post-neurocognitive testing to see if, in fact, there is a beneficial effect.

I think the more definitive study is the study that Ms. Embrey refers to, wherein the FDA has identified hyperbaric oxygen as an

investigative—as a new drug, if you will. And we are just on the verge of getting their approval and moving forward with this study.

True, there have been anecdotal reports of the benefits of hyperbaric oxygen, but there has not been a thoroughly prepared and conducted study to see if, in fact, that is the case. And that is precisely what we are doing, and actually doing it in a very aggressive manner, to get this done as expeditiously as we can.

Mr. DICKS. Admiral, do you have any comment on this? The Navy is the reservoir of expertise on this.

Admiral ROBINSON. The Navy helped facilitate a meeting in which many of the professionals who have contributed to the hyperbaric oxygen therapy literature came together with other professionals, who have been doing a great deal of work with neuroscience and with the effects of different modalities, treatments, medications and also oxygen on neural and brain tissue.

We did that in the January-February timeframe. We spent 2 days. It was widely attended by these professionals. It was very informative.

From that, we have gone out with Air Force, the Wilford Hall study, also with Louisiana University—LSU, and others, in fact—to try to find the best method of doing a prospective randomized trial that we could utilize to make sure that if we say that hyperbaric oxygen is a therapy for traumatic brain injury, that we can prove that and that we can write clinical practice guidelines that can be utilized across the United States—actually, across the world—because to put the imprimatur of a success on a therapy that has not been proven in the standard medical methodology, it has been proven in terms of anecdotal information—

Mr. DICKS. Let me just ask you on that point.

Admiral ROBINSON. Yes.

Mr. DICKS. Has there ever been any adverse consequence where it has been prescribed and utilized, has there been any adverse consequence?

Admiral ROBINSON. None that I have ever heard of, Congressman Dicks. But that doesn't necessary nearly mean it hasn't occurred; it just means that I don't know about it.

People who tend to give anecdotal information often don't necessarily tell all of the story, which is the reason that in medicine—which is prospective, randomized, multidisciplinary, and also multicentered—evidence-based trials are necessary to make sure that we can get the best evidence to go with the clinical practice guidelines.

The end result is, whatever I say is going to work for a Sailor, Airman, Marine, Soldier, a Coast Guardsman or their family member; but if whatever I say works from a Navy perspective or from an Army or Air Force perspective, we really base that on randomized, prospective, reproducible data that we can live with and build practice guidelines on. That is what we don't have yet.

Mr. DICKS. How long do you think this will take?

Admiral ROBINSON. I would anticipate—this is going very rapidly—I would say probably within the next 18 to 24 months we may have some evidence of how hyperbaric oxygen therapy is working in the trials that we have going. But that is a guess. I am not quite sure.

General SCHOOMAKER. Sir, and I will add to that, everything that has been said by my colleagues is exactly our position on this. I think one of the frustrations here is that hyperbaric oxygen has been around for many, many years.

Mr. MURTHA. Would you explain for the committee what we are talking about here?

General SCHOOMAKER. Sir, this is pressurized. This is putting a patient, with staff support, because it is fairly labor-intensive, into a high-pressure environment where the oxygen pressure around the patient and what is breathed in their lungs is higher than sea level.

So when you are recovering, for example, from a deep diving problem, what we call the bends, you have to be put back into an environment where you push, literally, air and oxygen and nitrogen back into the body to then slowly decompress them and reverse the problem.

In cases of resistant infection where we have bacteria that are growing deep in wounds, where we think if we raise the oxygen retention we may encourage wound healing, it has been used in that setting as well.

But in this setting, sir, it has never been demonstrated to be effective in a standard way where we know, number one, who are we treating? We are already having difficulty separating mild brain injury from post-traumatic stress because the symptoms are so overlapping. And then what are the total outcomes of that, positive and negative?

As Dr. Robinson said—I agree totally—unless you do a careful study you don't know if you are doing harm, and there are potentials for harm.

One of the frustrations we have had with this is a technology which has been around for decades, and concussions which have occurred on sports fields and on highways for decades has never been studied by this group. And when we offered, through your generosity, money to do careful studies, nobody came forward with credible research proposals that we do.

Finally, the military services said, enough, we are going to conduct the research. And that is what we are doing.

Mr. MURTHA. I appreciate that. Mr. Tiahrt.

WOUNDED WARRIOR TRANSITION

Mr. TIAHRT. Thank you, Mr. Chairman. I was recently up at Fort Riley and not long after that I went pheasant hunting with some soldiers that were in the Wounded Warrior unit. We had a great day. I spent all day with them. Some of the things they were going through I wasn't aware of, I don't think many Americans are aware of, especially in the area of TBI where we understand the long-term impact of having their brain jostled around.

The good thing about the MRAPs, for example, is we have a lot higher survivability rate. One of the downsides is, though, that these soldiers going through two or three or four major explosions like that can impact their brain because of the impact to it.

And would you explain so that we better understand what a Wounded Warrior transition unit is, like the one we have at Fort Riley?

General SCHOOMAKER. Yes, sir. The Army today has 36 such units across the Army and nine what we call community-based warrior transition units. These are special units that were developed after the problems were highlighted earlier of the transitional care that takes place from in-patient, outpatient, and beyond the traditional VA system and back into private medicine, or VA medicine, or back into uniform.

What we realized was that we had world-class, even cutting-edge patient care, and we had established outpatient practices, but very, very rudimentary. And, in fact, we had forgotten many of the lessons of earlier wars, where we transitioned patients successfully from in-patient to outpatient care, and then back into uniform or into private life or continued care, if required.

So we stood up a number of units actually staffed by nonmedical soldiers from all backgrounds. Young officers and enlisted, we trained them how to do that. We have put nurse case managers in place and primary care managers, physicians, nurse practitioners, physicians assistants, who provide primary care assistance. And that triad, then, is responsible for carrying the soldier, in a sense, with family, along the traditional pathway.

Currently we have 7,700, roughly, soldiers in the warrior transition units; wounded, ill, and injured soldiers. About 15 percent combat-wounded. About 50 percent are evacuated with other medical problems. About 30 percent identify problems like concussive injury or post-traumatic stress after they return. And about 30 percent are, frankly, injuries, illnesses that are not associated with the deployment, but may be training injuries or cancers or heart disease or other problems that soldiers are prone to, or motor vehicle accidents.

That is the construct, and it is working quite well. Our focus this year, now that we have set these units up and have staffed them successfully and standardized their practices, is to focus on what we call the comprehensive transition plan, which is a soldier- and family-developed plan for what they want to do, where they are going to go with this injury or illness, how we are going to recover them and get them back into uniform. And that is our highest priority, to get them back in uniform, if possible, or transition them back into private life, into the VA system if necessary.

Does that answer the question, sir?

Mr. TIAHRT. Yes, it does. Thank you. It was a very good explanation.

There are some instances around the country where there is a high discipline rate for these wounded soldiers that come back. And some bases have a different rate than others. Fort Drum, New York has every month, one out of 76 soldiers are going through article 15. In Kansas, where we have this Wounded Warrior transition unit, it is only 1 out of 309.

And I think it is because they have focused on working with these folks who have come back, and my personal experience in meeting one of these soldiers, a young sergeant had been through six explosions, he told me he has trouble reasoning with things he didn't before, like small calculations. He now carries a calculator around in his pocket because small addition problems is one evidence.

There was an article done by the AP back in March. I don't know if you are familiar with it or not, but it highlights how some bases are not working with these soldiers as well as others. And I would like you—it is called Disciplined Wounded Warriors—I would like you to check out that article, because I think there is a problem about being consistent in the military and helping these folks transition back to either Active Duty, full time, or back to civilian life.

MILITARY MEDICAL RECORDS

The last thing I wanted to ask you about, in both the military medical records and in private sector or health-care records, we are moving towards electronic medical records.

But I have noticed that in the VA, and certainly in the private sector, there is no standard interface for these different electronic record programs that are out there. So you can have, within the VA, somebody's military records or health-care records—excuse me—not being read when they change to a different facility.

They may be working at one of our remote clinics and then when they come into the VA hospital, there is not always a connection that is usable. In the private sector it is the same thing. Now, in any government program, they always have an interface control document that manages all the interfaces between the working systems.

Yet I don't think we have one in any of the services when it comes to medical records. And yet we are seeing services develop these medical records. So I would suggest somewhere inside the services—and I think you guys would be the logical initiator in this—develop an interface control document so that when medical records software is developed, it has the ability to interface with other softwares that are trying to do the same task.

General SCHOOMAKER. Yes, sir. Let me comment very quickly, first, on discipline rates. We are very concerned about installation-focused allegations that we are not sensitive to medical problems of soldiers who may have been brought up for administrative or nonjudicial punishment.

We have very active policies that soldiers not undergo administrative actions or nonjudicial punishment without a very thorough incorporation of their medical history and problems.

Brigadier General Gary Cheek, who commands the Warrior Transition Command overseeing all these units and their standard practices, has just completed a review of nonjudicial punishment at nine different installations. While we don't direct them, they can't direct that installation commanders or warrior transition commanders employ a kind of standard approach, because every case stands on its own, he is very reassuring that in fact our policies are working out there. Commanders are taking into account the medical conditions and problems of soldiers before implementing or taking administrative and nonjudicial action.

Quickly on the electronic health record, sir, we do have with the VA system a standard interface. In fact, we have a Bidirectional Health Information Exchange. Now it is called BHIE. It isn't to where we want it right now. We have very good exchange of information to the four polytrauma centers where the most severely injured soldiers are being sent.

General SCHOOMAKER. But you are absolutely right. We do not have with the private sector, to include our purchased care partners that were referred to by my colleagues earlier—we do not have a standard interface with thousands of practices and hospitals out there, and this is a national problem.

Mr. TIAHRT. Thank you, Mr. Chairman.

Mr. MURTHA. We have two panels today.

CONTINGENCY PLAN

Mr. MORAN. Except that what happens, Mr. Chairman, as you particularly will know, in the National Capital region affects the ability of this panel to carry out its mission. There is a relationship here.

I would like to ask Ms. Embrey, I understand the constraints you already explained. I don't think you ought to be worried about your job, but you are doing a fine job, but what if we don't make the deadline for Walter Reed in time? I know we talk about another panel who is focused on the weeds in this garden, but I want you to look at the larger picture, because many of us feel there are some very serious problems that need to be addressed if we are not able to achieve what needs to be achieved in what is now a pretty short period of time. We are talking really a year and a half. And as far as I can see, you are not going to meet that deadline, so that is going to have a major impact on all the operations you are responsible for. What are your contingency plans, Ms. Embrey?

Ms. EMBREY. Officially I think my contingency plan is to press harder and faster with the current program. But truly the contingency plan is when we get closer, we realize that as a Department we can't—we understand what the negative and positive effects are of where we are, and at a point in time we need to inform people about, you know, what they are and how we can come together to work through those problems. But right now we have a plan, we are committed to meeting it, and we are working it very hard.

Mr. MORAN. I know you are working hard, I know you have a plan, and I know you are committed to meeting it. In fact, when we tried to inject some judgment into the process, somebody over at DoD threatened to veto the whole bill if we suggested that you might extend the deadline so that we can actually achieve this transition in a reasonable period of time. That was probably true—or somebody like that. But he is gone now.

Mr. MURTHA. He is gone now.

Mr. MORAN. He is gone now. So now we are going to find out who reports to who.

Ms. EMBREY. We recognize we report to you.

CENTERS FOR EXCELLANCE

Mr. MORAN. There you go. I will wait until the chairman at least. Certainly, Vice Admiral Kearney understands that behind you there. Some of the problems here at Walter Reed, we are going to get into the nitty-gritty with the next panel, but we love the Centers for Excellence, you are doing a great job. But the space that you provided for the Centers for Excellence in the new facilities are considerably smaller than the space you have now; isn't that right?

How is that going to affect Centers for Excellence, which we like, which undoubtedly would need to expand to deal with the needs?

Ms. EMBREY. Centers of Excellence institutes and centers and the concept of how we are going to implement that across the Department, is actively being discussed now. Centers of Excellence may not necessarily need to have brick and mortar. A Center of Excellence by its terms implies that if you have a Center of Excellence, the other places aren't excellent, and we don't want that. We want to have a mechanism by which to ensure that the whole system is apprised and kept current on the best possible practices and deliver the best possible care anywhere. So the physical location and the brick-and-mortar location at Bethesda right now for the Defense Center of Excellence for Traumatic Brain Injury and Psychological Health, the location of the Defense Center of Excellence for Vision, I believe, is also going to be there. But there are going to be other locations and hubs throughout our system.

Mr. MORAN. I understand that, but I have a suspicion that in order to meet this arbitrary deadline, you are trying to stuff stuff into Fort Belvoir and the new—the other new hospital that you are building. Instead of looking for the most excellent design, you are just trying to figure out the expedient way to meet, again, the deadline. But I won't argue about that, I just want to raise it as an issue.

Apparently the Surgeon General wanted to comment on that.

General SCHOOMAKER. The only comment I would like to make, in addition to the fact that in every forum where we jointly go out, for example, in new Belvoir or the new Walter Reed National Military Medical Center, and is true throughout the BRAC process, we take a pause and say, no kidding, are we on track; are we going to run into problems? In every one of those fora, we have been assured by engineers and designers and the people building these things that we are going to meet the deadlines.

The second point I would like to make, and I hope it is developed in the next panel, is there has been a lot of focus on this new Walter Reed National Medical Center at the Bethesda campus, but, in fact, the beauty of the JTF CapMed—and with apologies, Vice Admiral Madison, I hope I am not putting words in your mouth here—but is that we have 500,000 beneficiaries in the Greater Metropolitan Washington area in 37 facilities, from Carlisle Barracks, Pennsylvania, to Quantico and Belvoir, the National Military Medical Center, Meade and others. And it is the coordination of care across this very dynamic metropolitan area, and to follow the movement of our families and soldiers and sailors, airmen and marines to the places where they can live and they can come.

So frankly, I am as excited or almost more excited about the new Belvoir, which has got tremendous capacity, and which is going to take some of the capacity and some of the functional elements of the centers for breast cancer, prostate cancer, heart disease, amputee recovery and the like and distribute those to where we can best serve the public. So this is a coordinated plan for the entire metropolitan area. We are too focused on one institution within that bigger plan.

Mr. MORAN. We want you to do it right.

General SCHOOMAKER. Yes, sir.

Mr. MORAN. Mr. Surgeon General. And to do that, you ought not have an arbitrary time line that fits an arbitrary decision of September of 2011, that is the whole point. And we are up against people who say, well, you may be right in terms of judgment, it is just that I have been given a job, so I am going to do the job come hell or high water. So that is our concern.

TRICARE

Let me ask a more general issue here. I have to obviously get into the Walter Reed stuff, but one of the problems that we are facing is that a lot of our soldiers and families after they return, they go back in the field, but we have long-term responsibility for their medical care. There is a high level of diabetes, obesity, lack of physical fitness once they get out of the military, and we wind up paying for that through military health-care programs, particularly TRICARE.

What are you doing in terms of preventive efforts to save us money to deal with some of these almost endemic problems with families, and particularly the soldiers who just don't maintain their physical fitness regimen?

Ms. EMBREY. In 2003, we developed a system to track the individual medical readiness of folks across the force, Active Duty and Reserve component. And we measure whether or not they have been assessed both physically and dentally and mentally on an annual basis. We assess people's health status through screenings, predeployment and postdeployment, twice.

We also have engaged in campaigns based on information and trends in utilization of alcohol, substance abuse of various types, tobacco principally. We have looked at obesity as an issue, and we have stepped up campaigns through the line who owns those programs for us and runs them for us. Each Service has significant programs that are addressing those issues. Some are more effective than others. We still do have an obesity problem, but frankly it is because we recruit folks who have these issues. And part of it is addressing cessation of those bad and risky behaviors.

We also have introduced and will be introducing in the next 60 days pilot programs to incentivize people to engage in more healthy behaviors, paying people to go to the gym and to not smoke and to do different things. It is a pilot. It is detailed in my testimony, and I outline some of the highlights of it, and I can give you more information about those. But that is a pay for—it is incentivized pay for outcomes that we are trying to achieve.

Mr. MORAN. It is just what I was looking for. You didn't mention it in your summary, so I didn't realize it was in your testimony. That is exactly what we ought to be doing. It is a small fraction of the cost of taking care of them, obesity and all kinds of other problems that are behaviorally related. TRICARE is going through the roof, and a little bit of money to incentivize them to be healthy now is going to save us billions in the long run. Thank you, Ms. Embrey.

General SCHOOMAKER. If I could just comment quickly, I think at the execution within hospitals and clinics, we have to incentivize commanders and clinics to do that, too. This is a problem in American health care. What we have been doing in Army medicine for

the last 4 or 5 years is to shift the pay for performance toward population health and toward preventive measures. In the last 2 years, we have 50,000, roughly, over-65 patients we care for. When we started this campaign, 25 percent of them, roughly, had their vaccination for common pneumococcal vaccine complete. We started incentivizing commanders and clinics that if you can raise the vaccination levels higher, we will pay you for it. We pay generously, handsomely, if they are brought to the emergency room with pneumonia or admitted; why don't we pay better if you prevent it? And now we are at 85 percent vaccinated.

General ROUDEBUSH. Sir, if I might add, Congressman Murtha has been instrumental in helping us establish diabetes outreach with UPMC and Wilford Hall, and, in fact, we have identified a cadre of folks. We are employing strategies and methodologies, and we are starting to see beneficial outcomes. So there is, I think, an active program to improve the health, improve the outcomes and ultimately certainly cut costs, but most importantly improve the health.

Mr. MORAN. Thank you.

Mr. MURTHA. Mr. Rogers.

VISION CENTER OF EXCELLENCE

Mr. ROGERS. Mr. Chairman, I know you want to get to the new panel, so I will be brief. I don't know who can answer this. Let me ask you about the Vision Center of Excellence, which I understand is in the works. What can you tell us about that?

Ms. EMBREY. It is a very high priority for us. We have appointed a director. We found a temporary location. We have five employees from the VA who are joining us. They have just visited the spaces. They have been in effect for a short time, but they haven't really gotten off the ground too well, primarily because we were authorized a considerable amount of money, but not appropriated any for that purpose. And so we took some money out of hide this last year to try to get it started, but we have a full complement of funds to expand and engage more fully an operating center.

Mr. ROGERS. When will that be in operation?

Ms. EMBREY. By next year. It is operating now, but next year we will have it fully operating.

Mr. ROGERS. Now, would you integrate with the VA?

Ms. EMBREY. Yes. Actually we just brought over five VA folks to actually staff the current temporary location in Skyline, and they are going to be moving over in the next couple of weeks. So we have five VA folks working in the center with the DoD folks.

Mr. ROGERS. Here is a problem: a constituent of mine, a young soldier who was injured about his head and face by an IED, but got out and had some vision in his right eye, but none in the other; enrolled in school, college, and then developed a problem. He had had operations in Germany at Walter Reed with head injuries; went to the VA hospital in Lexington, Kentucky, because he had had an infection and swelling bad. And the VA hospital there could not operate because they did not have the records of what they had done to him in Walter Reed in Germany, and he lost his eye, what was left of his eye, so he is blind now, because apparently they

could not get access to the military records of his previous treatment at the Army hospitals. Will that be remedied in this process?

Ms. EMBREY. Sir, I think the access to records, images particularly, we are working on a standard with the VA to ensure a standard exchange of imaging so that people can see. Right now there is no standard for medical imaging in any health-care environment. So what we are trying to do, by this fall we intend to have a standard that will enable rapid sharing of imaging anyplace in our system. But in the meantime, we had been working around by sending information, FedEx-ing and other kinds of things, but I am not familiar with this particular case, so if you would like to comment.

General SCHOOMAKER. I am very familiar with the case. I have spoken with the patient and reviewed all the records. Not to in any way discount the challenges of exchanging information between different systems, I have to say, sir, our review and the VA's review concluded that this was not a problem of exchange of medical records. In fact, the physician involved in the VA hospital had the entire medical record at his disposal. It happened to be a hard copy record.

So I don't want to back away from the problem that was raised earlier about the bidirectional exchange of the information and a digital record. That is our goal, and we do continue to work through problems there. But in this particular case, that young soldier's continued problem with vision, despite how the media has depicted it, frankly did not revolve around the exchange of medical records.

Mr. ROGERS. Well, I am glad to hear your report.

Let me conclude by saying that it just seems incomprehensible to me that the VA hospitals and the military hospitals have not had their records shared a long time ago. That seems a basic, elementary problem; do you not agree?

General SCHOOMAKER. Yes, sir. I think that all of us are frustrated by the pace at which this has taken place. I do also know that we are probably, in terms of national landscape of this problem, at the leading edge of solving problems for the Nation in this exchange of information. If it is problematic for us as two big, large Federal systems, we have no trouble within the military side, then out there in all of the practices and all of the different mom-and-pop operations around the electronic health record, it is truly problematic. So we are trying to solve some of these problems to demonstrate how it can and should be done.

Mr. ROGERS. What can we do to help with that problem?

General ROUDEBUSH. Sir, if I may comment, sir, and go back to Congressman Tiahrt's question about interface. Secretary Gates and Secretary Shinseki have taken a personal and very active interest in this in terms of mandating driving towards a common solution; not down-selecting to VistA or down-selecting to AHLTA, but going to a service-oriented architecture that gets to the interfaces, the architectures and the basic taxonomy that allows you to link these systems to get to a truly transparent and interchangeable health-care record that just has one record wherever that patient finds themselves.

Now, we live in the greater context of American medicine. So as we move this along, we do need to do it with policy, processes and

practices that are consonant with what we see in the private sector. And it is slow, and it is frustrating, but I think in terms of the last probably 2 to 3 months, we have seen more focus, the right focus, in my view, moving us towards that common solution. In the meantime we will continue to work the day-to-day interfaces.

Mr. MURTHA. The gentleman's time has expired. We are going to dissolve this panel. I ask that Mr. Bishop and Ms. Kilpatrick ask the first questions of the next panel.

Thank you very much.

Mr. BISHOP. Mr. Chairman, can I ask the next panel the questions I wanted to ask this panel?

Mr. DICKS. Are they going to stay?

INTRODUCTION

Mr. MURTHA. Welcome, gentleman. Gentlemen, we appreciate your patience. Next year I think we will separate the panel, because there is nobody more involved in health care that this subcommittee. Bill Young, his wife, myself. I just was out to Bethesda the other day, only a couple of patients, I am glad to hear that. But we can take a lot of credit for what has happened in health care, and we certainly do, but we appreciate and are gratified by the result. Of course, here we are talking about the region, and Mr. Moran has left.

Mr. MORAN. I am right here. I am trying to do my job here.

Mr. MURTHA. I appreciate it.

Mr. DICKS. Don't get him started.

Mr. MURTHA. If you could abbreviate your statements and let us get right to questions, because the Members obviously have all kinds of concerns about what is going on here in the region. And we depend on Mr. Moran to make sure he takes care of those problems, so we appreciate your coming before the committee.

Mr. Young, do you have any comments?

Mr. YOUNG. No, Mr. Chairman, I am anxious to hear the statements.

SUMMARY STATEMENT OF ADMIRAL MATECZUN

Admiral MATECZUN. Thank you, Chairman Murtha, Ranking Member Young, committee members. Thank you for the opportunity to share with you the Department's progress on realigning medical assets in the National Capital Region to create an integrated delivery system; a fully integrated, jointly operating and staffed health-care region. This transformation will allow DoD and the services to capitalize on their collective strengths; maintain high levels of readiness; provide second-to-none, world-class health care to servicemembers, retirees and their families.

Being responsible for delivering this integrated, world-class health care in the National Capital Region Joint Operating Area, JTF CapMed will operate two jointly manned treatment facilities comprising nearly 10,000 individuals, more than 3 million square feet clinical and administrative space, providing 465 beds of inpatient capability.

To achieve this we must oversee the transition of operations from the current Walter Reed Army Medical Center and National Naval

Medical Center to the new Walter Reed National Military Center and to the Fort Belvoir Community Hospital.

Our primary mission is the delivery of health-care services, including casualty care. The National Capital Region currently is our Nation's primary casualty reception site, and we have significant and world-class capabilities at Walter Reed Army Medical Center. The prosthetic capabilities are second to none in the world and are leading the world, as is the abilities, the capabilities at the National Naval Medical Center today to provide care for open traumatic brain injuries that are returning to our country.

The Aeromedical Staging Facility at Malcolm Grow is an extraordinarily capable facility, the best Aeromedical Staging Facility, I believe, today, and together they compromise a seamless reception capability for those patients that are returning on C–17s from across the world.

Fortunately, as the Chairman points out, casualty rates for complex trauma care are significantly down in the NCR; however, the number of psychological health cases is increasing at the same time. So we have seen a switch in the emphasis of the care that we need to deliver, but not in the need to be able to provide care for the wounded warriors who are returning here.

Mr. MURTHA. Does that include inpatient and outpatients?

Admiral MATECZUN. Yes, sir, it does.

We will continue to have capability to maintain this capability to receive casualties in the National Capital Region during transition to these new facilities and throughout the entire BRAC operation. We will, in fact, have significant new capabilities, including a comprehensive cancer center, which puts together many of the centers of which this committee, in particular members of this committee, have been so helpful in making sure that we maintain these capabilities. It will bring together the ability for the Trauma Registry—I'm sorry, the Bone Marrow Registry, Congressman Young, to bring those together with the Comprehensive Cancer Center in a way that has never been done before within the military health system.

There are also significant new capabilities at the Fort Belvoir Community Hospital. In fact, out of the 500,000 beneficiaries that live in the region, about half of them live in the southern half of the region, and that Fort Belvoir Community Hospital will grow to a 120-bed facility with significant new capabilities, including linear accelerators for oncology care, for radiation oncology and cardiac catheterization. So significant new capabilities there.

I will abbreviate any statement. I would be remiss as we near Memorial Day if I did not remember the 221 service medical members who have made the ultimate sacrifice in their service of both country and their fellow soldiers, sailors, airmen, marines, Coast Guardsmen. Your support, your extraordinary support, pays great honor to their service, and I will conclude my statement.

SUMMARY STATEMENT OF GENERAL VOLPE

General VOLPE. Chairman Murtha, Ranking Member Young, committee members, good morning. Thank you for giving us an opportunity to share with you the great effort that is made by the Department to enhance the health care in the National Capital Region. As we forge a new frontier in military medicine in the Na-

tional Capital Region by leveraging joint solutions and initiatives, we are committed to ensuring a more effective and more efficient delivery of health care.

For the first time in history, the Department will deliver health care in a fully integrated region, and JTF CapMed will oversee through operational control the first two truly joint hospitals at the Walter Reed National Military Medical Center at Bethesda as well as the Fort Belvoir Community Hospital in Virginia.

The two hospitals will be jointly staffed, jointly operated, jointly led and jointly governed. Servicemembers, veterans and their families will be better served by being able to receive their health care in a regional system which leverages the outstanding capabilities that each service has to offer.

We at JTF CapMed are very mindful that the massive transformation in the National Capital Region comprises more than BRAC alone and is a conglomerate of numerous complex initiatives. While BRAC provided the initial stimulus to realign the military health system resources within the National Capital Region, the Department utilized and will continue to utilize it as an opportunity to transform, integrate and reengineer how we deliver health care in the region.

I will abbreviate much of my opening statement, but I would like to mention finally that the real beauty of JTF CapMed is that it is a mechanism to integrate health care across the three services' medical system, to leverage the common capabilities that each service has to offer, while still respect unique requirements that each service must maintain. We are very proud to have an open working relationship with the three services, and the Assistant Secretary of Defense of Health Affairs, those on the Joint Staff in OSD, and there are procedures in place for us to work through the challenges that we face and to capitalize on the opportunities to improve the delivery of health care. The fact is that we all have a very common goal and culture of providing warriors and their families the world-class health care that they deserve.

Again, thank you for allowing us to share in the progress and the transformational efforts in the National Capital Region, and submitted the rest of my comments in the written statement, and look forward to your questions.

[The joint statement of Admiral Mateczun and General Volpe follows:]

NOT FOR PUBLICATION UNTIL RELEASED BY THE HOUSE COMMITTEE ON APPROPRIATIONS

JOINT PREPARED STATEMENT

OF

VICE ADMIRAL JOHN MATECZUN, MC, USN
COMMANDER, JOINT TASK FORCE, NATIONAL CAPITAL REGION MEDICAL

AND

MAJOR GENERAL PHILIP VOLPE, MC, USA
DEPUTY COMMANDER, JOINT TASK FORCE, NATIONAL CAPITAL REGION MEDICAL

BEFORE THE

HOUSE APPROPRIATIONS COMMITTEE

SUBCOMMITTEE ON DEFENSE

MAY 21, 2009

NOT FOR PUBLICATION UNTIL RELEASED BY THE HOUSE COMMITTEE ON APPROPRIATIONS

Chairman Murtha, Ranking Member Young and committee members, thank you for the opportunity to share with you the Department of Defense's (DoD) progress on realigning medical assets in the National Capital Region (NCR) to create the Military Health System's (MHS) first fully integrated, jointly-operated and staffed, healthcare region. This transformation will allow the DoD and the Services to capitalize on their collective strengths, maintain high levels of readiness and provide second-to-none, world-class healthcare to service members, retirees and their families.

2005 Base Realignment and Closure Law

As you know, the 2005 Base Realignment and Closure (BRAC) Commission recommendations constituted the largest realignment and transformation in the history of the MHS in the NCR. It consolidated the inpatient services of three Medical Treatment Facilities (MTFs) into two. It did this by establishing the Water Reed National Military Medical Center (WRNMMC), in Bethesda, Maryland, and a large community hospital at Fort Belvoir, Virginia (FBCH). It relocated existing functions at the Walter Reed Army Medical Center (WRAMC), in Washington, District of Columbia, to these two facilities.

Establishment of the Joint Task Force, National Capital Medical Region

On 27 November 2006, the Department approved the concept of establishing the NCR as a Joint Medical Market where MTFs would report to a Joint Senior Flag Officer. On 14 September 2007, in response to recommendations of the Independent Review Group and the President's Commission on Care for America's Returning Wounded Warriors (Dole-Shalala) the DoD Senior Oversight Council recommended and the Department established the Joint Task Force, National Capital Region Medical (JTF CAPMED) as a fully functional standing JTF reporting to the Secretary of Defense (SECDEF) directly through the Deputy Secretary of

Defense (DEPSECDEF). The Department chartered JTF CAPMED with a mission to ensure the effective and efficient delivery of world-class military healthcare within the NCR Joint Operating Area (JOA) using all available military healthcare resources within the JOA, while overseeing the consolidation and realignment of military healthcare within the JOA in accordance with the BRAC implementation of the WRAMC and Andrews Air Force Base recommendations. The charter also provided that JTF CAPMED conduct other missions as may be assigned to improve the management, performance, and efficiency of the MHS.

JTF CAPMED reached Initial Operational Capability (IOC) on 1 October 2007 and Fully Operational Capable (FOC) status on 30 September 2008. It is executing the assigned missions of overseeing the delivery of integrated healthcare in the NCR while ensuring readiness, and implementing BRAC. In addition, JTF CAPMED coordinates Health Service Support (HSS) missions in the NCR as a functional medical component of JTF NCR when it is activated, greatly simplifying the planning process for events such as the recent Presidential Inauguration, or a potential influenza epidemic.

On 15 January 2009, the Department directed the MTFs established in the NCR to become the first jointly-manned and governed hospitals in the MHS. It established WRNMMC and FBCH as Joint commands subordinate to JTF CAPMED, with the manpower document providing billets for the MTFs taking the form of a Joint Table of Distribution (JTD). Services still exercise operational control (OPCON) over the remainder of their respective MTFs in the JOA. DoD also approved a single civilian manning model for the medial personnel in NCR, creating the potential for new leadership and executive roles as well as expanded career progression for MHS civilians. In addition, It directed that deliberations continue and

recommendations be brought forth expeditiously, regarding the ultimate organizational alignment of JTF CAPMED.

As the Department's first and only Joint Task Force responsible for delivering integrated, world-class healthcare in a JOA, JTF CAPMED will operate two jointly-manned MTFs comprising nearly 10,000 individuals, more than 3 million square feet of clinical and administrative space and providing 465 beds of inpatient capability (345 at WRNMMC and 120 at FBCH). To achieve that objective JTF CAPMED is responsible for overseeing the seamless transition of operations from WRAMC to WRNMMC and FBCH without disruption to the quality of care or access to care within the region. This process is the single largest BRAC movement in MHS history and achieves a level of complexity that requires the meticulous and successive execution of tens of thousands of individual construction and transition items, identified in an Integrated Master Schedule (IMS) provided to Congress in response to section 2721 of National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2009.

JTF CAPMED Mission

Today the MHS provides America's service members, retirees and their families with the finest healthcare available in the world. Surveys have overwhelmingly and repeatedly shown that the military healthcare benefit is one of the primary reasons the all volunteer force is recruited and retained in the military. The Army's capabilities at WRAMC with amputee care are leading transformations in prosthetics care and rehabilitation world-wide; the Navy's expertise in open Traumatic Brain Injury (TBI) at NNMC is also renowned world-wide; and the newly renovated state-of-the-art aeromedical staging facility at Andrews Air Force Base provides a medically capable and caring atmosphere for our returning wounded warriors.

Together these capabilities achieve a synergy greater than the sum total of their parts, for those wounded in service to our country.

The Department's vision is to deliver the promise of providing world-class medical care to our nation's warriors, Service retirees and their families in the NCR. It will accomplish this vision through deliberate and successful planning to achieve a cultural shift from MTF-centric healthcare delivery to patient-centered healthcare provided in an integrated regional delivery system. The Department must achieve this transformation while maintaining and improving the current quality care that its MTFs collectively provide. This is especially important in FYs 2010-2011 (the transition period) when the Governance, manning, and budget execution for MTFs transfers from the three Services to JTF CAPMED.

JTF CAPMED guidance for this transition period has emphasized the importance of adhering to FY 2010-2011 Business Planning Guidance from Service Surgeons General and timelines, while simultaneously beginning regional initiatives that promote and improve quality, patient satisfaction, and enhance the effective and timely delivery of healthcare.

Not later than 15 September 2011, WRNMMC and FBCH will be directly aligned as subordinate commands of JTF CAPMED. JOA MTFs that are not specifically identified as joint facilities will continue to receive guidance from JTF CAPMED through Service Medical Components. Close collaboration among the Services, MTFs and JTF CAPMED will ensure an integrated healthcare delivery approach that optimizes facility and human resource capabilities to meet the ongoing needs of our patients.

JTF CAPMED Priorities

As America's primary casualty reception site for returning warriors from Iraq, Afghanistan and other areas where Americans remain in harms way, JTF CAPMED's number

one priority remains *casualty care*. It will answer the nation's call to care for its casualties without fail. It will plan to maintain capacity to continue this mission while simultaneously ensuring the Services' ability to deploy expeditionary forces assigned for duties within the NCR.

Our number two priority is *caring for the care givers*. Thankfully, wounded service members are surviving at a historical rate and caregivers are faced with providing long-term complex healthcare and rehabilitation for these patients. Additionally, many of our personnel have deployed and provided care under extraordinarily trying circumstances and must readjust and reintegrate into society as they return. This care requires significant time, compassion, and dedication. JTF CAPMED is dedicated to taking care of its healthcare personnel and providing them with the support they need to deliver world-class care.

We also must *be ready now*. The singular lesson we have learned from service around the globe is that we must be able to think about and plan for the unimaginable; we must be prepared to adjust and react when the worst happens. Without regional planning and training we will not be able to answer the NCR's call for help in disasters and emergencies.

In addition, we need to focus on robust and integrated r*egional healthcare delivery*. Integrated planning for the efficient and effective delivery of services on a regional basis is the key to quality care, mission success and to transforming the MHS for the benefit of its patients. We cannot afford to optimize operations at any single facility at the expense of operations at other MTFs or the entire region.

Finally, achieving *common business and clinical processes* will be necessary to achieve regional potential and the competitive advantages of joint operations. Differences that could impact patient safety and outcomes as our people work in different facilities across the region on a day to day basis cannot be tolerated.

JTF CAPMED Funding

Although JTF CAPMED is responsible for the direct oversight of the NCR Medical BRAC process, the majority of the medical NCR BRAC funding flows from Health Affairs/Tricare Management Activity directly to the Naval Facilities Engineering Command (NAVFAC) and U.S. Army Corps of Engineers (USACE) to execute the construction and outfitting at WRNMMC and FBCH, respectively.

During FY 2009, all funds for MTFs in the NCR will be distributed as they have been in the past through the Services. In FYs 2010 and 2011, the three medical department headquarters will receive funds from the Defense Health Program (DHP) and will determine appropriate amounts for distribution for their respective NCR MTFs. Then the Services will each coordinate with JTF CAPMED to determine how funding will be allocated among the NCR MTFs.

The Service Medical Departments, the Assistant Secretary of Defense for Health Affairs (ASD(HA)) and JTF CAPMED are preparing courses of action for DEPSECDEF consideration on how funding for NCR MTFs will be distributed and executed in FY 2012. A major challenge will be the determination of an equitable baseline to be transferred.

NCR BRAC Construction and Procurement Costs

JTF CAPMED has responsibility for oversight and successful execution of the BRAC construction projects associated with the WRAMC BRAC recommendation – the expansion and renovation of the National Naval Medical Center (NNMC) and associated projects to create the WRNMMC, and replacement of the DeWitt Army Community Hospital at Fort Belvoir, VA, with FBCH. It is also responsible for BRAC implementation of the Andrews Air Force Base recommendation and is in charge of ensuring that these recommendations are implemented by September 2011.

To provide world-class healthcare within the NCR, JTF CAPMED needs world-class providers, facilities and equipment. While the Services already train and retain many of the best and brightest health professionals in their fields at WRAMC and NNMC, JTF CAPMED is also working with industry experts in medical facility planning, construction and outfitting. These efforts will help define the path for establishing the new WRNMMC and FBCH as among the greatest medical facilities in the nation for healthcare delivery.

These projects are being executed through construction contracts held by NAVFAC and USACE, with JTF CAPMED and Medical Service leadership input, and participation in the design and transition process. JTF CAPMED is overseeing the initial outfitting of these facilities with equipment, furniture and supplies, such that they will be fully-mission capable by the BRAC deadline of 15 September 2011.

Bethesda's final footprint will include world-class inpatient and ambulatory medical center additions of more than 682,000 square feet. Alterations to the existing medical center are still in the planning stages but it is estimated that they will exceed 300,000 square feet. It also includes 500,000 square feet of administrative space, enlisted quarters and support facilities to support the Warrior Transition Services. Fort Belvoir will have a new state of the art community hospital (FBCH) of over 1.2M square feet, which will be the leading example of Evidence Based Design in this country. At the conclusion of BRAC, WRNMMC and FBCH will constitute upwards of 3M square feet of space - this includes space at WRNMMC and FBCH that BRAC does not impact. The BRAC and BRAC-related construction uses much of the buildable space on the Bethesda campus.

The estimated cost of these initiatives from FY 2006 to FY 2011 is $2.4 billion. As critical non-BRAC health care missions and programs continue to evolve and mature, the

Department must work diligently to ensure that appropriate space is identified at WRNMMC. The Department will continue to closely monitor these and other projects.

NCR BRAC Construction and Initial Outfitting and Transition Timeline

Completing the construction and IO&T timelines for Bethesda and Fort Belvoir is the most aggressive transition program that the MHS has carried out. While transition timelines are not foreign to the private sector, this project presents the unique challenge at WRNMMC of adding to a hospital while continuing to operate that hospital.

Acceleration will enable DoD to complete construction of the Ambulatory Care Center and the inpatient hospital addition at Bethesda ahead of schedule (now October 2010) and FBCH ahead of schedule (a phased approach with construction of different building there completing August 2010 through March 2011). Renovation of the existing hospital and the construction of support facilities at Bethesda, including the Warrior Transition Services, will be completed in July and August 2011 respectively.

After construction is completed, it will take time to outfit the buildings and transition medical services to the new facilities. JTF CAPMED is standardizing equipment throughout the JOA to allow for greater interoperability, achieve economies of scale and provide for patient safety standardization. While some clinic spaces could be available as early as April 2011 at both locations, the intent is to have an orderly transition that enables both facilities to operate at full capacity by 15 September 2011. JTF CAPMED is working closely with the Service Medical Components to coordinate the seamless transition of operations from WRAMC to WRNMMC and FBCH. Malcolm Grow Medical Center (MGMC) will continue its inpatient and outpatient services throughout the transition, and through 15 September 2011, in order to ensure availability of critical capabilities during transition.

In February 2009, JTF CAPMED sponsored a Transition Wargame simulation. The goal of the Wargame was to mobilize WRNMMC stakeholders (JTF CAPMED, Army, Navy and Air Force) into evaluating various strategies necessary to transition existing services at WRAMC to their final location, primarily WRNMMC and FBCH. At the end of the Wargame, an abbreviated move for most services during August 2011 was determined to be able to provide the most efficient and safe manner to transition staff and inpatients, while also conforming to industry standards and best practices. In addition, high priority integration and transition actions were identified that need to be completed prior to a consolidated move. The Wargame also determined that the transitional moves could be accomplished by the BRAC deadline of 15 September 2011.

To implement this transition, JTF CAPMED is using a Master Transition Plan (MTP). The MTP serves as the capstone document regarding the execution of JTF CAPMED's mission for BRAC. The MTP co-locates and analyzes interdependencies identified by the IMS with critical milestones and war gaming results to ensure the maintenance of significant medical capabilities within the JOA throughout the transition cycle. The MTP is intended to be dynamic in nature and incorporates adaptive planning.

JTF CAPMED, the WRAMC Director of Clinical Integration, NNMC Director of Clinical Integration, DeWitt Army Community Hospital Project Office and the 79th Medical Wing are developing a transition organization structure for execution. The goal is to effectively plan, integrate, execute and monitor all activities required to ensure a seamless transition from WRAMC to WRNMMC and FBCH. Currently, WRAMC has established a transition office in the Clinical Integration Directorate. This office has instituted functions necessary to transition patients from WRAMC to FBHC and WRNNMC. Departmental transition coordinators are

being hired for the following functional areas: Administration-Logistics, General Medical-Surgical Wards, Critical Care, Departments of Medicine, Surgery, Obstetrics, Pediatrics, Pharmacy and Warrior Transition. NNMC and DeWitt Army Community Hospital are currently organizing and hiring staffs for transition offices. These transition offices will ensure the execution of the MTP, at those sites.

The successful completion of BRAC is dependent upon timely funding and careful synchronization of the construction effort and management of acquisition, provisioning and transition. There are a number of priority actions, such as the awarding of Request for Proposal #2 at NNMC and the IO&T contracts that if delayed could present challenges. The Department will keep Congress and beneficiaries apprised of any changes in these areas.

Traffic Mitigation and Parking at WRNMMC

The Department is working closely with the State of Maryland, Congress, the Washington Metropolitan Area Transit Authority (WMATA) and the local community to address traffic congestion and parking issues that may impact the community as it establishes the WRNMMC. The Navy and the command at NNMC have taken the lead to diligently work with stakeholders to identify specific concerns and develop mitigation strategies.

Through the National Environmental Policy Act (NEPA) process, NNMC identified on-site projects such as enhancing entry control points and widening roads near the gates on the Bethesda installation, which will support traffic flow in and around the Campus. Through the Defense Access Road (DAR) Program, the Navy has also requested authority for the DoD to fund a project which would improve pedestrian access to the Medical Center Metro Station. Currently, WMATA is examining cost and feasibility options for this project.

The Department is committed to being an active member of the local community - fully considering the affect the realignment of operations to the new WRNMMC may have on the surrounding neighborhoods. It will continue to support NNMC as needed.

NCR Joint Operating Area Military and Civilian Manning

In order to operate two world-class hospitals (WRNMMC and FBCH) and deliver integrated health care for the first time across the NCR, it is imperative that JTF CAPMED retains the top minds in the healthcare field that have played a critical role in establishing WRAMC, NNMC, MGMC and Dewitt Hospital as premier inpatient facilities in the NCR. Some individuals may be concerned about where they will be assigned. It is to JTF CAPMED's benefit to retain the expertise of each and every civilian employee currently serving at the four MTFs. They link elements of consistency and institutional knowledge necessary to enhance our delivery of care to service members in the NCR and provide continuity of operations when Service personnel are deployed.

The Department formally approved a non-Service specific, DoD Civilian Manning Model for medical personnel in the NCR. It also directed that all billets at WRNMMC and FBCH be established as joint billets and documented within a JTD. The JTD has been drafted and includes service members and civilians from all three medical-providing Services. The draft is being coordinated among the Services and the Joint staff.

Two DoD actions - a Guaranteed Placement Program commitment to WRAMC civilian personnel and the decision to convert to DoD civilians in the new joint facilities - create unique opportunities in connection with the transition of MHS civilians in the NCR to a DoD workforce for the Joint medical facilities in 2011. The objective is to transition more than 4000 Army, Navy and Air Force civilians to a NCR force of DoD MHS civilians forming a common culture

that focuses on service excellence for patients. JTF CAPMED's goal, which we believe will be achievable for the vast majority of individuals at WRAMC and NNMC, is to place employees where they want to be located doing the work they want to do.

In September 2008, the JTF CAPMED Civilian Human Resources (CHR) Council was chartered to oversee the transition of civilian personnel to the regional end state. The members of the Council are WRAMC, NNMC and DeWitt Deputy Commanders who have the delegated authority to create and modify civilian personnel policy within their organizations. The role of the Council is to work collaboratively to mitigate the adverse impact of the required transitions while identifying, nurturing and leveraging opportunities to begin thinking and operating regionally on issues affecting civilian personnel. The Council is supported by the CHR Advisory Group that includes senior human resources experts with detailed knowledge of the interests and concerns of the civilian workforces in the facilities.

A pilot program is being developed to begin building a transitional civilian leadership cadre by enabling WRAMC, NNMC and DeWitt employees to compete regionally for supervisory positions that will exist in the new manning documents. In addition, a database consisting of personnel at these three institutions and MGMC has been created to enable the Council to analyze issues regionally, develop initiatives and modify policies that fully consider the desired goal of placing civilian employees in positions and locations that optimize both employee and mission performance.

Upon delivery of the final JTD, the CHR Council will begin the process of matching the numbers and types of positions in the two new facilities to the overall numbers and types of personnel in the three facilities. Every effort will be made to notify employees of their new

positions by Spring of 2010. All processes and procedures will be subject to the provisions of the collective bargaining agreements currently in effect at each of the facilities.

JTF CAPMED/JOA/MTF Governance

As you know, on 14 September 2007, the Department established JTF CAPMED as a fully functional JTF. DoD chartered JTF CAPMED with a mission of providing health care within the NCR that will continue long after the new WRNMMC and FBCH admit their first patients.

The Services currently exercise OPCON over their respective MTFs in the JOA, while JTF CAPMED currently exercises tactical control (TACON) over MTFs in the JOA. Not later than September 2011, JTF CAPMED will assume OPCON of WRNMMC and FBCH. Governance relationships with the outpatient MTFs in the NCR will likely remain the same.

JTF CAPMED is currently working within DoD to formulate an ultimate governance alignment that will protect the policy formulation and funding flow equities of the ASD(HA) and the DHP.

JTF CAPMED Decision making

For those issues requiring decisions at a higher level than JTF CAPMED, the Department's charter tasked the Under Secretary of Defense for Personnel and Readiness (USD(P&R)) and the Vice Chairman, Joint Chiefs of Staff to ensure the effective execution of the JTF CAPMED mission. Additionally, Commander JTF CAPMED (CJTF) coordinates risks through an Overarching Integrated Process Team for the Transition of Medical Activities in the National Capital Region (NCR OIPT) as necessary. The NCR OIPT is co-chaired by ASD(HA) and Deputy Under Secretary of Defense for Installations and Environment (DUSD(I&E)).

Linkage to the Services equities is strong as each Service's Vice Chief of Staff sit on the NCR OIPT. Recommendations are forwarded to DEPSECDEF for ultimate decisions.

Utilizing the NCR OIPT for coordination, two issues have been approved by the Department. The first issue was approval of a DoD Civilian Manning Model for NCR civilian medical personnel, creating DoD civilians, including a realignment of resources and an ultimate transfer of civilian personnel authorities to JTF CAPMED. The second was approval of a military staffing model which establishes WRNMMC and FBCH as joint hospital commands under JTF CAPMED.

Wounded Warriors

Maintaining the capability to serve as America's primary casualty reception site and caring for those casualties remains the number one of JTF CAPMED. This includes Warrior Transition Services, which will be established to consolidate care and support requirements for the most seriously wounded, ill or injured service members from WRAMC and NNMC who will receive care at WRNMMC. The Department provided for significant warrior care enhancements at Bethesda, which go well beyond the BRAC requirements. Patients needing recurring tertiary care will be located at WRNMMC and warriors needing other levels of care can be located at other MTFs within the NCR that best fit their need. Based on an inpatient needs analysis from the NCR BRAC team, JTF CAPMED projects that 355 warriors will receive outpatient care that will require their location to be on the WRNMMC campus, and that the Army will have room for 290 warriors at FBCH and 175 warriors at Fort Meade, when WRAMC closes.

Each Service employs different care models and administrative processes for providing wounded warriors with inpatient/outpatient care, non-clinical support, personnel benefits and medical disability/administrative separation proceedings. JTF CAPMED must thoughtfully

design support services for these wounded warriors while maintaining the command and control equities that the Services see as essential.

Pharmacy Operations

More patients will likely use the pharmacy services than they will utilize any other service or specialty at the new WRNMMC and FBCH. Due to the BRAC consolidation of the current WRAMC and NNMC, three outpatient pharmacies are planned; two at the new WRNMMC and one at FBCH. A chartered Pharmacy Workgroup, which includes Service Medical Component representation, has been in existence since August 2008 and is vigorously working the multitude issues on how to optimize a regional pharmacy system.

The current footprint for the two WRNMMC pharmacies appears to be sufficient for the expected prescription workload to be processed at the new facility. The focus currently is on appropriate equipment acquisition/reuse and ensuring proper staffing. More importantly, prescription filling processes are being examined and re-worked to decrease waiting times and provide enhanced customer service. Mail order refills hold promise as a model and WRAMC, NNMC, and DeWitt pharmacies are working closely to develop courses of action.

The Pharmacy Work Group has diligently examined current, and projected, prescription filling processes. To assist in this effort, the group is examining how current and projected technology can be exploited to help gain a more customer-focused service. The challenge is to change the processes for the greater benefit of patients.

Reports to Congress

JTF CAPMED is mindful of Congress's interest and support for NCR Medical transformation. As you know, section 2721 of the FY 2009 NDAA, among other things, required a milestone schedule for the transition WRAMC operations and a report on whether

plans for the new WRNMMC and FBCH will achieve the goal of providing world-class medical facilities. The Department delivered an interim report on 13 March 2009 and recently delivered the final report on the milestone schedule. The final milestone schedule states that the U.S. Army intends to cease clinical operations at WRAMC on 15 September 2011 and transfer the main post to the U.S. General Services Administration and the Department of State as soon as practical thereafter. The Department expects that the design of WRNMMC and FBCH will be completed during 2009 and that construction and renovations will be completed between the beginning of 2010 and August 2011. Transition of operations from WRAMC is planned over a compressed timeframe in August 2011-September 2011. As you review the report, JTF CAPMED will be pleased to discuss any further questions or concerns you may have.

A subcommittee of The Defense Health Board (DHB) has been tasked with providing an independent review of the construction and design plans at WRNMMC and FBCH. The Department has been working through these issues identified by that subcommittee during its review and anticipates the submission of its report to SECDEF shortly. DoD will review this report and will forward it to Congress.

Section 1674 of the FY 2008 NDAA requires a detailed transition plan regarding certain aspects of the relocation of operations and patients to WRNMMC and FBCH. JTF CAPMED is currently completing the MTP that will cover all aspects of the transition from WRAMC to WRNMMC and FBCH. It will lay out the sequence and timing of moves (clinical and others) from WRAMC to WRNMMC and FBCH. It will detail the individual actions required to ensure success of the transition. The plan is intended to be dynamic in nature and will continually evolve across the duration of the BRAC execution timeline. The MTP will also be used as the foundation for providing the Department's initial and quarterly reporting obligations under

Section 1674 of the FY08 NDAA. The Department plans on submitting the initial §1674 plan to Congress by no later than the end of FY 2009.

Conclusion

Mr. Chairman, Ranking Member Young and committee members, thank you all for your interest and support in NCR Medical transformation and the efforts the Department is taking to constantly improve its healthcare and healthcare support. JTF CAPMED is committed to providing wounded service members, their families and all MHS beneficiaries with world-class medical care and support.

Your support and oversight have made immeasurable contributions to this process. JTF CAPMED will continue to work with the Services and DoD to capitalize on its strengths and together the Department will deliver the finest, most robust, integrated regional health care system in the country. JTF CAPMED looks forward to a fruitful and collaborative partnership with you and thank you for this opportunity to be with you today.

Mr. MURTHA. General, you didn't mention the committee. You mentioned all the work you guys are doing. This is the first time that I remember that you stepped up to the table and put enough money in the budget. I mean, this committee has been in the forefront of health care, and you just gloss over that like we weren't even there.

General VOLPE. Sir, we are greatly appreciative of all the support by you, the Chairman, the Ranking Member and all the committee members through the years in the military.

Mr. MURTHA. Beverly Young ever talk to you about any of this health care?

General VOLPE. No, sir.

Mr. MURTHA. She is slipping.

Mr. YOUNG. If we give Beverly his name, I am sure she will.

Mr. MURTHA. Mr. Bishop.

PTSD

Mr. BISHOP. Thank you, Mr. Chairman.

May I just mention from the previous panel some concerns I had for the record. With regard to Lieutenant General Schoomaker's testimony, he had stated in his opening testimony that the fractured relationships and not PTSD account for or are related to many of the suicides, and I found that a little bit incredulous because many times the suicides relate to relationships that became fractured as a result of PTSD. And I was wanting for the record the Department to submit any studies that have been done to track the relationship and to test the relationship between fractured relationships and PTSD, because there is, I think, a great deal of likelihood that the underlying causes of the suicides relate to the PTSD as well as the multiple deployments that strain those familiar relationships.

And also, Ms. Embrey stated that doctors may prescribe whatever treatment they want if they think it will help the servicemember, and I think that, for the most part, folks have done that. The witness that was a three-star general who got the hyperbaric oxygen treatment for injuries he sustained and swears by it anecdotally, I might add. And I know that there is a need for the establishment of medically and scientifically proven studies, General Schoomaker, but if, in fact, these anecdotal studies document some benefit from the hyperbaric oxygen treatment, it would appear that if the doctors made—if it is made known to them that they do, in fact, as Ms. Embrey suggests, have leeway to recommend or prescribe some of these treatments, it perhaps would help the thousands of our Army and Marine soldiers suffering—who are suffering from PTSD, the spinal injuries and other nerve damage injuries which anecdotally suggest can be cured or definitely treated with the hyperbaric oxygen treatments.

Now, getting to the subject of this panel, I would just like to ask, I think it was in the appropriations report, in the language entitled "Medical Care in the National Capital Region," the committee expressed concern that in spite of the significant cost increases at the new Walter Reed, funding still had not been included for a number of facilities that already exist at the current Walter Reed center. And the planners hadn't solved the ingress and the egress prob-

lems and how that will be accomplished for patients and staff, given the fact that the patient and staff population will virtually double in a little more than 2 years.

Has the report been completed with regard to that? Have those ingress and egress problems been solved? Do you have a plan that speaks to that? When will the construction be completed for each of the two facilities? And when can the staff at Walter Reed be notified of their future employment, and vice versa, I guess, at Bethesda?

There are a number of these issues that we are concerned about. If you would sort of address those, I would be appreciative.

Admiral MATECZUN. Thank you, Congressman Bishop.

There is a 2721 NDAA 2009 report which was delivered 2 days ago, which includes an integrated master schedule of over 10,000 line items on tasks that must be accomplished to coordinate and finish these moves. That report, that integrated master schedule will lead to a master transition plan, which we will be completing this summer which have all the steps outlined, and that will be in fulfillment of the 1674 requirement of the NDAA 2008.

Mr. BISHOP. It was delivered to the committee, or it was delivered to the Secretary; to whom was it delivered?

Admiral MATECZUN. To the committee, sir. And so that may answer some of those questions.

In terms of being able to reach with 10,000 individuals that we have, and a fair number of them moving primarily out of Walter Reed and into both Bethesda and Fort Belvoir, we have significant resources devoted to try to make sure that we are letting them know in a timely way where they might be going. There is a guaranteed placement program available under the BRAC. We do need all of the workforce that we have today to be distributed amongst those two hospitals of the future.

The demanding documents themselves, we are in the process of finalizing coordination within the Department. And so once those two documents are finalized, we will know each of the positions at those hospitals, and then we will be able to start the process of working through who will fill each of those positions.

Mr. BISHOP. What about the equipment; how much of the major equipment at Walter Reed is going to be utilized at the new Walter Reed or at Fort Belvoir? And how much additional equipment is going to be required, have to be procured for each of those transitions?

Admiral MATECZUN. The Army's JTARA team did a review of all the equipment in the National Capital Region. About $50 million of the equipment that exists at Walter Reed today of the major equipment will be reusable within the new facilities. There is about a $400 million——

Mr. BISHOP. Fifty thousand dollars?

Admiral MATECZUN. Fifty million dollars.

There is about a $400 million initial outfitting and transition cost of the two new facilities. Those are included in the budget that was just—the President's budget that was just submitted.

Mr. BISHOP. So that $400 million includes the movement of the existing equipment that you will be able to continue to use, as well

as acquisition or the procurement of new equipment for the new facilities.

Admiral MATECZUN. Yes. Our strategy is to have a single contractor that does all of that, which is the norm out in the civilian world today.

Mr. BISHOP. What is the planned disposition for the existing facility there on 14th Street?

Admiral MATECZUN. Sir, I would have to go to the Department and get an answer. I believe that the BRAC law requires that the facilities be turned over to the General Services Administration, and that the General Services Administration make disposition.

Mr. BISHOP. Will it be part of your budget to do the cleanup and disposition, or that will be totally—normally under BRAC we have to do some cleanup. That is under the military construction bill. Usually there is a significant lag time for the cleanup, but it has to be budgeted and implemented, and, of course, it has to be paid for.

Admiral MATECZUN. Yes, sir. The business plan details on that I don't know. I am not responsible for executing the closure of Walter Reed. The move-out, I am responsible for it. But we will take that and come back with an answer for you.

[The information follows:]

The Army is responsible for the disposition and cleanup of the existing Walter Reed Army Medical Center (WRAMC). Current plans call for a Federal to Federal transfer of the 113 acres of WRAMC main post. The General Services Administration (GSA) has requested 34 acres and the Department of State the remaining 79 acres. The Department of State has recently amended their request asking for only 18 acres. The Deputy Assistant Secretary of the Army for Installations and Housing is working with GSA to see if GSA is interested in amending their request for the now remaining 61 acres. If no interest is found, the 61 acres will be declared surplus.

The extent of clean up is partially dependent on the future use of the facility (e.g. Federal tenants vice non-Federal tenants). However, regardless of who the future owners will be, DoD must terminate its Nuclear Regulatory Commission (NRC) license. The current estimate is approximately $14M to decommission all locations where radiological substances have been used and terminate the NRC license in order to release all buildings for unrestricted use. Estimates were based on the NRC-required Decommissioning Funding Plan of 2005.

Mr. BISHOP. Thank you.

Thank you, Mr. Chairman.

Mr. MURTHA. Mr. Hinchey.

REMARKS OF MR. HINCHEY

Mr. HINCHEY. Thank you, Mr. Chairman.

And I want to thank you both for all the important work that you do and the way in which you oversee all the work that a lot of other people do. But as we know, no matter what we do and how focused we are on it, nothing is perfect. There are a lot of issues that come up and a lot of problems that result. I know particularly over the last couple of years, you have really been doing a lot of really good work.

We have all had experience within the last few years of constituents of ours coming back from situations in Iraq and elsewhere and the consequences that they face. And in one particular case—more than one, but I have one in mind particularly because of the very dire circumstances. The guy was almost killed, but because of the

very good medical attention he got instantly in Iraq and in Germany, and then over here it declined, but nevertheless he has improved significantly, but there has been declining attention that has been focused on him. And I think that the circumstances there are that somebody who is no longer going to be functional in the context of the military, or maybe not even particularly functional in any context, may not be getting attention. And so I think that is something we really need to look at.

MEDICAL MALPRACTICE

There is another aspect, too, I just wanted to draw attention to, and that is back in the 1950s, maybe 1953, where the issue of medical malpractice was dealt with in a way that made—or eliminated responsibility, frankly, for medical malpractice. So we know that in the human context, no matter what we are doing, even in military and maybe even more so in military situations because of the tough circumstances that we have to experience in the military from time to time, that it may be more likely for military people to get disease, get normal kinds of things that anybody is subject to. And whether or not that is true, we know that at least it is going to be average for human beings, for normal people.

And what I have seen happen is that people who get sick, including specific dire elements like cancer, are not attended to effectively, and in some cases, even as I have seen the presence of cancer in people, even though the evidence of it is so apparent, has not been dealt with, not been admitted to, not been addressed in any way. So I am just wondering what you might be thinking about this.

I think that there are some things that we have to do here in the Congress to deal with this more effectively, and I just wonder what you may be thinking, particularly with regard to trying to as much as possible eliminate medical malpractice. We have not been able to do that, eliminate medical malpractice, in the normal medical circumstance for citizens, in normal hospitals and anyplace across the country. And I am from New York, and we haven't been able to do it there.

But this is something that I think needs attention, and I think that the situation of medical malpractice may be worse in the military than it is out in the general public. And I am just wondering what you think and what we need to do to address that problem.

Admiral MATECZUN. Congressman Hinchey, I will respond in some background ways, tell you what we are doing in the National Capital Region and what is happening in the military.

The malpractice rates, I think, in the military are not higher than they are out in the civilian world. There are statistics that go back years that take a look at the denominator of all the practice and the number of cases where we have actually made a settlement or reported somebody to the National Practitioner Data Bank.

I think the route to quality, the route to improvement is by reducing variation particularly in the way we practice, and elevating the standards so that here in the Capital Region, for instance, as we take a look at working across all of the hospitals and clinics that we have—I will just take a procedure, conscious sedation, what you get when you go to the dentist, or when you are getting

a colonoscopy or other procedures, can be done in 37, if not 57, different ways just in a couple of facilities. So one of the ways to improve is to make sure that we are doing it all the same way in an evidence-based way across all of those clinics that we have within the NCR, just as a quick example of how we might be able to, in an integrated delivery system, provide the care that these beneficiaries need.

Also we need to integrate that care consistently across them. So cancer care needs to be the same no matter what your entry point is into the system. So just a couple of examples on how to improve care.

General Volpe.

General VOLPE. Yes, sir. Thank you.

There are a few things that I think are fairly inherent to our military health system in all of the services, and that is between our fairly strict recruiting standards, our graduate medical education programs are second to none, and that is pretty much shown out on national board examinations in various specialty areas. And all of our physicians and clinicians do a magnificent job in leading the Nation in those scores. And our credentialing processes and procedures and maintenance of certification is also second to none throughout our system.

So from a quality aspect of the clinician that is in the military, we believe this is the best quality system there is, and I believe that is one of the reasons why Admiral Madison mentioned that our malpractice rate is less than what it would be in the general population.

Mr. HINCHEY. So do you think, as it is out in the rest of the country, that the people who deliver health care within the military context should be held accountable for medical malpractice escalations?

Admiral MATECZUN. They are held accountable for medical malpractice escalations.

Mr. HINCHEY. They are not held legally accountable.

Admiral MATECZUN. The providers have the same actions taken against them.

You may be referring to the Feres doctrine.

Mr. HINCHEY. Yes.

Admiral MATECZUN. Feres doctrine is beyond my expertise in answering the questions. I think we would be glad to take it back and get a written response back to you.

[The information follows:]

The Feres Doctrine is a legal doctrine that prevents Service members who are injured as a result of military service from filing claims against the federal government under the Federal Tort Claims Act. However, as stated below this does not mean that providers in military treatment facilities are not held responsible for care provided.

The Department of Defense (DoD) Military Health System (MHS) holds medical practitioners responsible for care provided. Even though they are not financially liable, their continued eligibility to practice medicine is at risk. There are several layers to the practitioner quality assurance program.

When a MHS beneficiary experiences an unanticipated outcome or adverse event, risk management and patient safety subject matter specialists collaborate to identify, analyze, and appropriately report these events. Processes are in place (for example, incident reporting and occurrence screens) to identify adverse events. Immediate action is taken to ensure patients, staff, and visitors are protected from additional injury and minimize the untoward effects of the event.

Every healthcare adverse event involving a MHS patient (Active Duty Service member or other TRICARE beneficiary) is reviewed whether or not harm occurs to the patient. The risk manager, patient safety officer, senior clinical staff, and MTF attorney, if available, will collaborate to determine the appropriate investigative processes for the adverse event. An adverse event that resulted in harm to the patient and presents a possible financial loss to the Federal Government (a malpractice claim or death/disability payment) is referred to as a potentially compensable event (PCE) and is investigated by the Risk Management Program. Significantly involved providers are identified and informed that a review of the PCE will take place.

A standard of care (SOC) review is conducted on the event in question with all significantly involved providers being considered. The SOC investigation includes a professional review of the care with a determination as to whether the SOC was "met" or "not met." Claims of alleged malpractice filed under the Federal Tort Claims Act, the Military Claims Act, or the Foreign Claims Act (Title 10 U.S.C., Chapter 163) (reference (c)), or death or disability payments are documented, tracked, and analyzed to determine contributory causes. Every alleged malpractice claim and every death or disability of a military member as a result of healthcare services includes a SOC determination for each significantly involved practitioner.

If a malpractice payment is made, or a death/disability payment related to healthcare is awarded, the Surgeon General will ensure a thorough and unbiased review of the facts of the case to determine if any of the significantly involved healthcare practitioner(s) did not meet the SOC. Reasonable cause to initiate an adverse privileging action includes, but is not limited to, a single incident of gross negligence, especially if it causes death or serious bodily injury, a pattern of inappropriate prescribing, a pattern of substandard care, abuse of legal or illegal drugs, and significant unprofessional conduct.

Our MTFs' SOC reviews, Risk Management Program, provider credentialing, and privileging and adverse actions meet the accreditation standards of the Joint Commission or the Accreditation Association for Ambulatory Health Care.

Mr. HINCHEY. If someone experiences medical malpractice, and they get seriously ill and even die, they, if they are still alive, or their family after they die cannot legally hold accountable the instrumentation of medical malpractice that caused the serious illness or the death.

Admiral MATECZUN. Yes, sir. We, I think, looking at it from our side, on the provider side, look at the compensation that they get. I am not an expert on it. I can tell you that as providers, we do hold them accountable. If they have had malpractice, they are reported to the National Practitioner Data Bank, and their privileges are removed or changed.

Mr. HINCHEY. Thank you. It is something we need to pay attention to. I thank you very much.

Mr. MURTHA. Well, now, without objection, we go to Mr. Moran.

PLAN FOR MOVING MEDICAL FACILITIES

Mr. MORAN. Thank you very much, Mr. Chairman.

As the panelists know, you required a comprehensive report to be delivered to this subcommittee so that we could have some confidence that the move from the three medical facilities into the two medical facilities would be done not just on time, which is not our major concern, but would be done right.

Now, we got late, very late, the report yesterday, within the last couple of days. Was it yesterday? Anyway, it was just a short while ago. But nevertheless, our superb staff, particularly Mr. Horner, has gone through it. But it is not adequate, it is not a comprehensive plan. What we were looking for is what steps need to be taken by when so that you can get this done without our warriors being

adversely impacted by the move. And you gave us this broad picture without adequate specificity.

I think you may want to have your staff talk to Mr. Horner, and he will tell you what it is we envision. We thought it was clear. But, for example, we would like to know how much it is going to cost. One of the things that concerns us is that BRAC in 2005 had a number of cost estimates, costs saved, and what it would cost us, and all of those estimates have been wrong, all of them. It said that it would cost $20 billion, and now we are told it is $32 billion. It said that we would save $36 billion, and now we are told we are lucky if we save $4 billion annually. That was the broad picture. There are 230 locations as a result of BRAC that have to be completed, and we are being told they are all going to be completed within the last 2 weeks of September 2011, including the realignment of Walter Reed Hospital. So you are going right up to the deadline. There is no plan B, and that is the concern of the committee and has been all along.

Now you can, first of all, respond, would the original savings and payback period from the transition to Walter Reed, are those numbers still accurate, the cost and the savings?

Admiral MATECZUN. No, sir.

Mr. MORAN. No, they are not. Do you have new numbers?

Admiral MATECZUN. Yes, sir. We can provide those to you. The COBRA estimates were not anywhere near what this project is going to cost.

Mr. MORAN. Well, Mr. Chairman, so here we are again. The BRAC estimates were nowhere near what it is actually going to cost us and what savings are going to be achieved. But again, we asked for a report; those numbers are not in the report.

I don't want to give you a hard time, because I know you were given an impossible mission, and to some extent you are the messenger of what we expected would be bad news in terms of adequate implementation. But that report was supposed to include cost estimates. So now, yes, we do need those cost estimates to be provided—this is a the committee that provides the money. We don't want to be told at the 11th hour, unless you give us all this extra money, we can't get it done. So, yes, we need those estimates.

Can you tell us——

Mr. MURTHA. Let me reinforce what the gentleman is saying. I went to the BRAC hearings. I very much opposed to closing down Walter Reed. Well, I lost that battle, but I remember distinctly they said it would cost $232 million to close it down. That was the figure that they gave. Principi, who was the Chairman, said the same thing: He was concerned about it. All of us were concerned about it. But over and over from the Defense Department we get inadequate figures, and then the taxpayer has to pay. Something happens, you come to us, representing the taxpayer, we do, and then we have to fork over money which we didn't anticipate, which then makes it very difficult to solve our budget problem.

So you need—and I told the Secretary of Defense this yesterday—you need to go back and start to get accurate figures for us so that we have a better estimate of how we can put a budget together. For instance, there was a $2½ billion shortfall in personnel costs. We have two or three hearings, two or three meetings in ad-

dition to the hearings about the military shortfall, we couldn't get it until the last minute exactly what those figures were.

Now, we have 15 people on our staff. It is impossible for us to have oversight, so we depend on you to give us that kind of information so that we can put together a logical budget.

So with that, I yield back to Mr. Moran.

ACCESSABILITY TO FACILITIES BY PERSONNEL

Mr. MORAN. Thank you, Mr. Chairman.

We have some problems. I know you are supposed to be looking at this, but I know they seem minor. The personnel, the employees at these facilities. One thing, for example, it is at a Metro stop at Bethesda. There is no Metro stop where they are going at Fort Belvoir. Have any of them been notified as yet where they will be going within a year and a half?

Admiral MATECZUN. No, sir. Until we have the actual manning documents themselves, which are 3,000 people, 3,200 people out at Fort Belvoir, 6,000 at Bethesda, we can't say this is the spot you are going to.

I can tell you in general the vast majority of civilian personnel will be accommodated where they would like to be. We surveyed the workforce at Walter Reed. Approximately 10 to 15 percent of them plan on taking retirement or some other BRAC-related eligibility, which would remove them from the workforce, and we estimate in our last run-through—this is a preliminary number—90 percent of the them would be able to stay north where they needed or if they wanted to stay north; i.e., at the Bethesda campus. We need to incentivize the other personnel, if we need to, to go down to Fort Belvoir, although Colonel Callahan has been doing a great job in recruiting people to come down there as part of the workforce.

Mr. MORAN. I appreciate that, but I need to underscore this again. We have a year and a half. None of the people have been told where they are going. Most of them are going to Fort Belvoir, but most in Bethesda want to stay in Bethesda, and you are telling them they can't. You are also telling us that 15 percent of them were going to drop out and take retirement. We have expanded facilities, we have a greater need for personnel, and yet 15 percent them are going to leave.

Our concern is the quality of care provided to the residents, the patients. So I don't know how you are going to get the new people to staff these expanded medical facilities when 15 percent have already notified you they are leaving, and the majority at Bethesda are going to stay at Bethesda when most are supposed to be going to Fort Belvoir.

I know my time is up, but these are issues that we need resolved, and you have been given an impossible task. The problem is the subcommittee made it clear this is impossible. And if the highest priority is the care of the patients, then we are going to fall short. And now we have a year and a half, and we are very much concerned that inadequate planning and certainly the estimates we demanded have not been provided, and they need to be.

Thank you, Mr. Chairman.

Mr. MURTHA. Mr. Young.

COMBINING ARMY AND NAVY HOSPITALS

Mr. YOUNG. Mr. Chairman, thank you very much.

In following the same line that Mr. Moran has initiated, General Volpe, you said that you had the two hospitals, and you don't have to respond to this, but my question is is one of them a Navy hospital, or is one an Army hospital, or are they both hybrid?

General VOLPE. Sir, we have the approval from the Department that both of these facilities will be joint. They will be placed on a joint table of distribution, which is a document that allows the commander of that facility to be responsible for all the people that are working in that facility regardless of what service that they are in. So we are able to get unity of effort through unity of command in those facilities and have one person responsible for the good, the bad and ugly that occurs in that facility.

Mr. YOUNG. You said, General, that two hospitals are jointly staffed, jointly managed and jointly governed. Somebody has to be in charge. When it is jointly, who is in charge?

General VOLPE. Sir, there will be a commander that is selected. It will either be by a rotational basis or nomination basis that is yet to be determined, but we have to work with the services on that process to do that. It will be under the operational control of JTF CapMed.

Mr. YOUNG. Will there be a super commander that would be in charge of both facilities, Fort Belvoir and Bethesda?

Admiral MATECZUN. Yes, sir. That is the joint task force.

Mr. YOUNG. Do we know who that is?

Admiral MATECZUN. That is me, sir.

Mr. YOUNG. And then each hospital will have a commander?

Admiral MATECZUN. Yes, sir.

Mr. YOUNG. Will Army and the Navy share those roles?

Admiral MATECZUN. That is one of the options, yes, sir, either to do it on a rotational basis or a nominative basis like all their joint positions.

Mr. YOUNG. Outside of the normal grumbling that takes place at any kind of merger whether it is military, civilian, political, whatever, and I am sure you have heard some of that, Mr. Moran has indicated some, is the merger going well, is it on track?

Admiral MATECZUN. Yes, sir, it is. And I would like to say that our concern, our primary concern, is and will always be the health care that we deliver. If we were not able to meet any of the deadlines that we think are out there, I would have no hesitancy about telling you about that and asking for your help.

Mr. MURTHA. Let me just interrupt Mr. Young. We need you to give us a plan.

Now, first time I heard we would have 35 different installations. My wife told me the other day, look over there, that is going to be part of the new Walter Reed. I didn't know that. I mean, I had no idea. It is along 95.

She may be wrong. She is not wrong very often, but you know, the wives talk to each other. And I don't say she is wrong, she is probably right. But the point I am making, we need to see what you are going to do here and what it is going to cost. That is what we need.

Now, we shift money to military construction, in many cases, because they need the money. So give us a plan so that we can live with it and figure out, in increments, what needs to be done.

Because what Mr. Moran is worried about is not going to happen—I mean it is going to happen as he predicts, unless you have the funding that is necessary in order to implement this. And all of us want to do the same thing. All of us want to have the money that is necessary for the troops to make sure there is care for not only the troops coming back, the troops that need care that have been back, and also the retirees, because there are so many of them in this general vicinity.

Okay, that is it. Without objection, the committee adjourns until after the recess.

[CLERKS NOTE.—Questions submitted by Mr. Bishop and the answers thereto follow:]

Question. LTG Schoomaker, you stated in your opening statement that "fractured relationships not PTSD account for a majority of the numerous suicides in the U.S. Army;" however, how can you be sure? Has an extensive study been done on the impact PTSD has on relationships and on families? If so what are the results?

Answers. Completed suicide is one of the leading causes of death among U.S. Soldiers, and suicide behaviors lead to unnecessary Soldier and family suffering. Based on our own data and what has been published in the peer reviewed literature, relationship issues are a very important factor in suicides. According to the most recent published DoD Suicide Event Report (DoDSER), 50% of individuals who committed suicide in 2007 had a failed spousal relationship (15% had a failed "other" relationship). By contrast, since 2003 only 5.5% of individuals who committed suicide had a medical encounter with a diagnosis of post traumatic stress disorder (PTSD).

According to analyses of Army suicides conducted by the Army's Center for Health Promotion and Preventive Medicine, there were 650 potential Army suicides from 1 Jan 2003—15 Apr 2009. Overall, 273/650 or 42% had a record of an outpatient encounter for a behavioral health diagnosis. Of the 650 suicides since 2003, 36 (5.5%) had a record of an outpatient encounter with a diagnosis of PTSD. That is very similar to the overall percentage of Soldiers with PTSD. Adjustment disorders (20.6%), mood disorders (17.7%), and substance abuse (16.3%) were the 3 most common categories of outpatient behavioral health encounters among those who committed suicide.

Intuitively, the notion that premorbid psychological/marital status, PTSD, suicide, and family pathology are intimately connected seems reasonable. PTSD is also thought to disturb the family system in those Families with good premorbid adjustment and to exacerbate pathology in those Families with maladaptive premorbid adjustment. These disturbed family interactions can increase the distress experienced by service members suffering from PTSD. Chronically increasing distress on the part of the service member may then cause increased family disturbance, and a downwardly spiraling vicious cycle results. The inability to escape this cycle may be a contributor to suicidal behaviors, especially among members with limited coping skills due to psychopathology and/or cognitive limitations. Although PTSD may be a contributing factor to the increase in suicides, by itself it does not explain the rising rates.

Question. LTG Schoomaker, on page 9, of your written testimony for record you state that the Chief of Staff of the Army, General Casey, has identified several shortcomings in his own Army health experience and that the "Army does not routinely assess all the elements of weilness, fitness, and human performance, other than the physical." Part of wellness is mental fitness. Mental fitness is compromised during PTSD. You have admitted that the Army does not routinely assess weliness or mental health in your testimony. How can you say that PTSD and suicides are not related?

Answer. Historically, the Army did not routinely assess all the elements of wellness, fitness, and human performance, other than the physical. We identified this as a shortcoming and have been developing a new approach to total fitness. On October 1, 2008 the Army established the Comprehensive Soldier Fitness Program with a mission to develop and institute a holistic, resiliency-building fitness program for Soldiers, Families, and Army civilians. The program focuses on optimizing five dimensions of strength: Physical, Emotional, Social, Spiritual, and Family. This ho-

listic approach to fitness will enhance performance (capability) and build resilience (capacity) of the Force in this era of persistent conflict and high operational tempo.

PTSD may be a contributing factor to the increase in suicides, but by itself it does not explain the rising rates. While this disorder draws significant media attention, it is only one of many behavioral health diagnoses that impact Soldiers and their Families. According to analyses of Army suicides conducted by the Army's Center for Health Promotion and Preventive Medicine, between 2003 and April 2009, a total of 650 potential suicides were committed by Army personnel. Overall, 273/650 or 42% had a record of an outpatient encounter for a behavioral health diagnosis. Of the 650 suicides since 2003, 36 (5.5%) had a record of an outpatient encounter with a diagnosis of PTSD. That is very similar to the overall percentage of Soldiers with PTSD. Adjustment disorders (20.6%), mood disorders (17.7%), and substance abuse (16.3%) were the 3 most common categories of outpatient behavioral health encounters among those who committed suicide.

Question. LTG Schoomaker, on page 9 of your testimony you state that "The Army does not always link available life skills and performance programs and interventions with Soldiers and Families until the need has been demonstrated by a negative behavior. And the Army does not teach Soldiers about the potential for post traumatic growth, nor give Soldiers the opportunity to validate their post traumatic growth during Post Deployment assessments." If the Army does not teach nor give Soldiers the opportunity to measure post traumatic growth or the lack of growth, how can you state before this committee that Post traumatic Stress Disorder (PTSD) is not related directly or indirectly to suicides? Your opening statement and your written statements contradict themselves and cause serious concern about the thoroughness that the Army is approaching the suicide epidemic within its ranks. What is your plan to start looking at PTSD and its relationship to suicides and the strain that PTSD puts on families? Please submit for record your plan and the results of any study done concerning PTSD and suicide.

Answer. Suicide is a tragic event and the Army is making a concerted effort to provide a holistic approach to address the increasing number of these events. Under the direct leadership of Vice Chief of Staff of the Army (VCSA), General Peter Chiarelli, the Army's holistic approach addresses not only suicide, but the underlying issues and factors that may contribute to the problem, including post traumatic stress. In March 2009, the VCSA established and chartered the multi-disciplinary Suicide Prevention Task Force. In April 2009 the Task Force published the Army Campaign Plan for Health Promotion, Risk Reduction, and Suicide Prevention. This Campaign Plan puts the Army on an aggressive schedule to address about 250 tasks related to doctrine, organization, training, materiel, leadership, personnel, and facilities. The plan also gives installation, garrison and military treatment facility commanders a checklist of items to guide immediate improvements in programs and services for Soldiers based on best practices gleaned from installation visits. Field commanders immediately notify the VCSA of every suspected suicide. He conducts a monthly review on every Soldier suicide with commanders and a Senior Review Group. The review challenges leaders and helps to share lessons learned to improve outreach efforts for Soldiers. This recurring review ensures the Army maintains an intense focus at the highest levels of leadership and allows for sharing information and learning from individual cases.

On October 1, 2008 the Army established the Comprehensive Soldier Fitness (CFS) Program with a mission to develop and institute a holistic, resilience-building fitness program foroldiers, Families, and Army civilians. The program focuses on optimizing five dimensions of strength: Physical, Emotional, Social, Spiritual, and Family. This holistic approach to fitness will enhance the performance (capability) and build resilience (capacity) of the Force in this era of persistent conflict and high operational tempo. One goal of the CSF program is to enhance post-traumatic growth.

The Army is working closely with some of the Nation's foremost experts on suicide prevention, to include the National Institute of Mental Health, to ensure their efforts reflect the most current mental, behavioral and psychological health research and treatments. This five year, longitudinal study will help identify modifiable risk and protective factors associated with suicide, mental disorders, and psychological resilience, by evaluating Soldiers across all phases of Army service. The goal of the study is to identify intervention options based on empirically-identified risk factors.

In March 2009, the Office of the Surgeon General engaged the RAND Arroyo Center to design and carry out a longitudinal study of Army families. This study, currently in the design phase, will recruit and follow 3000 married Soldiers and their Families across all phases of deployment. The objective is to assess the impact of deployment on Army families by measuring several outcomes including health, marital and family functioning, and child wellbeing. The study is due to begin in the

fall 2009 (following receipt of all necessary approvals and information for recruitment) and will gather data regularly over three years. Findings from the first wave should be available by early 2010.

Question. Ms. Embrey has stated that doctors can prescribe whatever treatment they desire if they believe that it would help the service member. In a previous appearance before this subcommittee she noted that alternative treatments such as yoga were being utilized to help treat patients. Why is there a resistance among the various service Surgeon Generals against the use of the hyperbaric chamber to treat Traumatic Brain Injury (TBI)?

LTG Roudebush's Answer. The Air Force Medical Service is open to new and progressive treatments for those with TBI; however, the Department of Health and Human Services has not yet approved HBOT hyperbaric chamber (HBOT) therapy for the treatment of traumatic brain injury (TBI) as a covered condition, due to the lack of supporting evidence for its clinical efficacy. There is some evidence that this treatment may improve survival in those with serious TBI although there is no evidence yet that HBOT improves functional outcomes in acute severe TBI. Overall, based on a thorough review of all available scientific information, there does not appear to be adequate support for the recommendation of HBOT in the acute or chronic management of individuals with TBI. As a result, HBOT is not currently considered the standard of care for TBI. The Defense Center of Excellence for Psychological Health and TBI issues is sponsoring a large, multi-site, randomized clinical trial with Food and Drug Administration investigational new drug to answer the question of HBOT (hyperbaric chamber) efficacy. We are fully engaged with the Defense Center of Excellence in order to initiate this effort as soon as possible and look forward to the outcomes. There are also two other Defense Department level pilots studies that have recently begun. These and future studies will assure that we are utilizing safe and effective treatments for our patients with TBI.

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LTG Schoomaker's Answer. I am very supportive of conducting high quality clinical trials to determine the effectiveness of hyperbaric oxygen therapy (HBOT) for traumatic brain injury (TBI). According to a review of the medical literature, the clinical evidence remains insufficient to prove effectiveness of HBOT for TBI. The Department of Health and Human Services has not approved use of HBOT for the treatment of TBI as a covered condition due to the lack of supporting evidence for clinical efficacy. There is evidence from trials in humans to support that HBOT may improve survival, but not functional outcomes, in cases of acute severe TBI. There are no high quality clinical trials in humans of HBOT for acute mild TBI or for subacute or chronic complications from TBI of any severity.

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Admiral Robinson's Answer. While yoga is an essentially risk-free activity, there is risk associated with the use of hyperbaric oxygen therapy (HBOT). This is dramatically evidenced by a chamber fire on May 1, 2009 at Ocean Hyperbaric Neurological Center in Lauderdale by the Sea that resulted in 90% second and third degree burns to a four-year-old patient, and the death of his grandmother on May 2, 2009 who accompanied him in the chamber. This tragedy involved a child being treated for cerebral palsy, like TBI, a condition for which HBOT is not a recognized treatment. No validated scientific evidence or peer community review has established that hyperbaric oxygen is either safe or effective in the treatment of traumatic brain injury. To this end, three DoD supported clinical trials are underway and/or under development to evaluate the feasibility and efficacy of hyperbaric oxygen therapy for this indication. Scientifically determining whether hyperbaric oxygen is efficacious in treating traumatic brain injury is an essential first step in establishing the potential risk/benefit ratio of this therapy.

Question. I have heard several of the service Surgeon Generals describe anecdotal reports of success using the hyperbaric chamber to treat TBI. Please provide the committee a list and report of these anecdotal successes of the hyperbaric chamber treatments for TBI treatment and provide a report of your current medically approved method. What is the status of your medical validation of the hyperbaric

chamber for use as a treatment of TBI? How long has this validation been underway and how long will it take to complete? Please provide the committee with these answers.

LTG Roudebush's Answer. The anecdotal reports primarily come from civilian providers, most notably Dr. Paul Harch at Louisiana State University. He presented some of his cases at the Defense Center of Excellence sponsored HBO2 in Traumatic Brain Injury (TBI) Consensus Conference held in Alexandria, VA, in early December 2008. Dr. Harch would need to be separately contacted for any details as he has not as yet published them, at least to our knowledge.

The Air Force Medical Service is open to new and progressive treatments for those with TBI, however, the Department of Health and Human Services has not yet approved hyperbaric chamber (HBOT) therapy for the treatment of TBI as a covered condition, due to the lack of supporting evidence for its clinical efficacy. There is some evidence that this treatment may improve survival in those with serious TBI although there is no evidence yet that HBOT improves functional outcomes in acute severe TBI. The Defense Center of Excellence for PH and TBI issues is sponsoring a large, multi-site, randomized clinical trial with Food and Drug IND to answer the question of HBOT efficacy. We are fully engaged with the Defense Center of Excellence in order to initiate this effort as soon as possible and look forward to the outcomes. There are also two other Department of Defense level pilots studies that have recently begun. These and future studies will assure that we are utilizing safe and effective treatments for our patients with TBI.

Question. I have heard several of the service Surgeon Generals describe anecdotal reports of success using the hyperbaric chamber to treat TBI. Please provide the committee a list and report of these anecdotal successes of the hyperbaric chamber treatments for TBI treatment and provide a report of your current medically approved method. What is the status of your medical validation of the hyperbaric chamber for use as a treatment of TBI? How long has this validation been underway and how long will it take to complete? Please provide the committee with these answers.

LTG Schoomaker's Answer. The Defense Centers of Excellence (DCoE) for Psychological Health and Traumatic Brain Injury sponsored a consensus conference in December 2009 regarding Hyperbaric Oxygen Therapy (HBOT) in TBI. Over 60 subject matter experts from the Department of Defense (DoD), Department of Veterans Affairs (VA), and academia attended. The DCoE directed the HBOT in TBI Steering Committee to conduct a clinical research trial to investigate the efficacy of HBOT for Service members with mild to moderate TBI. The study, titled "Hyperbaric oxygen applied late after mild to moderate traumatic brain injury: A prospective multicenter double-blind randomized controlled trial," is anticipated to begin in Aug 2009, pending approval from the Food and Drug Administration (FDA). Institutional Review Board (IRB) approval is close to completion. Study completion is anticipated within 18 months. This study is a Phase 3 or definitive clinical trial intended to answer the important question of efficacy. The entire project represents a unique "joint" approach to rapidly conduct urgently needed clinical research. The study will enroll 300 active duty subjects at four DoD clinical HBOT sites (WHMC/Brooks City Base, TX; Ft Carson, CO; Ft Hood, TX; and Camp Pendleton Marine Base, CA). Baseline and outcome assessments will be conducted at Ft Carson, CO.

Three complementary "pilot" or phase 2 studies are also underway that could also show efficacy. First, a study by Dr. Lindell Weaver, LDS Hospital/Intermountain Medical Center, Salt Lake City, UT titled "Hyperbaric oxygen for brain injury". This began in 2003 to study the feasibility of hyperbaric oxygen for patients with persistent chronic TBI sequelae greater than one year following brain injury. Second, a study by Dr. Jason Cho, Wilford Hall Medical Center and Brooke Army Medical Center, San Antonio, TX titled "Treatment of moderate to mild cognitive dysfunction caused by TBI with hyperbaric oxygen therapy (HBOT)". This study has enrolled 10+ subjects with a target of 50 subjects, 25 treated and 25 sham treated subjects with diagnosis of TBI and perception of cognitive dysfunction. Third, a study by Dr David Cifu, Virginia Commonwealth University/Medical College of Virginia Hospital, Richmond, VA titled "Hyperbaric Oxygen Therapy (HBO2T) for Post-Concussive Symptoms (PCS) after mild TBI: A Randomized, Double Blinded, Sham-Controlled, Variable Dose, Prospective Trial" is anticipated to begin in summer 2009 and be complete within six months.

The DoD is committed to rapidly, but safely, determining the efficacy of HBOT for mild to moderate TBI. Findings from these studies may warrant a new standard of care for patients with chronic TBI, justify future research, and change reimbursement policy regarding HBOT for TBI.

Question. I have heard several of the service Surgeon Generals describe anecdotal reports of success using the hyperbaric chamber to treat TBI. Please provide the

committee a list and report of these anecdotal successes of the hyperbaric chamber treatments for TBI treatment and provide a report of your current medically approved method. What is the status of your medical validation of the hyperbaric chamber for use as a treatment of TBI? How long has this validation been underway and how long will it take to complete? Please provide the committee with these answers.

Admiral Robinson's Answer. Navy medicine has no anecdotal information from the use of hyperbaric medicine to treat TBI. There have been no treatments performed on TBI patients in Navy operational hyperbaric chambers that have received Navy medicine authorization.

Currents studies include:

1. The Air Force at Wilford Hall has been conducting clinical trials using hyperbaric oxygen for TBI since January 2009. Air Force is currently still enrolling subjects. Completion is projected at one year after initiation but may be delayed due to recruitment difficulties.

2. DARPA has funded a VA Richmond Virginia study headed by Dr. David Cifu, a nationally recognized TBI expert. It is awaiting final IRB approval prior to initiation. This study will use the Naval Operation Medicine Institute hyperbaric chamber facility in Pensacola, Florida. Start projected August 2009 and completion in one year.

3. Defense Center of Excellence for Psychological Health and Traumatic Brain Injury is pending final IRB approval for a very large multicenter study utilizing Navy mobile fly away recompression chambers and mobile standard Navy double lock chambers placed at Ft Carson, CO; Ft Hood, TX; and Camp Pendleton Marine Base, CA, in addition to use of the fixed hyperbaric facility at Brooks City-Base, TX. This study is currently pending completion of IRB review and is projected to start mid-August 2009 based on chamber availability. Hyperbaric trials are expected to be completed in one year's time.

Question. The Army and its integrated healthcare partners and providers are manned at 60% of the current mental healthcare need. PTSD, TBI, Mental and Behavioral Health are being treated in variant ways throughout the DOD, VA, and civilian healthcare systems. There are currently no mechanisms to control the quality of care, certify the standardization of patient centric evidence-based best practices, and knowledge to ensure the integration of culturally competent care by Physicians and Allied Health Providers. Thus, the service members, their families, and our veterans are being sub-optimally screened, diagnosed, treated and managed by mental Healthcare Physicians and Allied Health Providers. The lack of core universal patient centric training is resulting in poor outcomes. For example, there are sub-populations of the military community that may be disproportionately impacted by PTSD, TBI, Mental and Behavioral Health conditions. It is critical to recognize that 46% of the Army's enlisted ranks are between 17–25 years of age. This age range is medically classified as adolescence (10–25 years) and will require Mental Healthcare Physicians and Allied Health Providers to be uniformly trained in the age appropriate related care management. Does the military have providers trained to look at this age group? Does the military provide cultural competency training for its providers so that they can recognize cultural traits that impact the diagnosis of PTSD or TBI?

LTG Roudebush's Answer. It's an excellent point that a large percentage of military members are between 18 and 25 years of age. In fact, 38.9 percent of active duty Air Force members are below the age of 26, including 45.2 percent of our enlisted force. The American Psychiatric and Psychological Associations, as well as the National Association of Social Workers, have stated that there is a critical shortage of child and adolescent mental health providers in the United States. Currently 10 percent of Air Force psychiatrists are Child and Adolescent Fellowship trained, while all our psychiatry residents receive child and adolescent training and are licensed to provide care to this age group. The majority of active duty clinical social workers receive Air Force facilitated age appropriate training throughout their careers as part of their annual continuing medical education, as well as age appropriate training being part of their graduate degree programs. Active duty clinical psychologists are trained in child and adolescent treatment as part of their post-doctoral internships, and we have fellowship trained child psychologists serving in our Educational and Developmental Intervention Services program sites.

All Council on Social Work Education accredited graduate schools must include course work in cultural diversity as well as being considered a core competency for clinical social workers. The American Psychological Association also requires all accredited graduate degree programs to include course work in cultural diversity.

In general, civilian accreditation agency guidelines such as the 2008 Joint Commission require staff participation in education and training specific to the needs

of the patient population served by the medical facility whether inpatient or outpatient. The patient population is inclusive of all age groups and addresses cultural diversity of patients and staff members.

Other means of training include professional standards of practice, licensure, certification, and continuing education. Pre-deployment and cultural specific orientation programs help familiarize deploying medical members prior to arriving "in-country".

Recognition, diagnosis, and care of all patients returning with possible PTSD or TBI are a high priority of military medical staff. Pre- and Post-Deployment Health Assessments are required for all deploying personnel and are reviewed closely. Additionally, multiple education and training initiatives have been initiated for medical staff to more rapidly recognize PTSD or TBI and provide timely and appropriate care for our returning warriors.

Question. The Army and its integrated healthcare partners and providers are manned at 60% of the current mental healthcare need. PTSD, TBI, Mental and Behavioral Health are being treated in variant ways throughout the DOD, VA, and civilian healthcare systems. There are currently no mechanisms to control the quality of care, certify the standardization of patient centric evidence-based best practices, and knowledge to ensure the integration of culturally competent care by Physicians and Allied Health Providers. Thus, the service members, their families, and our veterans are being sub-optimally screened, diagnosed, treated and managed by mental Healthcare Physicians and Allied Health Providers. The lack of core universal patient centric training is resulting in poor outcomes. For example, there are sub-populations of the military community that may be disproportionately impacted by PTSD, TBI, Mental and Behavioral Health conditions. It is critical to recognize that 46% of the Army's enlisted ranks are between 17–25 years of age. This age range is medically classified as adolescence (10–25 years) and will require Mental Healthcare Physicians and Allied Health Providers to be uniformly trained in the age appropriate related care management. Does the military have providers trained to look at this age group? Does the military provide cultural competency training for its providers so that they can recognize cultural traits that impact the diagnosis of PTSD or TBI?

LTG Schoomaker's Answer. I respectfully dispute the allegation that we do not have mechanisms to control the quality of care, certify the standardization of patient centric evidence-based best practices, or knowledge to ensure the integration of culturally competent care. The Army Medical Department Center and School (AMEDD C&S) provides training that includes instruction by the foremost experts in the field of Post Traumatic Stress Disorder which include Dr. Foa and her team providing insight regarding Prolonged Exposure; Dr. Resick and her team with a focus of expertise in Cognitive Processing Therapy; and Dr. Silver and his team who provide training for providers on Eye Movement Desensitization & Reprocessing. These experts provide ongoing consultation for the AMEDD C&S instructors and selected students currently being trained to become subject matter experts (SME) in evidence based research practices for the Army. The treatment protocols being used and taught have been identified as proven evidence-based therapies by the American Psychiatric Association and American Psychological Association and are approved clinical practice guidelines of the Departments of Veterans Affairs and Defense. These patient-centric, evidence-based practices are being widely used in the Army, the Veterans Health Administration, and across the Department of Defense. These three treatment protocols have proven to provide solid research outcomes for effective treatment of trauma injuries of patients from diverse backgrounds and age-groups.

The AMEDD C&S provides the most up-to-date, current, and effective on-line training addressing the issues of PTSD and Trauma Brain Injury (TBI). This training is required for all social workers and nurses, and is also available to all medical providers. This Distributive Learning product includes 12 modules that are readily available and located on the Military Health System (MHS) learning portal. This portal has modules addressing issues related to PTSD and families; general cross-cultural considerations; and PTSD training for the Primary Care Clinician. This training is a required pre-requisite for behavioral health personnel to attend formal clinical training.

The behavioral health professional working in the Army is accustomed to working with the 17–25-year-old Soldiers. The percentage of Soldiers in this age group is not a new phenomenon. It is not unusual for providers to adjust their assessment and treatment interventions to various age groups based on their training. Even though age, culture, at risk populations, and trends are addressed in the AMEDD C&S curriculum, the curriculum developers are consistently and continually reviewing current literature and tapping the extensive knowledge base provided by their consult-

ants for ways to improve courses and programs. Our curriculum is systematically updated to incorporate lessons learned, new processes and approaches, and adjustments to ensure age-appropriateness of the content and teaching methodology. The AMEDD C&S is in the process of assessing and evaluating numerous courses to determine whether or not there is a need to create formal uniform lesson plans to specifically focus on the 17–25 age group.

Lastly, the Army Medical Department has a process to ensure credentialing of medical treatment facilities (MTF) responsible for providing clinical experiences of students. Much of the accreditation responsibility rests with each MTF and includes ensuring that providers are credentialed based on age competency levels. Supporting documentation such as diplomas, licensing certificates, letters of recommendation, and proof of training are required. This requirement supports our declaration that our Soldiers and their Families are receiving the best treatment possible from qualified staff.

Question. The Army and its integrated healthcare partners and providers are manned at 60% of the current mental healthcare need. PTSD, TBI, Mental and Behavioral Health are being treated in variant ways throughout the DOD, VA, and civilian health care systems. There are currently no mechanism to control the quality of care, certify the standardization of patient centric evidence-based best practices, and knowledge to ensure the integration of culturally competent care by Physicians and Allied Health Providers. Thus, the service member, their families, and our veterans are being sub-optimally screened, diagnosed, treated and managed by mental Healthcare Physicians and Allied Health Providers. The lack of core universal patient centric training is resulting in poor outcomes. For example, there are sub-populations of the military community that may be disproportionately impacted by PTSD, TBI, Mental and Behavioral Health conditions. It is critical to recognize that 46% of the Army's enlisted ranks are between 17–25 years of age. This age range is medically classified as adolescence (10–25 years) and will require Mental Healthcare Physicians and Allied Health Providers to be uniformly trained in the age appropriate related care management. Does the military have providers trained to look at this age group? Does the military provide cultural competency training for its providers so that they can recognize cultural traits that impact the diagnosis of PTSD or TBI?

Admiral Robinson's Answer. By providing decentralized, primary care-centric, and multi-disciplinary healthcare services, Navy Medicine's psychological health (PH) program reduces Mental Health stigma, establishes and supports evidenced-based best practices, and ensures culturally competent healthcare practices. Utilizing a Deployment Health, readiness-based model understandable to all service members irrespective of age, Deployment Health Clinic providers involved with warrior care are provided supplemental training to help reduce stigma, foster cultural tolerance, and offer evidenced-based practices. Navy Medicine does employ mental health providers specifically trained in child and adolescent care. Navy Medicine is profoundly aware of the additional challenges related to the healthcare needs of the 17–25 year age group—inclusive of higher suicide risk, motor-vehicular accident rate, and substance abuse predilection; and contributes regularly to these efforts through line-sponsored Cross Functional Teams. Fiscal Year 2008 saw the establishment of the Navy Operational Stress Control (OSC) program. Navy Medicine is actively supporting this line-owned program to build resilience and reduce mental health stigma across the broader Navy/Marine Corps culture, including various training programs that address age, ethnic and socioeconomic differences as well as various provider-specific training programs. Cultural Diversity is a CNO initiative. Navy Medicine augments these efforts in two ways: (a) Education and training for individual Sailors and Marines that normalizes MH care and appreciation of cultural diversity across the military and civilian population, and (b) education and training for healthcare providers that establishes evidence-based practices and supports cultural diversity.

[CLERK'S NOTE.—End of questions submitted by Mr. Bishop. Questions submitted by Mr. Murtha and the answers thereto follow:]

Question. It is the Committee's understanding that there is a national shortfall of psychiatrists and other mental health providers.

Is the Department of Defense (DoD) utilizing web-based clinical mental health resources to help compensate for this personnel shortfall?

Answer. The DoD has several ongoing initiatives to address web-based technologies. On June 1, 2009, TRICARE Management Activity (TMA) issued a contract

modification to its three Managed Care Support Contractors, identifying a 60-day implementation timeline to institute the following requirements:

- Develop a 24/7 web-based educational and TRICARE employee assistance program counseling via interactive audio-visual telecommunications to Service members and their families; and,
- Develop a network of originating sites capable of providing telemedicine/telepsychiatry care.

DoD is using web-based mental health resources to provide both pre-clinical and clinical services and to ensure that technology is fully leveraged across the spectrum of care for mental health concerns. It is expected that such resources will augment the overall range of services in the Military Health System, and may help to compensate for shortfalls in clinical personnel at some sites. Resources such as afterdeployment.org, realwarriors.net, and MilitaryOneSource provide a range of "pre-clinical" psycho-educational, self-assessment, and self-care resources for warriors, veterans, and military families.

TMA is revising its policy manual to reimburse network providers for clinical services using synchronous audio and visual technologies including web-based care. It is anticipated that this policy revision will increase the number of web-based clinical resources.

Mental health providers within military medical treatment facilities are evaluating web-based services such as Defense Connect Online to provide clinical care between facilities. Currently, there are several initiatives underway to evaluate and expand this capacity, most of which are led by the National Center for Telehealth and Technology, a Center in the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury.

Question. What are the challenges in utilizing web-based clinical mental health resources relative to face-to-face visits with mental health professionals?

Answer. Web-based clinical mental health resources can be either "pre-clinical," entailing educational support and stress- and other self-management tools (e.g., afterdeployment.org), or "clinical," in which counseling services are rendered in real time by a credentialed provider. For web-based clinical applications, telemedicine is generally safe and efficacious but that telemental health delivered directly into a user's home raises concerns about safety and the management of potential high-risk behaviors. Traditional face-to-face counseling provides a relatively secure setting in which safeguards can be quickly implemented regarding such high-risk concerns.

We have initiated a demonstration project to provide a telemental health component that includes real time clinical services delivered by a credentialed provider from the provider's location to a supervised originating site. The TRICARE Managed Care Support Contractors will establish multiple originating locations to allow users to access telemental health services.

Question. How has the Department of Defense (DoD) utilized web-based clinical mental health resources for Guard and Reserve soldiers?

Answer. Resources such as afterdeployment.org, realwarriors.net, NationalResourceDirectory.org, and MilitaryOneSource provide a range of web-based "pre-clinical" psycho-educational, self-assessment, and self-care resources for warriors, veterans, and military families—whether Active Duty, Guard, or Reserve. These resources are available 24/7, linked to triage call centers, and are easily accessed.

The TRICARE Management Activity issued a contract modification to the three Managed Care Support Contractors to institute 24/7 web-based educational and TRICARE employee assistance program counseling via interactive audio-visual telecommunications to Service members and their families, and to develop a network of originating sites capable of providing telemedicine/telepsychiatry care.

FISCAL YEAR (FY) 2010 DEFENSE HEALTH PROGRAM (DHP)

Question. Madame Secretary, David Chu, then Undersecretary of Defense for Personnel and Readiness, testified on the FY 2007 DHP budget that the projected total military health spending to pay for all health-related costs including personnel expenses, and the contribution to fund retiree health costs to be $39 billion. The FY 2010 budget request, including all costs associated with the DHP is $46.8 billion. This request is $7.8 billion above the estimate in 2007.

What accounts for the increase?

Answer. The Department's continued commitment to the care of its troops and their families accounts for the increase. This is most evident by adding baseline funding for traumatic brain injury and psychological health, wounded, ill, and injured, and enduring requirements for Overseas Contingencies Operations which have been historically funded by way of supplemental appropriations. Significant

restoration and modernization funding was added to ensure energy efficient, state of the art military treatment facilities. Additionally, funding is increased to meet growing healthcare costs driven by greater demands for healthcare due to both increased users and higher utilization of benefits.

Question. What does this figure include?

Answer. The $46.8 billion reflects the Military Health System's total Unified Medical Program. The specific amounts which comprise this number are included in the table below. The DHP Appropriation includes Operation and Maintenance (O&M), Research, Development, Test, and Evaluation (RDT&E), and Procurement budget activities. Costs outside of the DHP include Military Construction (MILCON), Medicare Eligible Retiree Healthcare Fund (MERHCF), salaries for Military Personnel (MILPERS), and Base Realignment and Closure (BRAC).

[In millions of dollars]

Appropriation	FY 2010 President's Budget
O&M	$26,968
Procurement	322
RDT&E	613
MILCON	1,042
MERHCF	9,104
MILPERS	7,672
BRAC	1,076
Total Cost of Military Healthcare	46,798

UNIFIED MEDICAL PROGRAM WITH NORMAL COST CONTRIBUTION LESS BRAC

[In millions of dollars]

Approp;riation	FY 2010 President's Budget
O&M	$26,968
Procurement	322
RDT&E	613
MILCON	1,042
MERHCF Normal Cost Contribution	10,751
MILPERS	7,672
Total Cost of Military Healthcare	47,368

Question. What factors are increasing the cost of the total program?

Answer. From a Military Health System perspective, the major cost drivers increasing the cost of the DHP are increased users of the benefit, increased utilization by these users, and healthcare inflation. Simply put, TRICARE is an excellent healthcare benefit which is extremely cheap by any standard and satisfaction rates are very high. With the help of the Congress, we have significantly improved restoration and modernization, sustainment, and construction of facilities to provide world class healing environments for our wounded, ill, and injured, and invested substantially in increased staff to improve access. Finally, we have added significant research funding to our baseline request focused on the signature wounds of the current battlefield.

Question. Were the pharmacy copayments assumed as well, even though in previous years the dollar totals have not been reached?

Answer. The FY 2010 President's Budget, Private Sector Care (PSC) controls only assume that portion of pharmaceutical costs that the Department historically pays. In other words, PSC pharmaceutical costs reflect the drug costs less the copayments made by the beneficiaries.

This question does not apply to the In-House Care Pharmacy program as beneficiaries are not required to make copayments for pharmaceuticals dispensed in military treatment facilities.

MILITARY HEALTHCARE SYSTEM

Question. The military medical services continue to adapt to the changing needs of military members and their families, but one of the major issues is recruiting and retention of qualified healthcare personnel. A problem faced in previous years was access to facilities and promptness of care.

Can you please explain how each of you has made adjustments to address access to facilities and improve the care received?

Ms. Embrey's Answer. We have established a network of private care providers to augment the MTF's capability and capacity around each military treatment facility (MTF). When an MTF cannot satisfy the demand for healthcare, it uses the established referral process to obtain timely care for TRICARE beneficiaries from private care sources. As a result of the combination of MTF and network healthcare resources, TRICARE is able to provide its beneficiaries timely access to care.

LTG Schoomaker's Answer. The Army Medical Command (MEDCOM) has directed significant attention and effort over the last year to improving access to care. The Surgeon General published an Access to Care (ATC) Campaign Plan containing eleven focus areas that cover a wide spectrum of ATC and customer service issues.

Increasing access to enrolled beneficiaries is a specific focus area. This initiative benefits all enrolled beneficiaries, to include new recruits, potential re-enlistees, and their families. An emphasis on enrollment capacities and patient assignment to Primary Care Providers by name ensures that all beneficiaries enrolled to an MTF are assured timely medical care from their Primary Care Manager using the most appropriate healthcare venue: "The right provider, at the right time, in the right venue." Ensuring our MTFs' capabilities align with the number of beneficiaries assigned improves access by reducing over-enrollment in inadequately staffed facilities. Our goal is to ensure each MTF tracks daily to ensure they have Primary Care Providers available to meet our enrolled beneficiaries' needs. MTFs are required to offer beneficiaries a referral to the TRICARE civilian network when the MTF is unable to provide care within access to care standards. Another key and closely related element is reducing administrative burdens on health care providers, to ensure they are available for patient care. MEDCOM is also increasing beneficiary awareness and understanding of the various ways to obtain care and the processes involved, including how to obtain appointments by phone and via the Internet (TRICARE On-Line).

Admiral Robinson's Answer. Navy Medicine has revised its Access to Care (ATC) Strategy to provide Medical Treatment Facilities (MTFs) and clinics a framework to implement and sustain a systemic, proactive, and responsive access plan that meets or exceeds beneficiary expectations and ATC standards. The ATC strategy and Access to Care Management Policy for Navy Medicine Military Treatment Facilities are designed to ensure the most optimal patient and family-centered care. With strong senior leadership and support, the policy articulates roles, responsibilities, and expectations for all of Navy Medicine.

LTG Roudebush's Answer. The Air Force Medical Service (AFMS) is in the midst of deployment of a Family Health Initiative model to improve medical operations for providers and beneficiaries. The model provides greater access for patients, improved Primary Care Manager (PCM) continuity, and a simplified process for appointments. This model has lowered the number of enrolled beneficiaries from 1,500 per PCM to 1,250 to increase continuity, quality of health care, and to retain greater numbers of family practitioners. Additionally, the AFMS has streamlined the hiring of contract and GS providers to increase the supply of appointments to its beneficiaries.

The AFMS has developed a set of comprehensive metrics. Measures address access to care for TRICARE beneficiaries, to include Wounded Warriors and their families, to determine if services at Air Force Military Treatment Facilities (MTFs) are provided within congressionally enacted access standards. The access standards are 1 day for urgent care, 7 days for routine appointments, and 28 days for specialty care.

If capacity does not exist or the care cannot be provided within the access to care standards in accordance with 32 CFR 199.17, AFMS MTFs are directed to refer their enrollees to the network for not only specialty care, but for primary, urgent and routine care. To ensure that this arrangement is running optimally, the Air Force Surgeon General has requested the Air Force Audit Agency audit primary care, urgent and routine network care referrals in Fiscal Year 2010 to see if network capacity is available and to determine if any inefficiency in the process can be found.

Question. How can this Committee help the Military Health System remain vital?

Ms. Embrey's Answer. This Committee has been extremely helpful in providing direction and resources to the Defense Health Program (DHP) for improvements to facilities and access, enhancements to healthcare, and case management for our wounded, ill, and injured Service members, as well as enhancements to our baseline research efforts. We are extremely grateful for the marvelous support this committee has provided.

The largest problem we face is the escalating cost of the healthcare benefit and its impact to the Department's other competing missions. The current benefit structure is a bargain, and includes no mechanism to maintain balance between the Government and the beneficiary share of healthcare costs. We must engage in open dialogue with the Congress and explore options to restore the fiscal balance to the DHP and reduce the burden of healthcare costs to the Department.

LTG Schoomaker's Answer. The Committee has been exceptionally generous and supportive in recent years. That generosity has enabled significant improvements in our Service Medical Departments. The most important thing the Committee can do is to continue to recognize and support the value that robust Service Medical Departments bring to the Department of Defense and the Nation. Capable Service Medical Departments are essential for promoting the health and optimal clinical outcomes for our beneficiaries, recruiting and retaining medical personnel, as well as training and sustaining essential skills. Robust Service Medical Departments produce strong and ready military forces in support of the Nation and optimize the care, rehabilitation, and transition of our wounded, ill, and injured Soldiers. Specifically, to remain robust we must have the resources necessary to invest in infrastructure and human capital in order to generate the comprehensive healthcare capacity required to meet the needs and expectations of the Department and our beneficiaries.

Recent investment in facility infrastructure has been without precedent. However, additional funding in facility renovation and modernization, information technology infrastructure, capital equipment and Military Construction (MILCON) is still beneficial and necessary. Almost a third of Army hospitals are over 50 years old, and another third are 25–50 years old. They require continued renovation and modernization to operate effectively. Our information technology infrastructure needs to keep pace with the technology we employ in cutting edge healthcare. We must have the procurement and operating funds necessary to equip our new facilities and recapitalize equipment beyond its useful life. Our older hospitals must be replaced because they cannot be effectively renovated to the outpatient based healthcare delivery model used today. The recent increase in the medical MILCON program significantly addressed some of our pressing needs. We also continue work towards recapitalizing medical clinics, dental clinics, medical research and force protection type facilities (blood processing, preventive medicine, etc).

Healthcare relies almost completely on skilled people to deliver a service. To attract and retain the people we need we must invest in human capital. We must offer people rewarding work in a safe and professional environment. We must adequately train and compensate them. Today there is keen competition in most markets for the highest quality uniformed, civil service, and contract medical-nursing professionals, administrative staff (such as contracting officers, safety and surety experts, technical specialists and the like), and scientists. We must have the funding available to offer competitive wages as well as civilian and military incentives in the form of recruiting and retention bonuses, scholarships, and loan repayments. Funding the authorized civilian pay raise is one critical action in this area.

A robust Service Medical Department not only delivers healthcare to the sick or injured, it also provides extensive and effective health promotion and prevention services. Attempts to resource the Services only for coded healthcare payable by commercial sector insurance companies threatens the resources necessary to provide the comprehensive health programs that our military requires. We need continued support to expand the comprehensive health and Soldier fitness programs that truly strengthen our Army.

We must also continue to recognize the effects of protracted overseas contingency operations on our military. The demand for and utilization of healthcare services is on the rise. The Service Medical Departments must be funded to build the capacity necessary to meet that demand within reasonable access standards while improving quality and patient satisfaction. Managing the care of our beneficiaries within the Service Medical Departments is the best value option for the long term.

Carry over authority is a key provision that provides much needed flexibility to meet changing demands in the medical community. Supporting this authority at no less than 2% of appropriated amounts would be of significant benefit. The carry over authority serves to help us optimize resources in support of new programs such as

Traumatic Brain Injury, Brain Health, Warrior Transition and Care Program, Army Substance Abuse Program, and other Wounded Ill and Injured initiatives.

Admiral Robinson's Answer. One of the major challenges facing Navy Medicine, and the Military Health System in general, is meeting the operational wartime requirements while at the same time providing a well-deserved health care benefit within the funding constraints of the Defense Health Program. Since the inception of the TRICARE program, overall cost-sharing elements have remained the same in spite of increasing health care costs and expanding benefits. To address these challenges, the Department of Defense (DoD) needs congressional authority to change fees and co-payments in an effort to maintain both a generous health care benefit and a fair and reasonable cost-sharing arrangement between beneficiaries and the DoD.

Additionally, Navy Medicine welcomes the Committee's continued support in maintaining the right workforce to deliver medical capabilities across the full range of military operations, through the appropriate mix of accession, retention, education, and training incentives.

LTG Roudebush's Answer. People are our most critical asset and it is, therefore, imperative that the Air Force Medical Service recruit and retain the very best. The Health Professions Scholarship Program (HPSP) is our most successful recruiting tool, and we are seeing early positive trends in retention from our other financial assistance and pay plans. The Fiscal Year 2009 Defense Appropriations bill appropriated of $13 million to support the Air Force Reserve portion of HPSP. This appropriation was critical in maintaining a viable program this year.

We also appreciate the tremendous support provided to modernize our aging Air Force medical infrastructure. Your continued strong support of our recapitalization and sustainment, restoration and modernization initiatives will allow us to deliver quality care in state-of-art facilities.

Question. Are there any claims or reimbursement issues/delays relating to the beneficiary population? If so, please explain the problems and what you are doing to rectify the situation.

Ms. Embrey's Answer. There are no claims processing issues or delays relating to the TRICARE beneficiary population. The TRICARE Managed Care Support Contracts include a requirement for compliance with stringent claims processing accuracy and timeliness standards. The contractors provide guarantees that they will meet these standards and are subject to financial penalties for falling short. They have consistently operated at or above the standards, placing TRICARE among the leading health plans in claims processing performance.

A key principle of the Department of Defense's activity in reimbursement design has been the protection of access to services. The statute requires that TRICARE reimbursement rates be determined, to the extent practicable, in accordance with the same reimbursement rules as apply to payments for similar services by Medicare. In the following circumstances waivers of this requirement are permitted by statute and used to ensure adequate access to care:

- Network Waivers—If it is determined that higher rates are necessary to ensure availability of an adequate number and mix of qualified network providers, TRICARE can increase reimbursement to the lesser of (a) an amount equal to the local fee for service charge or (b) up to 115 percent of the CHAMPUS Maximum Allowable Charge.
- Locality Waivers—If it is determined that access to specific healthcare services is severely impaired, higher payment rates can be applied to all similar services performed in a locality. Payment rates can be established through the addition of a percentage factor to an otherwise applicable payment amount, by calculating a prevailing charge, or by using another Government payment rate.

LTG Schoomaker's Answer. The Office of The Army Surgeon General supports expedited claims processing under the TRICARE program. Timely claims processing is essential to ensure provider willingness to participate in the TRICARE program. Further, this has a relational impact on beneficiary access to civilian care. We are not aware of any issues or delays in the claims reimbursement process. Furthermore, there continues to be multiple sources of information to assist beneficiaries in this process. The TRICARE web site has a separate claims information web page where beneficiaries can obtain relevant information and check the status of a claim. DoD continues to administer the Debt Collection Assistance Officer (DCAO) program which helps beneficiaries needing assistance to resolve claims issues/problems.

Admiral Robinson's Answer. Navy Medicine is committed to ensuring beneficiary claims are properly and promptly processed. Through the Beneficiary Counseling and Assistance Coordinator (BCAC) and Debt Collection Assistance Officer (DCAO) Programs, we have made great progress with addressing claims and reimbursement issues and delays with the support of our Managed Care Support Contractors. A

challenge remains with enrollment and eligibility of our Reserve Component (RC) members when activated and de-activated. Gaps in coverage due to the Service members' lack of understanding of the benefit structure, and their lack of timely enrollment can result in "gaps" in coverage which ultimately result in unpaid claims. Navy Medicine continues to promote education and awareness through the BCAC, DCAO as well as information shared during Transition Assistance Program (TAP) classes which are provided to all exiting Service members.

LTG Roudebush's Answer. We are not aware of claims or reimbursement issues that would negatively affect a beneficiary's access to care in the Continental U.S. TRICARE Private Sector Claims processing has improved substantially over the past several years. With few exceptions, the vast majority of TRICARE network claims are processed and paid within 30 days or less. The very few that are not paid within 30 days are usually due to incorrect personal information on the beneficiary's claim form, or involve claims that may potentially involve third party liability payers and thus require more thorough legal reviews, or are high dollar claims which require medical review due to their complexity.

At our overseas locations where there is no TRICARE network, we are working with the TRICARE Management Activity on refining host-nation medical claims payments to overseas providers to ensure good relationships with those healthcare providers who support us with a steady-state continuum of care for our forces and their families stationed overseas.

Question. What has been done to increase efficiencies in healthcare delivery?

Ms. Embrey's Answer. Efficiencies have been achieved in the delivery of healthcare in the direct care and purchased care sectors through a variety of mechanisms. These include leveraging information technology, enhancing the pharmacy program, improved customer service and claims processing, and partnering with our Managed Care Support Contractors (MCSCs) to improve business processes. Benefits achieved from each of these are discussed below.

Information Technology

TRICARE has improved its health information technology systems to facilitate the rapid exchange of health information. These systems are designed to improve data management and to streamline applications and processes, thereby making access to services and benefits for our beneficiaries easier, faster, and more secure. Examples include: secure electronic health records (document medical conditions, prescriptions, diagnostic tests); online enrollment and information updates; online drug comparisons with the *Uniform Formulary Search Tool* (lists medication availability and alternatives, compares costs, provides drug information); and, automated patient safety with the *Pharmacy Data Transaction Service* (tracks all prescriptions whether filled through a Military Treatment Facility, network, or mail order pharmacy, reducing the likelihood of adverse drug to drug interactions or duplicate treatments).

Pharmacy Program Enhancements

TRICARE fills more than 100 million prescriptions annually for the 6.6 million beneficiaries who use their pharmacy benefit. The TRICARE Mail Order Pharmacy (TMOP) is the largest commercial mail-order account within the pharmacy industry. It takes only seven minutes for a beneficiary to telephonically convert a prescription from the retail to mail order pharmacy system. Although beneficiaries with other health insurance (OHI) for prescription drugs must first file with their primary payer, once completed, their claim can be filed electronically with TRICARE when using a TRICARE retail network pharmacy. Due to an online, real-time coordination of benefits (COB) program, there is no longer a need to file a paper claim. The COB program is managed by Express Scripts and other Department of Defense (DoD) contractors. Express Scripts is one of the nation's largest Pharmacy Benefit Management companies. The COB program simplifies the reimbursement process for beneficiaries who have drug benefit coverage with multiple sources and saves DoD an estimated $1 million annually in claims processing costs. The implementation of the on-line COB program allows pharmacies to submit both primary and secondary coverage online for TRICARE beneficiaries, resulting in the beneficiary incurring little or no out-of-pocket expenses. Prior to the COB program, beneficiaries would have to pay for expenses not covered by their primary health insurance and then file a manual claim after the fact for reimbursement under TRICARE for their secondary coverage.

Although TMOP and its predecessor, the National Mail Order Pharmacy, have been available to DoD beneficiaries since the late 1990s, they have never been heavily used. TMOP offers benefits to both DoD and its beneficiaries since DoD negotiates prices that are considerably lower than those for retail drugs and the bene-

ficiary receives up to a 90-day supply for the same copayment as a 30-day supply at a retail pharmacy. Concerned that beneficiaries were not taking advantage of a good benefit, DoD launched a marketing campaign in February 2006 to increase beneficiary awareness of the benefits offered by the TMOP. As a result, utilization increased from 26.2 percent in Fiscal Year (FY) 2006 to 30 percent in FY 2007.

Customer Service and Claims Processing

The number of claims processed continues to increase, reaching more than 158 million in FY 2007. The processing of retained claims for the past six years continues to exceed the TRICARE performance standard of 95 percent retained claims processed in 30 days.

TRICARE continues to work with providers and claims processing contractors to increase processing of claims electronically, rather than in mailed, paper form. Electronic claims submissions use more efficient technology requiring less transit time between the provider and payer, are usually less prone to errors or challenges, and usually result in prompter payment to the provider. The TRICARE Regional Offices have been actively collaborating with the MCSCs to improve the use of electronic claims processing.

The percentage of non-TRICARE for Life claims processed electronically for all services increased to more than 85 percent in FY 2007, up 4 percentage points from the previous year, and more than 27 percentage points since FY 2004.

The congressionally mandated TRICARE Encounter Data (TED) record system collects, verifies, and tracks billions of dollars annually in purchased care claims and encounter data for the Military Health System. TEDs are submitted by TRICARE claims processing contractors in batches for processing, and volumes frequently exceed more than one million records a day. TED's automated prompt processing of purchased care claims data records is a measurable incentive for more health providers to accept and treat over nine million TRICARE beneficiaries. TED helps ensure that purchased care claims reimbursement is faster and more efficient by tracking claims immediately after submission, posting payments and denials, and systematically following up on unpaid claims. The result is shorter billing cycles and reimbursements paid within 30 days, one of the fastest claims processing cycles in the healthcare industry. In FY 2006, nearly 177 million TED records were processed for an estimated Government expenditure of more than $13 billion.

Electronic Surveillance System for Early Notification of Community-based Epidemics (ESSENCE) Medical Surveillance

DoD has developed an improved version of ESSENCE, a Web-based syndromic surveillance application, to examine DoD healthcare data for rapid or unusual increases in the frequency of certain syndromes. An increase in frequency may be a sign of diseases occurring during possible outbreaks of communicable illnesses or from the possible use of biological warfare agents. Earlier identification of a disease outbreak may allow for an earlier intervention and a reduced incidence of illness.

LTG Schoomaker's Answer. Of the three Services, the Army delivers healthcare most efficiently. In fiscal year 2008, the Army Medical Department (AMEDD) delivered more than 49% of the outpatient and 53% of the inpatient healthcare provided by the DoD Service Medical Departments with only 43% of the funding. Additionally, the AMEDD had the lowest cost per disposition and lowest cost per visit of the three services, 17% and 13% below the service averages respectively. The AMEDD continues to concentrate on improving access to healthcare and was able to provide over 1.1 million more outpatient encounters to our beneficiaries in FY08 than we did just two years prior. In the past five years we have achieved an 11.6% increase in total healthcare output. That represents care that did not go to the TRICARE contractor but instead remained in the direct care system where we were able to continue providing high quality, well-managed healthcare documented in our electronic health record.

To help achieve efficiency, MEDCOM uses the Balanced Scorecard strategic management system as the principal tool by which to guide and track the Command to improve operational and fiscal effectiveness, and better meet the needs of patients, customers, and stakeholders. One of our strategic objectives is to Optimize Resources and Value. An initiative to help achieve this is the implementation of Lean Six Sigma (LSS). Our command-wide LSS Program is a leader among the Army and fuels continuous performance improvement through data-driven decision-making and strategically-aligned project execution.

Additionally, we have implemented a process that aligns resources to outputs and outcomes to incentivize efficient and effective operations. This methodology is known as the Performance Based Adjustment Model (PBAM) and has recently won recognition from Army as a best practice. The PBAM provides financial incentives for im-

provements in access, efficiency, healthy outcomes, and patient satisfaction. It has contributed not only to efficiency gains but also to quality gains. Since October 2006 the percentage of our beneficiary population that meets the Healthcare Effectiveness Data and Information Set (HEDIS) screening criteria for the nine preventive medicine HEDIS metrics has steadily climbed from less than 29% to greater than 48%. Pneumococcal vaccinations for the over-65 beneficiaries alone increased from less than 24% to greater than 80%. The AMEDD continues to seek effective strategies and incentives that optimize resources and value.

Admiral Robinson's Answer. Navy Medicine issued revised policy on Access to Care, "Navy Medicine Policy 09–004–Access to Care Management Policy for Navy Medicine Military Treatment Facilities (MTFs)." This policy provides tools to help MTF Commanding Officers ensure efficient MTF business processes that support access to care (ATC) are developed and implemented. These business processes are designed to identify and eliminate barriers to accessing care, and optimize patients' ability to get needed care in a timely manner. This policy directs MTF Commanding Officers to implement consistent business processes and guidance endorsed by all the Surgeons General. The policy establishes standardized roles, responsibilities, definitions, and guidance for implementing, sustaining, and managing ATC throughout Navy Medicine. The implementation of the processes and procedures in the policy are a central component of MTF access processes.

LTG Roudebush's Answer. The Air Force Medical Service is making continuous progress in improving the efficiency of our healthcare delivery through partnerships between our medical treatment facilities and Veterans Affairs (VA) facilities; and also through vigorous activities to enhance processes in our hospitals and clinics.

We continue to add new joint initiatives with the VA, sharing facilities, specialty services to improve access and provide a broader range of services for both beneficiary populations. These initiatives are good for the patients and help ensure our specialists provide the full range of clinical care needed for their own currency. We meet regularly with our VA counterparts through the Department of Defense Healthcare Executive Council to review new initiatives.

In October 2008, we stood up the Air Force Medical Operations Agency (AFMOA) in San Antonio, Texas to consolidate support and oversight to healthcare operations for all 75 Air Force hospitals and clinics. A prime driver for this action was the intent to enhance efficiency through standardized processes in our healthcare operations aimed at improving quality of care and getting the most clinical production from resources. AFMOA is now applying efficiency tools such as Lean and Six Sigma in two major Air Force-wide initiatives: the Family Health Initiative and the General Surgery Currency/Operating Room Efficiency Project.

The Family Health Initiative reconfigured primary care staffing and established standard procedures that are improving access, improving continuity of care and enhancing coordination of care for patients with complex health disorders. This initiative implements the Patient Centered Medical Home concept in Air Force Family Health Clinics. Implementation began in 2008 and will be completed at all Air Force medical treatment facilities by 2012.

The General Surgery Currency/Operating Room Efficiency Project developed a standard approach to improving access for surgical consultations and increasing the utilization of operating rooms. This project employs innovative metrics to monitor progress in maximizing use of the clinical capacity in our hospitals. The project will improve access for patients needing surgical care while also ensuring the clinical currency of surgeons, critical care physicians, nurses and technicians needed for aeromedical evacuation and deployed trauma care.

AFMOA is currently considering other projects focused on quality, efficiency and clinical currency. A review of Air Force Medical Service manpower and funding standards is under way to provide the tools to optimally match distribution of resources to requirements driven by the mission and demand for healthcare. We will use the results of this review to strategically provide resources at locations where healthcare demand needs to be met, while providing clinical currency opportunities needed for the readiness of our physicians, nurses, and technicians.

Our medical treatment facilities and AFMOA maintain strong working relationships with their Army and Navy counterparts and the TRICARE Regional Offices to ensure a coordinated, unified effort to provide services in each location.

NAVY SPECIFIC MEDICAL ISSUES

Question. Does the President's Budget submission for fiscal year 2010 reflect what you need for combat casualty care?

Answer. Yes, based on current requirements. A portion of funding that had been provided via Supplementals has been added to our program of record budget control,

beginning in Fiscal Year 2010. If requirements increase in the future, additional funding may be required to continue the same level of patient care.

Question. How has the Navy adjusted its medical end-strength, both operationally and for beneficiaries, to account for the recent growth in Marine Corps?

Answer. Marine Corps (Blue in Support of Green) Operational End Strength Plus Up by Medical Corps and Fiscal Year:

ANNUAL GROWTH BY FY

Designator/Rate	FY07	FY08	FY09	FY10	FY11	Total
Medical Corps	17	17	116	13	122	155
Dental Corps	.....	18	6	.....	6	30
Med Svs Corps	2	7	23	4	7	43
Nurse Corps	.....	.....	6	1	9	16
Subtotal "O"	9	32	51	8	44	144
Subtotal "E" (HM)	68	356	169	27	144	764
Total	77	390	220	35	188	908

CUMMULATIVE GROWTH BY FY

Designator/Rate	FY07	FY08	FY09	FY10	FY11
Medical Corps	7	14	30	33	55
Dental Corps	0	18	24	24	30
Med Svs Corps	2	9	32	36	43
Nurse Corps	0	0	6	7	16
Subtotal "O"	9	41	92	100	144
Subtotal "E" (HM)	68	424	593	620	764
Total	77	465	685	720	908

Marine Corps (Blue in Support of Green) Operational End Strength Plus Up by USMC Activity and Billet Distribution:

AUIC	MARINE CORPS ACTIVITY NAME	Total
00243	MCRD SAN DIEGO	21
00263	MCRD PARRIS ISLAND	33
08321	2ND MAR DIV FMF LANT	141
09131	MAG 31 MCAS BEAUFORT SC	4
09167	MAG 26 MCAS NEW RIVER NC	13
31053	3RD MAW UNITS CAMP PENDLETON	5
31948	3RD MARDIV DET	4
42412	2ND MEDICAL BATTALION	136
42415	3RD MEDICAL BATTALION	25
44564	1ST DENTAL BATTALION 1MLG 1MEF	9
44573	2ND DENTAL BATTALION 2MLG 2MEF	9
4509A	1ST MARINE SPECIAL OPS BN	53
45241	NAVY SUPPORT UNIT 2001	6
46623	3D MAW MIRAMAR I MEF	13
47790	3RD MAW UNITS 29 PALMS	4
48139	1ST MAR DIV DET 29 PALMS	43
50014	WOUNDED WARRIOR REGIMENT	2
55205	CG I MEF	2
55207	CG II MEF	2
55211	CG III MEF	3
57079	1ST MAW FUTEMA	2
57080	2D MAW CHERRY POINT	22
67360	3RD MAR DIV FMF PAC	13
67366	3RD COMBAT ENGINEER BATTALION	27
67408	3RD RADIO BN FMFPAC	1
67436	3RD MARINE LOGISTICS GROUP	19
67446	1ST MARINE LOGISTICS GROUP	88
67448	1ST MAR DIV FMF PAC	66
67906	USMC FORCES SPEC OPS COMMAND	65
68408	2D MARINE LOGISTICS GROUP	77
Grand Total		908

BUMED USMC In-Garrison Health care:

No military end-strength has been added to BUMED in response to the USMC Grow the Force (GTF) initiative. BUMED endstrength adjustments are captured below according to USMC Medical Treatment Facility (MTF) growth site.

Adjustment to endstrength is indicated by Staffing by Skill Type and reflects change from the baseline year of 2007, when GTF initiated. Skill Type I Clinicians have admitting privileges and Skill Type II Direct Care Professionals do not have admitting privileges but see patients in clinic. Direct Care Para-Professionals are health support staff such as radiology technologist. Adjustments to endstrength are as follows:

NH Hawaii

MTF AVAILABLE STAFF FTEs				
Total Staffing by Skill Type	**Feb F07**	**Dec FY09**	**Change FY07 to FY09**	**% Change FY 07 to FY09**
Administrative/Clerical	88	124	36	41%
Direct Care Para-Prof	226	227	1	0%
Registered Nurse	10	27	17	170%
Direct Care Prof	35	44	9	26%
Clinician	38	43	5	13%
Total Staff	397	465	68	17%

Note for NH Hawaii: No FY09 civilian hiring initiative.

NH Camp Lejeune

MTF AVAILABLE STAFF FTEs				
Total Staffing by Skill Type	**Feb F07**	**Feb FY09**	**Change FY07 to FY09**	**% Change FY 07 to FY09**
Administrative/Clerical	370	411	41	11%
Direct Care Para-Prof	625	776	151	24%
Registered Nurse	148	194	46	31%
Direct Care Prof	104	137	33	32%
Clinician	104	127	23	22%
Total Staff	1,351	1,645	294	22%

Note for NH Camp Lejeune: FY09 civilian hiring initiative projects gain up to 175 FTEs. This includes 125.0 FTE civilian and 50.5 FTE contract personnel.

NHC Quantico

MTF AVAILABLE STAFF FTEs				
Total Staffing by Skill Type	**Feb F07**	**Feb FY09**	**Change FY07 to FY09**	**% Change FY 07 to FY09**
Administrative/Clerical	71	87	16	23%
Direct Care Para-Prof	138	152	14	10%
Registered Nurse	14	20	6	43%
Direct Care Prof	17	29	12	71%
Clinician	20	19	(1)	-5%
Total Staff	260	307	47	18%

Note for NH Quantico: No FY09 civilian hiring initiative.

NH Cherry Point

MTF AVAILABLE STAFF FTEs				
Total Staffing by Skill Type	**Feb F07**	**Feb FY09**	**Change FY07 to FY09**	**% Change FY 07 to FY09**
Administrative/Clerical	102	95	-7.0	-7%
Direct Care Para-Prof	134	164	30.0	22%
Registered Nurse	37	32	-5.0	-14%
Direct Care Prof	25	28	3.0	12%
Clinician	23	20	-3.0	-13%
Total Staff	321	339	18.0	6%

Note for NH Cherry Point: FY09 civilian hiring initiative projects gain up to 16.0 FTEs. This includes 1.0 FTE civilian and 15.0 FTE contract personnel.

NH Beaufort

MTF AVAILABLE STAFF FTEs				
Total Staffing by Skill Type	**Feb F07**	**Feb FY09**	**Change FY07 to FY09**	**% Change FY 07 to FY09**
Administrative/Clerical	209	245	36	17%
Direct Care Para-Prof	280	326	46	16%
Registered Nurse	29	69	40	138%
Direct Care Prof	31	41	10	32%
Clinician	24	34	10	31%
Total Staff	573	715	142	25%

Note for NH Beaufort: FY09 civilian hiring initiative projects gain up to 16.0 FTEs. This includes 20.0 FTE civilian and 6.0 FTE contract personnel.

NH Okinawa

MTF AVAILABLE STAFF FTEs				
Total Staffing by Skill Type	**Feb F07**	**Feb FY09**	**Change FY07 to FY09**	**% Change FY 07 to FY09**
Administrative/Clerical	258	236	(22)	-9%
Direct Care Para-Prof	440	456	16	4%
Registered Nurse	118	122	4	3%
Direct Care Prof	91	67	(24)	-26%
Clinician	88	83	(5)	-6%
Total Staff	995	964	(31)	-3%

Note for NH Okinawa: FY09 civilian hiring initiative projects gain up to 60.0 FTEs. Specific FTE available information includes: 6.0 FTE Clinicians (Primary Care and Emergency Medicine), 1.0 FTE Licensed Mental Health Provider, 2.0 FTE Pharmacists, 2.0 FTE Physical and Occupational Therapy, 11.0 FTE Registered Nurses, 5.0 FTE Dental Hygienists, 27 FTE Direct Care Para-professionals, and 6 FTE Safety and Occupational Health Staff.

NH Camp Pendleton

MTF AVAILABLE STAFF FTEs				
Total Staffing by Skill Type	**Feb F07**	**Feb FY09**	**Change FY07 to FY09**	**% Change FY 07 to FY09**
Administrative/Clerical	498	479	(19)	-4%
Direct Care Para-Prof	697	680	(17)	-2%
Registered Nurse	159	189	30	19%
Direct Care Prof	101	129	28	28%
Clinician	159	157	(2)	-1%
Total Staff	1,614	1,634	20	1%

Note for NH Camp Pendleton: FY09 civilian hiring initiative projects gain up to 103.0 FTEs. Specific FTE available information includes: 9.0 FTE Clinicians (Primary Care and Emergency Medicine), 5.0 FTE Licensed Mental Health Providers, 4.0 FTE Pharmacists, 2.0 FTE Nurse Midwives, 4.0 FTE Physical and Occupational Therapy, 9.0 FTE Registered Nurses, 14.0 FTE Dental Hygienists, 32.0 FTE Direct Care Para-professionals, 19.0 FTE Admin/Clerical and 5.0 FTE Safety and Occupational Health Staff.

NH Twenty-Nine Palms

MTF AVAILABLE STAFF FTEs				
Total Staffing by Skill Type	**Feb F07**	**Feb FY09**	**Change FY07 - FY09**	**% Change FY 07 to FY09**
Admin/Clerical	160	140	(20)	-13%
Direct Care Para-Prof	277	197	(80)	-29%
Registered Nurse	53	50	(3)	-6%
Direct Care Prof	30	30	-	0%
Clinician	35	31	(4)	-11%
Total Staff	555	448	(107)	-19%

Note for NH 29 Palms: FY09 civilian hiring initiative projects gain up to 14.0 FTEs. Specific FTE available information includes: 3.0 FTE Registered Nurses, 2.0 FTE Direct Care Para-professionals, 4.0 FTE Admin/Clerical and 5 FTE Safety and Occupational Health Staff.

IN-HOUSE MEDICAL CARE

Question. The Department has been using the "Efficiency Wedge" to encourage the Services to treat more patients at the military treatment facilities (MTFs). This practice withholds some healthcare funding centrally. Funds are released based on the Services' success in achieving throughput at their MTFs.

Please describe the Department of Defense budgeting practice known as the "efficiency wedge."

Answer. A valuation study based on workload produced by the MTFs in Fiscal Year (FY) 2003 revealed that the cost to provide services in the direct care system generally exceeds the cost to purchase the care through the Private Sector Care network. To contain costs, a negative wedge was removed from Service budgets and was phased in over the period FY 2005 to FY 2009, based on each Service's relative efficiency. The intent was for the Services to carefully analyze the costs to produce care versus purchase care from the private sector and shape the care delivered in the direct care system based on the most cost effective delivery method.

The primary reason our direct care facilities exist is to provide healthcare training for medical personnel who must be prepared to deploy anywhere in the world to provide medical support to our Armed Forces. Thus, inherently there will be significant inefficiency in such a system. Each year, the Service Surgeons General sought relief from Congress for the negative wedge included in their respective programs. The Congress consistently restored significant amounts of the wedge through the appropriations process. The Department understood Congressional guidance and, effective with the FY 2010 budget request, fully restored all funding removed based on inefficiency.

Question. What issues arise from these efficiencies? Please be specific.

Answer. The removal of the wedge was intended to align quality care with the most cost-effective venue, whether that is in the military treatment facilities (MTFs) or through the Managed Care Support Contract network. Achievement of that goal requires buy-in and precise analytical work. Such buy-in was never fully achieved and, as the Operational Tempo of current operations increased, along with the casualties from ongoing operations, efficiency became a very low priority. There were claims that the wedge forced the Services to remove capacity, which resulted in care shifting from the MTFs to the managed care network. An opposing view would be that the beneficiary chose to receive care through the managed care network and has freedom of choice since 2004 when the requirement to obtain a non-availability statement from the MTF to receive care through the network was removed.

Question. Does this hinder your budgeting process?

Answer. Health Affairs' role has always been to ensure the taxpayer receives maximum value for their contribution to the Department of Defense. In principle, the efficiency wedge was appropriate to match resources to the value of care produced in the Direct Care System. As workload declines and facilities are downsized or closed, the responsible action in the best interest of the American taxpayer is to align the funding where the demand for healthcare exists, either in the military treatment facilities or in the private sector.

Question. Is the amount provided in the budget request sufficient for the Services?

Answer. The funding requested in Fiscal Year 2010 is sufficient for all three Services. Each of the Surgeons has testified in support of this statement.

Question. How else have you been increasing workload at the military treatment facilities?

Answer. Comparing overall workload between Fiscal Year (FY) 2003 and FY 2008, the Army has increased workload while the Navy and Air Force have declined. However, each Service has committed to increasing their overall productivity by reconfiguring or adding infrastructure, optimizing provider/support staff mix, and working to recapture workload where it makes financial and clinical sense. As their workload increases, they are reimbursed financially via the Prospective Payment System in which additional workload is rewarded with additional funding.

Question. Has lack of personnel or infrastructure played any role in decreased workload?

Answer. Personnel deployments, unavailability of suitable replacements, and hiring lag all adversely affect workload. Infrastructure limitations may also hinder workload productivity. However, the Services continue to work aggressively to overcome these challenges and increase workload where it makes clinical and financial sense.

One way we attempt to mitigate the impact is by providing additional funding. In Fiscal Year (FY) 2008, we provided roughly $207 million via the Overseas Contingency Operations Supplemental Appropriations to hire contractors and temporary civilians for medical backfill, to replace deploying members. In FY 2009, we antici-

pate providing up to $224 million in such funding. Congress and the Department have, in recent years, committed substantial additional funds to sustainment, restoration, and modernization which offered the Services an opportunity to improve their infrastructure. Additional workload is also rewarded with additional funding via the Prospective Payment System which provides resources that can be used to modify or increase available space.

Question. Has the funding Congress provided for Facilities, Sustainment, Restoration and Modernization (FSRM) increased the ability of the medical facilities writ large increase workload capacity?

Answer. FSRM funding provided to the Defense Health Program has enabled significant repair, restoration, and modernization of our aging military treatment facilities. This work has generally facilitated workload capacity, improved functionality, and enhanced the appearance and aesthetic environment at many of our locations. Ultimately, the improvements are accomplished to improve patient outcomes, enable better clinical performance, and generally enhance our beneficiaries' healthcare experiences.

EVALUATING THE CONDITION OF HEALTHCARE FACILITIES

Question. What have you done to evaluate the quality of medical care being provided at medical treatment facilities?

Ms. Embrey's Answer. We have a robust mechanism to ensure the quality of healthcare delivered in our military treatment facilities (MTFs). We utilize nationally recognized quality metrics to continually assess the care provided and to identify opportunities for improvement in both the inpatient and outpatient settings. All MTFs are required to maintain accreditation by an approved healthcare accrediting organization. The Joint Commission and Accreditation Association for Ambulatory Health Care survey the MTFs to meet this requirement. Additionally, MTFs are inspected through specific program accreditations/certifications such as blood bank, laboratory, and mammography. These accreditation and certification processes facilitate our ability to ensure our performance is consistent with national civilian healthcare standards.

We are involved in a number of national initiatives focused on healthcare quality, including the Centers for Disease Control and Prevention National Healthcare Safety Network, National Surgical Quality Improvement Program, National Perinatal Information Center, and the Agency for Healthcare Research and Quality (AHRQ) quality and patient satisfaction indicators. In collaboration with AHRQ, we developed and nationally disseminated TeamSTEPPS, an evidence-based teamwork system aimed at optimizing patient outcomes by improving communication and teamwork skills among healthcare professionals.

Clinical subject matter experts from the Department of Veteran Affairs and the Department of Defense work collaboratively to develop and maintain current clinical practice guidelines based on ever evolving scientific evidence. Clinical quality studies are conducted annually through a contract with a civilian organization to assist us with the assessment and improvement of the care we provide. In addition to the system-wide quality activities noted, each MTF and parent Service monitors the quality and safety of healthcare delivered in our MTFs. Information from the MTFs is shared via the Service Representatives on established collaborative working groups and forums. This infrastructure is designed to ensure maximum communication of quality related information and knowledge exchange.

LTG Schoomaker's Answer. We have a robust mechanism to ensure the quality of healthcare delivered in our military treatment facilities (MTFs). We use nationally recognized quality metrics to continually evaluate the care provided and to identify opportunities for improvement in both the inpatient and outpatient settings. All MTFs are required to maintain Joint Commission accreditation. Additionally, MTFs are inspected through specific program accreditations/certifications such as blood bank, laboratory, and mammography. These accreditation and certification processes facilitate our ability to ensure our performance is consistent with national civilian healthcare standards. We are involved in a number of national initiatives focused on healthcare quality including the Centers for Disease Control and Prevention National Healthcare Safety Network, National Surgical Quality Improvement Program, National Perinatal Information Center, and the Agency for Healthcare Research and Quality (AHRQ) quality and patient satisfaction indicators. In collaboration with AHRQ, we developed and nationally disseminated TeamSTEPPS, an evidence-based teamwork system aimed at optimizing patient outcomes by improving communication and teamwork skills among health care professionals. The Army Medical Department serves as the Department of Defense (DoD) lead for the development of evidence based clinical practice guidelines in collaboration with the De-

partment of Veterans Affairs. Clinical quality studies are conducted annually through a DoD contract with a civilian organization to assist us with the assessment and improvement of the care we provide. In addition to the system-wide quality activities noted, each MTF monitors the quality and safety of healthcare delivered in our MTFs. Information from the MTFs is reported to Headquarters, Army Medical Command and shared with the other Services through Military Health System level quality committees. This infrastructure is designed to ensure maximum communication of quality related information and knowledge exchange.

Admiral Robinson's Answer. Navy Medicine's Quality Assurance system provides continuous monitoring of the quality of healthcare delivered in our military treatment facilities (MTFs) by using nationally recognized quality metrics for assessment of the care provided and identification of opportunities for improvement. Navy Medicine actively participates in DoD sponsored national initiatives including the Centers for Disease Control and Prevention National Healthcare Safety Network and the National Perinatal Information Center.

In addition, all Navy Medicine's hospitals and clinics are evaluated using the same Joint Commission (TJC) standards as US civilian hospitals. TJC focuses on improving the safety and quality of healthcare provided to the public by accrediting healthcare organizations and offering healthcare improvement services. Navy hospitals and clinics are accredited, while individual healthcare providers are licensed and certified. As active participants in TJC accreditation process, we embrace TJC standards that focus on maintaining the clinical skills of our providers. TJC standards include the Focused Provider Performance Evaluation (FPPE) and Ongoing Provider Performance Evaluation (OPPE) programs.

To maintain an infrequently used skill, a provider may be assigned to another facility for temporary duty where the patient volume and MTF capacity and capability exist. In the event that a specific medical procedure cannot be safely supported with the required staff and resources at a facility, clinical privileges to perform that procedures will not be granted to the provider and the medical procedure will not be performed.

Upon a provider's transfer to another MTF, the provider participates in FPPE to assure clinical competency. Navy Medicine quality scope is broad and includes: partnering with external organizations that evaluate Navy Medicine's clinical programs; maintaining robust internal programs that focus on risk management, patient safety and patient advocacy; establishing personal relationships with each patient who becomes a vital member of the health care team; and facilitating continuing education efforts for all staff members.

LTG Roudebush's Answer. The Air Force Medical Service (AFMS) uses multiple measures and agencies to evaluate and sustain our high quality of medical care. Overall quality is assessed through National Accreditation Agencies—The Joint Commission (TJC) and the Accreditation Association for Ambulatory Health Care. These two agencies validate our compliance with clinical quality assurance and allow comparison with civilian healthcare agencies. Second, we participate in several national initiatives including Centers for Disease Control and Prevention, The National Surgical Quality Improvement Program, the National Perinatal Information Center and the Agency for Healthcare Research and Quality quality and satisfaction indicators. Third, we follow national metrics for inpatient care through TJC's ORYX measurements and outpatient care through the Health Employer Data Information Set published by the National Committee for Quality Assurance. Within the AFMS, we centrally participate, track, and publish "Lessons Learned" from each Root Cause Analysis review of all significant medical incidents, and from each Medical Incident Investigation. Finally, each Medical Treatment Facility performs at a minimum one Failure Effects Analysis a year. These are also tracked centrally and lessons shared throughout the Air Force.

Question. Have you evaluated the physical state of your facilities?

Ms. Embrey's Answer. At least once every three years all of our medical treatment and research facilities are inspected, the physical state evaluated, and documented. Deficiencies are addressed as funds become available.

LTG Schoomaker's Answer. Yes, every three years all medical facilities (category 500 buildings) and medical research facilities are evaluated by an engineered assessment to determine system component deficiencies and years remaining of service life. The data is used to formulate annual objectives for funded programs. Activities review and update facility deficiency data annually for appropriate priorities and costs associated with the deficiencies. Annual investment plans are created in conjunction with the updated analysis.

Admiral Robinson's Answer. Per the FY 2008 National Defense Authorization Act (NDAA) (Section 1648), Bureau of Medicine and Surgery (BUMED) activities inspect military medical treatment facilities (MTFs) and specialty medical care facilities.

The inspections are conducted by BUMED annually using standards and checklists developed by the Senior Oversight Committee, Line of Action (LOA) 5 Working Group in 2007.

In addition, the material condition of BUMED's facilities has historically been inspected by professional engineering teams once every three years using a single inspection service provider and a common set of evaluation criteria that are consistent with all applicable codes and standards. Sustainment Restoration and Modernization (SRM) requirements identified during the inspection process are documented in single web accessible database using the COTS product VFA facility.

All of BUMED's hospitals participate in the accreditation process for the Joint Commission. The accreditation process is continuous, data-driven and focuses on operational systems critical to the safety and quality of patient care.

At the activity level, facility management personnel conduct zone inspections as required with non facilities management personnel assigned to the activity (typically E–7 and above corpsman), participate in fire inspections, and review deficiencies identified by maintenance personnel (government or contractor) while performing preventative maintenance inspections (PMIs).

LTG Roudebush's Answer. Yes. The Air Force Health Facilities Division, at a minimum, conducts biennial comprehensive assessments of our medical facilities worldwide to determine adequacy of clinical space, patient access, and reliability of facility infrastructure. Deficiencies identified and validated through these visits, and those identified locally, are continually prioritized and addressed as funds become available.

Question. What changes/improvements have you made to your medical care continuum and/or facilities with all of the Facilities Sustainment, Restoration, and Modernization (FSRM) provided by this Committee? What is the status of any backlog?

Ms. Embrey's Answer. The age and dated designs of many of our facilities create numerous obstacles to providing modern world-class healthcare. Functional modifications and infrastructure repairs are necessary to optimize the delivery of state-of-the-art healthcare to our beneficiaries. In addition to routine annual utility and infrastructure upgrades across the entire inventory, we have begun renovations to create more efficient layouts of clinical, ancillary, and support spaces in our facilities. The funding provided has stabilized backlog growth.

LTG Schoomaker's Answer. The committee's support of the Army's healthcare facilities and infrastructure has been superb and has enabled the Army to provide consistently reliable facilities across the medical care continuum. Over the past several years this funding has allowed the Army to eliminate a majority of its backlog of critical infrastructure deficiencies, ensuring our mechanical, electrical and other critical building systems continue to operate reliably every day. Besides the millions of dollars of improvements to our hospitals and medical clinics, the Army was also able to drastically improve the poor conditions of nine of our dental clinics and seven of our veterinary clinics.

Admiral Robinson's Answer. With the FSRM provided by the Committee, Navy Medicine has executed and/or is planning to execute construction contracts to perform various repairs and restorations throughout Navy Medicine. For example, Navy Medicine is planning to execute a contract to complete the renovation of the Wounded Warrior Barracks at Naval Medical Center San Diego, CA; and also to restore the Heating, Ventilating, and Air Conditioning (HVAC) systems at Naval Hospital Yokosuka, Japan and Naval Health Clinic Whiting Field, FL.

Annual major facility projects programming is approximately $100M per year. The FSRM provided by the Committee supplemented Navy Medicine's Fiscal Year 2009 budget for facility changes/improvements to ensure that we stayed consistent with the annual programming requirement.

LTG Roudebush's Answer. Since 2007, one third of our medical sites have benefited from increased FSRM funding for modernization. In addition to routine annual utility and infrastructure upgrades across the entire inventory, we have begun renovations to create more efficient layouts of clinical, ancillary and support spaces in our facilities. The age and outdated designs of many of our facilities create numerous obstacles to providing modern world-class healthcare. Functional modifications and infrastructure repairs are necessary to optimize the delivery of state-of-the-art healthcare to our beneficiaries.

The Air Force Medical Service has a $298.7 million backlog of currently identified sustainment, restoration and modernization projects.

Question. Please explain how the services' "case manager" will effect the medical care of wounded or ill service members.

LTG Schoomaker's Answer. The Army's Warrior Care and Transition Program, established two years ago, uses a team approach to case management referred to as

the Triad of Care. Each wounded, ill, or injured Soldier (Warrior in Transition) in the program is assigned to a triad consisting of a Primary Care Manager (usually a Physician), a Nurse Case Manager, and a Squad Leader. This team, along with the Soldier and the Soldier's family, work together to coordinate the care and support each Warrior in Transition receives to ensure a coordinated, directed, and effective approach to recovery, rehabilitation, and reintegration either back to duty or prepared to transition to productive private citizen and veteran status.

Central to the management of medical care for Warriors in Transition is the Comprehensive Transition Plan (CTP). The CTP serves as each Soldier's road map on the way to recovery and integration. The CTP is developed by the Warrior in Transition with the support of a multidisciplinary team of medical, rehabilitative, and behavioral health professionals, chaplains, social workers, and the Soldier's Triad of Care. With the CTP to which to refer, review, and follow, the entire care team is able to work in concert to deliver the most effective outcome for each Soldier. This is the true value of case management—a comprehensive assessment and approach to help each Soldier reach his or her desired goal. Along the way to this goal, the Triad of Care continues to manage the process by regularly evaluating each Soldier's progress, making any necessary adjustments in approach to keep the process moving forward, and functioning as the rudder that steers each Soldier along the way to recovery.

Effective case management ensures timely and efficient use of resources; keeps the process of care and recovery moving in the desired direction; allows timely and effective intervention to avoid unnecessary delay or concern; and in no small way provides the reassurance and confidence all Soldiers or Family need to feel truly valued and reassured that their best interests are being addressed. Within the Triad of Care, this translates to regular and frequent assessment of each Soldier's plan, ongoing dialogue with the Soldiers themselves, and immediate intervention as necessary to coordinate care delivery, resolve issues, and keep everyone informed and focused.

Admiral Robinson's Answer. Case Management affects the medical care of Wounded, Ill, and Injured service members in a positive way. Case managers provide the Wounded, Ill, and Injured member with individualized care that is specific to the needs of the service member and those of his or her caregivers.

A comprehensive assessment in conjunction with the multidisciplinary health care team is performed to determine the service member's needs. Based on the assessment, an individualized plan of care is developed; the plan consists of quality, cost-effective interventions that will help the Wounded, Ill, and Injured service member in the journey towards recovery and reintegration. To ensure agreement and compliance, the patient and/or caregiver reviews and signs off on the plan of care. Case managers coordinate care and assist service members as they navigate through the healthcare system resulting in defragmentation of care, appropriate utilization of resources, and optimization of recovery. The Medical Care Case Managers collaborate with Navy Safe Harbor and USMC Wounded Warrior Regiment Recovery Care Coordinators and Non-medical Care Managers to support Sailors, Coast Guardsmen, Marines, and their families holistically.

A smooth transition of care either to another facility, i.e. Veterans Administration Medical Centers or a different healthcare setting is coordinated by the case manager. Contact is made between the transferring case manager and the receiving case manager to exchange pertinent information and ensure the patient's seamless transition of care and recovery needs.

LTG Roudebuch's Answer. The Services' case managers use a collaborative process to assess, plan, implement, coordinate, monitor and evaluate care and services to best meet the complex healthcare needs of wounded or ill service members. This is accomplished through a process of continuous communication with the patient, family members, and healthcare providers, and the identification of best available resources within the service member's community to promote highest quality, cost-effective outcomes.

Military case management programs are designed to help wounded and ill service members achieve optimal level of wellness, enhance quality of life, improve patient and family satisfaction with medical services, minimize complications of catastrophic injury, and obtain optimal self-management and independence. To accomplish these outcomes, case management programs are built to achieve specific goals:

- Adopt strategies to provide integrated services
- Coordinate care, ensuring continuity and compliance with treatment regimens
- Enhance collaboration with interdisciplinary healthcare team members
- Ensure timely and effective interventions
- Improve patient and family satisfaction with the healing process

- Minimize fragmentation of care
- Provide high quality, cost-effective care

The complex health needs of wounded or ill service members, which may be physical, behavioral, emotional and/or educational in nature, require the intense coordination and collaboration of military case managers to ultimately return the service member to his or her highest possible level of wellness and personal independence in an expeditious manner.

Question. Can the Surgeons General provide some examples of how combat casualty care has evolved since the beginning of OEF/OIF? How have services been expanded/adapted to meet the needs of our wounded warriors?

LTG Schoomaker's Answer. Since the beginning of these operations, the Army has made great strides in increasing the survivability of our wounded and injured Soldiers on the battlefield. Basic first aid equipment prior to the start of the war was just a bandage issued to a Soldier. Currently, each soldier is issued an Individual First Aid Kit (IFAK) that contains a haemostatic dressing (Combat Gauze), tourniquet (Combat Application Tourniquet), adhesive tape, nasopharyngeal airway, and gloves. Providing the correct tools addresses the two leading causes of death on the battlefield: severe hemorrhage and an inadequate airway. Using these tools, we have expanded the concept of first aid and buddy care, as first responders often provide the critical life saving steps. Army Medicine played an important role in the improvements to the Mine Resistant Ambush Protected (MRAP) ambulance, Army Combat Helmet, Combat Arms Ear Plugs, Improved Outer Tactical Vest, and Fire Retardant Army Combat Uniform. 25,000 Warrior Aid and Litter Kits (WALK) have been procured to support current combat operations. The WALK is stowed onboard vehicles to be used by the first responder. The WALK complements the IFAK and the Combat Life Saver Bag. It contains a foldable litter and the tools to treat and overcome the three most common causes of preventable combat deaths on the battlefield (hemorrhaging, tension pneumothorax, and inadequate airway).

The MRAP-Ambulance provides increased protection to our crews and patients. To make the MRAP-Ambulance the most capable ground ambulance in the Army today, we integrated "spin-out" technology from the Future Combat System Medical Vehicles. The combat medic is able to leave the Forward Operating Bases to conduct medical evacuation missions and can provide world class en-route care to wounded Soldiers. Army Medicine also developed Casualty Evacuation Kits (CASEVAC) for both the MRAP and High Mobility Multipurpose Wheeled Vehicle (HMMWV) ambulances to increase capability. These efforts provided the combat medic with field ambulances built for survivability in the challenging environment of asymmetric warfare.

Our Soldier/Medics, including Physicians, Nurses, and Corpsmen, receive the highest level of pre-deployment trauma training ever provided. It is a critical link between standard medical care and the intense battlefield environment Soldiers face in the current conflicts. By recreating the high-stress situations medics will face in Iraq and Afghanistan, this training allows for the refinement of advanced trauma treatment skills and sensitization to hazardous conditions, thereby allowing medics to increase their confidence and proficiency in treatment.

To improve upon the care and support provided to our Wounded, Ill, and Injured, the Army Developed the Warrior Care and Transition Program (WCTP). In just two years, the WCTP has made extraordinary inroads toward transforming the way the Army cares for wounded, ill, and injured Soldiers and their Families. The Army has robustly resourced 36 Warrior Transition Units and 9 Community Based Warrior Transition Units, established a proven approach to care management through the triad of care concept, centralized support to Warriors in Transition and their Families by co-locating support services in Soldier Family Assistance Centers, and implemented the Comprehensive Transition Plan approach to help Soldiers plan and attain their recovery goals.

Admiral Robinson's Answer. The most significant evolution of theater medical care for injured Sailors and Marines has been the widespread teaching and application of Tactical Combat Casualty Care (TCCC). It is becoming increasingly apparent in 2009 that the basic tenets of TCCC are sound and have been successful on the battlefield. For example, the 75th Ranger Regiment reported that of 482 casualties in Iraq and Afghanistan (including 31 fatalities), there were no preventable deaths identified in Ranger units. This unit has a long-standing standard of teaching TCCC to every combatant in their units, so that the most critical life-saving interventions such as tourniquets can be accomplished by every one of their unit members.

Perhaps the most successful single TCCC intervention has been the widespread re-introduction of tourniquet use on the battlefield. Despite not going to the GWOT with modern tourniquets, U.S. military troops now routinely carry well-made tourniquets into combat. Tourniquets have now been documented to be remarkably ef-

fective at saving lives in casualties with isolated extremity trauma. Other TCCC interventions such as nasopharyngeal airways, oral antibiotics, needle decompression of tension pneumothorax, and surgical airways when needed have not only proven effective, but have also helped to reduce both the training requirements and the medical equipment load out carried by combat medical personnel compared to previous battlefield trauma management techniques.

In addition to in theater care that has previously been addressed, enhanced care coordination and access to psychological health care through primary and specialty care ensures highest quality of care to our Wounded, Ill and Injured. Emphasis on destigmatized portals of care to meet the needs of wounded warriors and their families, coupled with cooperation in care with the VA has improved availability and quality of care.

LTG Roudebush's Answer. One example is the development of a Joint Theater Trauma System (JTTS), initiated in 2003 in Operation Iraqi Freedom (OIF) with the establishment of a joint data registry (Joint Theater Trauma Registry—JTTR), and progressing to an improved regionalization of trauma care. The JTTS includes coordinated placement of medical/surgical specialists and a process improvement program. It has improved global collaboration across all levels of care and rehabilitation via satellite multimedia communications and cultivated numerous clinical practice guidelines with broad concurrence across military and civilian specialty areas.

As another example, the advancement of damage control concepts through ongoing research and data collection has contributed to the development of new massive transfusion protocols (patients requiring more than ten units of blood) incorporating increased ratios of blood products (red blood cells, plasma, platelets) and the use of fresh whole blood when components are not available. This has allowed survival rates greater than 70 percent. These damage control concepts have now been extended to the immediate recovery period and critical care units. Casualty care has also benefitted from modifications in wound management concepts due to our recent experience with extensive tissue damage and contamination, to include abdominal wound management with progressive closure of the abdominal wall via multiple operations ad irrigation with a large amount of saline fluids. The use of negative pressure wound devices (also known as vacuum assist devices) has led to lower infection rates, less pain and decreased workload on nurses/technicians from dressing changes.

We have reinstituted the use of the tourniquet as part of the hemorrhage control algorithm. Tourniquets were considered heresy after Vietnam in both civilian and military practice. However, tourniquet use in OIF/OEF has led to a significant reduction in mortality from extremity hemorrhage. In addition, there has been an adjustment of hemorrhagic control adjuncts, for example, adding combat gauze as a first line therapy and removing other adjuncts deemed to have adverse outcomes or less effectiveness based on research and data collection.

Since the beginning of OEF/OIF, there has been the development of Burn Resuscitation Guidelines. The development of these guidelines was in response to overresuscitation (large volumes of fluids) of burn patients, resulting in significant complications ad mortality. The new guidelines have significantly reduced complications such as abdominal compartment syndromes and infections, as well as mortality.

The Air Force Medical Service has taken an active role in adapting to challenges of the battle injured and then adapting our care through the spectrum of care delivery to maximize wellness. The U.S.'s casualty fatality rate for OIF and OEF is the lowest that it has ever been, compared to previous U.S. wars and conflicts. The high survival rates are directly related to improved individual body armor as well as a combination of medical efforts including full implementation of damage control resuscitation and surgery concepts, improved critical care, advanced hemostatic devices and agents, coordinated pre-deployment battlefield injury care training, and increased joint medical interoperability. The AFMS contributes to this outstanding achievement through its support of two Level III Air Force Theater Hospitals, Expeditionary Medical Support, Army Forward Surgical Teams, and Joint Forces Special Operations missions. Advancement in the care of battlefield injury continues to emerge from the area of operations and expand to civilian trauma practice, including the concept of transfusing equal ratios of pack red blood cells to plasma in massive blood transfusion situations. This revolutionary concept has led to 80 plus percent survival rates.

One adaptation of our healthcare service to meet the needs of the Wounded Warrior is an enhanced focus on our Airmen and their psychological health. Exposure to battlefield trauma places airmen at risk for combat stress symptoms and possible mental health problems such as depression or post-traumatic stress disorder. To support our Airmen, the Air Force has taken a proactive approach of education, symptom recognition, and encouraging help-seeking. One example is the Landing

Gear program, which is based on the metaphor that, no matter how powerful an aircraft is in the air, properly functioning landing gear is necessary to safely launch (i.e., deploy to war) and recover (i.e., redeploy to home station). In the same way, Airmen are taught that recognizing risk factors in themselves and others along with a willingness to seek help is the key to functioning effectively across the deployment cycle. During pre-deployment, Landing Gear training explains deployment stress, the deployed environment, typical reactions, ways to manage stress, and how to get help if needed. During reintegration and reunion the program lays the foundation for what to expect after deployment and facilitates a smooth reentry into work and family life. The Air Force is using programs such as this to build upon our Wingman Culture. For Airmen, being a Wingman means recognizing when other Airmen are distressed and having the courage to care and become involved.

Question. Do you have any concerns about delivery of healthcare services to family members in the direct care system?

Ms. Embrey's Answer. We continue to assess the healthcare needs of family members utilizing the direct care system as well as the ability of the system to meet those needs. The Military Health System (MHS) leadership recognizes the continuing challenge of providing timely, consistent access to care at our installations. This will remain an area of focus for the MHS in the year ahead.

LTG Schoomaker's Answer. One of the first concerns I identified as Army Surgeon General was our inadequate facility infrastructure. Investment in our facility infrastructure over the last two years has been without precedent and I thank the Congress and this Committee for its generous support. Continued funding in facility renovation and modernization, information technology infrastructure, capital equipment, and Military Construction (MILCON) is still beneficial and necessary to deliver healthcare in the direct care system.

While we have made significant progress improving the functionality of our aged facility inventory, I am concerned that the number of providers deploying to support ongoing Overseas Contingency Operations creates turbulence in the access and delivery of services to Soldiers and their Families. We have attempted to mitigate this turbulence through a variety of methods, including increased employment of civilian providers and contract providers. We have established a Human Capital Distribution Plan to assess, plan, implement, and evaluate the military, civilian, and contracted personnel resources to optimize support of healthcare in the direct care system.

I have made access to care and beneficiary satisfaction key priorities. My command has implemented an aggressive Access to Care Campaign Plan containing eleven focus areas that cover a wide spectrum of access and customer service issues. Among the focus areas are the alignment of treatment facility capacity with the number of enrolled beneficiaries; improving provider availability; and leveraging technology for efficiencies to include managing clinic appointment schedules.

One area where I have no concerns is quality care. The quality of health care rendered at our military treatment facilities is absolutely first-rate. All Army hospitals are accredited by The Joint Commission, which also accredits civilian hospitals. Outcome studies of the National Quality Management Program, a DoD-sponsored program that monitors military facilities, show military care usually meets or exceeds civilian benchmarks. Civilian professionals on residency review committees generally regard the Army graduate medical education as among the best in the nation. The board certification passing rate for graduates of Army residency and fellowship programs is 96 percent on the first try, well above the national average. Approximately 93 percent of Army physicians eligible for specialty board certification are certified.

Admiral Robinson's Answer. Patient and family-centered care is Navy Medicine's core concept of care, ensuring that the patient is provided the right health care service, at the right time, at the right place, with the right provider. It identifies each patient as the essential participant in his or her own health care and recognizes the vital importance of the family, military culture, and the chain of command in supporting our patients. Navy Medicine is constantly monitoring and evaluating the quality and timeliness of the health care provided to beneficiaries. In response to this monitoring and evaluation, Navy Medicine has revised its Access to Care (ATC) Strategy to provide Medical Treatment Facilities (MTF) and clinics a framework to implement and sustain a systemic, proactive, and responsive access plan that meets or exceeds beneficiary expectations and ATC standards. The ATC strategy and Access to Care Management Policy for Navy Medicine Military Treatment Facilities are designed to ensure the most optimal patient and family-centered care. With strong senior leadership and support, the policy articulates roles, responsibilities, and expectations for all of Navy Medicine. Navy Medicine has also established qual-

ity processes to meet the highest standards of healthcare possible for our Nation's honored warriors and their families.

Additionally, Navy Medicine is implementing and evaluating a "best practice" model of health care delivery, the patient and family-centered Medical Home Model, in two of our major medical centers. The Medical Home Model is a concept of care that includes a team of physicians, nurses, and support staff providing care to their enrolled patients. The Medical Home Model guarantees access to the care giving team for urgent health care needs within 24 hours, monitors the health needs of patients and proactively contacts them for convenient follow-up care that includes hassle-free appointment scheduling.

Some challenges do exist within the direct care system to include limited specialty care services at some MTF related to specialties deploying in theater however, Navy Medicine is actively addressing this challenge by augmenting services through other direct care sources and through the TRICARE managed care support contractors. In addition, Navy Medicine is actively engaged to identify and lower administrative barriers between other federal agencies and civilian institutions to provide seamless integration of care for our patients.

LTG Roudebush's Answer. For decades the Air Force Medical System has ingrained a continuous process to positively improve access and quality in the direct care system. With the high operations tempo and deployments the challenge of meeting access within the direct care system has been met in partnership with Managed Care Support Contractors. Quality continues to be monitored and validated through National Accreditation Agencies—The Joint Commission and The Accreditation Association for Ambulatory Health Care. These two agencies validate our compliance with clinical quality assurance and allow comparison with civilian healthcare agencies.

Our Managed Care Support Contract (MCSC) partners ably respond to the challenges of maintaining the best health care services for our beneficiaries. The MCSCs supplements the care available in the direct care system with both network and non-network civilian healthcare professionals, hospitals, pharmacies, and suppliers to provide better access and high-quality service, while maintaining the capability to support military operations. We have leveraged the MCSC to ensure our families are provided timely access to quality healthcare delivery.

The TRICARE Operations and Patient Administration Flights at the local Medical Treatment Facilities participate in regularly schedule forums with the MCSCs to discuss any challenges with the delivery of healthcare within the region, addressing both quality and access. Any concerns that cannot be resolved at the lower level are then elevated to the TRICARE Regional Offices for resolution.

The AFMS has a check and balance system to ensure both access and quality health care services are continuously monitored and improved.

ONGOING OPERATIONS

Question. What percentage of care for activated soldiers and dependents is in the base budget? What percentage is requested in supplemental?

Answer. Our estimated Fiscal Year (FY) 2009 Operation and Maintenance (O&M) funding, excluding supplemental funds, is $24.6 billion. Our anticipated FY 2009 O&M supplemental funding is $1.6 billion. Thus, roughly 94% of our O&M funding is in the regular O&M appropriation and 6% is via the supplemental appropriation. These percentages are representative of previous years.

Question. If there is no supplemental, how would you fund the care for our Service members at facilities like Landstuhl, Walter Reed, Balboa, and Brooke Army Medical Centers?

Answer. Providing high quality, accessible healthcare is our number one priority and most important obligation. This is especially true with respect to our most fragile beneficiaries, the wounded, ill and injured soldiers, sailors, airmen, and Marines. In the absence of a supplemental appropriation, we would redirect the required amount of funding from available resources to support the direct healthcare requirements. This strategy would have a resounding, negative impact on the Military Health System programs that had funding removed.

Question. Would you continue to fund the expanded Military Amputee Care Program and the Army Burn Unit?

Answer. Funding for amputee care centers and burn units was "baselined" in the Defense Health Program budget beginning in Fiscal Year 2010 and are no longer dependent upon supplemental funding for their day-to-day operations.

Question. How would you cover the healthcare expenses of the Active Duty and Reserve Components' dependents and families related to Operation Iraqi Freedom/ Operation Enduring Freedom?

Answer. Providing high quality, accessible healthcare is our number one priority and most important obligation. In the absence of a supplemental appropriation, we would redirect available resources, as required, to support direct healthcare requirements. This strategy would have a resounding, negative impact on the Military Health System programs that had funding removed.

Question. How would the necessary medical supplies such as bandages, blood supply, and equipment be supplied to theater and funded?

Answer. Additional costs for medical supplies are included in the Department's supplemental appropriation request for Overseas Contingency Operations (OCO). The majority of these requirements are generated by models and planning factors based upon the number of personnel, types of units deployed, and the types of contingency operations expected during the deployment. The funding included in the OCO supplemental for supplies is allocated to the Military Services or to the Defense Health Program depending where the costs are incurred.

ADDITIONAL TROOPS IN IRAQ

As a result of the President's Afghanistan strategy review, the Secretary of Defense has increased forces for Operation Enduring Freedom by 21,000 including 17,000 combat troops and 4,000 trainers.

Question. How will additional troops deployed to Afghanistan affect the Military Health System (MHS) and its ability to treat the families and dependents?

Answer. When our medical personnel deploy, we generally lose capability in the military treatment facility (MTF) supporting the deployment. However, in advance of the deployment, MTF commanders work with the TRICARE Managed Care Support Contractors to either provide physicians and ancillary staff to work in the MTF and refine the civilian TRICARE network to ensure that needed care is available, either in the MTF or in the network.

The MHS is structured so that the purchased care subsystem augments MTFs by expanding, as necessary, to absorb overflow of workload from the direct care subsystem when the MTFs experience increases in demand for services or reduction in capability and/or capacity due to staff deployments. The efficacy of this structure has been proven throughout deployments, with data from a number of sources—formal surveys of providers and beneficiaries, monitoring of TRICARE customer service logs, regular meetings with the Military Coalition, data showing the capacity of TRICARE purchased care to absorb a tremendous increase in mental health workload since 9/11—all indicating that the MHS has been functioning as designed, with no systemic problems preventing our beneficiaries from accessing purchased health care services. We anticipate this to continue when additional deployments to Afghanistan occur.

Question. What additional medical personnel will be needed to support the additional troop presence in theater?

Answer. The number and skills of medical personnel in theater is dependent upon the size and missions of the Forces assigned, which require operational decisions, not medical decisions. Therefore, the Joint Staff and the Combatant Commander determine the need and assign the staffing requirement to the Service components. The Services would determine which medical resources were available and assign specific units.

ADDITIONAL TROOPS IN AFGHANISTAN

Question. What additional medical evacuation capabilities will be required?

Answer. In January 2009, United States Central Command (USCENTCOM) submitted two requests for forces to increase the capability currently in Afghanistan. The Joint Staff, in conjunction with United States Forces Afghanistan (USFOR–A) and USCENTCOM, conducted further analysis, and based on those recommendations, sourced additional medical evacuation (MEDEVAC) and surgical assets to further augment the medical and evacuation capabilities in Afghanistan. To cover the period prior to the arrival of the main augmentation forces, including the Combat Aviation Brigade, a MEDEVAC "bridging strategy" was put in place with the intent to immediately increase MEDEVAC capability in theater prior to the arrival of these assets. By March 2009, the MEDEVAC Bridging Solution assets were in place and operating in Regional Commands (RC) East and South.

The requested Forward Surgical Teams, Level III Augmentation Package, Medical Command and Control Headquarters (HQs) and additional MEDEVAC Company have arrived in theater and are conducting operations. USCENTCOM continues to evaluate the performance of these medical assets through their transition into theater and assumption of the medical support mission. To do this, USCENTCOM has instituted weekly reporting of MEDEVAC performance, which is briefed to the

USCENTCOM commander. MEDEVAC missions that do not meet standards are analyzed to determine the cause(s) which led to the missed standard and, when appropriate, what actions are being taken to resolve identified problems. Overall MEDEVAC mission times have been decreasing since the addition of the Combat Aviation Brigade and its MEDEVAC Company, and we expect to see further improvements to RC East (RC–E) and RC South (RC–S) as the basing footprint and MEDEVAC procedures continue to be refined in theater.

Approximately 90 days after the arrival of the final combat units, there will be enough data collected to determine whether there are sufficient assets in place in RC–E and RC–S to support the increased theater requirements in these areas and achieve the Secretary of Defense directed MEDEVAC standard of 60 minute mission completion time. However, as International Security Assistance Force and USFOR–A continue to expand operations farther into RCs West and North, the preliminary assessment is that additional resources will be required to meet the 60-minute standard in these two RCs. This Request for Forces is still being refined by USFOR–A and will be forwarded to the Joint Staff for sourcing once it has completed formal vetting within CENTCOM HQs.

DEPLOYMENT OF MEDICAL UNITS AND PERSONNEL

Question. Recent military medical deployments, in particular for Operation Enduring Freedom, have shown we do not deploy the same way we train. For instance, there are different systems in place for medical reset and replenishment during exercises versus combat operations.

How do you propose to resolve the differences between medical training and deployment?

Answer. Medical training can be divided into two types. Doctrinal training, oriented toward support of the war fighter in any theater, provides a framework for medical support of combat operations in any theater. This training insures both the medical community and the line understand in medical lockstep during the initiation of a new operation because there is little room for misunderstandings during that time. Initial deploying medical units then generally deploy as they train.

As the operation continues, doctrine may give way to local situational requirements. This adaptability is a strength of the United States military. New units rotating in will have the second type of medical training—pre-deployment training—which considers and includes local requirements; thus those units will also deploy as they train.

The progress of medical technology is rapid and we push the latest capabilities to the most needed deployment locations. This may leave the exercise facilities with something different. However, focuses of exercise training are process and standards of operation, so medical providers can adapt and apply their training to whatever equipment is available at the deployed location.

Question. What shortfalls currently exist within the Military Health System that relate to the Global War on Terrorism and ongoing operations in and around the area of responsibility?

Answer. Additional costs related to the Global War on Terrorism are included in the Department's supplemental appropriation request for Overseas Contingency Operations (OCO). The majority of these requirements are generated by models and planning factors based upon the number of personnel, types of units, and the types of contingency operations expected during the deployment. The funding included in the OCO supplemental is allocated to the Military Departments or to the Defense Health Program based upon where the costs are incurred.

Question. How are the costs of training medical personnel reimbursed to the Services?

Answer. Additional costs for medical training are included in the Department's supplemental appropriation request for Overseas Contingency Operations (OCOs). The majority of these requirements are generated by models and planning factors based upon the number and types of personnel and units deployed and the types of contingency operations expected during the deployment. The funding included in the OCO supplemental for training medical personnel is allocated to the Military Departments or to the Defense Health Program based upon where the costs are incurred.

Question. How are the Services reimbursed for resupplying combat medical units?

Answer. Additional costs for medical supplies are included in the Department's supplemental appropriation request for Overseas Contingency Operations. The majority of these requirements are generated by models and planning factors based upon the number and types of personnel and units deployed, and the types of contingency operations expected during the deployment. Medical costs are included in

these generated requirements and are allocated to the Military Departments or to the Defense Health Program based upon where the costs are incurred.

Question. What is the monthly burn rate for healthcare before and during Operation Iraqi Freedom/Operation Enduring Freedom?

Answer. Baseline funding for the Defense Health Program (DHP) represents the cost of providing healthcare in a normal peacetime environment; that is, exclusive of major contingencies or wartime operations. Because the Department has funded contingency operations by means of emergency wartime supplemental appropriations, it is possible to calculate the average monthly expenditures for both normal operations and for contingency/wartime operations.

($Millions)	2000	2001	2002	2003	2004	2005	2006	2007	2008
Defense Health Program Operation & Maintenance	10,524	12,411	16,384	18,113	20,181	22,355	25,852	23,694	25,316
Monthly Average	877	1,034	1,365	1,509	1,682	1,863	2,154	1,975	2,110
Global War on Terror	0	0	0	705	888	1,063	1,090	1,073	1,461
Monthly Average	.....	.....	.....	59	74	89	91	89	122
Total	10,524	12,411	16,384	18,818	21,069	23,418	26,942	24,767	26,777
Monthly Average	877	1,034	1,365	1,568	1,756	1,952	2,245	2,064	2,231

Question. What problems still exist, if any, with pre- and post-deployment examinations and Service members' medical records?

Answer. At this time, the two important electronic systems used to document the assessments and to provide medical care (electronic medical records) do not communicate with each other. The Pre- and Post-Deployment Assessments, as well as the Post-Deployment Health Reassessments are captured electronically, but they are not in the individual's *electronic* medical record. The original copies of the assessments are filed in the permanent (hard copy) of the individuals' medical records. We are working to close this gap. In the future, medical providers will be able to view the health assessments whenever they treat the Service member.

Question. What solutions has Health Affairs discussed to alleviate some of the costs that the Services themselves are having to bear?

Answer. Costs the Services are bearing are funded via supplemental appropriations. Additional costs associated with the deployment of medical units and personnel are included in the Department's supplemental appropriation request for Overseas Contingency Operations. The majority of these requirements are generated by models and planning factors based on the number and types of personnel and units deployed and the types of contingency operations expected during the deployment. Medical costs are included in these generated requirements and are allocated to the Military Departments or to the Defense Health Program based upon where the costs are incurred.

Question. Has the quality of care at military treatment facilities (MTFs) decreased with the number of men and women being called to support the ongoing operations?

Answer. The quality of care within MTFs has not decreased although many men and women are supporting the ongoing operations. The Strategic Plan, developed in concert with the Surgeons General and the Joint Staff supports the MHS mission (to provide optimal health care services—anytime, anywhere) and is designed to support MTF operations during periods of sustained deployment of personnel. Through adherence to, and application of, the principles of the MHS strategic planning tool, the Balanced Scorecard, we have demonstrated positive results in both quality of care measures and through beneficiary satisfaction surveys.

Question. What has been done to maintain the level of care at the Military Treatment Facilities (MTFs)?

Answer. The Military Health System was designed to provide optimal health services in support of our Nation's military mission. National security necessitates the deployment of military medical professionals to operational settings. One way we attempt to mitigate the impact on Military Treatment Facilities (MTFs) of deploying military medical professionals is by providing additional funding to them, via Overseas Contingency Operations Supplemental Appropriations, to hire contractors and temporary civilians to "backfill" the deployed Service members. In FY 2008, we provided roughly $207 million in such funding, in FY 2009 we anticipate providing up to $224 million. However, since we cannot fully replace the deployed staff, even with reservists and contracted healthcare providers, we must also rely on our network of civilian providers established by our Managed Care Support Contractors

(MCSCs). The TRICARE networks provide eligible beneficiaries with access to a global network of private-sector healthcare providers, hospitals, and pharmacies. The network providers are fully credentialed, highly qualified providers, and the hospitals are accredited by a nationally recognized healthcare accreditation organization. The healthcare provided in each network is monitored by the MCSCs under their own quality management programs with oversight by TRICARE Management Activity (TMA) regional offices. Additionally, ongoing monitoring by an external contractor through the National Quality Monitoring Contract assesses and reports to TMA on the care provided by the MCSCs.

COMBAT CASUALTY CARE AND BODY ARMOR

Question. Body armor has done a good job of saving lives but has changed the types of injuries treated by the healthcare system. The killed-in-action rate in Afghanistan and Iraq is half what it was in World War II and a third less than Vietnam and Desert Storm. This is due to the battlefield medical teams doing a better job of stabilizing the wounded and getting them to doctors. Also, the Department has recorded the highest casualty survivability rate in modern history with more than 90% of those wounded surviving. Also, the added protection can cause additional strain on the body that was not previously experienced.

Due to the types of injuries, have you had to change the types of medical personnel in theater? If so, how?

Ms. Embrey's Answer. Body armor has improved protection of the trunk (including the neck), leaving the head, and extremities (shoulders to fingers, hip joint to toes) at relatively greater risk for injury. This means that extremity injuries have become more common, as have survivable head injuries. Traditionally, orthopedic surgeons have cared for extremity injuries, but general surgeons in theater have adapted, so we have maintained the skills needed.

With the rise in survivable head injuries, we have added neurosurgeons and neuromedically trained support personnel (nurses and technicians). The rise in complexity of surviving casualties and the use of intensive care providers for post-operative intensive care (freeing surgeons to continue operating) have increased the requirement for intensive care staff, both medical and nursing.

LTG Schoomaker's Answer. The Army Medical Department conducts regular and repeated assessments of our medical performance on the battlefield and in deployed environments. These assessments cover the full range of doctrine, organization, training, materiel, leadership, personnel, and facilities. We have made modifications and improvements to each of these aspects over the course of seven years of combat.

While the basic types of medical units deployed has not changed (combat medics, aeromedical evacuation assets, front line medical companies, forward surgical teams, and combat support hospitals), we have added critical care physicians and trauma surgeons to our hospitals. We have also added a dedicated Deputy Chief of Staff position at our hospitals to relieve the Chief of Surgery from most administrative responsibilities, allowing the Chief of Surgery to focus on clinical matters. With respect to other medical personnel in theater, we have added a physical therapist to each maneuver Brigade Combat Team to help these warfighters address physical readiness issues and prevent them from wearing down due to the rigors of combat operations, to include the strain caused by protective equipment. We also augment our Combat Support Hospitals with extra physical therapists to care for the injured and wounded and help expedite their return to duty. Additionally, we have focused attention on delivery of behavioral healthcare in theater by reinstituting a psychiatrist on the Division Surgeon's staff, increasing the number of behavioral health providers, and improving the distribution of behavioral health providers across the battlefield.

Admiral Robinson's Answer. The combination of improved body armor and the extensive use of Improvised Explosive Devices in the current conflict have led to some different patterns of injury and survivability, especially with increased rates of severe extremity injuries and traumatic brain injuries. However, the medical personnel taking care of injured Service Members in theater, including surgeons, primary care physicians, and corpsmen/medics are well trained in the entire spectrum of casualty care. As such, there has not been a need to change the types of medical personnel deployed into theater due to injury type sustained by Service Members.

That having been said, there is also an increased recognition of combat stress as an issue that impacts operational readiness. This recognition has led to an increased number of mental health professionals being deployed into theater since the beginning of the current conflicts.

LTG Roudebush's Answer. In the past three years, we have been fairly stable with our overall capabilities and injury types have not driven major changes in our de-

ployed personnel, yet some additions have been made to work with the local population, which comprises approx 2/3 of our care at our large facilities. Such examples include addition of pediatric and OB/GYN providers. Additionally in response to lessons learned, our critical care staffing has evolved.

We have made numerous advances in education and training, equipment, and protocols. Other advances include the use of tourniquets, far-forward surgery, access to medical evacuation, heightened awareness of sequelae of injury (e.g., Traumatic Brain Injury), advances in orthopedics, limb salvage techniques to include early fasciotomy, control of hypothermia, fresh whole blood and full component therapy.

The largest level III hospitals have been staffed to capabilities which closely mimic the best trauma hospitals in the States, to include vascular and thoracic surgery, burn and virtually every surgical subspecialty minus organ transplantation. With the increase in capability we've also vastly increased the support to these specialties to include quantitative and qualitative improvements in imaging (CT, angiography), use of blood and blood products, medications, laparoscopy and other minimally invasive techniques, etc.

We have added new personnel roles such as the Trauma Czar, a highly skilled trauma-trained subspecialist, who coordinates and directs the symphony of trauma care with many other subspecialists. This role has been advanced by Air Force medicine at Balad and subsequently Bagram as another example of improvement in the delivery of trauma care that has evolved over time. The current status of this innovation is the development of a formal Trauma Czar course at the Joint Theater Trauma System (JTTS) with inputs from military and civilian experts.

Data collection has also been a component in improvements in personal protective equipment, vehicle improvements, resuscitation, and many local and system-wide policy and procedure improvements.

And last but not least, the development and implementation of an integrated JTTS with in-theater medical personnel supported by a Continental U.S. based organization utilizing a state of the art Defense Department Trauma Registry to conduct continuous performance improvement and rapidly make changes to the system to improve care of the wounded is an innovation probably never thought of prior to 2001.

We continuously assess the needs/capabilities required and have already shifted one of our JTTS nurses from Balad to Bagram to meet the increased volume of patients in Afghanistan. As the focus shifts to OEF and the change in operations tempo, additions are already being made to mirror what was in place at Balad, such as trauma/critical care surgeons and other subspecialty/critical care providers.

Advances in blood availability and use are another example of response to lessons learned. Blood and blood products have been pushed far forward in theater, with state of the art equipment and training to support their use. This brings out the point that not just physician staffing has changed based on the volume and types of injuries, but nursing and ancillary staffing has advanced as well.

Question. How have you changed the training and equipment for the combat lifesaver compared to training and equipment carried prior to Operation Iraqi Freedom and Operation Enduring Freedom?

LTG Schoomaker's Answer. The training for Combat LifeSavers (CLS) has never been more necessary. CLS serve as the bridge between self-aid/buddy aid and the Combat Medic. The Army Medical Department continuously incorporates lessons learned from OIF/OEF to enhance the program's relevance and effectiveness. Prior to OIF/OEF, the combat lifesaver program was fundamentally a first aid course. The program focused on preventive medicine, dehydration, use of intravenous (IV) fluids as a primary method of trauma resuscitation, and tourniquet application as a final option. IV training consumed 70% of the available course training time. The program was trained at the unit level under local supervision of the organic combat medics and physician assistants. The generally accepted basis of allocation was one combat lifesaver per squad, crew, or equivalent size element.

As a direct result of OIF/OEF the CLS program is now aligned with the principles of Tactical Combat Casualty Care (TC3). The emphasis has shifted from a basic first aid course to a generalized operational medicine course aimed at treating preventable causes of battlefield deaths. This fundamental change in the program has aligned the CLS with the combat medic, strengthening medical cohesion. The CLS program has undergone additional modifications as a direct result of OIF/OEF, including:

- The basis of allocation of CLS has increased from one per squad to 100% of the Force.
- Tourniquets are used as a primary means of controlling extremity bleeding (#1 cause of death in current operations).

• Combat gauze (a hemostatic dressing) is used for controlling hemorrhage of non-compressible injuries.
• Training now includes airway skills to include proper body positioning and placement of a nasopharyngeal airway.
• Training includes use of a 14-gauge needle for needle decompression. Injuries to the chest, resulting in significantly troubled breathing are associated with a tension pneumothorax (collapsed lung). Introduction of a needle into the chest to relieve the pressure is a lifesaving procedure formerly taught only to medics.

Question. How have you changed the training and equipment for the combat lifesaver compared to training and equipment carried prior to Operation Iraqi Freedom and Operation Enduring Freedom.

Admiral Robinson's Answer. The most significant evolution of theater medical care for injured Sailors and Marines has been the widespread teaching and application of Tactical Combat Casualty Care (TCCC). It is becoming increasingly apparent in 2009 that the basic tenets of TCCC are sound and have been successful on the battlefield. For example, the 75th Ranger Regiment reported that of 482 casualties in Iraq and Afghanistan (including 31 fatalities), there were no preventable deaths identified in Ranger units. This unit has a long-standing standard of teaching TCCC to every combatant in their units, so that the most critical life-saving interventions such as tourniquets can be accomplished by every one of their unit members.

Perhaps the most successful single TCCC intervention has been the widespread re-introduction of tourniquet use on the battlefield. Despite not going to the GWOT with modern tourniquets, U.S. military troops now routinely carry well-made tourniquets into combat. Tourniquets have now been documented to be remarkably effective at saving lives in casualties with isolated extremity trauma. Other TCCC interventions such as nasopharyngeal airways, oral antibiotics, needle decompression of tension pneumothorax, and surgical airways when needed have not only proven effective, but have also helped to reduce both the training requirements and the medical equipment load out carried by combat medical personnel compared to previous battlefield trauma management techniques.

Question. How have you changed the training and equipment for the combat lifesaver compared to training and equipment carried prior to Operation Iraqi Freedom and Operation Enduring Freedom.

LTG Roudebush's Answer. The Air Force Medical Service in 2005 fielded a completely updated Improved First Aid Kit (IFAK) providing our warfighters increased life-saving capabilities. The new Hemorrhage Control (Combat Application Tourniquet and Hemostatic Bandage) and Airway Management supplies are the newest additions found in the IFAK. The Combat Application Tourniquet is a one-piece unit which allows one-handed application for hemorrhage control. Quickclot Combat Gauze, also included, can be fit to any size or shape wound, to include penetrating wounds, and immediately stops life-threatening bleeding. A nasopharyngeal airway tube was added to the IFAK and allows our airmen to establish an airway, when needed. Previous First Responder First Aid Kits had few of these new critical combat casualty components.

Our Self Aid and Buddy Course added these improvements to its curriculum. In this course our airman are taught to use these additions to their first aid kit, increasing the individual's capability to provide buddy care and provide intervention for the two leading causes of death on the battlefield, severe hemorrhage and inadequate airway. In addition, the Self Aid and Buddy Course has been improved to increase the emphasis on "Wingman Responsibilities" for Post-Traumatic Stress Disorder symptoms as well as suicidal airmen. Highlighting these responsibilities enables those individuals outside the wire to look after each other, particularly when no mental health capability is immediately available.

Question. Can the Surgeons General provide some examples of how combat casualty care has evolved since the beginning of OEF/OIF?

LTG Schoomaker's Answer. Since the beginning of these operations, the Army has made great strides in increasing the survivability of our wounded and injured Soldiers on the battlefield. Basic first aid prior to the start of the war was just a bandage issued to a Soldier. Currently, each soldier is issued an Individual First Aid Kit (IFAK) that contains a haemostatic dressing (Combat Gauze), tourniquet (Combat Application Tourniquet), adhesive tape, nasopharyngeal airway, and gloves. Providing the correct tools addresses the two leading causes of death on the battlefield: severe hemorrhage and an inadequate airway. Using these tools, we have expanded the concept of first aid and buddy care, as first responders often provide the critical life saving steps.

Hemorrhage and temperature control are critical for the survival of a wounded soldier. The emerging emphasis is on patient warming and has become the preferred modality of care on the battlefield. Fluid replacement on the battlefield is no longer

recognized as the immediate treatment of choice for blood loss in trauma related battlefield injuries. Thermo regulation through the use of a warming blanket with an internal heat source instead has become the recommended standard of care.

Combat Lifesavers are non-medical Soldiers who are given specialized training to augment the combat medic. The Combat Lifesaver has been a force multiplier for many years but has recently been provided enhanced training to address severe hemorrhage, airway management, chest decompression, and patient warming. The Combat Lifesaver bag and components have seen a physical change as well. A new bag design has been introduced to provide users with quicker access to components. In addition, a large strap cutter was added for patient vehicle extraction and rapid clothing removal.

Army Medicine played an important role in the improvements to the Mine Resistant Ambush Protected (MRAP) ambulance, Army Combat Helmet, Combat Arms Ear Plugs, Improved Outer Tactical Vest, and Fire Retardant Army Combat Uniform. 25,000 Warrior Aid and Litter Kit (WALK), have been procured to support current combat operations. The WALK is stowed onboard vehicles to be used by the first responder. The WALK complements the IFAK and the Combat Life Saver Bag. It contains a foldable litter and the tools to treat and overcome the three most common causes of preventable combat deaths on the battlefield (hemorrhaging, tension pneumothorax, and inadequate airway). The MRAP-Ambulance provides increased protection to our crews and patients. To make the MRAP-Ambulance the most capable ground ambulance in the Army today, we integrated "spin-out" technology from the Future Combat System Medical Vehicles. The combat medic is now able to leave the Forward Operating Bases to conduct medical evacuation missions and can provide world class en-route care to wounded soldiers. Medicine also developed Casualty Evacuation Kits (CASEVAC) for both the MRAP and HMMV ambulances to increase capability. These efforts provided the combat medic with field ambulances built for survivability in the challenging environment of asymmetric warfare.

Last and perhaps most important, our Soldier/Medics, including Physicians, Nurses, and Corpsmen, receive the highest level of pre-deployment trauma training ever provided. It is a critical link between standard medical care and the intense battlefield environment Soldiers face in the current conflicts. By recreating the high-stress situations medics will face in Iraq and Afghanistan, this training allows for the refinement of advanced trauma treatment skills and sensitization to hazardous conditions, thereby allowing medics to increase their confidence and proficiency in treatment. Army Medicine remains on the forefront of medical technology and training ensuring that the finest soldiers in the world receive the finest medical care on the battlefield.

Admiral Robinson's Answer. The most significant evolution of theater medical care for injured Sailors and Marines has been the widespread teaching and application of Tactical Combat Casualty Care (TCCC).

In addition to in theater care that has previously been addressed, enhanced care coordination and access to psychological health care through primary and specialty care ensures highest quality of care to our Wounded, Ill and Injured. Emphasis on destigmatized portals of care to meet the needs of wounded warriors and their families, coupled with cooperation in care with the Department of Veteran Affairs has improved availability and quality of care.

LTG Roudebush's Answer. One example is the development of a Joint Theater Trauma System (JTTS), initiated in 2003 in Operation Iraqi Freedom (OIF) with the establishment of a joint data registry (Joint Theater Trauma Registry—JTTR), and progressing to an improved regionalization of trauma care. The JTTS includes coordinated placement of medical/surgical specialists and a process improvement program. It has improved global collaboration across all levels of care and rehabilitation via satellite multimedia communications and cultivated numerous clinical practice guidelines with broad concurrence across military and civilian specialty areas.

As another example, the advancement of Damage Control Concepts through ongoing research and data collection has contributed to the development of new massive transfusion protocols (patients requiring more than 10 units of blood) incorporating increased ratios of blood products (red blood cells, plasma, platelets) and the use of fresh whole blood when components are not available. This has allowed survival rates greater than 70 percent. These damage control concepts have now been extended to the immediate recovery period and critical care units. Casualty care has also benefitted from modifications in wound management concepts due to our recent experience with extensive tissue damage and contamination, to include abdominal wound management with progressive closure of the abdominal wall via multiple operations and irrigation with a large amount of saline fluids. The use of negative pressure wound devices (also known as vacuum assist devices) has led to lower in-

fection rates, less pain and decreased workload on nurses/technicians from dressing changes.

We have reinstituted the use of the tourniquet as part of the hemorrhage control algorithm. Tourniquets were considered heresy after Vietnam in both civilian and military practice. However, tourniquet use in OIF/OEF has led to a significant reduction in mortality from extremity hemorrhage. In addition, there has been an adjustment of hemorrhagic control adjuncts, for example, adding combat gauze as a first line therapy and removing other adjuncts deemed to have adverse outcomes or less effectiveness based on research and data collection.

Since the beginning of OEF/OIF, there has been the development of Burn Resuscitation Guidelines. The development of these guidelines was in response to overresuscitation (large volumes of fluids) of burn patients, resulting in significant complications and mortality. The new guidelines have significantly reduced complications such as abdominal compartment syndromes and infections, as well as mortality.

Question. How have services been expanded/adapted to meet the needs of our wounded warriors?

Ms. Embrey's Answer. We have expanded and adapted many services to meet the needs of our wounded Service members. One example is our tremendous focus to return amputees to pre-injury (or close as possible) levels of performance. Prosthetic technology, surgical approaches to amputee care, rehabilitation science and techniques have combined to produce new approaches to maintaining or even exceeding pre-injury capabilities. Another example is the capability to rapidly transport critical casualties from the theater of operations to definitive care military medical centers in the United States. This rapid transport promotes early intervention by well trained and experienced specialty care teams and continuity of care. Ultimately, this rapid transport to a stateside care location provides continuity of care for the Service member from surgery through to recovery.

We have expanded support services to assist Service members and their families in financial and other matters while in recovery and transition, either back to the Force or into civilian life. The Services have all implemented programs to ensure appropriate care and assistance, and a new pilot program has improved the transition from the Department of Defense to the Department of Veterans Affairs' responsibility within the Disability Evaluation System for both Departments.

LTG Schoomaker's Answer. The transformation of Warrior Care began in April 2007 with the development of the Army Medical Action Plan (AMAP), which outlined an organizational and cultural shift in how the Army cares for its wounded, ill, and injured Soldiers. Over the past 23 months, the AMAP evolved into the Army Warrior Care and Transition Program (WCTP), fully integrating Warrior Care into institutional processes across the Army. In just two years, the WCTP has made extraordinary inroads toward transforming the way the Army cares for wounded, ill, and injured Soldiers and their Families. The Army has robustly resourced 36 Warrior Transition Units and 9 Community Based Warrior Transition Units, established a proven approach to care management through the triad of care concept, centralized support to Warriors in Transition and their Families by co-locating support services in Soldier Family Assistance Centers, and implemented the Comprehensive Transition Plan approach to help Soldiers plan and attain their recovery goals. True to the Army's credo of never leaving a fallen comrade, and with the support of Congress, we have begun the process of building Warrior Transition Complexes to create a safe and accessible environment to accomplish the enduring mission of caring for our brave men and women who have freely sacrificed their well-being in defense of freedom.

In coordination with the Department of Veterans Affairs, the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (TBI), and the Defense and Veterans Brain Injury Center—the Army continues to expand resources dedicated to TBI research and treatment. For most TBI cases, our Soldiers and family members can expect a full recovery with no lasting mental or physical effects. Receiving prompt care is a key to returning to the highest functional level possible. Thanks to generous congressional funding, the Army is at the forefront of TBI treatment, care, and support. From improved training for our providers, to expanded screening and treatment at our forward combat medical facilities, to additional personnel, resources and training for our primary care physicians, nurse case managers, and our wide variety of specialists, Soldiers and Families affected by TBI have access to the full range of Army support.

Service members who have lost limbs as a result of wounds received in Afghanistan or Iraq are receiving the best medical care available in state of the art facilities at Walter Reed and Brooke Army Medical Centers. As part of the Armed Forces Amputee Care Program, multidisciplinary teams from more than a dozen specialties

work together to address the psychological, social, vocational, and spiritual needs of our Soldiers, marines, sailors, and airmen, in addition to their physical rehabilitation. Over the past decade, a cultural shift has occurred within the military, giving individuals with limb-loss the opportunity to stay on active-duty service. Advances in medical, surgical and rehabilitative care, as well as prosthetic design, help individuals achieve this goal. Whether or not the Soldier desires, or has the ability, to remain on active duty service, the Army is committed to helping all amputees reach their maximal function and return to the highest possible quality of life.

Admiral Robinson's Answer. Navy Medicine has supported a number of programs to meet the increasing needs of our wounded warriors. In Fiscal Year 2008, $31.95 Million of Psychological Health-Traumatic Brain Injury (PH–TBI) supplemental funds supported the contracting of 187.5 positions enterprise-wide. This effort has been expanded in Fiscal Year 2009 to $47.37 Million to support the contracting of 411 positions (including the continuation of Fiscal Year 2008 positions) enterprise-wide. Increased staffing at the MTF level has facilitated the creation of new wards and clinics such as the TBI and Related Disorders (TBIRD) at Naval Hospital Camp Pendleton (NHCP), the Comprehensive Combat Casualty Care Center at Naval Medical Center San Diego (NMCSD), and the addition of a new PH–TBI ward at National Naval Medical Center (NNMC). Unprecedented success has also been achieved with the formation of an "Admin Cell" at NNMC that tracks entry and exit of patients into the system, maximizes capture of Relative Value Units (RVU), and reports on treatment efficacy. Other successes include increased inpatient and outpatient encounters (26,000 mental health visits at Naval Hospital Camp Lejeune (NHCL) this past year), improved capability to provide evidence-based group therapies, and increased outreach to Individual Augmentee/Global War on Terrorism Support Assignments (IA/GSA) personnel.

Additional supplemental funds enhanced existing services or addressed existing gaps. Receiving a total of $10.5 Million in Fiscal Year 2008 and Fiscal Year 2009, the Naval Center for Combat and Operational Stress Control (NC COSC) offers Post Traumatic Stress Disorder (PTSD) specialized knowledge and intervention, research support, interactive website, and houses a library for OSC content and best practices. NC COSC implemented OSC Training at the IA Combat, Command Leadership, and Senior Enlisted levels and hosted the February 2009 Defense Centers of Excellence (DCoE) for PH–TBI Quarterly Planning Summit. Navy Medicine used $2.99 Million in Fiscal Year 2008 to provide psychological health outreach coordinators and support staff at the five Navy Regional Reserve Component Commands (RCCs). The outreach teams act as a "safety net" for Navy Reservists and their families (who are at risk for not having their stress injuries identified and treated in an expeditious manner) and improve their overall mental health. The Reserve outreach teams received $6.53 Million in Fiscal Year 2009 to support the continuation of the Navy component and to expand services to include the Marine Corps Reserves. Navy Medicine has also taken new steps to support the Marine Corps Wounded Warrior Regiment with Fiscal Year 2008 and Fiscal Year 2009 total of $2.04 Million. Funds support the provision of clinical services staff to: support a comprehensive psychological health and TBI program which ensures that every Marine and Sailor assigned to a Marine Corps unit receives the best prevention, identification, and treatment available; assist in developing policies and implementing procedures; and facilitate clinical assessment and management of individual cases.

LTG Roudebush's Answer. The Air Force Medical Service (AFMS) has taken an active role in adapting to challenges of the battle injured and then adapting our care through the spectrum of care delivery to maximize wellness. The U.S. casualty fatality rate for Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) is the lowest that it has ever been, compared to previous U.S. wars and conflicts. The high survival rates are directly related to improved individual body armor as well as a combination of medical efforts including full implementation of damage control resuscitation and surgery concepts, improved critical care, advanced hemostatic devices and agents, coordinated pre-deployment battlefield injury care training, and increased joint medical interoperability. The AFMS contributes to this outstanding achievement through its support of two Level III Air Force Theater Hospitals, EMEDS, Army Forward Surgical Teams, and Joint Forces Special Operations missions. Advancement in the care of battlefield injury continues to emerge from the area of operation and expand to civilian trauma practice, including the concept of transfusing equal ratios of pack red blood cells to plasma in massive blood transfusion situations. This revolutionary concept has led to 80 plus percent survival rates.

One adaptation of our healthcare service to meet the needs of the Wounded Warrior is an enhanced focus on our Airmen and their psychological health. Exposure to battlefield trauma places airmen at risk for combat stress symptoms and possible

mental health problems such as depression or post-traumatic stress disorder. To support our Airmen, the Air Force has taken a proactive approach of education, symptom recognition, and encouraging help-seeking. One example is the Landing Gear program, which is based on the metaphor that, no matter how powerful an aircraft is in the air, properly functioning landing gear is necessary to safely launch (i.e., deploy to war) and recover (i.e., redeploy to home station). In the same way, Airmen are taught that recognizing risk factors in themselves and others along with a willingness to seek help is the key to functioning effectively across the deployment cycle. During pre-deployment, Landing Gear training explains deployment stress, the deployed environment, typical reactions, ways to manage stress, and how to get help if needed. During reintegration and reunion the program lays the foundation for what to expect after deployment and facilitates a smooth reentry into work and family life. The Air Force is using programs such as this to build upon our Wingman Culture. For Airmen, being a Wingman means recognizing when other Airmen are distressed and having the courage to care and become involved.

Question. What are the new, emerging technologies that make the combat lifesaver more effective in saving the lives of Military personnel?

Ms. Embrey's Answer. "Combat Lifesaver" (CLS) is a term used to designate a level of emergency response training. A CLS is a non-medic soldier with moderate emergency medical training who can provide care at the point of wounding. The CLS is instructed in various techniques to treat and stabilize injuries related to combat. The CLS doctrine was developed to increase survivability in combat environments where the combat medic may not be readily available. Skills of the CLS include basic casualty evaluation, airway management, chest injury and collapsed lung management, bleeding control, intravenous drip therapy, and medical evacuation requests.

The greatest contributing factor in increasing the effectiveness of CLS is improved training. Now, all soldiers are trained to CLS level. That training has been enhanced with the development of simulators for life saving procedures. Research continues to develop more realistic simulators that mimic the physiologic responses of the body to both injury and treatment.

Supplies needed to perform the life saving interventions are contained in the Individual First Aid Kit. Issued to each soldier, the kit consists of a tourniquet, combat gauze (impregnated with a material to stop bleeding), a nasal airway, and other supplies. It replaces the single gauze bandage previously issued to each soldier.

The majority of preventable deaths may be saved by stopping bleeding. The research community is engaged to improve tourniquet devices and application guidelines, improve hemostatic bandages to treat external bleeding, and investigating new, emerging technologies to stop internal bleeding.

Once the bleeding is stopped, the CLS can start intravenous lines for fluid replacement. Starch based fluids that are equally as effective at replacing lost blood volume as saline solutions are the product of efforts to identify the most appropriate agents to be added to standard resuscitation treatments. Work continues to identify better fluids with increased capabilities to:

- Control the degree of inflammation following trauma
- Maintain adequate transportation of oxygen to the tissues
- Restore/maintain normal blood clotting capability

Recent studies have established early control of pain can result in improved long-term outcomes for combat casualties. A nasal spray for relief of acute pain that could be administered by CLS is nearing Food and Drug Administration approval.

Evacuation of casualties to the next level of care is facilitated by the Warrior Aid and Litter Kit (WALK). This kit, carried on tactical vehicles, includes a large supply of first aid supplies and a collapsible litter. Having the litter available on site reduces the time required to load a casualty onto the evacuation platform (helicopter, ground ambulance, or other vehicle).

Control of body temperature is important in treating casualties. Even in a desert environment, casualties need support to maintain a satisfactory temperature. The Hypothermia Prevention and Management Kit, a space blanket type sleeping bag with a self contained chemical heat source, provides a simple method of keeping patients warm and is available in the WALK.

LTG Schoomaker's Answer. "Combat Lifesaver" is a term used to designate a level of emergency response training. A Combat Lifesaver (CLS) is a non-medic Soldier with moderate emergency medical training to provide care at the point of wounding. The CLS is instructed in various techniques to treat and stabilize injuries related to combat, to include, but not limited to, blast injury, amputation, severe bleeding, penetrating chest injuries, simple airway management, and evacuation techniques. The CLS doctrine was developed as an effort to increase survivability in combat environments where the combat medic may not be readily available. Skills of the CLS

include basic casualty evaluation, airway management, chest injury and collapsed lung management, controlling bleeding, intravenous drip therapy, and requesting medical evacuation.

The greatest contributing factor in increasing effectiveness of CLS is improved training. Where previously there were a few CLS in troop units, now all Soldiers are trained to that level. That training has been enhanced with the development of simulators for life-saving procedures. Research continues into developing more realistic simulators that mimic the physiologic responses of the body to both injury and treatment.

Supplies needed to perform the life-saving interventions are contained in the Individual First Aid Kit (IFAK). Issued to each Soldier, the kit consists of a tourniquet, Combat Gauze (impregnated with a material to stop bleeding), a nasal airway, and other supplies. The IFAK replaces the single gauze bandage previously issued.

The majority of preventable deaths may be saved by stopping hemorrhage. The research community is engaged in a continuous process of improving tourniquet devices and application guidelines, continuously improving hemostatic bandages to treat external bleeding, and focusing on new, emerging technologies to stop internal bleeding.

Once the bleeding is stopped, CLS start intravenous lines for fluid replacement. Starch based fluids that are equally as effective at replacing lost blood volume as saline solutions are the product of the continuous process of identifying the most appropriate agents to be added to standard resuscitation treatments. Work continues to identify better fluids with increased capabilities to:

- Control the degree of inflammation following trauma
- Maintain adequate transportation of oxygen to the tissues
- Restore/maintain normal blood clotting capability

Recent studies have established early control of pain can result in improved long-term outcomes for combat casualties. A nasal spray for relief of acute pain which could be administered by CLS is nearing FDA approval.

Evacuation of casualties to the next level of care is facilitated by the Warrior Aid and Litter Kit (WALK). This kit, carried on tactical vehicles, includes a large supply of a wide array of first aid supplies and a collapsible litter. Having the litter available on site reduces the time required to load a casualty onto the evacuation platform (helicopter, ground ambulance, or other vehicle).

Control of body temperature is important in treating casualties. Even in a desert environment, casualties need support to maintain a satisfactory temperature. The Hypothermia Prevention and Management Kit, a space blanket type sleeping bag with a self contained chemical heat source, provides a simple method of keeping patients warm and is available in the WALK.

Admiral Robinson's Answer. The Marine Corps Combat Lifesaver is trained in techniques to minimize blood loss, control hemorrhaging, treat for shock, maintain an open airway, treat broken bones, and evacuate casualties. Training also covers identifying and treating bleeding wounds, bone fractures, burns, and several complications caused by wounds typically incurred on the battlefield. Naval Medical RDT&E has a focus area in combat casualty care that focuses on equipment and techniques that enhance these basic skills.

Naval Medical R&D has responded to identified needs for far forward care in:

Hemostatic Agents for Treatment of Life-Threatening Hemorrhage: Marine Corps Systems Command (MARCORSYSCOM) sponsored the Naval Medical Research Center (NMRC) Combat Casualty Care Directorate to assess 12 different hemostatic formulations to include current standard of care preparations HEMCON® and QuikClot®. The QuikClot Combat Gauze™ was judged superior to all other hemostatic preparations. The report to the Committee for Tactical Combat Casualty Care in February and April 2008, along with results from Army investigators, led to a recommendation to deploy Combat Gauze as the hemostatic preparation of choice. The results were transitioned to the MARCORSYSCOM Sponsor for USMC Individual First Aid Kit (IFAK) deployment.

Maintaining an open airway: Cricothyrotomies, a technique for maintaining an open airway, are reported to be a problem during forward care of casualties. Interviews with conventional and SOF first responders have indicated that the existing capability is often compromised during field operations. The Navy, USMC, and Army, working with a commercial partner, have a device in late Test & Evaluation that shows great potential for enhancing this critical capability. The Cric™ Cricothyrotomy Kit allows one-handed operation to illuminate (visible or IR), incise, spread, and hold open the incision for insertion of a breathing tube. The two current versions are amenable for use in the hospital or by EMTs. A military version is planned for FY10 introduction.

LTG Roudebush's Answer. Likely, the biggest technological contributions to more effective first aid on the battlefield are the evolution and fielding of hemostatic dressings, the Combat Application Tourniquet and changes guidelines via the Committee on Tactical Combat Casualty Care that emphasize the early application of tourniquets, and improved IV fluids such as Hextand. From a research and development perspective, Air Combat Command is engaged in several initiatives to improve combat medic effectiveness.

Blood Pharming will provide the capability to produce a ready supply of fresh, universal donor packed red blood cells in theater. Theoretically this system will produce an unlimited blood supply without risk of infectious disease transmission, and can be located at an air head or near the theater of operations, reducing shipping and distribution times and significantly improving blood freshness.

The Field Intravenous Fluid Reconstitution device will result in a Food and Drug Administration-approved IV solution at deployed locations for immediate use or storage. The concept is to transport IV bags with salt, glucose and lactated ringers dry powder concentration, and reconstitute in theater with sterile, Food and Drug Administration-approved water generated on site from the local military water supply.

The Deployable Oxygen Generation System—Small (DOGS–S) device (also mentioned as a response to question MUR017) is being designed to concentrate ambient oxygen (21 percent) into 93 percent therapeutic oxygen and continuously supply this oxygen product directly to patients. DOGS–S will fit into a medium-size medical rucksack, be one man-portable, and used on the ground or in aircraft. DOGS–M is in the production phase with five units expected for delivery in July 2009.

Natural Language Processing is companion software to the electronic health record that processes text files and extracts medical data elements and automatically populates a database. The information and/or trends identified from the database strengthen medical surveillance and enhance command situational awareness of overall health of the population at risk.

AEROMEDICAL EVACUATION

Question. Aeromedical evacuation is distinctly an Air Force mission, and a critical component of the Air Force's global reach capability.

What makes aeromedical evacuation distinctly different today vice the 1991 Gulf War?

Answer. The Air Force's responsive aeromedical evacuation system is built on universally qualified aeromedical crews augmented by critical care air transport teams flying on non-dedicated aircraft under a unified mobility command and control structure. After the 1991 Gulf War, U.S. military doctrine evolved to adopt a new casualty replacement policy, smaller medical presence in theater and overseas, and movement of stabilized casualties versus the Gulf war paradigm of "only stable patients fly air evac". Today's aeromedical evacuation (AE) system allows for unprecedented flexibility because AE crews are not qualified on specific airframes but are universally qualified to provide care in the air on any mobility aircraft. Through the use of alert aircraft and In System Selects (diverting an aircraft) urgent patients are being transported on average within seven hours and priority patients within nine hours. Not only are patients in general being moved back to the Continental U.S. quicker than any time in history, the movement of the most severely injured/ill patients is done rapidly with the integration of critical care transport teams in deployed aeromedical evacuation units marrying specialized clinical capability with the AE crews and aircraft. As a result, medical support for OIF/OEF has required one tenth the beds and one fifth the medical personnel in theater returning patients to the U.S. in one seventh the time than during the 1991 Gulf War. Since September 11, 2001, the aeromedical evacuation system has moved over 64,000 patients including almost 12,000 battle-injured; the battle-injured movements alone exceed all patients moved during the Gulf War.

AEROMEDICAL EVACUATION TODAY VICE 1991

Today, aeromedical evacuation and Critical Care Air Transport Team synergy allows Intensive Care Unit level "Care In The Air" 24/7 anywhere, anytime.

Today, if Mobility Air Forces airframes can land there, we can deliver aeromedical evacuation/Critical Care Air Transport Team capability there.

Today, aeromedical evacuation unit type codes are far lighter, leaner, and rapidly deployable in a few hours; Aeromedical Evacuation Liaison Teams, Mobile Aeromedical Staging Facilities, Aeromedical Evacuation Operations Teams, bringing secure redundant communications, enabling patient regulation from far forward, austere locations.

Today, our rapid aeromedical evacuation capability of moving patients in one to three days from the area of responsibility to Continental U.S. has made the benchmarks of the past obsolete. In the past a tactical evacuation of 7 days and strategic evacuation of 7 to 14 days was ideal.

Today, aeromedical evacuation missions with leveraged Air to Air Refueling can execute nonstop missions for cases such as burn patients from Balad Air Base to Brook Army Medical Center, San Antonio in less than 24 hours.

Today, the C–17 Globemaster III supports the highest standards of aeromedical evacuation capability; integral oxygen, lighting, temperature control, a very high quality care environment, with critical range, speed and refueling capabilities.

Question. The Committee understands that the Air Force is exploring advanced technologies to monitor the condition of pilots in flight and to improve health outcomes for patients during aerovac operations. Can you provide some examples of the type of projects being undertaken by the Air Force Health Services?

Answer. The Air Force Research Laboratory Human Performance Directorate and Human Performance Integration Directorates under the 711th Human Performance Wing do not currently have any projects related to the monitoring of the condition of pilots during flight. Routinely, our flight surgeons take all precautionary measures to ensure the readiness of pilots with annual physical examinations, ophthalmologic exams, stress tests, and centrifuge exercises, so that if a pilot's physiology changes, or a new disease diagnosed, flight surgeons can take appropriate action for the sake of flight safety.

The Air Force Medical Service has a number of efforts underway to improve health outcomes for patients during aeromedical operations.

The Vacuum Spine Board was procured recently and fielded for use by Critical Care Air Transport Teams. The Patient Proning Device, a related initiative, will provide the ability to rotate patients to provide comfort, alleviate pressure, or provide therapeutic treatments is underway.

The Patient Isolation Unit will provide Air Mobility Command the capability to isolate and treat biologically contaminated patients in the aeromedical evacuation (AE) system. The Food and Drug Administration-approved Patient Isolation Unit will expand the capability to allow AE teams to safely move contaminated/contagious patients safely.

The Aeromedical Evacuation Electronic Medical Record (AE EMR) will provide documentation of medical history and care, storage, retrieval, and forwarding of those records generated while the patient is transiting the AE system. The AE EMR will ensure AE providers have the needed patient information to make diagnostic and treatment decisions during transport, and information will also be available to medical staff at receiving fixed medical facilities in real time for enhanced continuity of care.

Question. The Committee understands that monitoring the condition of patients during aerovac operations presents challenges. Are there research efforts underway to improve the technology used to monitor patients during aerovac.

Answer. The Air Force Medical Service (AFMS) is moving critically injured patients on aeromedical evacuation (AE) missions with great success. Still, the AE environment poses unique challenges while caring for these intensive care unit type patients on the back of a cargo aircraft. High noise levels (average of 85 decibells) can interfere with voice recognition, obscure audible signals and alarms on equipment, and increase crew fatigue. Usually, AE missions fly at an altitude to maintain cabin pressures of about 8,000 feet. Decreased oxygenation inherent at altitude can worsen some medical conditions making monitoring that much more important. Monitoring patients during flight is both crucial and difficult, and the AFMS has several initiatives underway to improve technology used to monitor patients during AE.

Air Mobility Command's number one priority is an Enroute Critical Care System (ECCS). This system will integrate equipment required to care for most critical care patients into one patient movement platform. It consists of capabilities to provide: (1) Physiologic Monitoring (heart rate, respiration/breathing rate); (2) Hemodynamic Monitoring and Intervention (blood pressure, shock); (3) Ventilation; (4) Oxygen; (5) Fluid Resuscitation; and (6) Flexible Power Utilization. The monitoring aspects of the ECCS will also include alarms to alert the medical team to changes in condition that require re-assessment of the patient to guide medical decision making. This is a validated initiative and is scheduled to begin operational test and evaluation in Jan 2010.

Non-Invasive Monitoring for Traumatic Brain Injury (TBI) will provide new triage/screening, diagnostic, and monitoring capabilities for TBI patients in far forward locations, during evacuation and recovery. It should provide early definitive diagnosis of TBI. Additionally, TBI will be monitored during AE missions for any pro-

gression in severity to guide care and documentation of a patient's condition. Current invasive type monitors could subject the patient to infections where a non-invasive monitor would mitigate that risk. This initiative is currently in the requirements validation process.

The Acoustic Stethoscope will greatly enhance the ability to hear diagnostic quality heart, lung, and bowel sounds, and take manual blood pressures during AE missions. Currently, at times, it is extremely difficult to adequately monitor these important diagnostic measures due to high ambient noise levels on the flight line and in the air, but developments in noise cancelling technologies will ensure a drastic improvement. This initiative is currently in the requirements validation process.

A Non-Invasive Compartment Syndrome Monitor will measure and monitor tissue perfusion and compartment pressures. It is thought that altitude contributes to the development of compartment syndrome, a condition that can lead to loss of a limb due to decreased circulation. Research is underway for a device to prevent or detect compartment syndrome and to help guide a medical decision for surgical intervention.

MORALE

Question. Generals, when asked the question, in prior hearings, "how is morale in your branch of service", each of you replied that morale was very high. The ongoing operations continue to dominate the news and consequently the thoughts and concerns of American citizens. Operational tempo is high and extended deployments have made direct and lasting impacts on service members and their families.

Based on these continuing and challenging conditions, how would you describe morale in your service today?

LTG Schoomaker's Answer. I would still describe morale in the Army as high. Our Soldiers and Families are doing remarkably well while serving during very stressful times. They continue to impress and inspire me. The data support my assessment. The Sample Survey of Military Personnel (SSMP) is conducted on behalf of the Army G–1 each Spring and Fall. Key findings from the Fall 2008 survey are summarized for career intent, morale, reasons for leaving the Active Army before retirement, and quality of life/job satisfaction. Results on officers' and enlisted Soldiers' plans to stay in the Army are improving (more positive). Morale is steady. For both officers and enlisted Soldiers, "Amount of time separated from family" continues to be the primary reason for leaving or planning to leave the Army before retirement. Satisfaction levels with quality of life (well-being) and job satisfaction are increasing for both officers (25 of 58 factors) and enlisted Soldiers (15 of 58). Most notable are increases in satisfaction with "Quality/Availability of Army family programs" and "Level of educational benefits."

Admiral Robinson's Answer. Between 2000 and 2008, morale has improved substantially among both enlisted and officer personnel. In 2000, 14 percent of enlisted personnel and 27 percent of officers rated command morale as "very high" or "high." In 2008, 31 percent of enlisted personnel and 56 percent of officers rated morale as "very high" or "high." The three factors most affecting positive morale among both officer and enlisted personnel are; quality of shipmates, immediate supervisors, and educational programs. Other factors cited include compensation and health care benefits.

LTG Roudebush's Answer. Morale remains high across the Air Force Medical Service. A significant number of Air Force medical technicians have enlisted since the start of Operations IRAQI/ENDURING FREEDOM. There have been 16,648 new medics from calendar year 2002–2009. Retention remains high, with all enlisted primary Air Force Specialty Code (AFSC) manned at (as of June 2009) greater than 91 percent (107 percent overall). Eleven (of 17) enlisted medical AFSCs currently earn selective reenlistment bonuses, continuing our ability to retain quality, motivated medics. The transition to Air Expeditionary Force (AEF) banding from AEF cycles will continue to provide greater stability and predictability of deployments for the majority of our enlisted forces. Mental health technician) are our sole enlisted AFSC in a 1:2 dwell in AEF Band D and manning is at 95 percent.

Question. What steps have you taken to ensure that families of our service members are adequately cared for during the Global War on Terrorism?

LTG Schoomaker's Answer. In support of the Army Family Covenant, in November 2008, Army Medicine leaders signed the Army Warrior Healthcare Covenant, reaffirming our commitment to provide world-class care to wounded Soldiers and their Families. The covenant pledges sustained care that is commensurate with the sacrifices that Soldiers and Families have made. It provides for first-rate care in a healing environment for recovery, rehabilitation, and reintegration. It is Army Medi-

cine's goal for all of our patients to feel valued, empowered, and comfortable talking with us about any healthcare concerns they and their families face.

As further support of the Army Family Covenant, I have made access to care and beneficiary satisfaction two of Army Medicine's key priorities. We are implementing an aggressive Access to Care Campaign Plan containing eleven focus areas that cover a wide spectrum of access and customer service issues. Among the focus areas are the alignment of treatment facility capacity with the number of enrolled beneficiaries; improving provider availability; and, leveraging technology for efficiencies to include managing clinic appointment schedules.

Admiral Robinson's Answer. DOD and Navy Medicine are committed to providing quality health care for the families of our service members supporting the Global War on Terrorism. Below are examples:

• Patient and Family Centered Care is Navy Medicine's core concept of care. Our collective efforts focus on providing beneficiaries with a quality healthcare experience that integrates the resources of our MTFs and the purchased care system (Managed Care Support Contractors.)

• Navy Medicine Strategic Goals have been refined and aligned with an emphasis placed on meeting or exceeding patient quality expectations while providing convenient access, lasting results, preventive health, and the mitigation of health risk. Additionally, patients are encouraged to be active participants in their healthcare. We recognize the vital importance of the family, military culture, and the chain of command in supporting the families of our service members.

• Each military treatment facility (MTF) and clinic has a health benefits advisor (Beneficiary Counseling and Assistance Coordinator—BCAC) to assist beneficiaries in using their health care benefit by providing accurate and timely information and guidance on how best to use our health care system. There is enhanced coordination with our purchased care system (Managed Care Support Contractors) to ensure continuity of care when medical providers deploy in support of operational requirements.

• Navy Medicine has actively supported and integrated both the Navy Safe Harbor Program and the Marine Wounded Warrior Program to enhance the overall care of our wounded ill and injured.

• Navy Medicine provides support to dependent children through a full spectrum of child and adolescent psychological health services at major CONUS medical centers, as well as overseas hospitals which have exceptional family member programs, such as Okinawa and Yokosuka.

• Navy Medicine leverages the Ombudsman Program to promote healthy and self-reliant families. The Ombudsman serves as a critical information link between command leadership and Navy families. They are trained to disseminate information both up and down the chain of command, including official Department of the Navy and command information, command climate issues, psychological health information, return/reunion/reintegration initiatives, and local quality of life (QOL) improvement opportunities.

LTG Roudebush's Answer. The Air Force Medical Service (AFMS) has a broad range of activities that directly support the Airmen and their families in both the delivery of healthcare as well as quality of life support programs.

To ensure medical care is meeting our beneficiaries' needs, the AFMS has an aggressive Veterans Administration/Department of Defense sharing agreement strategy. These programs capitalize on healthcare services of the Federal Healthcare delivery system ensuring direct support of our families. Sharing agreements are economically beneficial and provide access to services that may not be available in either the Department of Defense or the Veterans Administration as independent entities.

Our Managed Care Support Contract (MCSC) partners ably respond to the challenges of maintaining medical combat readiness while providing the best health care services for our beneficiaries. The MCSC supplements the care available in the direct care system with both network and non-network civilian healthcare professionals, hospitals, pharmacies, and suppliers to provide better access and high-quality service, while maintaining the capability to support military operations. We have leveraged the MCSC to ensure our families are provided timely access to quality care delivery.

The AFMS is undertaking a refinement of the delivery of Primary Care through the Family Health Initiative. Two goals have been established for this program: enhance our delivery of services to our population, and enhance the complexity of the patients seen. The Family Health Initiative utilizes a patient-centered medical home model to provide adequate staffing. This model makes coordination of all a patient's care the primary focus of the team and is lead by a family practice physician with an assigned support staff ready to meet the patient's needs.

Medical Treatment Facilities and assigned staff are an integral part of the Integrated Delivery System and the Community Action Information Board, which actively works programs in support of our families. An ongoing action plan between the Airmen and Family Readiness Centers and the Medical Treatment Facilities allow the community to weave a fabric of programs that are both preventive and supportive to lessen the impacts of deployments and high ops tempo.

Question. What are your medical concerns for the deployment of new soldiers?

LTG Schoomaker's Answer. My major medical concerns for new Soldiers are behavioral health, musculoskeletal, and asthma conditions that exist prior to enlistment. The best data on new Soldiers (recruits) is available from the Accessions Medical Standards and Research Activity, Walter Reed Army Institute of Research. They track the attrition of Service Members for medical and other reasons.

In Fiscal Year 2008 the Army discharged 1,959 Soldiers for conditions that existed prior to service. This was out of 80,517 enlisted accessions including both non-prior and prior service. The number of EPTS discharges by diagnosis include 445 (22.7%) for behavioral health, 510 (26.0%) for musculoskeletal, and 130 (6.6%) for asthma. All other diagnoses totaled 874 (44.6%).

Initial analysis has concluded that the medical accession screening and waiver process is efficient in identifying individuals with potentially disqualifying conditions and determining that waivers can be offered for at least the common conditions without degrading deployment of the affected individuals.

Admiral Robinson's Answer. (Admiral Robinson's assuming re-directed for Sailors and Marines and that "new" refer to new deployments and not the age or rank of the service member):

With respect to mental health:

Social support is a demonstrated protective factor that insulates Sailors and Marines with respect to important deployment outcomes like acute stress response (ASR), Post-Traumatic Stress Disorder (PTSD), and Depression. Unmitigated Operational Stress compounded by multiple combat deployments may play a role in weakening social support at home and in the family. Failed relationships ultimately translate into divorce, isolation from friends and family, and, as a proximate cause, suicidality.

Social support for Navy Individual Augmentees (IAs) is especially worrisome given that IA Sailors often deploy to units where the Sailor has few, if any, established social bonds. Whereas the Sailor might not be "new" to the force, previously inexperienced roles, novel job descriptions, and new unit affiliation contribute to operational stress. Further, IA sailors return to commands where the majority of people have not shared their experience. In particular, a specific type of IA assignment known as a Global Support Assignment (GSA), requires that both the Sailor, and if applicable their family, undergo a deployment in-between two duty stations. Consequently, the GSA Sailor and his or her family lose social bonds with their old duty station and face the challenges of relocation—replete with the re-establishment of new and often unfamiliar support systems. To counter these Individual Augment related concerns, a recently established Command Individual Augment Coordinator (CIAC) position now oversees deployment related readiness, support, and transition for this population of warrior.

While multiple deployments carry with it specific mental health risks, too little combat experience is also a known risk factor for another unique set of mental and physical health risks. Sailors and Marines deploying to Iraq and Afghanistan for the first time, and in particular IA Sailors, require realistic training in order to prepare to enter the combat zone for the first time, a situation that reinforces the maxim of "train like you fight, fight like you train."

With respect to General Medical Health Issues:

Navy Medicine shares with the public the concern that burn-pits in the Areas of Operation may impart unknown health risks to exposed Sailors and Marines. Navy Medicine aggressively supports on-going and continuous health surveillance for exposure related concerns.

LTG Roudebush's Answer. The Air Force is concerned about the medical needs of all of its deploying airmen regardless of level of experience or age. In that regard the Air Force Medical Service conducts pre- and post-deployment screening to assess the health and well being of the force both with new deployers and those who have greater experience. The pre-screening process for deployers is designed to provide all necessary preventive health measures, immunizations as an example, that are required for the area of operations in question. All Airmen, regardless of experience, are afforded multiple opportunities to seek medical and mental health care before, during and after deployment to ensure both their physical and mental well-being.

MENTAL HEALTH

Question. The Committee has great concern about mental health and post-traumatic stress disorder (PTSD) that affect our Military Service members and families. In all of your statements, you state that the Department of Defense has made great progress in this area.

How much is currently being spent on mental health?

Answer. Although, the Defense Health Program does not budget by the type of patient care, it is possible to estimate future expenses based upon historical execution and then add planned funding enhancements. The following table includes the Fiscal Year (FY) 2008 execution and projected expenditures on Mental Health services by the military treatment facilities in the Direct Care System and Private Sector Care (PSC) for all beneficiary categories. It includes estimated enhancements that are a result of the Department's and Congress' emphasis on Psychological Health (PH) initiatives. The Department has made sufficient funding available to meet all established requirements in support of PH.

[In thousands of dollars]

Source of Care	FY 2008 Estimated Costs	FY 2009 Estimated Costs	FY10 Estimated Costs
Direct Care	$658,746	$691,684	$726,268
PSC	541,946	569,043	597,495
PH Enhancements	261,795	392,349	471,793
Total Estimated Mental Health Costs	1,462,487	1,653,076	1,795,556

Notes: Inflation assumed at 5% for both Direct Care and Private Sector Care. Enhancement is from PH funding appropriated in FY 2008 and FY 2009 and added to the baseline in program review.

Question. What types of programs and funding across the Services are there for substance abuse, mental healthcare programs for military and dependents, as well as access to care and outreach programs?

Answer. Behavioral health and substance use disorder treatment are available for Military Service members and their families at military treatment facilities (MTFs) and through the TRICARE network. Care provided at MTFs may vary depending on the size of the facility. In addition, a number of programs have been developed to increase access to care and to provide education and support to Service and Family Members.

Services available at MTFs

Service Members can receive assessment and treatment for a full range of problems or conditions, including mental health and substance use disorders, at MTFs. Family member services at MTFs vary from clinic to clinic based on the number of MTF behavioral health providers. If services are not available at the MTF for family members, they can access services through the TRICARE network. The Department of Defense (DoD) has also partnered with the Department of Health and Human Services in order to increase access to care at MTFs through the assignment of mental health providers who are Commissioned Officers in the United States Public Health Service to MTFs.

Services available through the TRICARE Network

PSYCHOTHERAPY

- TRICARE covers both outpatient and inpatient psychotherapy.
- In addition to individual psychotherapy, TRICARE covers: Group Therapy, Family Therapy, Collateral Visits (a non-treatment visit to gather information and implement treatment goals), Play Therapy (a form of individual psychotherapy used to diagnose and treat children with psychiatric disorders), and Psychological Testing (when provided in conjunction with otherwise covered psychotherapy).

ACUTE INPATIENT PSYCHIATRIC AND RESIDENTIAL TREATMENT CARE

- Acute inpatient psychiatric care may be covered on an emergency or non-emergency basis.
- Residential treatment center care provides extended care for children and adolescents with psychological disorders that require continued treatment in a therapeutic environment.

INPATIENT SUBSTANCE USE DISORDER REHABILITATION

• An inpatient rehabilitation center is a facility that provides medically monitored, 24 hours per day, seven days per week, interdisciplinary, addiction-focused treatment to adolescents and/or adults who have psychoactive substance use disorders.

PARTIAL HOSPITALIZATION

• Partial hospitalization provides interdisciplinary therapeutic services at least three hours per day in any combination of day, evening, night, and weekend treatment programs. These services are available for individuals with both mental health disorders and substance use disorders.

Access to care in the TRICARE network:

To ensure that family members can access mental health without barriers, TRICARE allows eight outpatient visits for family member beneficiaries with no preauthorization or referral required each fiscal year for mental health treatment. A family member beneficiary can self refer for these first eight outpatient mental health visits. Beneficiaries may receive psychological testing and medication management visits at the same time that are not counted against the eight unmanaged visits. Additional treatment beyond eight sessions may be authorized if needed.

Prevention/Outreach

In addition, a number of programs have been developed by the DoD and the Services that provide education, support, and out reach to Service members and their families. These include:

• afterdeployment.org at *http://www.afterdeployment.org/*. This comprehensive web resource, developed under the direction of the DoD, deploys state-of-the-art Internet-based education, assessment, skill-building and treatment tools that can be used by Service members alone; used in conjunction with primary care manager support; or used in conjunction with mental health care providers. Users have access to online assessments, learning tools, and proven self-help strategies to help participants understand their adjustment concerns and engage in self-initiated help for their behavioral health problems, including symptoms related to post-traumatic stress. The site is designed to attract and serve Reserve, National Guard, and Active Duty Service members and their family members who have not yet sought medical care and are not receiving treatment, though it is expected that the resources offered at the site will be extremely useful to those persons who are already in treatment. Problem-focused programs (sleep, anger, depression, stress, etc.) are tailored to meet the needs of Service members and their families.

The Mental Health Self-Assessment Program (MHSAP) at *https://www.militarymentalhealth.org/welcome.asp*. MHSAP is a voluntary, anonymous mental health and alcohol screening and referral program offered to families and Service members affected by deployment or mobilization. It is offered online 24/7, as well as through in-person events. The MHSAP is funded by the DoD's Office of Health Affairs.

Family Assessment for Maintaining Excellence Initiative. This pilot project provides voluntary, mental wellness and healthy relationship assessment for Active Duty Service members and their spouses. There are six components of the program: awareness, education, screening, evaluation, follow up, and public awareness.

Fleet and Family Support Centers/Marine Corps Community Service Centers/Health and Wellness Centers on Bases (and other similar services). Provide stress and anger management classes, mental health assessment, individual and group counseling, family counseling and other related services. These all provide opportunities for Service members and their families to uncover stress-related symptoms, speak with mental health professionals about those symptoms, and seek/receive guidance on means to obtain.

MilitaryOneSource at *http://www.militaryonesource.com/*. In addition to offering 24/7 information and resources, Military OneSource can provide a referral to in-person counseling. When there is a need, a consultant can refer a Service member or eligible family member to a licensed professional counselor in the local community for face-to-face counseling sessions at no cost to the Service member or their family members. The benefit addresses short-term concerns only and is limited to twelve sessions per identified issue. It is not designed to address long-term issues such as child and spouse abuse, suicidal ideation, and mental illness. Individuals in need of long-term treatment are referred to a military treatment facility and/or TRICARE for services. The fact that clients see the Military OneSource provider for 12 sessions does not impact the beneficiary's ability to access mental health treatment under TRICARE.

Question. Admiral, the Navy has established 13 Deployment Health Clinics to facilitate health assessments for post-deployment physical and mental health concerns. Can you give the Committee a brief update as to what you are seeing at those clinics?

Answer. Navy Medicine increased the number of Deployment Health Centers (DHCs) to 17 during Fiscal Year 2008 to expand the capacity for easily accessible non-stigmatizing deployment related healthcare. With a multidisciplinary staff of primary care and mental health providers, the DHCs complement services that are offered in the military treatment facility or in garrison at the unit level. Since inception, the DHCs have accomplished over 150,000 patient encounters. Approximately 50% of the visits were for deployment health assessments and individual medical readiness requirements. Psychological healthcare accounted for nearly 25% of the encounters, while another 25% were for various deployment related health concerns.

Question. With the establishment of second mental health assessments for soldiers, specifically the Reserve Components returning from theater, who will be performing this type of work? How will the non-military doctors and nurses performing these assessments be financially compensated?

Answer. The Department of Defense manages a Reserve Health Readiness Program contract to provide the Post-Deployment Health Reassessment (PDHRA) to the Reserve Component Service members who have returned from a deployment. A mental health assessment is a significant portion of the PDHRA. The non-military physicians and nurses performing the PDHRA under this contract are paid with appropriated funds through this contract.

Question. How much funding is included in the Fiscal Year (FY) 2010 budget submission for psychological health (PH) and traumatic brain injury (TBI)?

Answer. In FY 2010, the Defense Health Program (DHP) baselined additional Operation and Maintenance funding for TBI/PH initiatives. Funding added for PH is $472 million and $178 million for TBI. This includes all funding for all components, including the Defense Centers of Excellence, to pay for all initiatives and programs.

DEVELOPMENT AND MANUFACTURING OF BIOLOGICAL COUNTERMEASURES

Question. The need for the Nation to be prepared for chemical, biological, radiological, and nuclear attacks has been clear for decades. Based on the unmet needs for biologic production capability, the Defense Advanced Research Projects Agency has been studying the requirements necessary for a dedicated capability.

What is the role of the Defense Health Program (DHP) in helping to assess threats with respect to chemical, biological, radiological, and nuclear attacks?

Answer. Chemical, biological, radiological, and nuclear (CBRN) threat assessments are performed and validated by the Joint Staff, the Services, and the Intelligence community. The DHP does not have a direct role in performing CBRN threat assessments, but provides assistance in two ways. The DHP provides subject matter expertise (when requested) to help the Joint Staff, Services, and Intelligence community assess health impacts of CBRN threats. The DHP (through funding) and the Services are responsible for operating the United States' military medical treatment facilities (MTFs) throughout the world. These MTFs are required to be familiar with potential CBRN threats in their areas and prepare for them through training and exercises.

Question. What is the relationship between the Defense Health Program (DHP) and the Defense Advanced Research Projects Agency (DARPA) to address unmet needs for biologic production capability?

Answer. DARPA and DHP medical research and development programs are coordinated so that the DHP can leverage DARPA's basic research for subsequent transition to applied research and advanced development. DARPA is also a principal member of the Armed Services Biomedical Research Evaluation and Management Committee that is co-chaired by the Assistant Secretary of Defense for Health Affairs.

Over the past 16 years, the Department of Defense (DoD) has evaluated perceived gaps in DoD biodefense and vaccine production facilities. In more recent years, the Department of Health and Human Services (HHS) and DoD have contracted with emerging biotechnology innovators and contract manufacturers for successful advanced development and manufacturing of a number of biodefense medical countermeasures. Existing contractors are capable of delivering required products and many are investing heavily in production facilities in the United States, which increases capacity and further addresses perceived capability gaps. A 2007 survey of the biopharmaceutical contractor manufacturing industry indicates that installed processing capacity increased by 14% since 2006 and the trend is expected to continue for the next few years ("Biopharmaceutical Contract Manufacturing: Recent Industry Growth," S. Wheelwright, American Pharmaceutical Outsourcing).

The DARPA effort to evaluate the need for a dedicated manufacturing capability was completed in 2008. In July 2008, in response to the DARPA study, the Special Assistant to the President for Biodefense and Senior Director for Biodefense at the

Homeland Security Council requested that HHS and DoD conduct an analysis of alternatives (AoA) "to identify the optimal facilities and operating model for addressing the gap in production and manufacturing of medical countermeasures against weapons of mass destruction threats in a manner that provides the best long-term value to the United States Government." The independent AoA focuses on the advanced development, Food and Drug Administration approval, and sustainment phases for biodefense countermeasures. The DARPA recommendation is only one possible long-term alternative being assessed by DoD and HHS.

Question. What is the current situation with the Department's mission to protect military personnel against biological weapons?

Answer. The Department of Defense (DoD), through the Joint Project Manager Chemical Biological Medical Systems (CBMS) of the Joint Program Executive Office for Chemical and Biological Defense, is procuring anthrax vaccine, smallpox vaccine, and vaccinia immune globulin (treats rare but serious adverse events associated with smallpox vaccine). CBMS is also developing a plague vaccine and a botulinum toxin vaccine, both in Phase 2 clinical trials. In Fiscal Year 2010, CBMS will initiate advanced development efforts on a filovirus vaccine to protect against weaponized Ebola and Marburg viruses. Additionally, DoD has fielded the Joint Biological Agent Identification and Diagnostic System (JBAIDS) worldwide and to all Services. The JBAIDS is a deployable laboratory analytical system that provides rapid and highly accurate identification of ten different biological threat agents in clinical, food, and environmental samples.

Question. What is the current assessment of the threat of biological weapons?

Answer. The threats from chemical, biological, radiological, and nuclear attacks are validated and compiled in a classified report, which is subsequently released by the Chairman of the Joint Chiefs of Staff. Agents relevant to a specific geographic area of responsibility that are identified in the Joint Chiefs of Staff (JCS) classified threat list are available from the Defense Intelligence Agency. However, there are many other Department of Defense organizations involved in evaluating biological agent threats to United States Forces and military installations.

Question. How many countermeasure vaccines have been produced?

Answer. The Joint Project Manager Chemical Biological Medical Systems of the Joint Program Executive Office for Chemical and Biological Defense is obtaining Food and Drug Administration approval of the anthrax vaccine, smallpox vaccine, and vaccinia immune globulin (treats rare but serious adverse events associated with smallpox vaccine).

Question. What is the current manufacturing capability for biodefense countermeasures?

Answer. The 2007 survey of the biopharmaceutical contract manufacturing industry, ("Biopharmaceutical Contract Manufacturing: Recent Industry Growth", S. Wheelwright, American Pharmaceutical Outsourcing, May 2008, p. 16) indicates that installed processing capacity increased by 14 percent since 2006, and the trend is expected to continue for the next few years. Another recent industry survey found that over the next five years, contract manufacturing organizational capacity for biopharmaceutical products is expected to expand by 91 percent for cell culture and 33 percent for microbial fermentation ("Very Large Scale Monoclonal Antibody Purification: The Case for Conventional Unit Operations," B. Kelley, Biotechnology Progress 23 (5): 995–1008, 2008). From these recent studies, pharmaceutical contract manufacturing organizations are projected to expand capacity more than the integrated biotechnology industry. Capacity has transitioned from a period of relative undersupply to one of moderate oversupply. Based on this assessment, there is ample capacity to manufacture biodefense medical countermeasures.

The greater challenge remains the discovery and development of biodefense medical countermeasures, to include demonstrating their effectiveness in representative model systems so that manufacturers can obtain approval from the Food and Drug Administration (FDA). The FDA ruling titled, "New Drug and Biological Products; Evidence Needed to Demonstrate Effectiveness of New Drugs When Human Efficacy Studies Are Not Ethical or Feasible," commonly referred to as the "Animal Efficacy Rule," amended the FDA's drug and biologic regulations to "allow appropriate studies in animals in certain cases to provide substantial evidence of effectiveness of new drug and biological products used to reduce or prevent the toxicity of chemical, biological, radiological, and nuclear substances." Although given relatively little attention since it was promulgated, the Animal Efficacy Rule creates a new regulatory paradigm for measuring efficacy by permitting FDA to approve drugs and biologics for counterterrorism uses based on animal data when it is unethical or unfeasible to conduct human efficacy studies.

Question. To what extent is this a problem with advanced development and manufacturing?

Answer. The Department of Defense (DoD) has not encountered problems securing the capability or capacity to develop and manufacture vaccines from established contractors. In fact, recent industry studies and market research have identified excess industry capacity available for advanced development and manufacture of these types of products. The Joint Project Manager Chemical Biological Medical Systems of the Joint Program Executive Office for Chemical and Biological Defense has received significant interest from the pharmaceutical industry (including large companies) for future development efforts.

The greater challenge remains the discovery and development of biodefense medical countermeasures, to include demonstrating their effectiveness in representative model systems so that manufacturers can obtain approval from the Food and Drug Administration (FDA). The FDA ruling titled, "New Drug and Biological Products; Evidence Needed to Demonstrate Effectiveness of New Drugs When Human Efficacy Studies Are Not Ethical or Feasible," commonly referred to as the "Animal Efficacy Rule," amended the FDA's drug and biologic regulations to "allow appropriate studies in animals in certain cases to provide substantial evidence of effectiveness of new drug and biological products used to reduce or prevent the toxicity of chemical, biological, radiological, and nuclear substances." Although given relatively little attention since it was promulgated, the Animal Efficacy Rule creates a new regulatory paradigm for measuring efficacy by permitting FDA to approve drugs and biologics for counterterrorism uses based on animal data when it is unethical or unfeasible to conduct human efficacy studies.

Question. Has the Department involved academic institutions and industry to help expand its capabilities?

Answer. Recent industry studies and market research have identified an excess of industry capacity available for advanced manufacturing process development and manufacture of medical countermeasures. The Department of Defense (DoD) has received significant interest from academia and the pharmaceutical industry to participate in future development efforts, including interest from large pharmaceutical companies. In recent years, the Department of Health and Human Services (HHS) and DoD have contracted with emerging commercial biotechnology innovators and contract manufacturers for successful advanced manufacturing process development for the manufacturing of biodefense medical countermeasures. Existing contractors are capable of delivering required products and many are investing heavily in production facilities in the United States, which has the potential to increase capacity and further address perceived capability gaps. In addition, DoD broad agency announcements have resulted in numerous contract and grant awards to academic institutions. DoD also participates in the HHS venues targeted at academia and industry, such as the upcoming Chemical, Biological, Radiological, and Nuclear Medical Countermeasures Workshop for 2009.

Question. How much has been spent to date on biodefense countermeasures?

Answer. Between program inception in Fiscal Year 1997 and May 2009, the Department of Defense has spent $968 million on Research, Development, Test and Evaluation (advanced development funding) and $546 million on procurement of biodefense vaccines and diagnostics. This does not include science and technology efforts and procurement of biodefense therapeutic medical countermeasures such as ciprofloxacin, doxycycline, and non-medical biodefense countermeasures not managed by the Joint Project Manager Chemical Biological Medical Systems of the Joint Program Executive Office for Chemical and Biological Defense.

Question. What is the biodefense surge capability if we receive a threat? Attack?

Answer. The Department of Defense currently maintains stockpiles of licensed vaccines to support full force protection. Advanced development vaccine programs of the Chemical Biological Medical Systems of the Joint Program Executive Office for Chemical and Biological Defense are designed to support full force requirements. Many existing manufacturers are not working at full capacity and in the event of an emergency; the Defense Production Act could be used to issue contracts with the "highest national urgency" designation for the expansion of production capabilities for critical security needs.

Question. How has other legislation such as Bioshield affected the fielding of such biological countermeasures? Is legislation without a funding mechanism a hindrance more than a help?

Answer. While Bioshield funding does not support the Department of Defense (DoD) procurement requirements, it does support the procurement of biodefense medical countermeasures for the Strategic National Stockpile (SNS). DoD and the Department of Health and Human Services are collaborating through the SNS to ensure civilian and military requirements are met and to reduce government costs.

Legislation without a funding mechanism is a hindrance because it causes us to take funding from existing programs to cover new efforts.

CENTERS OF EXCELLENCE

Question. These centers are nationally recognized and have enabled military medicine to be in the forefront in the advancement of modern medical care. The Congress directed that funds for operation be included in the Fiscal Year (FY) 2010 submission.

How much money is included for the operation of each of these Centers of Excellence in the FY 2010 President's Request?

Answer. The table below identifies the amount of funding requested for the Centers of Excellence Congress directed to be included in the FY 2010 submission:

Program	FY 2010 Funding (millions)
Breast Cancer Center	$5.310
Gynecological Cancer Center	4.820
Integrative Cardiac Health	3.380
Pain and Neuroscience	4.000
Integrated Translational Prostate	3.490
Total	21.000

Question. Why is the amount in the 2010 budget less than last year's amount?

Answer. The five Centers of Excellence are resourced at the Fiscal Year (FY) 2010 levels based upon the availability of funds within the Defense Health Program. A review of the Centers of Excellence will be conducted during FY 2010 to assess the mission of the Centers and the type and amount of funding to accomplish that mission. The assessment will also consider the capability of the Centers of Excellence mission to support translational biomedical/clinical research.

Question. Which of the five Centers of Excellence (Breast Care, Gynecological, Prostate, Integrated Cardiac Health, Pain, and Neuroscience) named in the 2009 appropriations report are included in the design of the new Walter Reed National Medical Center?

Answer. All five Centers of Excellence are currently included in the design of the new Walter Reed National Medical Center.

Question. How much space is included in this design?

Answer. The amount of space planned for each of the centers in the Defense Centers of Excellence (DCoE) is as follows:

CoE	Space (sq. ft.)
Breast Care	7,100
Gynecological	4,520
Prostate	7,000
Integrated Cardiac Health	8,141
Neuroscience:	
Chronic Pain	5,777
Acute Pain	1,803
ARAPMI *	TBD
	~34,341 sq. ft.

*Army Regional Anesthesia and Pain Management Initiative.

Question. How does the amount of space planned compare with that currently available at Walter Reed Army Medical Center (WRAMC)?

Answer. The following table depicts the amount of planned space at Walter Reed National Naval Medical Center (WRNNMC) compared with currently available space at WRAMC:

Centers of Excellence	~Current Space WRAMC (sq. ft.)	Planned Space WRNNMC (sq. ft.)	Difference (sq. ft.)
Breast Care	3,209	7,100	+3,891
Gynecological	5,578	4,520	−1,058
Prostate	8,619	7,000	−1,619
Integrated Cardiac Health	9,569	8,141	−1,429

Centers of Excellence	~Current Space WRAMC (sq. ft.)	Planned Space WRNNMC (sq. ft.)	Difference (sq. ft.)
Neuroscience:			
Chronic	2,750	5,777	+3,027
Acute	620	1,803	+1,183
ARAPMI *	4,000	TBD	TBD

*Army Regional Anesthesia and Pain Management Initiative.

Question. Why is the amount of space less than is currently provided?

Answer. The Breast Care and Pain Centers of Excellence actually gain space. The small reduction in space provided for Gynecological/Oncology, Prostate, and Integrated Cardiac Health Centers of Excellence is due to three primary factors:

1. There is more effective use of shared spaces in the new design. Support spaces including clean utility, soiled utility, waiting, staff lounges, and other support functions are shared across departments where practical thus reducing the total area required for each department.

2. The corridors in the new outpatient building (Building A) are sized to business occupancy standards (5'0") versus many of the existing healthcare occupancy corridors (8'0"), as appropriate. This significantly reduces the gross area required by each department.

3. Third, the new design is custom sized for individual room requirements whereas, in the existing Centers of Excellence, individual components were laid into available rooms which met and/or often exceeded the actual requirement. For example, there are offices and exam rooms in former patient bedrooms which are much larger than required for the office and exam functions. The physical layout provides rooms that are designed specifically for their individual function and closely follow Department of Defense Space Planning Guidelines for each space.

MEDICAL SCHOLARSHIPS

Question. This situation continued in 2007 with roughly the same number of scholarships available and the same number and percentages awarded. In 2008, the Department of Defense instituted a Critical Skills Accession Bonus (CSAB). As a result, the Department was able to fill virtually all the available scholarships.

Please provide a brief description of the CSAB program for each Service.

Answer. This CSAB provides a one time $20,000 bonus for Health Professions Scholarship Professions students when accessed into the military (at the beginning of medical or dental school). The Air Force uses the program for medical students, while the Army and Navy use it for both medical and dental students. Section 663 of the National Defense Authorization Act for Fiscal Year 2008 (Public Law 110–181), provides the authority for the accession bonus.

Question. What are the reasons that the Services had to resort to providing a bonus in addition to a scholarship to attract medical personnel?

Answer. The Army and the Navy were not filling their Health Profession Scholarship Program positions. The Air Force filled their positions but had fewer applicants. Some of the possible reasons are:

- A decline in pool of male medical school students (higher mix of females with less propensity to serve).
- Perceptions of Operation Iraqi Freedom/Operation Enduring Freedom negatively affecting interest in serving in the Military.
- A 2004 study by the Association of American Medical Colleges reported that 60% of medical students' families are in the top 20% of incomes,[1] suggesting these medical students are less in need of a scholarship.

Question. Why did the Navy decrease the number of available scholarships from 300 in previous years to 225 in fiscal year 2008?

Answer. In early 2007, when the fiscal year 2008 Medical Corps Health Professions Scholarship Program (HPSP) accession goal was established, Navy was configuring our physician pipeline to meet end strength reductions associated with planned military to civilian conversions.

Question. How many scholarships is the Navy awarding in 2009 and how many are proposed in this fiscal year 2010 budget?

Answer. Navy is awarding 245 Health Professions Scholarship Program (HPSP) scholarships plus 25 Health Sciences Collegiate Program (HSCP) scholarships in

[1] Jolly, P. Medical School Tuition and Young Physician Indebtedness. AAMC 2004.

2009. HPSP and HSCP scholarship goals for FY2010 have not yet been approved by the Chief of Naval Personnel.

Question. Why did the Army increase the number of medical scholarships in fiscal year 2008 from approximately 300 in previous years to 360?

Answer. The Army increased the number of medical scholarships in fiscal year 2008 from approximately 300 in the previous year to 360 in fiscal year 2008 in order to make up for shortfalls resulting from missed missions for medical scholarships for the previous 3 years (2005–2007).

Question. How many medical scholarships is the Army awarding in 2009 and how many are proposed in the fiscal year 2010 budget?

Answer. We are projecting to fill 100% (365) of scholarships for 2009 and we have provided United States Army Recruiting Command with a mission to recruit for 300 scholarships in fiscal year 2010.

Question. Are the Services having any problems meeting the Department's medical manning requirements?

Answer. The most recent Health Manpower Personnel Data System Report shows:

CLOSE-OUT DATA BY CORPS—FISCAL YEAR 2008

Corps	Auth	Fills	% Filled	Diff
Medical	11,487	11,530	100.37	43
Dental	3,109	2,851	91.70	−258
Nurse	9,732	9,438	96.98	−294
Med Svc	7,870	7,730	98.22	−140
Army Spec	1,177	1,299	110.37	122
Bio Science	2,345	2,182	93.05	−163
Vet	427	445	104.22	18
Total	36,147	35,475	98.14	−672

SHORTAGES

Corps and Specialty	Auth	Fills	% Filled	Diff
Medical:				
CardioThoracic	45	37	82.22	−8
Family Med	1,217	1,159	95.23	−58
Gastro	70	60	85.71	−10
Gen Surgeon	412	403	97.82	−9
Neurosurgeon	40	35	87.50	−5
Psychiatry	319	308	96.55	−11
Urology	87	86	98.85	−1
Dental:				
Comprehensive	551	532	96.55	−19
Endodontics	113	111	98.23	−2
General Dentistry	1,343	1,106	82.35	−237
Orthodontics	72	69	95.83	−3
Nurse:				
Critical Care	1,182	1,052	89.00	−130
Family Nurse Practitioner	194	152	78.35	−42
General Nursing	1,283	591	46.06	−692
Mental Health	47	45	95.74	−2
Neonatal ICU	95	72	75.79	−23
CRN Anesthesia	624	514	82.37	−110
Nurse Mid-Wife	84	81	96.43	−3
Operating Room	63	59	93.65	−4
Pediatric Nurse Practitioner	63	59	93.65	−4
Other:				
Pharmacist	526	472	89.73	−54
Physician's Assistant	1,276	1,248	97.81	−28
Psychologist	630	548	86.98	−82
Podiatrist	65	58	89.23	−7

LUNG CANCER RESEARCH

Question. The Committee directed the Army to provide a plan on the uses of these funds 120 days after enactment and to include Walter Reed in the formulation of this plan.

Please provide a detailed description of the Department of Defense's (DoD's) plans to obligate this funding in compliance with congressional direction.

Answer. The Congressionally Directed Medical Research Program (CDMRP) uses a flexible execution and management cycle from receipt of appropriations through oversight of research grants. The first major milestone of the Peer-Reviewed Lung Cancer Research Program (LCRP) was the stakeholders meeting on February 22–23, 2009. Renowned scientists and clinicians from academia, Walter Reed Army Medical Center, and the United States Military Cancer Institute, as well as six lung cancer survivors and advocates participated to discuss issues and gaps critical to the identification, treatment, and management of early lung cancer and the establishment of a tissue bank. Participants identified nine gaps and five advancement opportunities for establishing a tissue bank, 19 gaps and six advancement opportunities for early identification of early lung cancer, and 10 gaps and 15 advancement opportunities for treatment and management of early lung cancer, all of which aligned with the congressional direction.

Utilizing the recommendations from the stakeholders, an Integration Panel of 11 experts in the lung cancer field from academia, DoD, and five disease survivors and advocates determined the program priorities and an investment strategy for the Fiscal Year (FY) 2009 LCRP. The following seven areas of emphasis were developed, and research submitted to the FY 2009 LCRP must address at least one of the areas:

1. Identification or development of non-invasive or minimally invasive tools to improve the detection of the initial stages of lung cancer.
2. Identification and development of tools for screening or early detection of lung cancer.
3. Understanding the molecular mechanisms that lead to clinically significant lung cancer.
4. Identification of the mechanisms that lead to the development of the various types of lung cancer.
5. Identification of innovative strategies for prevention and treatment.
6. Understanding predictive and prognostic markers to identify responders and non-responders for early lung cancer.
7. Understanding acquired resistance to treatment.

Five award mechanisms for funding competitive research and the establishment of a tissue bank were identified:

1. Lung Cancer Bio-specimen Resource Network Award provides support for the development of a lung cancer bio-repository resource consortium.
2. Collaborative Translational Research Award supports multi-institutional, multidisciplinary collaborations among clinicians and laboratory scientists.
3. Concept Award—supports the exploration of a highly innovative new concept or untested theory that addresses at least one of the FY 2009 areas of emphasis.
4. Lung Cancer Promising Clinician Research Award supports a research project performed by promising physician-researchers.
5. LCRP Clinical Fellow Research Award supports a research project performed by clinical fellows under the guidance of a mentored designated mentor with an established lung cancer research program.

Question. Why hasn't the committee received a copy of this plan since it has been almost eight months since enactment of the Fiscal Year 2009 bill?

Answer. Unfortunately, in an effort to ensure coordination with all interested parties, the process took far longer than anticipated. The United States Army Medical Research and Materiel Command prepared the required plan and report near the beginning of the calendar year and we began the coordination process on January 22, 2009. At this time, the coordination and revisions requested by the coordinating office are nearly complete, and the report will be signed out within two weeks.

Question. Will the report include an early detection and screening pilot program for our high risk military population?

Answer. Currently, the Fiscal Year (FY) 2009 Lung Cancer Research Program does not have a specific award mechanism for a detection and screening pilot program for a high risk military population. However, each of the five award mechanisms for FY 2009 requires that the research address one or more of the areas of emphasis, which include:

1. Identification or development of non-invasive or minimally invasive tools to improve the detection of the initial stages of lung cancer;

2. Identification and development of tools for screening or early detection of lung cancer. Screening may include, but is not limited to, computed tomography scans, radiographs, other imaging, biomarkers, genetics/genomics/proteomics, and assessment of risk factors;
3. Understanding the molecular mechanisms that lead to clinically significant lung cancer;
4. Identification of the mechanisms that lead to the development of the various types of lung cancer;
5. Identification of innovative strategies for prevention and treatment;
6. Understanding predictive and prognostic markers to identify responders and non-responders for early lung cancer; and,
7. Understanding acquired resistance to treatment.

These areas of emphasis are aligned with the Congressional language from the September 28, 2009 report which states, "The bill includes $20,000,000 for lung cancer research. Lung Cancer is the most lethal of all cancers taking more lives each year than all the other major cancers combined. Furthermore, the five-year survival rate for lung cancer remains at 15 percent, and a major challenge is that 70 percent of the diagnoses are late stage. Military personnel have heightened exposure to lung cancer carcinogens. These funds shall be for competitive research and the establishment of a tissue bank. Priority shall be given to the development of the integrated components to identify, treat, and manage early curable lung cancer. The Army is expected to provide a plan for these funds and to include Walter Reed Army Medical Center in the formulation of this plan. The plan shall be submitted to the congressional defense committees 120 days after enactment of this Act."

This language does not specify funding an early detection and screening pilot program for our high risk military population; however, the areas of emphasis in our award mechanisms encourage the submission of such an early detection and screening pilot program for our high risk military population.

Question. If not, why not?

Answer. The Congressional language from the September 28, 2009 report does not specify funding an early detection and screening pilot program for our high risk military population; however, the areas of emphasis in our award mechanisms encourage the submission of an early detection and screening pilot program for our high risk military population.

MILITARY HEALTHCARE FACILITIES

Question. As you assess the military medical programs and services and adapt to the changing needs of military members and their families:

What are your impressions of the quality of DoD medical facilities and the TRICARE services provided in those facilities?

Answer. The geographic range of JTF CAPMED's Joint Operation Area (JOA) stretches as far north as New Jersey, skirts West Virginia and extends south into Virginia. It includes 37 medical treatment faculties (MTFs), including the new Walter Reed Military Medical Center (WRNMMC) and Fort Belvoir Community Hospital (FBCH).

Although a formal comprehensive assessment of the medical facilities in the JOA has not been undertaken, MTF physical condition appears to range from "fair" to "excellent". Each Service currently manages the repair, maintenance and operations of their facilities separately. Although the model for providing sustainment, restoration and modernization (SRM) funding is the same across the MHS, how it is applied varies somewhat between the Services, yielding varied condition levels. SRM funding models adopted by DoD in the last decade are based upon continued maintenance of facilities beginning in "like new" condition. Historic underfunding of facility repair and maintenance before the new models were adopted resulted in accelerated deterioration of many building systems. Although it will take time to accomplish, a goal of JTF CAPMED is to assure proper resourcing in facilities accounts to result in consistency in quality, safety, access and appearance in all of the facilities in the JOA.

For the most part these MTFs lay outside the TRICARE access standards for referral care (60 miles or 60 minutes drive time). Generally patients from these MTFs are not referred to the larger MTFs in or near the DC beltway. The Army and Navy manage these MTFs and their scopes of practice and the services offered are determined by them. The scope of care and services offered are limited to primary & acute care in support of active duty and their family members and occupational health services as required for the civilian work force. The TRICARE Management Activity and the TRICARE Regional Office, North together with the TRICARE managed care support contractor, Health Net, provide a good network of civilian pro-

viders for the military beneficiaries in these areas more removed from Washington, DC, when they need specialty care services beyond the capabilities of these MTFs.

Question. In your written statement you reference the important activities that are underway at all facilities affected by BRAC. Can you touch upon the activities currently going on in the National Capitol Area?

Answer. There are a multitude of important activities currently underway at the medical treatment facilities (MTFs) affected by BRAC in the National Capital Region (NCR). Notwithstanding construction and renovation, the Department's primary effort has been focused on integrating military healthcare delivery in the NCR. To this end, JTF CAPMED has been coordinating with the NCR medical components of the Army, Navy, and Air Force to integrate processes and ensure the best utilization of resources available which will eliminate redundancies, enhance clinical care, promote health professions education and joint training, and enhance military medical research opportunities. Some examples include developing a joint manning document for the new Walter Reed National Military Medical Center (WRNMMC) and Fort Belvoir Community Hospital (FBCH), designing warrior transition services for wounded warriors while maintaining the command and control equities that the Services see as essential, and standardizing surgical care operations so that surgeons and patients can more easily receive care closer to home in any of the MTFs with operating rooms.

Question. What investments has the Department made in the infrastructure of the military health system?

Answer. The BRAC recommendation to realign Walter Reed Army Medical Center (WRAMC), coupled with warrior care enhancements directed by the Department, will fundamentally change the landscape of health care in the National Capital Region. The Department is expanding and renovating the National Naval Medical Center (NNMC) to create the Walter Reed National Military Medical Center (WRNMMC), and replacing the DeWitt Army Community Hospital (DACH) at Fort Belvoir, VA, with Fort Belvoir Community Hospital (FBCH). This $2.4B total investment represents the single largest integrated investment in resources into medical facilities in the history of the Military Health System. However, even while the construction projects funded by this program are underway, Operation & Maintenance funding continues to be leveraged at all three locations, to ensure continued safe operations, until all construction is completed and the legacy facilities have closed and gone through the disposition process.

Question. What investments are currently needed?

Answer. Successful culmination of the National Capital Region (NCR) Medical BRAC effort will not represent the end of capital investment in medical infrastructure at the new Walter Reed National Military Medical Center (WRNMMC) and Fort Bevloir Community Hospital (FBCH). BRAC funding added healthcare capability to accommodate the redistribution of the Walter Reed Army Medical Center (WRAMC) workload and capabilities through new construction, additions, and renovations, in order to meet the mandates of BRAC recommendations. However, portions of the medical infrastructure and the supporting installations at Bethesda and Fort Belvoir still require funding to upgrade and repair. Both Services maintain project requirements listings, and JTF CAPMED is working with both the Army and Navy to prioritize such projects for funding. Additionally, in order to properly guide future investments in these facilities to support the strategic mission of the WRNMMC, the FBCH and the entire JTF CAPMED inventory, JTF CAPMED has begun the development of long range strategic and capital investment master plans.

JOINT TASK FORCE–NATIONAL CAPITAL REGION

Question. On 12 September 2007 the Deputy Secretary of Defense issued a memorandum establishing the Joint Task Force–National Capital Region (JTF CapMed). The purpose of the organization was to ensure the effective and efficient delivery of world-class military health care within the National Capital Region Tricare Subregion by utilizing all military health care resources. The memorandum tasked you to report to the Under Secretary of Personnel and Readiness, David Chu.

Given that Mr. Chu is no longer at the Defense Department, who do you report to now and is this memorandum still in effect?

Answer. While the Under Secretary of Defense for Personnel and Readiness (USD(P&R)) and the Vice Chairman, Joint Staff were directed to oversee the initial establishment efforts of JTF CAPMED, JTF CAPMED's establishment charter explicitly defines a direct reporting relationship to the SECDEF through DEPSECDEF. JTF CAPMED is currently working with the Department to formulate an ultimate governance alignment that will recognize both the joint command

and control equities and the policy formulation and fund flow equities of the Assistant Secretary of Defense for Health Affairs (ASD(HA)).

Commander, JTF CAPMED also coordinates key decisions and issue status through an Overarching Integrated Process Team for the Transition of Medical Activities in the National Capital Region (NCR OIPT) as necessary. The NCR OIPT is co-chaired by ASD(HA) and Deputy Under Secretary of Defense for Installations and Environment (DUSD(I&E)). In addition, each Service's Vice Chiefs of Staff sit on the NCR OIPT as do the Assistant Secretaries for Installations and Manpower and Reserve Affairs.

Question. Why didn't the reporting chain have you reporting to the Assistant Secretary of Defense, Health Affairs, isn't this unusual?

Answer. It would be unusual for JTF CAPMED to report to the Assistant Secretary of Defense, Health Affairs (ASD(HA)), as JTF CAPMED has been chartered with command authority. If the Department had established a formal reporting relationship between JTF CAPMED and the ASD(HA) it would have been structured with the control, direction and authority typical of an agency or activity, not that of an entity with command and control authority. The ASD(HA) retains the same policy, oversight and funding authorities that are typically exercised in relation to the Service Medical Departments.

Question. Exactly what is the relationship between the Service Surgeons General and your organization?

Answer. JTF CAPMED maintains a collaborative relationship with the three Service Surgeons General (SGs), but primarily works though each Service's medical component commander (via tactical control relationships) for the National Capital Region (NCR) Joint Operating Area (JOA) to carry out its mission. JTF CAPMED also participates in the Assistant Secretary of Defense for Health Affairs Senior Military Medical Advisory Council, which includes the 3 SGs.

JTF CAPMED has tactical control over Service medical treatment facilities and personnel in the NCR JOA, while Services retain operational control. However, not later than 15 September 2011, the Department has directed that JTF CAPMED take operational control of the new Walter Reed National Military Medical Center (WRNMMC) and Fort Belvoir Community Hospital (FBCH).

Question. The Army has a Major General at Walter Reed Army Medical Center assigned as the Commander, North Atlantic Medical Region (NAMR). Isn't she responsible for all TRICARE activities in the National Capital Region (NCR) as well as the operations of Walter Reed Army Medical Center and the Fort Belvoir community hospital?

Answer. TRICARE Regional Office—North (TRO–N), which covers the National Capital Region (NCR), is one of three regional offices that manages regional contract support to military healthcare providers in the U.S.-based TRICARE regions. Each TRO is responsible for, among other things, management of the TRICARE contracts for all eligible Military Health System (MHS) beneficiaries in the region, the provision of support to the military medical treatment facility (MTF) Commanders in their delivery of health care services for MTF-enrolled beneficiaries and funding of regional initiatives to optimize and improve the delivery of health care.

The commander of Army North Atlantic Regional Medical Command (NARMC) is responsible for all Army medical units and their activities in the NCR, as well as some outside of the NCR. Commander NARMC acts as the component commander within JTF CAPMED only for Army medical forces within the NCR.

Currently, the Commander of NARMC is responsible for the operations of Walter Reed Army Medical Center (WRAMC) and DeWitt Army Community Hospital (DACH) at Fort Belvoir and will maintain responsibility until those organizations are deactivated. The Commander of NARMC will not be responsible for the two new joint medical facilities, Walter Reed National Military Medical Center (WRNMMC) and Fort Belvoir Community Hospital (FBCH), when they are established before 15 September 2011.

Question. Does Commander, NAMR work for you?

Answer. The Commander of JTF CAPMED exercises tactical control (TACON) over the Commander of Army North Atlantic Regional Medical Command (NARMC) and Army forces assigned to the Commander of NARMC in the National Capital Region (NCR) Joint Operating Area (JOA). The Commander of NARMC exercises Army operational control authorities over all assigned forces.

JTF CAPMED exercises this same TACON relationship with the Navy and Air Force medical component commanders in the NCR JOA.

Question. If not, what is her role and what is the command relationship with your organization?

Answer. The Commander of Army North Atlantic Regional Medical Command (NARMC) is the Army Component Commander for the Commander of JTF

CAPMED in the National Capital Region (NCR) Joint Operating Area (JOA). Commander, JTF CAPMED exercises tactical control over Army NCR JOA medical forces through the Commander of NARMC.

ARMED FORCES INSTITUTE OF PATHOLOGY

Question. In Fiscal Year (FY) 2008, the Congress established a Joint Pathology Center (JPC) as a successor to the Armed Forces Institute of Pathology (AFIP).

What actions have been taken by the Department to preserve AFIP's capabilities until the new Joint Pathology Center is fully operational?

Answer. The AFIP capabilities have been maintained in accordance with the mission and requirements outlined in the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2008 to perform this mission for the Military Services and other Federal agencies. The JPC will provide the same pathology consultation services as AFIP does today to Federal agencies, as provided by the JPC authority in the NDAA for FY 2008. Consistent with the Base Realignment and Closure Commission's final recommendations, the previous program of providing diagnostic consultation services to the civilian community is being discontinued. The implementation of a JPC will be coordinated with the closure of AFIP to optimize utilization of AFIP personnel, equipment, and supplies, consistent with JPC mission requirements.

Question. What actions have been taken by the Department to establish a Joint Pathology Center (JPC)?

Answer. In April 2008, the Assistant Secretary of Defense for Health Affairs (ASD(HA)) chartered a JPC workgroup that included the senior leadership from the Armed Forces Institute of Pathology (AFIP), Uniformed Services University of the Health Sciences, the Services, Department of Defense (DoD), Department of Veterans Affairs, and Department of Health and Human Services to develop options for a JPC within DoD. Based on these recommendations, the ASD(HA) chose to establish the JPC as part of the new Walter Reed National Military Medical Center, under the Joint Task Force National Capital Region Medical (JTF CapMed). The JTF CapMed, with AFIP assistance, developed a concept of operations for a JPC that was presented to the Defense Health Board and the AFIP Board of Governors. Based on feedback from these boards, and the Department's Senior Military Medical Advisory Council, JTF CapMed is finalizing an implementation plan for a JPC under their governance. Once approved, JTF CapMed and the AFIP will begin coordinating the closure of AFIP with the implementation of the JPC. Initial operating capability is targeted for July 2010 and full operating capability is planned by mid-September 2011. The JPC will provide the functions required by the National Defense Authorization Act for Fiscal Year 2008: provide diagnostic consultations for the Military and other Federal agencies, establish a Program Management Office to manage consultations (required by Base Realignment and Closure), provide pathology education and research, and maintain and modernize the tissue repository.

Question. Where will the Center be located and when will it be fully operational?

Answer. The Center will be located on the Bethesda campus, with the new Walter Reed National Military Medical Center, the Joint Task Force National Capital Region (JTF CapMed), and, due to space and funding constraints, the Forest Glen Campus where the Tissue Repository will be located. The Center locations will be consolidated when funds and facilities become available. The implementation plan is being finalized by the JTF CapMed, with assistance from the Armed Forces Institute of Pathology, and will include a milestone for initial operational capability in July 2010 and full operational capability in mid-September 2011 when Base Realignment and Closure requires the Walter Reed Army Medical Center campus to be vacated.

REPORTING REQUIREMENTS ON THE NEW WALTER REED NATIONAL MEDICAL CENTER

Question. This report was due 45 days after enactment and a similar report on the transition plan was required by the appropriations committees 120 days after enactment of the fiscal year 2009 appropriations bill.

What is the status of the reports required under these provisions?

Answer. In response to Section 2721(d) of the Fiscal Year (FY) 2009 National Defense Authorization Act (NDAA), the Department delivered an interim submission to Congress on 13 March 2009 and approved its final report on 14 May 2009. The Department's understanding from this committee was that the 14 May 2009 submission that was delivered to Congress satisfied both the requirements from section 2721(d) of the FY 2009 NDAA and the FY 2009 Defense Appropriations Conference Report.

In addition, the Department plans to submit the report required by Section 1674(a) of FY 2008 NDAA by late Summer 2009, which will include more detailed

plans about the Walter Reed Army Medical Center transition and a Master Transition Plan.

Question. It has been four years since the Department submitted its Base Closure recommendations, why is it taking so long to provide this information to the Congress?

Answer. The 2005 Walter Reed Army Medical Center (WRAMC) BRAC recommendation only marked the first step in the military medical realignment currently under way in the National Capital Region (NCR). Since then, the Department has greatly expanded the scope of the medical transformation in the NCR in ways such as identifying additional wounded warrior transition requirements in the region, directing the integration of military healthcare delivery in the NCR Joint Operating Area (JOA), establishing the new Walter Reed National Military Medical Center (WRNMMC) and Fort Belvoir Community Hospital (FBCH) as the military's first jointly staffed and governed medical treatment facilities (MTFs) and converting a significant number of government civilians at the NCR Service facilities to become a DoD civilian workforce—thereby significantly enhancing their career development potential.

The Department has provided information to Congress throughout this significant evolution through the President's Budget, congressional briefings and site visits and report/interim submissions. In addition, it chartered NCR Medical Joint Task Force (JTF CAPMED) with the mission of overseeing the primary components of this complex transition. JTF CAPMED reached full operating capability on 30 September 2008 and since then has moved quickly and efficiently to create a milestone schedule for the transition, which has been delivered to Congress. JTF CAPMED is also nearing completion of a Master Transition Plan (MTP), which will be an adaptive planning document that describes in greater detail the individual actions required to transition current hospitals to the regional end state. The initial version of the MTP is anticipated to be completed in late Summer 2009.

Question. When can the Congress expect to receive a final copy of responses to these provisions?

Answer. Section 2721 of the Fiscal Year 2009 National Defense Authorization Act required the Secretary of Defense to: (b) establish a design review panel to determine whether design/plans for Walter Reed National Military Medical Center (WRNNMC) are "world-class"; (c) submit a cost estimate for closing Walter Reed Army Medical Center (WRAMC) and relocating operations to WRNMMC and Fort Belvoir Community Hospital (FBCH); (d) submit a milestone schedule for transition/relocation of operations from WRAMC to WRNMMC and FBCH.

The Department noted its cost estimate for the project as the President's Budget in the cover letter accompanying an interim report delivered to Congress on 13 March 2009. In addition, in response to section 2721(d) of the NDAA for FY 2009, a milestone schedule was approved by the Department on 14 May 2009. The Department's understanding from this committee was that the 14 May 2009 submission that was delivered to Congress satisfied both the requirements from section 2721(d) of the FY 2009 NDAA and the FY 2009 Defense Appropriations Conference Report.

As for section 2721(b) of the NDAA for FY 2009, the Department directed the Defense Health Board (DHB), National Capital Region (NCR) BRAC Subcommittee to review the design plans for the WRNMMC and FBCH and advise the Secretary of Defense regarding whether the design, in the view of the panel, will achieve the goal of providing world-class medical facilities. The DHB has not yet delivered to the Secretary of Defense its recommendations regarding the design. Since the DHB is an independent body the Department does not exercise control over when the DHB will submit its report to the Secretary of Defense, but has communicated the deadline set by Congress. The report is near completion and once it is delivered to the Secretary of Defense the Department will provide the DHB's report and its assessment of the board's recommendation to Congress in a timely manner.

COLLABORATIVE DESIGN

Question. Did the Department appoint an independent body to review the design plans to ensure the new facility is truly world class?

Answer. As per section 2721(b) of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2009, the Department directed the Defense Health Board, National Capital Region BRAC Subcommittee to review the design plans for the Walter Reed National Military Medical Center (WRNMMC) and the new military hospital at Fort Belvoir (FBCH) and advise the Secretary of Defense regarding whether the design, in the view of the panel, will achieve the goal of providing world-class medical facilities.

Question. Do we now have a world class design for the new WRNMMC?

Answer. The design efforts to meet BRAC requirements at Walter Reed National Military Medical Center (WRNMMC) and Fort Belvoir Community Hospital (FBCH) have employed industry best practices by some of the country's leading architectural firms. The highly progressive FBCH design includes numerous Evidence Based Design and "green" practices. The design and construction efforts at WRNMMC are similarly progressive but did not include all elements of the medical campus or the full renewal of all renovated areas.

The Defense Health Board National Capital Region BRAC Subcommittee is formulating its report on this issue, as required by section 2721(b) of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2009.

Question. When was this design completed?

Answer. Design for the construction and partial renovation at the Walter Reed National Military Medical Center (WRNMMC) for the new inpatient and outpatient additions were completed in April 2009 and the designs for the warrior transition services and renovations are scheduled to be completed by December 2009.

Question. Who was appointed to this panel and what were their credentials?

Answer. The Defense Health Board, National Capital Region BRAC Subcommittee members include:

—Dr. Kenneth W. Kizer (Chair)—Medsphere Systems

—Col (Ret) Richard J. Andrassy, MD—University of Texas Houston Health Science Center

—Lt Gen (Ret) Paul K. Carlton, Jr., MD—Texas A&M University System Health Science Center

—Mr. Raymond F. DuBois—Center for Strategic and International Studies (CSIS)

—BG (Ret) James J. James, MD—Center for Public Health Preparedness and Disaster

—Dennis S. O'Leary, MD—President Emeritus, The Joint Commission

—Mr. Phillip E. Tobey—Smith Group

—Ms. Cheryl L. Herbert—Dublin Methodist Hospital

The Defense Health Board, National Capital Region BRAC Subcommittee supporting subject matter experts include:

—Ms. Tammy Duckworth—Department of Veterans Affairs

—Mr. Andrew Mazurek—Navigant Consulting

—Mr. Charles M. Olson—Mayo Clinic Rochester

—Mr. John Pangrazio—NBBJ Architecture, Planning and Design

—Dr. A. Ray Pentecost III—Clark Nexsen

—Mr. Orlando Portale—Polomar Pomerado Health

—Mr. Stephen C. Schimpff—University of Maryland

The Department can provide individual biographies upon request.

Question. How many times did this panel meet?

Answer. The Defense Health Board, National Capital Region BRAC Subcommittee held meetings on September 29, 2008, November 17–18, 2008, and January 15–16, 2009 and held two telephone conferences on September 22, 2008 and December 12, 2008.

Question. What were the findings of the panel?

Answer. The Defense Health Board has not yet delivered its recommendations regarding the design plans for the Walter Reed National Military Medical Center and the new military hospital at Fort Belvoir (FBCH) to the Secretary of Defense, as required by section 2721(b) of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2009.

Question. Have the results of their review been provided to the Congress?

Answer. No, the Defense Health Board has not yet delivered to the Secretary of Defense its recommendations regarding the design plans for the National Military Medical Center and the new military hospital at Fort Belvoir, as required by section 2721(b) of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2009.

Question. If not when will they be provided?

Answer. Since the Defense Health Board is an independent body the Department does not exercise control over when the DHB will submit its report to the Secretary of Defense, but has communicated the deadline set by Congress. The report is near completion and once it is delivered to the Secretary of Defense the Department will provide the DHB's report and its assessment of the board's recommendation to Congress in a timely manner.

INDEPENDENT COST ESTIMATE

Question. What is the total cost to implement the BRAC 2005 proposals for medical care in the National Capital Region? Provide all costs not just construction costs.

Answer. The current estimated total cost from FY 2006 to FY 2011 for the expansion and renovation of the National Naval Medical Center (NNMC) and associated projects to create the Walter Reed National Military Medical Center (WRNMMC), and replacement of the DeWitt Army Community Hospital at Fort Belvoir, VA, with Fort Belvoir Community Hospital (FBCH) is $2.4 billion. This total includes: the design, construction, equipment, outfitting, and transition activities associated with the creation of new health care capabilities at the WRNMMC and FBCH. It also includes additional parking at both locations, the construction of new Wounded Warrior transition services, and other administrative and support functions at Bethesda required to accommodate related functions relocating from the Walter Reed Army Medical Center campus. However, it does not include final property disposal and environmental cleanup costs for the closure of Walter Reed Army Medical Center.

Question. Have these costs been verified by an Independent Cost Estimate?

Answer. Section 2721(c) of the National Defense authorization Act (NDAA) for Fiscal Year (FY) 2009 required a cost estimate which was provided in the cover letter accompanying the Department's Section 2721 interim submission dated 13 March 2009. There was not a requirement to do an independent estimate, but the DoD budget process and the bid process provide opportunities to vet the construction agent estimates. In addition, the Government Accountability Office reviews the BRAC costs annually. The combination of these processes provides sufficient review of the costs.

Question. What was the original cost estimate when BRAC 2005 was submitted?

Answer. The 2005 original estimate for transitioning operations at Walter Reed Army Medical Center (WRAMC) to Bethesda, MD and Fort Belvoir, VA was $853M. These costs did not include the costs of the non-medical treatment aspects of the WRAMC recommendation, which also include moving various research and support functions from WRAMC to other locations.

Question. Why have the costs increased by so much?

Answer. Cost growth for the new Walter Reed National Military Medical Center (WRNMMC) at Bethesda and the Fort Belvoir Community Hospital (FBCH) between May 2005 and the present is due to several factors.

The 2005 original estimate for transitioning operations at Walter Reed Army Medical Center (WRAMC) to Bethesda, MD and Fort Belvoir, VA was $853M. These costs did not include the costs of the non-medical treatment aspects of the WRAMC recommendation, which also include moving various research and support functions from WRAMC to other locations.

Between May 2005 and September 2006, DoD performed detailed requirements and cost analysis for the healthcare requirements associated with the Walter Reed Army Medical Center (WRAMC) BRAC actions in the National Capital Region (NCR). These refinements resulted in almost doubling the required floor space and a $473M increase in MILCON costs above the original BRAC estimates.

The remaining approximately $1.1B cost increase comes in two main parts: $679M in MILCON cost growth at both WRNMMC and FBCH resulting from decisions to primarily enhance and also accelerate construction in support of wounded warriors and $392.4M for additional construction projects and outfitting costs for both hospitals. The latter portion was added during the FY10–15 Program Objective Memorandum (POM) process. Details are as follows.

$679M increase:

• *Inflation ($83M):* The original construction budgets for BRAC were based on FY04 pricing guides, whereas the new budgets reflect the DoD's FY07 pricing guide.

• *Construction Schedule Acceleration ($123M):* DoD responded to requests from the Congress to accelerate the construction schedule for the projects related to WRAMC BRAC including both WRNMMC and FBCH.

• *Warrior Care Enhancements ($473M):* Several elements were added to the expanded medical center and supporting facilities at Bethesda to better respond to the expected influx of Warriors in Transition and their families. They include enhancing 30 outdated Intensive Care Unit beds, 66 new private medical surgical hospital bed rooms, increased non-clinical medical center support facilities, space for a primary care clinic dedicated to treatment of Warriors in Transition (WIT), a WIT unit headquarters, accessible housing for junior enlisted staff and WITs, dining facility expansion for WITs, a fitness center capable of servicing WITs and sized for the new Bethesda staff and parking sufficient for the additional patients, family and staff.

$392.4M Increase:

• *MILCON ($146M):*

$59.9M for Ft. Belvoir in support of the construction for the new facility and expanded parking

$46.0M for Bethesda traffic mitigation measures

$28.0M in additional parking at Bethesda

$5.6M in re-pricing of the dental clinic at Fort Belvoir

$6.5M to address base infrastructure updates to support the National Intrepid Center of Excellence (NICoE)

• *O&M ($246.4M):*

$243.0M for Bethesda and Belvoir in additional Initial Outfitting & Transition (IO&T) funding to address requirements developed from detailed reviews of the requirements from the market

$3.4M in re-pricing for the dental clinic IO&T requirement

Question. Are additional cost increases expected?

Answer. There are some components of the overall project that do not yet have final pricing. The combination of the final pricing and any other issues uncovered as renovation proceeds may lead to cost changes. Any cost increases will be addressed in the Fiscal Year (FY) 2011 president's budget (PB) submission or if necessary in FY 2010 PB and FY 2009 Overseas Contingency Operations (OCO) funding execution (with concomitant reprogramming notifications).

Question. What were the original annual savings and payback period when the BRAC 2005 was enacted?

Answer. As stated in the BRAC commission report, the annual savings was estimated to be $145M with a six year payback.

Question. What is the current annual estimated savings and payback period?

Answer. The current estimate is that the recommendation will generate $170M in annual savings for the entire recommendation. Payback is around 16 years.

Question. With what you know now, does this project make fiscal sense?

Answer. Yes. Savings estimates and payback do not include the substantial costs that will be avoided to recapitalize the existing Walter Reed Army Medical Center nor did it account for the enhanced wounded warrior mission. BRAC afforded the Department the opportunity to consolidate infrastructure in the National Capital Region and provide care via an integrated regional delivery network. The focus on BRAC was not only savings, but transformation of the infrastructure.

Question. If so, please explain why?

Answer. Significant investments in health care infrastructure were required prior to BRAC, and the comprehensive strategy represented by BRAC is more effective than a series of independent, Service specific investments. Prior to the BRAC decision, military health care in the National Capital Region (NCR) was unintegrated and operated with outdated infrastructure. Delivery of specialty care was redundant across three geographically separate medical centers, and although significant strides had been made to integrate care, the fiscal inefficiencies of operating separate facilities, and two distinct medical installations within a 5 mile radius could not have been overcome.

Community hospital and outpatient care was similarly not integrated across Service lines, and not focused on providing the appropriate level of care conveniently located to the patient population. The DoD hospital and medical center infrastructure in the NCR was aging, and more than 4 million square feet of existing facility infrastructure for the three Services required recapitalization in the next decade. Walter Reed Army Medical Center (WRAMC) and National Naval Medical Center (NNMC) were both designed in the early 1970s based upon dated healthcare delivery models and technology and as a result were in need of update.

In 2002, it was estimated that an investment of almost $750M for WRAMC alone would be required to update the building infrastructure and convert it to a configuration optimal for current models of care. Such a sizeable investment in the current location, of course, would still not have resolved the operational challenges. Additionally, Service funding processes challenged proper facility investment and operational planning in the NCR. For example, in spite of a growing multi-service demand in the Virginia portion of the market, the original replacement project for the 1957 vintage Ft. Belvoir Community Hospital was only sized to meet the Army demand model. Without the BRAC decision to optimize health care delivery by making this investment in an integrated solution, sizeable, Service-based investments in infrastructure would not have resulted in an integrated delivery system and would have perpetuated operational inefficiencies and redundancies for decades to come.

MEDICAL CARE IN THE NATIONAL CAPITOL REGION-TRANSITION PLANNING

Question. In addition, the fixed year 2009 DOD Appropriations bill expressed concerns over challenges with the transition of over 1,500,000 patients from the three hospitals to two new facilities. We directed you to submit a thorough and detailed milestone schedule which outlines prove out of the facilities, transition of staff personnel as well as care of service members and their families.

Has that detailed report been completed?

Answer. Yes. In response to Section 2721(d) of the Fiscal Year (FY) 2009 National Defense Authorization Act (NDAA), the Department delivered an interim submission to Congress on 13 March 2009 and approved its final report on 14 May 2009. The Department's understanding from this committee was that the 14 May 2009 submission that was delivered to Congress satisfied both the requirements from section 2721(d) of the FY 2009 NDAA and the FY 2009 Defense Appropriations Conference Report.

In addition, the Department plans to submit the report required by Section 1674(a) of FY 2008 NDAA in late Summer 2009, which will include more detailed plans about the Walter Reed Army Medical Center transition and a Master Transition Plan.

Question. Has the problem of ingress and egress been solved?

Answer. The staff of the National Naval Medical Center (NNMC) has worked closely with local and state officials to resolve issues related to traffic congestion in the vicinity of NNMC and improve access to and egress from the NNMC Campus. Traffic mitigation measures will occur both on the Bethesda Campus and outside the Campus gates.

On Campus. Improvements to access roads, gate houses, and anti-terrorism/force protection measures as well as construction of a truck inspection station and small visitor's center will result in improved access to and egress from the Campus and also provide improved security measures. At present, funding for the on-Campus improvements is budgeted at $26 million apportioned across FY 2010 ($18.4 million) and FY 2011 ($7.6 million).

Off Campus. The NNMC staff members have worked closely with Montgomery County and Maryland State Highway Administration to design improvements which will facilitate greater access to the Campus from public transportation and major thoroughfares. DoD has committed $1 million of the budgeted $26 million to improve a turn lane at the Campus North Gate which will facilitate safer access to and egress from the Campus for cross traffic on Rockville Pike/Hwy 355. Consistent with the results of our Environmental Impact Statement (EIS), the Department has submitted a needs report to the Defense Access Road (DAR) Program requesting examination and certification of options that will help ease pedestrian traffic crossing Rockville Pike/Hwy 355 to the NNMC Campus. At present, $20M has been allocated in FY 2011 for this project. As is the case with all future budgets, the funding for these projects is subject to change as the FY 2011 budget is reviewed and finalized within DoD.

Question. What is the plan to solve ingress and egress?

Answer. Projects are designed and programmed for funding for improvements at all five gates, to include enhancing METRO access, as previously stated. Considerable efforts are also being made by the Bethesda Installation to enhance the use of alternative transportation. National Naval Medical Center (NNMC) is working closely with local transportation authorities to improve scheduling, actively encouraging carpooling and the use of public transit subsidies and improving bus stops proximate to the base and bicycle paths.

Additionally, analysis is underway to determine if the volume of outpatient traffic coming to Walter Reed National Military Medical Center (WRNMMC) can be effectively mitigated by increasing distributed primary care services (including pharmacy) off of the WRNMMC campus and by leveraging programs such as mail order and mail refill pharmacy.

Question. When do you plan on the completion of construction for each of the two facilities?

Answer. Construction of the new Fort Belvoir Community Hospital is scheduled for full completion by April 2011, and the construction of facilities and renovations at Bethesda will continue through August 2011. At both locations, various building components will come on line in sequence such that equipping, outfitting, commissioning, and training activities can be coordinated over an extended period prior to the final movement of patient care.

Question. Approximately 1,900 of the personnel at WRAMC are supposed to move to the new Walter Reed and 2000 are supposed to move to the new Fort Belvoir

community hospital. Have those individuals been notified of where they will be moving?

Answer. Not at this time. Individual notifications will be made as soon as possible after the new joint manning documents for the Walter Reed National Military Medical Center (WRNMMC), Fort Belvoir Community Hospital (FBCH) and Andrew's Air Force Base (AAFB) which are currently being vetted by the Services and approved for release.

Since the manning documents for the two new joint hospitals (WRNMMC and FBCH) include new organizational structures, they must be thoroughly reviewed to determine the most appropriate placements for current civilian employees at Walter Reed Army Medical Center (WRAMC) and National Naval Medical Center (NNMC). NCR Medical Joint Task Force's goal, which we believe will be achievable for the vast majority of individuals at WRAMC, is to place employees where they want to be located doing the work they want to do. For military members, the Army, Navy and Air Force will assign forces to joint billets at WRNMMC, AAFB and FBCH.

Question. When can the medical staff at Walter Reed expect to be notified of their future employment?

Answer. Based on the anticipated release of the joint manning documents in September 2009, NCR Medical Joint Task Force expects to begin to notify civilian employees of their future position and duty stations by Spring 2010. The Army will determine how they will fill the Army billet requirements at the two new joint hospitals, Walter Reed National Military Medical Center (WRNMMC) and Fort Belvoir Community Hospital (FBCH), and at Andrews Air Force Base (AAFB). Army personnel currently at Walter Reed Army Medical Center (WRAMC) will be notified by the Army based on its specific selection and notification processes.

Question. Do you find it troubling that there is no final personnel plan?

Answer. There is and has been a plan to transition healthcare and support staff currently employed in the National Capital Region (NCR) to the regional end state. It began with the development of the Program for Design (PFD), which gave the initial estimates of personnel in each facility. It then took the form of establishing the Directors of Integration (DCIs) at both Walter Reed Army Medical Center (WRAMC) and National Naval Medical Center (NNMC). The DCI's are cross-service personnel whose task is to prepare the WRAMC and NNMC staffs for the eventual integration. The DCIs have been an integral part of shaping the future workforce for the two new joint facilities—Walter Reed National Military Medical Center (WRNMMC) and Fort Belvoir Community Hospital (FBCH). Similar efforts are underway to prepare staff at Dewitt Army Community Hospital (DACH) and Andrews Air Force Base (AAFB).

The overall personnel plan has further evolved with the development of joint manning documents which describe the Service mix within each facility. These documents are currently under review by the Services and Joint Staff and are expected to be released by September 2009. The Civilian personnel plan has been guided by a Civilian Human Resources Council (CHRC) that includes multi-Service stakeholders. The CHRC has been and will continue to oversee the transition and integration of the civilian employees at WRAMC, NNMC DACH and AAFB into a regional force of DoD Military Health System civilians.

The elements of the personnel plan will be laid out in the Master Transition Plan (MTP). The MTP is an adaptive planning document that describes in greater detail the individual actions required to transition the current hospitals to the regional endstate. The initial version of the MTP is anticipated to be completed by late Summer 2009.

Question. How much of the major equipment at Walter Reed will be utilized at the new WRNMMC or Fort Belvoir?

Answer. The DoD Joint Technology Assessment and Requirements Analysis (JTARA) assessment reviewed the current condition and life expectancy of all major equipment items valued at over $100,000, such as radiology systems, to determine viability for reuse. Thirty five percent of these equipment items are programmed for reuse at the new facilities. Additionally, a review of almost 11,000 items of equipment with a value under $100,000 was undertaken by the staff and it was determined that approximately 20% of these items will be programmed for reuse.

Approximately $19.9M worth of equipment will be reused at the new Walter Reed National Military Medical Center (WRNMMC) and $26.8M worth at Fort Belvoir Community Hospital (FBCH). The objective to reuse equipment must be carefully balanced with the requirement to continue safe and effective care without degradation. As a result, these quantities and values will continuously fluctuate. As movement plans continue to be fine tuned, these items will continue to be evaluated for feasibility and practicality of their reuse.

Question. Please provide a detailed list of all equipment which will be reutilized and to which location it will be sent?

Answer. Target lists for reuse of equipment valued over $100,000 are included below. Targets lists for reuse of equipment valued less than $100,000 comprise nearly 40 pages at this time and that list can be provided to the committee upon request.

Analysis is still ongoing to determine whether each of these items can actually be reused without degradation of service or incurrence of excessive expense for temporary provisions. The attached spreadsheets indicate the equipment origin and destination locations for items going to the new Walter Reed Army Medical Center (WRNMMC). The Architect/Engineer for WRNMMC has been provided the cutsheets for the reuse equipment and is evaluating the list against the building design to determine if the building design is suitable for reuse of the selected reuse items.

The location information for the reuse items tentatively identified for Fort Belvoir Community Hospital (FBCH) is not yet finalized. FBCH only recently completed user reviews for their equipment requirements and are in the process of assessing the Joint Technology Assessment and Requirements Analysis (JTARA) and non-JTARA reuse items against these requirements. They will perform a similar review of the building design to determine whether it will support the reuse of the equipment identified. Other evaluation criteria that is considered is whether the reuse items meet the objectives for standardization and whether the items from Walter Reed Army Medical Center (WRAMC) will be available when the items are required onsite at FBCH for outfitting.

These lists are updated daily and are likely to change as the region approaches transition to the new facilities depending on the clinical analysis and possibility of interruption of healthcare.

Planned List of WRAMC equipment valued over $100,000 for reuse at WRNMMC					
As of 28 May 09 Equipment Nomen	WRAMC Room	Manufacturer	Model	TYPE	Acquisition Cost
OPERATING MICROSCOPE		ZEISS	OPMI SENSERA	OTOLARYNGOLOGY	$109,117
ECHOCARDIOLOGY	3L55	GE	VIVID 7	ULTRASOUND	$162,990
ECHOCARDIOLOGY	3L54	GE	VIVID 7	ULTRASOUND	$162,990
ULTRASOUND	1R SUITE	PHILIPS	IU 22	ULTRASOUND	$233,650
R/F SYSTEM	GI CLINIC	GE	PRECISION 500D	GASTROENTEROLOGY	$298,566
ULTRASOUND	1G12	GE	LOGIQ 9	ULTRASOUND	$201,394
STEREOTACTIC SYSTEM		LANDMARX	EVOLUTION PLUS	OTOLARYNGOLOGY	$143,726
BONE DENSITOMETER		HOLOGIC	DISCOVERY	BONE DENSITOMETRY	$99,000
MAMMOGRAPHY SYSTEM	1X10	LORAD/HOLOGIC	M-IV	MAMMOGRAPHY	$87,088
MAMMOGRAPHY SYSTEM	1X12	LORAD	M-IV	MAMMOGRAPHY	$104,328
GAMMA CAMERA DUAL-HEAD	7B03	PHILIPS	FORTE SKYLIGHT	NUCLEAR MED	$549,598
RADIOGRAPHIC/FLUOROSCOPIC	1X42A	GE	PRECISION 500D	FLUOROSCOPY	$307,630
OPERATING MICROSCOPE		LEICA	OH4	OR	$215,933
ULTRASOUND	IR SUITE	SONOSITE	180 PLUS	ULTRASOUND	$48,793
EXCIMER LASER		ALCON	ALLEGRETTO WAVE	OPHTHALMOLOGY	$245,000
ECHOCARDIOLOGY	3L44	SIEMENS	SEQUOIA 512C	ULTRASOUND	$203,276
ANGIOGRAPHY, BIPLANE, DIG DETECT	4X11	PHILIPS	ALLURA XPER FD20/10	ANGIO/INTERVEN RAD	$2,024,648
ECHOCARDIOLOGY	PORTABLE	SIEMENS	CYPRESS	ULTRASOUND	$0
RADIOGRAPHIC/FLUOROSCOPIC	1X46A	GE	ADVANTX	FLUOROSCOPY	$352,390
LINEAR ACCELERATOR	1H33	VARIAN	2100 iX	RAD THERAPY	$1,905,175
UROLOGY R/F SYSTEM	4F23	SIEMENS	UROSKOP	UROLOGY	$263,824
CT Scanner	1G32	GE	LIGHTSPEED VCT X	CT	$980,841
MRI 1.5-T	5M26	GE	SIGNA HD	MRI	$2,405,224
CARDIAC CATH LAB, BIPLANEPLANE	4B03 (LAB A)	GE	INNOVA 2121-IQ	CARDIAC CATH	$1,697,210
CARDIAC CATH LAB, SINGLE PLANE	4117 (LAB B)	GE	INNOVA 3100 IQ	CARDIAC CATH	$1,106,912
CARDIAC CATH LAB	4B07 (LAB C)	GE	INNOVA 2100 IQ	CARDIAC CATH	$772,139
ECHOCARDIOLOGY	TREADMILL RM	GE	Vivid 9	ULTRASOUND	$195,378
ULTRASOUND	Radiology	PHILIPS	IU 22	ULTRASOUND	$172,375
DUAL-HEAD SPECT/CT 6 SLICE DIAG	7C07	SIEMENS	SYMBIA	NUCLEAR MED	$1,183,796
EKG ARCHIVING AND ANALYSIS (CARDIOLOGY)	Cardiology	GE	MUSE	PATIENT MONITORING SYS	$176,610
				TOTAL	$16,409,601

Planned List of WRAMC equipment valued over $100,000 for reuse at Fort Belvoir					
As of 19 May 09 Equipment Nomen	WRAMC Room	Manufacturer	Model	TYPE	Aquision Cost
CT SIMULATOR		PICKER	PQ2000S	RAD THERAPY	$1,824,807.00
RECORD AND VERIFY		IMPAC		RAD THERAPY	$158,812.00
LINEAR ACCELERATOR	1H33	VARIAN	2100C	RAD THERAPY	$1,905,175.00
CR READER	RAD CORE	FUJI	FCR 5000	COMPUTER RAD	$253,000.00
CR READER	RAD CORE	FUJI	FCR 5000	COMPUTER RAD	$253,000.00
STERILIZER PLASMA		ASP	STERRAD 100S	CMS	$96,630.00
GENERAL PURPOSE RADIOGRAPHIC	1E63 OUTPAT RAD	GE	PROTEUS	X-RAY	$88,840.00
GENERAL PURPOSE RADIOGRAPHIC	1C60 OUTPAT RAD	GE	PROTEUS	X-RAY	$88,840.00
LINEAR ACCELERATOR		VARIAN	2100SC	RAD THERAPY	$2,284,699.00
GENERAL PURPOSE RADIOGRAPHIC	1X22A	GE	PROTEUS	X-RAY	$160,483.00
GENERAL PURPOSE RADIOGRAPHIC	5A27	GE	PROTEUS	ORTHOPEDICS	$171,514.00
CR READER	UROLOGY	FUJI	XG5000	COMPUTER RAD	$121,445.00
GENERAL PURPOSE RADIOGRAPHIC	1X16A	GE	PROTEUS	X-RAY	$171,514.00
MRI 1.5-T	5M23	GE	HORIZON LX EXCITE HD	MRI	$732,980.00
R/F SIMULATOR		NUCLETRON	OLDELF	RAD THERAPY	$1,389,882.00
FEMTOSECOND LASER		AMO	INTRALASE	OPHTHALMOLOGY	$245,000.00
				TOTAL	$9,946,621.00

Question. How much additional equipment will need to be procured for both WRNMMC and Fort Belvoir and how much has been budgeted in previous years and how much is in the fiscal year 2010 President's Budget?

Answer. The Initial Outfitting and Transition budget of approximately $550M will provide the equipment and transition services for both Walter Reed National Military Medical Center (WRNMMC) and Fort Belvoir Community Hospital (FBCH) after placement of all reusable equipment from Walter Reed Army Medical Center (WRAMC).

The table below provides the amount executed in fiscal year 2007, 2008 and 2009 for National Naval Medical Center (NNMC) and DeWitt Army Community Hospital (DACH). For the purpose of this response equipment is defined as medical equipment with a value greater than $100,000.

	Bethesda	Fort Belvoir
FY07 Executed	$15,059,632.40	$942,382
FY08 Executed	$18,190,520.18	$1,034,661
FY09 Executed	$8,073,051.71	$318,433
*FY10 Planned	$7,262,659.41	

*The table includes the NNMC requirements planned for fiscal year 2010. However, the Army Medical Department centrally budgets for medical equipment greater than $100,000 and Medical Treatment Facility requirements are prioritized and funded in the year of execution. This makes it unfeasible to provide an accurate amount for the fiscal year 2010 President's Budget for Fort Belvoir.

Question. What do you consider the pacing items for the transition from the old to the new facilities?

Answer. National Capitol Region Medical Joint Task Force (JTF CAPMED) sponsored a Clinical Transition Wargaming Exercise in February 2009 to address this question. A copy of that report has been made available to Congress. The exercise determined that patient safety and satisfaction is best maintained by retaining virtually all services at Walter Reed Army Medical Center (WRAMC) until a short transition period in the late Summer of 2011. Of critical concern is making certain that all the conditions are established for the continuity of care and services supporting the wounded warrior population.

The key pacing, or "trigger" milestones for transition are below:

- *June 2009*—Establish Central Program Management Office and approve initiate contract for Joint Transition/Integration Teams.
- *October 2009*—Fully staff Joint Transition/Integration Teams and focused Transition Cells at Walter Reed, Bethesda, and Belvoir.
- *~January 2010*—Commence comprehensive turnkey equipment procurement and transition services (move and activation) contract.
- *October 2010*—Establish Joint Command structure to ensure unity of effort of physical transition.
- *March 2011*—Complete NNMC occupancy of new outpatient and inpatient buildings at Bethesda.
- *June 2011*—Complete transition of all Dewitt operations to the new Fort Belvoir Community Hospital.
- *Late Summer 2011*—Transition all operations from Walter Reed to Bethesda and Belvoir.

Other significant items that are scheduled to be completed in the third and fourth quarter of FY 2011 include delivery of wounded warrior facilities, administrative buildings, parking garages and entrance gate improvements on the Bethesda campus. All of these items are scheduled to be completed in the third and fourth quarter of FY 2011.

For further detail please refer to the Department's milestone schedule submission, as required by section 2721(d) of the FY 2009 National Defense Authorization Act (NDAA), which was approved on 14 May 2009 and delivered to Congress.

Question. Are you concerned with the transition and how long do you estimate you will have from the completion of construction to September 15, 2011 when the move must be completed?

Answer. Completing the construction and Initial Outfitting & Transition (I&OT) timelines for Bethesda and Fort Belvoir is the largest transition program that the Military Health System has carried out. While such transition challenges are not foreign to the private sector, this project presents the unique challenge at Bethesda of adding to a hospital while continuing to operate that hospital. Ensuring a safe and effective transition is the JTF CAPMED's first priority.

Completion of several key facilities on the Bethesda campus will not be achieved until late Summer 2011. An analysis of industry healthcare relocations found that it is common and prudent practice to relocate major operations over a short period of time, or all at once. By concentrating the actual move process to a compressed

timeframe, this strategy minimizes the disruption to patient care and confusion for patients, and is safer than trying to extend operations across two separate locations. This is accomplished following several months of preparatory activities to ensure that the new spaces are fully outfitted, equipped, and commissioned and staff and patients are trained and oriented in advance of the move. Patient scheduling and admitting will be managed to ensure continuity of care over this move period.

For further detail please refer to the Department's milestone schedule submission, as required by section 2721(d) of the FY 2009 National Defense Authorization Act (NDAA) that was dated 14 May 2009 and delivered to Congress.

Question. What actions are you taking to mitigate these concerns?

Answer. The Department is implementing the milestone schedule, as required by section 2721(d) of the FY 2009 National Defense Authorization Act (NDAA) that was approved on 14 May 2009 and delivered to Congress.

Question. What is the planned disposition for the existing Walter Reed Army Medical Center?

Answer. The Army is responsible for the disposition of the existing Walter Reed Army Medical Center (WRAMC). Current plans call for a Federal to Federal transfer of the 113 acres of WRAMC main post. The General Services Administration (GSA) has requested 34 acres and the Department of State the remaining 79 acres. The Department of State has recently amended their request asking for only 18 acres. The Deputy Assistant Secretary of the Army for Installations and Housing is working with GSA to see if GSA is interested in amending their request for the now remaining 61 acres. If no interest is found, the 61 acres will be declared surplus.

Question. How much is estimated to clean up and dispose of the facility?

Answer. The Army is responsible for the cleanup and disposal of the Walter Reed Army Medical Center (WRAMC) facility. The extent of cleanup is partially dependent on the future use of the facility (e.g., Federal tenants vice non-Federal tenants). However, regardless of who the future owners will be, DoD must terminate its Nuclear Regulatory Commission (NRC) license. The current estimate is approximately $14M to decommission all locations where radiological substances have been used and terminate the NRC license in order to release all buildings for unrestricted use. Estimates were based on the NRC-required Decommissioning Funding Plan of 2005.

MISSIONS OF JOINT TASK FORCE—NATIONAL CAPITAL REGION (JTF CAPMED)

Question. Does JTF CAPMED have missions that go beyond NCR BRAC coordination?

Answer. In September of 2007, the Department established JTF CAPMED as a fully functional standing JTF located on the National Naval Medical Center (NNMC) campus and reporting directly to the Secretary of Defense through the Deputy Secretary of Defense.

JTF CAPMED was chartered to lead the way for the effective and efficient consolidation and realignment of military healthcare delivery in the National Capital Region (NCR) Joint Operation Area (JOA). To accomplish this mission, JTF CAPMED is coordinating with the NCR medical components of the Army, Navy, and Air Force to integrate processes and ensure the best utilization of resources available which will eliminate redundancies, enhance clinical care, promote health professions education and joint training, and enhance military medical research opportunities. In addition, JTF CAPMED has been tasked to oversee implementation of the 2005 BRAC recommendation that directed the realignment of functions at Walter Reed Army Medical Center (WRAMC) in Washington, DC to Bethesda, MD, establishing the Walter Reed National Military Medical Center (WRNMMC), and a community hospital at Fort Belvoir, VA (FBCH).

The NCR's JOA stretches as far north as New Jersey, skirts West Virginia and extends south to Bowling Green, VA. It includes 37 Medical Treatment Facilities (MTFs), including WRNMMC and FBCH, and 12K military and civilian employees. The region comprises over 545K eligible beneficiaries and 282K MTF enrollees.

Not later than the BRAC deadline of 9/15/11, the new WRNMMC in Bethesda, MD and FBCH in Fort Belvoir, VA will be aligned as joint commands subordinate to JTF CAPMED. In addition, to allow for greater interoperability throughout the region, JTF CAPMED will have tactical control of the other JOA MTFs (outpatient) while the Service Medical Departments retain operational control. JTF CAPMED will be the allotment administrator for $1.3B supporting all assigned MTFs.

JTF CAPMED has become the functional provider of Health Service Support (HSS) to the DoD, U.S. NORTHCOM, Joint Force Headquarters National Capital Region (JFHQ–NCR), and multiple interagency partners within the National Capital Region for training exercises; National Security Special Events (NSSEs) and De-

fense Support of Civil Authority (DSCA) support missions; and contingency planning. Since activation, JTF CAPMED has deployed 130 medical support teams within the NCR in order to provide advanced trauma/cardiac life support, emergency medical services, basic life support, ground evacuation support, vaccinations and liaison support on such events as the 56th U.S. Presidential Inaugural; State of the Union Addresses; the Papal Visit; Joint Sessions of Congress involving the Irish and U.K. Prime Ministers; the Joint Service Open House; State Funeral exercises; and multiple national observance ceremonies throughout the District of Columbia.

Question. The specified missions for JTF CAPMED include healthcare delivery. Do you have any disaster or contingency roles?

Answer. JTF CAPMED has an active contingency/disaster role within the National Capital Region (NCR) Joint Operating Area (JOA). When directed by the Secretary of Defense, JTF CAPMED conducts and provides integrated Health Service Support (HSS) within the framework of Defense Support to Civil Authorities (DSCA) in accordance with the National Response Framework (NRF) pursuant to the Requests for Assistance (RFA) from civil authorities. JTF CAPMED maintains its command relationship with Secretary of Defense while maintaining a general support (HSS) relationship with USNORTHCOM and a direct support (HHS) relationship with Joint Task Force National Capital Region (JTF-NCR). This Health Service Support is provided within the authorities of 11 different USNORTHCOM Conceptual Operations (CONOPs) Plans and six JTF-NCR CONOPS Plans.

Recently, JTF CAPMED took the lead DoD medical role for novel swine-origin influenza A/H1N1 support within NCR JOA. Moreover, JTF CAPMED provides medical forces and consequence management within the NCR JOA in support of National Security Special Events and as needed to Office of the Attending Physician, U.S. Congress. The creation of JTF CAPMED has streamlined and created efficiencies for providing unified and integrated medical support in response to disasters/contingencies.

Question. Will medical personnel in the new hospitals still deploy to Iraq and Afghanistan?

Answer. Yes. Depending upon the mission, all military personnel assigned to JTF CAPMED may be required to fill Combatant Commander requests for forces, as determined by the Services.

Question. Why does it make sense to regionalize healthcare delivery in the NCR?

Answer. Effective and efficient healthcare delivery within the National Capital Region (NCR) Joint Operating Area (JOA) is achieved by alignment to one Joint commander integrating care to provide an integrated delivery system. This allows for the integration of processes and ensures the best utilization of resources available which will eliminate redundancies, enhance clinical care, promote health professions education and joint training, and enhance military medical research opportunities.

Each Branch of Service otherwise has little incentive in overlapping catchment areas to plan for the care of the entire beneficiary population. This leads to cost and workload shifts causing inefficiencies and increasing costs to the Department. Moreover, lack of integration of care provides a structure for intra-Medical Treatment Facility referrals impacting beneficiaries and their family members. A Joint Commander gives other DoD, Federal, State, academic and local government agencies a single point of contact simplifying contingency planning and speeding response in a crisis as well.

Question. Are all capabilities being planned for the new Walter Reed National Military Medical Center installation NCR BRAC related?

Answer. Although all capabilities being planned for the Walter Reed National Military Medical Center (WRNMMC) installation support the future operations of the WRNMMC directed by BRAC, the establishment of the Defense Center of Excellence for TBI/PTSD research and additional Fisher Houses are being funded privately. Additionally, many other projects, such as the establishment of the Vision Center of Excellence and the Joint Pathology Center on the installation are also non-BRAC projects, but enhance the overall mission of WRNMMC.

Question. Will the significant realignment of resources to Fort Belvoir support your healthcare delivery mission?

Answer. Yes. The Multi-Service Market Office, the Joint Cross Service Working Group and the BRAC Commission confirmed findings that over the last several decades commands, patients and families have located in the southern part of the National Capital Region. Fort Belvoir Community Hospital (FBCH) will be closer to more patients than Walter Reed National Military Medical Center (WRNMMC). A robust community hospital and outpatient clinic system at Fort Belvoir will significantly improve access to care and reduce drive times for active duty service members and other beneficiaries.

Question. Will the NCR BRAC process affect your ability to provide casualty care in the NCR?

Answer. No. As America's primary casualty reception site for returning warriors from Iraq, Afghanistan and other areas where Americans remain in harm's way, JTF CAPMED's number one priority remains casualty care. Our ability to provide high-quality casualty care during the National Capital Region (NCR) BRAC process will in no way be affected; in fact, the ultimate transition to the new facilities will greatly enhance the NCR's capabilities for wounded warrior care.

Question. Please talk about what you have accomplished since your inception.

Answer. JTF CAPMED reached Initial Operational Capability on 1 October 2007 and reached Full Operational Capability (FOC) on 30 September 2008. Since reaching FOC, JTF CAPMED has realized numerous accomplishments. Among them are the following:

- The Department approved a DoD Civilian Manning Model for National Capital Region (NCR) Joint Operating Area (JOA) 20 Oct 2008. Phased implementation will start with Walter Reed National Military Medical Center (WRMMC) & Fort Belvoir Community Hospital (FBCH).
- The Department approved a Military Personnel Staffing Model 15 Jan 09. Continues JTF CAPMED as a joint military command, establishing WRNMMC and FBCH as subordinate joint commands.
- JTF CAPMED is coordinating a joint manning document for civilians and military at the new WRNMMC, FBCH and Andrews Air Force Base.
- JTF CAPMED helped establish Directors of Integration (DCI) at both Walter Reed Army Medical Center (WRAMC) and National Naval Medical Center (NNMC). The DCI's are cross-service personnel whose task is to prepare the WRAMC and NNMC staffs for the eventual integration.
- JTF CAPMED prepared, and the Department approved, a milestone schedule for transition of operations from WRAMC to WRNMMC and FBCH, as required by Section 2721(d) of the Fiscal Year 2009 National Defense Authorization Act.
- JTF CAPMED is coordinating BRAC NCR Master Transition Plan (MTP) to direct execution of BRAC and maintenance of critical medical capabilities during the transition process.
- JTF CAPMED has successfully started integration of healthcare delivery in the NCR JOA.
  - Completed 160+ Clinical and administrative/logistic Concept of Operations Plans and will provide the foundation document guiding the provision of healthcare across the Joint Operation Area (JOA).
  - Air Force Referral Management System Tracking Tool now used by all referral management staff in JOA, allowing for consistent application of business rules. Standard practices also implemented in patient appointing and monitoring key performance measures.
  - Implementation of the first-ever JOA-wide synchronized influenza immunization program, resulting in the synchronized ordering, delivery, and administration of vaccine, so all Medical Treatment Facilities (MTFs) in the JOA start their programs at the same time and prevent beneficiaries from "chasing" vaccine from one facility to another.
  - Production of a strategic plan for credentials and privileging that utilizes a regional concept of operation for bylaws reconciliation and adverse privileging actions.
  - Inclusion of all JOA facilities into a benchmark Surgical Optimization and Standardization initiative.
  - Roll out of an AHLTA Clinical Enhancement project throughout the region.
  - Decision to use national standards for our ambulances when Advanced Cardiac Life Support or Basic Life Support ambulance is requested for a National Special Security Event.
  - For the Presidential inauguration, standardized the equipment for the roving medics and the aid stations; established a MTF JOA bed status/sit-rep for situational awareness and planning in the event of a Mass Casualty Incident.
  - Established the Trauma Service at WRAMC.
- JTF CAPMED has assumed the role as National Capital Region (NCR) Medical Force Provider to Joint Forces Headquarters NCR.
- JTF CAPMED has successfully provided support to the following Health Service Support missions to the Department of Defense:
  - White House Communication Agency Medical Readiness Support
  - National Memorial Day Observance
  - Joint Service Open House
  - JFHQ-NCR Joint State Funeral Training Exercise
  - National Veterans Day Observance Support

- Support to White House Communication Agency (WHCA) Service Member Readiness Processing
- Support of the Groundbreaking Ceremony for the Walter Reed National Military Medical Center (WRNMMC)
- Support of National Memorial Day Observance 2008
- Support of National Peace Officers' Memorial Service

• JTF CAPMED has successfully provided support to the following Defense Support to Civil Authorities missions:

- Annual National Peace Officer's Memorial Service
- Joint Session of Congress (Prime Minister Brown)
- Presidential Address to the Joint Session of Congress
- 56th Presidential Inaugural
- G-20 Summit
- Pentagon 9–11 Memorial Dedication
- Prime Minister of Ireland address to Congress
- Papal Visit to the National Capital Region (NCR)
- State of the Union Address

Question. With each Service Medical Component employing different concepts of care delivery and processes, how will you develop common practices within the NCR that will be suitable for a multi-Service pool of beneficiaries?

Answer. Working closely with the Assistant Secretary of Defense for Health Affairs (ASD (HA)) and the Service Surgeons General, JTF CAPMED is prioritizing the operations of care necessary to meet the expectation of world-class integrated healthcare delivery. The focus is to blend the best of each Service and then shape those processes for what is best for the patient.

ASD(HA) is supporting JTF CAPMED's mission by using the National Capital Region (NCR) as a test bed for Military Health System initiatives such as surgical optimization and AHLTA enhancement. As the annual planning cycle begins again, JTF CAPMED will take the next steps to implement common standards for the patient care supporting business processes that improve access to care and patient satisfaction.

[CLERK'S NOTE.—End of questions submitted by Mr. Murtha.]

WEDNESDAY, JUNE 3, 2009.

FISCAL YEAR 2010 AIR FORCE POSTURE

WITNESSES

HON. MICHAEL B. DONLEY, SECRETARY OF THE AIR FORCE

GENERAL NORTON A. SCHWARTZ, CHIEF OF STAFF, UNITED STATES AIR FORCE

INTRODUCTION

Mr. DICKS. This morning the committee will hold an open hearing concerning the Air Force fiscal year 2010 budget request. We are pleased to welcome two distinguished witnesses, Mr. Michael B. Donley, Secretary of the Air Force, General Norton A. Schwartz, Chief of Staff of the Air Force. They are very well qualified to discuss these areas and to answer the questions of the committee.

Secretary Donley, General Schwartz, thank you all for being here this morning. This committee is very interested in hearing what you have to say about the Air Force's fiscal year 2010 budget. Specifically as you are well aware, some of us on the committee are anxious to hear the status of the KC–X competition and particularly how you will address the issues that led the General Accountability Office to overturn last year's competition.

In addition, the Air Force budget includes the retirement of over 250 fighter aircraft yet to date. The Air Force has been unable to provide a schedule for retirement of the aircraft or a plan for reassignment of personnel. We look forward to your testimony and to a spirited and informative question and answer session.

Before we hear you I would like to call on our Ranking Member this morning, Kate Granger of Texas, for any comments you would like to make.

Ms. GRANGER. Thank you, Mr. Chairman. I have no comments.

Mr. DICKS. Okay. Secretary Donley, we understand that you and General Schwartz will each make an opening statement. You may proceed with your summarized statement. Your entire statement will be placed in the record and you may proceed as you wish.

SUMMARY STATEMENT OF SECRETARY DONLEY

Mr. DONLEY. Thank you, Mr. Chairman and members of the committee. I appreciate the opportunity to appear before you today to discuss the Air Force's fiscal year 2010 budget.

It has been almost a year since General Schwartz and I took on these roles as Chief and Secretary. And I must tell you I could not have had a better partner in this work than General Schwartz. In recent months, Secretary Gates and Admiral Mullen led a constructive dialogue about necessary changes in our national defense priorities and areas of emphasis. Our discussions emphasized taking

care of our most important asset, which is our people; rebalancing our capabilities to fight and win the current and most likely conflicts in front of us, while also hedging against other risks and contingencies; and reforming how and what we buy.

We have contributed our analysis and judgment throughout this process. With OSD, our sister Services and interagency partners, we have undertaken several strategic reviews in the Air Force over the last year. Last fall we refined the Air Force's mission statement. We articulated our five strategic priorities and refined our core functions to more clearly articulate the Air Force's role in national security.

We also made progress in areas that required some focused attention up front, such as strengthening the Air Force's nuclear enterprise, preparing to stand up our cyber-numbered Air Force, articulating our strategy for irregular warfare and counterinsurgency operations, consolidating our approach in the Air Force for global partnerships, and advancing stewardship of the Air Force's energy program.

Our reviews were guided by the concept of strategic balance, which has several meanings for us. As Secretary Gates and Admiral Mullen have described, balance means prevailing in today's fight while also being able to respond across the spectrum of conflict to emerging hybrid threats. Balance also means allocating investment across our 12 diverse but complementary core functions. And balance also means organizing, training and equipping ourselves as an Air Force across our Active and Reserve components.

Our budget proposal recognizes that people are the heart and soul of America's Air Force. Without them our organizations and equipment would grind to a halt. In fiscal year 2010, we are reversing the previously planned reductions in Air Force Active Duty end strength with commensurate adjustments in Reserve components. We will also grow our civilian cadre, especially the acquisition workforce. At the same time, we will continue to reshape our skill sets with particular emphasis on stressed career fields and missions that need our attention now, such as intelligence, surveillance and reconnaissance, acquisition, maintenance, cyber operations and nuclear matters.

In fiscal year 2010 we are also driving more balance into our force structure. In theater, the demand for intelligence, surveillance, and reconnaissance (ISR) and special operations capabilities continues to increase. So we will increase unmanned combat air patrols (CAPS) from 34 today to 43 by the end of fiscal year 2010, as well as increase special operations forces (SOF) end strength by about 550 personnel.

We also took a broader strategic look at the total combat Air Force capabilities. And there is a general view in the Department's leadership that the United States has enough tactical air capability. With that in mind, we judge this as a prudent opportunity to accelerate the retirement—the planned retirement—of older aircraft, as we have done in this budget.

As a result, we will reshape the portfolio of the fighter force by retiring about 250 of our oldest tactical fighters, completing production of the F–22 program at 187 aircraft and committing to planned F–22 upgrades, and readying the fifth generation F–35 Joint Strike

Fighter program to become the workhorse of our new fighter fleet going forward.

We will also ensure balance for joint airlift needs by completing the C–17 production, continuing to modernize our C–5s, reinitiating the C–130J production line and transitioning the C–27J program from the Army to the Air Force. In particular, the Department made a judgment that about 316 strategic airlift tails in the program of record is adequate to meet our needs. We also conducted a business case analysis that identified alternatives to improve our current strategic airlift capability at less cost than simply buying more C–17s.

We will enhance stability and remove risk in our military Satellite Communications (SATCOM) programs by extending our Advanced Extremely High Frequency (AEHF) and Wideband Global SATCOM (WGS) inventories and continuing partnerships with commercial providers. While AEHF does not give us all the capabilities of the projected Transformational Satellite (TSAT) program, adding additional AEHF and WGS satellites does provide additional MILSATCOM capability until we can gain confidence about the affordability and requirements for TSAT-like capabilities in the future.

We also placed additional emphasis on Air Force acquisition. We recently published our acquisition improvement plan to focus our efforts on several key areas. First, to revitalize the Air Force's acquisition workforce. Second, improving the requirements generation process. Third, instilling budget and financial discipline into our programs. Fourth, improving the Air Force's major systems source selection process. And fifth, establishing clear lines of authority and accountability within acquisition organizations.

I look forward to working with this committee in the future and with our OSD leadership as we address Defense acquisition improvements going forward. Over the coming months the Air Force will, with the other Services, participate in several major reviews, including the Quadrennial Defense Review, Nuclear Posture and Space Posture Reviews. And from these analyses we will better understand the needs, requirements and available technologies for long-range strike, as well as our requirements and potential joint solutions for personnel recovery.

Stewardship of the United States Air Force, Mr. Chairman, is a responsibility that General Schwartz and I take very seriously. We are grateful for the support that we get from this Committee and we do look forward to working with you in the months ahead.

Mr. DICKS. Thank you Mr. Secretary.

General Schwartz.

SUMMARY STATEMENT OF GENERAL SCHWARTZ

General SCHWARTZ. Mr. Chairman, Congresswoman Granger and other members of the committee, I am proud to be here with Secretary Donley representing your Air Force.

The United States Air Force is fully committed to effective stewardship of the resources that the American people place in our trust, a commitment founded on our core values of integrity first, service before self, and excellence in all we do. Guided by these

core values, American airmen are all working courageously every day with precision and reliability.

I recently had a chance to take a trip to visit with some of our airmen who are serving in various locations around the world and they are providing game-changing capabilities to the combatant commanders in the air and on the ground. Last year American airmen conducted 61,000 sorties in Operation Iraqi Freedom, some 37,000 sorties in Operation Enduring Freedom. That is 265 sorties each and every day.

Airmen also serve on convoys and in coalition operation centers and delivered 2 million passengers and some 700,000 tons of cargo in the United States Central Command area of responsibility last year. Dedicated airmen directly support CENTCOM operations from right here in the United States by providing command and control of unmanned aerial vehicles, while our nuclear operations professionals support the umbrella of deterrence for the Nation and its allies across the globe.

As well, our space professionals are providing truly amazing capabilities ranging from early warning to precise global positioning, navigation and timing.

Through Secretary Donley's guidance and leadership, we have set a course to provide even greater capabilities for the Nation and to balance our priorities to meet a spectrum of challenges.

The top priority is to reinvigorate our Air Force nuclear enterprise as outlined in a nuclear roadmap. We are also fueling capabilities that allow us to innovate partnerships with joint and coalition teammates to win today's fight by expanding intelligence, surveillance and reconnaissance with the procurement of 24 MQ–9 Reaper unmanned aerial systems.

At the same time we will continue support for our most precious asset: our people. We are focused on providing programs that develop and care for our airmen and their families with world-class quality of service and honor our commitments that we have made, the lasting commitments that we have made, to our wounded warriors.

Part of ensuring support for airmen means providing them with the tools they need to do their jobs effectively. Therefore, we are modernizing our air and space inventories, organizations and training with the right, yet difficult, choices.

In addition to programs that Secretary Donley just mentioned, we are committed to providing robust air refueling capability. We also intend to increase efficiency by retiring aging aircraft and we will complete the production of the F–22 at 187 aircraft and the C–17 at 205 aircraft, subject to congressional approval.

In recent testimony Admiral Mullen stated we are what we buy. Following his lead, we intend to maintain stewardship of America's resources for our war fighters in the field as well as taxpayers at home by recapturing acquisition excellence and fielding the right capabilities for the Nation, on time and within budget.

Mr. Chairman, with our core values guiding us, the Air Force will continue to provide our best military advice and stewardship, delivering global reach, vigilance and power for America.

Thank you for your continuing support of the United States Air Force and particularly for our Airmen and their families. Sir, I look forward to your questions.

[The joint statement of Secretary Donley and General Schwartz follows.]

DEPARTMENT OF THE AIR FORCE

PRESENTATION TO THE COMMITTEE ON APPROPRIATIONS

SUBCOMMITTEE ON DEFENSE

UNITED STATES HOUSE OF REPRESENTATIVES

SUBJECT: FISCAL YEAR 2010 AIR FORCE POSTURE STATEMENT

STATEMENT OF: THE HONORABLE MICHAEL B. DONLEY
SECRETARY OF THE AIR FORCE

GENERAL NORTON A. SCHWARTZ
CHIEF OF STAFF, UNITED STATES AIR FORCE

June 3, 2009

NOT FOR PUBLICATION UNTIL RELEASED
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SUBCOMMITTEE ON DEFENSE
UNITED STATES HOUSE OF REPRESENTATIVES

BIOGRAPHY

UNITED STATES AIR FORCE

MICHAEL B. DONLEY

Mr. Michael B. Donley is the Secretary of the Air Force, Washington, D.C. He is the 22nd Secretary and was confirmed Oct. 2, 2008. He is responsible for the affairs of the Department of the Air Force, including the organizing, training, equipping and providing for the welfare of its more than 300,000 men and women on active duty, 180,000 members of the Air National Guard and the Air Force Reserve, 160,000 civilians, and their families. He also oversees the Air Force's annual budget of approximately $110 billion.

Mr. Donley has 30 years of experience in the national security community, including service in the Senate, White House and the Pentagon. Prior to assuming his current position, Mr. Donley served as the Director of Administration and Management in the Office of the Secretary of Defense. He oversaw organizational and management planning for the Department of Defense and all administration, facility, information technology and security matters for the Pentagon.

From 1996 to 2005, Mr. Donley was a Senior Vice President at Hicks and Associates, Inc., a subsidiary of Science Applications International Corporation, and a consultant to DOD and the State Department on national security matters. From 1993 to 1996, he was Senior Fellow at the Institute for Defense Analyses. During this period he was a Senior Consultant to the Commission on Roles and Missions of the Armed Forces and participated in two studies on the organization of the Joint Staff and the Office of the Chairman, JCS. Prior to this position, he served as the Acting Secretary of the Air Force for seven months, and from 1989 to 1993 he was the Assistant Secretary of the Air Force (Financial Management and Comptroller).

Mr. Donley supported two Presidents and five National Security Advisers during his service at the National Security Council from 1984 to 1989. As Deputy Executive Secretary he oversaw the White House Situation Room and chaired interagency committees on crisis management procedures and continuity of government. Earlier, as Director of Defense Programs, Mr. Donley was the NSC representative to the Defense Resources Board, and coordinated the President's quarterly meetings with the Joint Chiefs of Staff. He conceived and organized the President's Blue Ribbon Commission on Defense Management (the Packard Commission), coordinated White House policy on the Goldwater-Nichols DOD Reorganization Act of 1986, and wrote the National Security Strategy for President Reagan's second term. He was also a Professional Staff Member on the Senate Armed Services Committee from 1981 to 1984.

Mr. Donley served in the U.S. Army from 1972 to 1975 with the XVIIIth Airborne Corps and 5th Special Forces Group (Airborne), attending the Army's Intelligence and Airborne Schools and the Defense Language Institute. Mr. Donley earned both Bachelor of Arts and Master of Arts degrees in international relations from the University of Southern California. He also attended the Senior Executives in National Security program at Harvard University.

EDUCATION

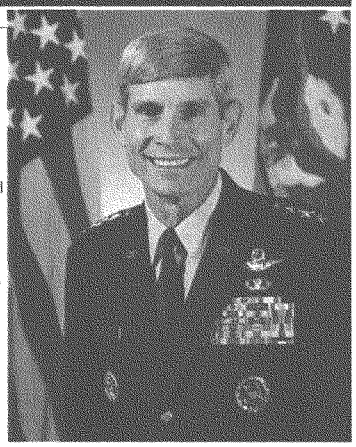
1972 U.S. Army Intelligence School, Fort Huachuca, Ariz.
1973 Defense Language Institute, Monterey, Calif.
1974 U.S. Army Airborne School, Fort Benning, Ga.
1977 Bachelor of Arts degree in international relations, University of Southern California, Los Angeles
1978 Master of Arts degree in international relations, University of Southern California, Los Angeles
1986 Senior Executives in National Security program, John F. Kennedy School of Government, Harvard University, Cambridge, Mass.

CAREER CHRONOLOGY
1. 1972 - 1975, U.S. Army, XVIIIth Airborne Corps and 5th Special Forces Group (Airborne), Fort Bragg, N.C.
2. 1978 - 1979, Editor, National Security Record, Heritage Foundation, Washington, D.C.
3. 1979 - 1981, Legislative Assistant, U.S. Senate, Washington, D.C.
4. 1981 -1984, Professional Staff Member, Senate Armed Services Committee, Washington, D.C.
5. 1984 - 1987, Director of Defense Programs, National Security Council, the White House, Washington, D.C.
6. 1987 - 1989, Deputy Executive Secretary, National Security Council, the White House, Washington, D.C.
7. 1989 - 1993, Assistant Secretary of the Air Force (Financial Management and Comptroller), Washington, D.C.
8. 1993, Acting Secretary of the Air Force, Washington, D.C.
9. 1993 - 1996, Senior Fellow at the Institute for Defense Analyses, Alexandria, Va.
10. 1996 - 2005, Senior Vice President at Hicks and Associates, Inc., a subsidiary of Science Applications International Corporation, McLean, Va.
11. 2005 - 2008, Director of Administration and Management, Office of the Secretary of Defense, Washington, D.C.
12. 2008 - present, Secretary of the Air Force, Washington, D.C.

(Current as of October 2008)

BIOGRAPHY

UNITED STATES AIR FORCE



GENERAL NORTON A. SCHWARTZ

Gen. Norton A. Schwartz is Chief of Staff of the U.S. Air Force, Washington, D.C. As Chief, he serves as the senior uniformed Air Force officer responsible for the organization, training and equipping of nearly 700,000 active-duty, Guard, Reserve and civilian forces serving in the United States and overseas. As a member of the Joint Chiefs of Staff, the general and other service chiefs function as military advisers to the Secretary of Defense, National Security Council and the President.

General Schwartz graduated from the U.S. Air Force Academy in 1973. He is an alumnus of the National War College, a member of the Council on Foreign Relations, and a 1994 Fellow of Massachusetts Institute of Technology's Seminar XXI. He has served as Commander of the Special Operations Command-Pacific, as well as Alaskan Command, Alaskan North American Aerospace Defense Command Region, and the 11th Air Force. Prior to assuming his current position, General Schwartz was Commander, U.S. Transportation Command and served as the single manager for global air, land and sea transportation for the Department of Defense.

General Schwartz is a command pilot with more than 4,400 flying hours in a variety of aircraft. He participated as a crewmember in the 1975 airlift evacuation of Saigon, and in 1991 served as Chief of Staff of the Joint Special Operations Task Force for Northern Iraq in operations Desert Shield and Desert Storm. In 1997, he led the Joint Task Force that prepared for the noncombatant evacuation of U.S. citizens in Cambodia.

EDUCATION

1973 Bachelor's degree in political science and international affairs, U.S. Air Force Academy, Colorado Springs, Colo.
1977 Squadron Officer School, Maxwell AFB, Ala.
1983 Master's degree in business administration, Central Michigan University, Mount Pleasant
1984 Armed Forces Staff College, Norfolk, Va.
1989 National War College, Fort Lesley J. McNair, Washington, D.C.
1994 Fellow, Seminar XXI, Massachusetts Institute of Technology, Cambridge

ASSIGNMENTS

1. August 1973 - September 1974, student, undergraduate pilot training, Laughlin AFB, Texas
2. October 1974 - January 1975, student, C-130 initial qualification training, Little Rock AFB, Ark.
3. February 1975 - October 1977, C-130E aircraft commander, 776th and 21st tactical airlift squadrons, Clark Air Base, Philippines
4. October 1977 - December 1977, student, Squadron Officer School, Maxwell AFB, Ala.
5. December 1977 - October 1979, C-130E/H flight examiner, 61st Tactical Airlift Squadron, Little Rock AFB, Ark.

6. October 1979 - November 1980, intern, Air Staff Training Program, Office of the Deputy Chief of Staff for Plans, Operations and Readiness, Headquarters U.S. Air Force, Washington, D.C.
7. November 1980 - July 1983, MC-130E flight examiner, 8th Special Operations Squadron, Hurlburt Field, Fla.
8. July 1983 - January 1984, student, Armed Forces Staff College, Norfolk, Va.
9. January 1984 - April 1986, action officer, Directorate of Plans, Office of the Deputy Chief of Staff for Plans and Operations, Headquarters U.S. Air Force, Washington, D.C.
10. May 1986 - June 1988, Commander, 36th Tactical Airlift Squadron, McChord AFB, Wash.
11. August 1988 - June 1989, student, National War College, Fort Lesley J. McNair, Washington, D.C.
12. July 1989 - July 1991, Director of Plans and Policy, Special Operations Command Europe, Patch Barracks, Stuttgart-Vaihingen, Germany
13. August 1991 - May 1993, Deputy Commander for Operations and Commander, 1st Special Operations Group, Hurlburt Field, Fla.
14. May 1993 - May 1995, Deputy Director of Operations, later, Deputy Director of Forces, Office of the Deputy Chief of Staff for Plans and Operations, Headquarters U.S. Air Force, Washington, D.C.
15. June 1995 - May 1997, Commander, 16th Special Operations Wing, Hurlburt Field, Fla.
16. June 1997 - October 1998, Commander, Special Operations Command, Pacific, Camp H.M. Smith, Hawaii
17. October 1998 - January 2000, Director of Strategic Planning, Deputy Chief of Staff for Plans and Programs, Headquarters U.S. Air Force, Washington, D.C.
18. January 2000 - September 2000, Deputy Commander in Chief, U.S. Special Operations Command, MacDill AFB, Fla.
19. September 2000 - October 2002, Commander, Alaskan Command, Alaskan North American Aerospace Defense Command Region and 11th Air Force, Elmendorf AFB, Alaska
20. October 2002 - October 2004, Director for Operations, the Joint Staff, Washington, D.C.
21. October 2004 - August 2005, Director, the Joint Staff, Washington, D. C.
22. September 2005 - August 2008, Commander, U.S. Transportation Command, Scott AFB, Ill.
23. August 2008 - present, Chief of Staff, Headquarters U.S. Air Force, Washington, D.C.

FLIGHT INFORMATION
Rating: Command pilot
Flight hours: More than 4,400
Aircraft flown: C-130E/H, MC-130E/H/P, HC-130, AC-130H/U, YMC-130, MH-53 and MH-60

MAJOR AWARDS AND DECORATIONS
Defense Distinguished Service Medal with two oak leaf clusters
Distinguished Service Medal
Defense Superior Service Medal with oak leaf cluster
Legion of Merit with two oak leaf clusters
Defense Meritorious Service Medal
Meritorious Service Medal with two oak leaf clusters
Air Force Commendation Medal with oak leaf cluster
Army Commendation Medal

EFFECTIVE DATES OF PROMOTION
Second Lieutenant June 6, 1973
First Lieutenant June 6, 1975
Captain June 6, 1977
Major Nov. 1, 1982
Lieutenant Colonel March 1, 1985
Colonel Feb. 1, 1991
Brigadier General Jan. 1, 1996
Major General March 4, 1999
Lieutenant General Jan. 18, 2000
General Oct. 1, 2005

(Current as of August 2008)

The 2009 Air Force Posture Statement articulates our vision of an Air Force ready to fulfill the commitments of today and face the challenges of tomorrow through strong stewardship, continued precision and reliability, and dedication to persistent Global Vigilance, Reach and Power for the Nation.

INTRODUCTION

Today, the United States faces a spectrum of challenges to our national security and global interests. As an integral member of the Joint team, America's Air Force provides the critical capabilities of *Global Vigilance, Global Reach,* and *Global Power.* The United States Air Force is "*All In*" today's Joint fight. At the same time, our investments in new capabilities will ensure we are ready for tomorrow's challenges. The mission of the United States Air Force is to "*fly, fight,* and *win*...in air, space and cyberspace"—as an integral member of the Joint team that ensures our Nation's freedom and security.

A BALANCED APPROACH

Today's uncertain international security environment requires a balance-driven approach to prevail in today's operations, and prepare for tomorrow's challenges by identifying and investing in new capabilities and force structure. This balanced approach postures the Air Force to provide an array of capabilities to Combatant Commanders across the spectrum of conflict—from building partnership capacity to ensuring the readiness of strategic deterrence forces.

AIR FORCE CORE FUNCTIONS

Our Air Force's foremost responsibility is to organize, train, and equip Airmen to meet the needs of our National leadership and Combatant Commanders. Our Fiscal Year 2010 budget proposal reflects a commitment to the twelve Air Force Core Functions, which provide the framework for investment and training.

AIR FORCE CORE FUNCTIONS

1. Nuclear Deterrence Operations	*7. Special Operations*
2. Air Superiority	*8. Global Integrated ISR*
3. Space Superiority	*9. Command and Control*
4. Cyberspace Superiority	*10. Personnel Recovery*
5. Global Precision Attack	*11. Building Partnerships*
6. Rapid Global Mobility	*12. Agile Combat Support*

The Air Force FY10 budget proposal reflects a commitment to our Core Functions that will be informed by numerous reviews of the overall defense-planning construct. Through the Quadrennial Defense Review (QDR), the Nuclear Posture Review (NPR), the Space Posture Review (SPR) and internal mid-term reviews, we will continue to sharpen and institutionalize our Core Functions. These capabilities, combined with the extraordinary commitment and dedication of our Airmen, provide our Nation with truly exceptional air, space and cyber power.

NUCLEAR DETERRENCE OPERATIONS

For more than 60 years, the Air Force has proudly served as stewards of a large portion of our Nation's nuclear arsenal. We operate, maintain and secure these nuclear forces to deter potential adversaries and to prevail if deterrence fails. Recent incidents and assessments have

highlighted performance shortfalls, and we are diligently working to ensure the safety, security and reliability demanded for this vital capability.

Our FY10 budget proposal addresses many of the recommendations provided by the various assessments of the Air Force nuclear enterprise. Our overall investment in nuclear deterrence operations in FY10 is $4.9B, which includes increasing nuclear related personnel by 2,500 and adding a fourth B-52 squadron. The FY10 budget proposal places additional emphasis on nuclear weapons security, committing $72M to strengthen the physical integrity of our Weapon Storage Areas.

Through a back-to-basics approach, the Air Force is re-emphasizing accountability, compliance and precision in the nuclear enterprise. We are reorganizing our nuclear forces in a manner that reduces fragmentation of authority and establishes clear chains of supervision for nuclear sustainment, surety and operations. These changes include: 1) consolidating all nuclear sustainment matters under the Air Force Nuclear Weapons Center; 2) establishing a new Air Staff nuclear directorate responsible for policy oversight and integration of our nuclear enterprise activities; and 3) standing up Air Force Global Strike Command, which is already operating in a provisional status at an interim location. Global Strike Command will consolidate Air Force Intercontinental Ballistic Missiles and nuclear-capable bombers under a single command, and is on track to activate later this year.

AIR SUPERIORITY and GLOBAL PRECISION ATTACK

Air Superiority and Global Precision Attack remain the foundations of our ability to deliver *Global Power.* In FY10, we are investing $21B into these Core Functions.

New and unprecedented challenges to our Nation's Air Superiority continue to emerge, and threaten to remove the technological advantage enjoyed by our Air Force. Our adversaries continue to invest in highly capable surface-to-air missile technology, which threatens even our most advanced combat aircraft. Likewise, emerging adversaries may now pose a significant air threat by leveraging inexpensive technology to modify existing airframes with improved radars, sensors, jammers and weapons.

To meet these challenges and assure freedom of movement for the Joint team, the Air Force continues to invest in weapons and platforms for Global Precision Attack. The Joint Air Surface Standoff Missile—Extended Range, will enable our aircrews to attack targets precisely while negating or avoiding surface threats. Similarly, the Laser Joint Direct Attack Munition will enhance our capability to strike moving or static targets efficiently and precisely.

The F-22 and F-35 are key components of the Air Force's future Air Superiority and Global Precision Attack Core Functions. Given their low-observable characteristics and ability to fuse information from multiple sensors – key components of their 5th Generation designs – these aircraft are far more survivable and lethal than our current 4th Generation force. While the F-35 is optimal for Global Precision Attack, it also serves as a complementary capability to the F-22, which is optimal for Air Superiority. Together, they form the backbone of a fighter force that will ensure the United States maintains a decisive edge in an increasingly lethal threat environment. We support the current investment strategy that ends F-22 production at 187 aircraft. The Air Force will invest $4.1B in FY10 to procure 10 F-35s as part of the Department of Defense's strategy to ramp up production. By accelerating the procurement ramp, we can lower unit procurement costs while also making the platform more cost competitive for our Coalition partners.

Our FY10 budget proposal accelerates the integration of our Guard and Reserve components into new and emerging mission sets, including unmanned aerial systems, F-22 and F-35

missions. By considering Air National Guard and Air Force Reserve Command for inclusion in emerging mission areas and basing strategies, we capitalize on the experience and unique skill sets that our Air Reserve Components contribute to the Total Force.

We are also modernizing our existing bomber force to increase its effectiveness and survivability against emerging threats, while meeting the requirements of today's Joint Force Commanders. We have fielded a state-of-the art infrared, electro-optical targeting pod on the B-1 to provide an additional, persistent sensor on the battlefield to self-target weapons, or provide real-time streaming video to ground forces. We are also modernizing our B-2 fleet by improving the radar, integrating the Link-16 data link and adding extremely high frequency satellite communication capabilities for nuclear command and control. In addition, investments in low observable maintenance improvements will decrease sustainment costs and reduce aircraft downtime. In accordance with the Secretary of Defense's budget guidance, we will not pursue the development of the Next Generation Bomber until we have a better understanding of the requirements, technologies, and concept of operations for this capability – all of which are expected to be addressed in the QDR.

Restructuring Our Combat Air Forces
This year, the Department of Defense provided guidance for the military to eliminate excessive overmatch in our tactical fighter force and consider alternatives in our capabilities. Acting on this guidance, the Air Force examined emerging, advanced threats and then analyzed our Combat Air Forces' capabilities against them. Our intent was to ensure the proper mix of platforms that meet requirements while minimizing excess inventory and deriving the most capability from our limited resources.

After a comprehensive review of alternatives, the Air Force saw an opportunity to reshape our aging fighter force via an accelerated retirement of our oldest legacy fighters. The review weighed the benefits of retiring aircraft nearing their expected service life, against near-term risk. The analysis also considered the "game-changing" capabilities of low observable platforms like the B-2, F-22 and F-35 that possess the ability to access areas defended by advanced surface-to-air missile systems.

Once the size and scope of the reduction was determined, the Air Force presented its implementation plan to the Combatant Commanders, Joint Staff and the Office of the Secretary of Defense. Accelerating the retirement of roughly 250 legacy F-15s, F-16s and A-10s enables us to redistribute over $3.5B in the next six years to modernize our Combat Air Forces into a smaller, but more capable force – one that is balanced across our Active and Reserve Components and meets our commitments at home and abroad. This restructuring also facilitates the movement of approximately 4,000 manpower positions that will be realigned to support growth in priority missions such as manned and unmanned aerial surveillance systems, ISR support and the nuclear enterprise.

Our current fleet of legacy and 5th Generation aircraft represent our readiness to fulfill today's commitments, while our FY10 budget proposal invests in a future force mix to meet tomorrow's challenges.

RAPID GLOBAL MOBILITY
Global Reach ensures our Joint team can deploy, maneuver and sustain large forces on a global scale. In Iraq and Afghanistan, Air Force air mobility assets are central to sustaining the Joint and Coalition team. On any given day, Air Force C-5s deliver life-saving Mine Resistant Ambush Protected vehicles into theater; C-17s airdrop critical supplies to forward-based ground forces via the revolutionary GPS-aided Joint Precision Airdrop System; and C-130s provide tactical airlift to move theater-based personnel and equipment. Highly skilled aeromedical

transport teams swiftly evacuate combat casualties, ensuring our wounded warriors receive the best possible medical care. And Air Force air refueling aircraft continue to play a vital, daily role in extending the range and persistence of almost all other aircraft of the Joint force. The FY10 budget proposal reflects our commitment to sustaining and modernizing these critical national capabilities.

Replacing the aging KC-135 fleet remains the Air Force's top acquisition priority. The FY10 budget proposal supports the release of a request for proposal in summer 2009 with a contract award early in FY10.

The FY10 budget proposal continues efforts for modernization and includes funding to begin the shut down of the C-17 production with a fleet of 205 aircraft. Modernization of our C-5 fleet continues through the Avionics Modernization Program and Reliability Enhancement and Re-engining Programs, and during FY10 we will continue recapitalizing our intra-theater airlift capability by re-initiating the C-130J production line following one year procurement gap and procuring 3 C-130J aircraft for $394M.

The Air Force will also begin procuring C-27J in FY10 to provide mission-critical/time-sensitive airlift in direct support of our Joint partners. The FY10 budget proposal procures eight C-27Js, as the first step toward a total procurement of 38 C-27Js. The Air Force continues to work closely with the United States Army to accept full management of the Joint Cargo Aircraft (JCA) program and the direct support airlift mission.

SPECIAL OPERATIONS

Air Force special operations capabilities are playing an increasingly vital role in supporting US Special Operations Command (USSOCOM) and geographical Combatant Commanders. We are also responding to significant growth in the requirements for Irregular Warfare (IW) capabilities with major investments in special operations airlift, close air support and Intelligence, Surveillance and Reconnaissance (ISR).

Our FY10 budget proposal reflects the Air Force's commitment to special operations capabilities, and includes $862.6M for the procurement of 4 MC-130Js and 5 CV-22s. AFSOC will expand its special operations ISR force structure by activating a squadron of MQ-9 Reapers, in addition to the already operational MQ-1 Predator squadron. Additionally, we are recapitalizing our MC-130E/P fleet with newer, more capable MC-130Js for low-level air refueling, infiltration, exfiltration and resupply of special operations forces. At the same time, we will convert 8 MC-130Ws to AC-130 gunships, and procure additional CV-22s.

GLOBAL INTEGRATED ISR

Operations in Iraq and Afghanistan have highlighted the increasing need for timely, fused data from all available sources. To meet this need, we are greatly expanding our airborne ISR force structure of manned and unmanned ISR assets. In FY09, we will field the MC-12W to provide increased full-motion video and signals intelligence. Additionally, our FY10 budget proposal continues major investments in unmanned aircraft, transitioning from the MQ-1 Predator to the MQ-9 Reaper, with $489M for 24 additional MQ-9s to increase our total UAS combat air patrols from 34 CAPs today to our goal of 50 CAPs by the end of FY11. We are also investing $84M to integrate the Wide Area Airborne Surveillance (WAAS) onto existing and new MQ-9s, providing 12 times the number of streaming video spots per aircraft. Our FY10 budget proposal also contains funding for five RQ-4 Global Hawk UAVs, which provide persistent ISR from high-altitude orbits. We are also balancing our ISR personnel requirements by re-examining our training programs for intelligence professionals, creating new duty specialty codes, and establishing trial programs to develop ISR operators.

COMMAND AND CONTROL
The Air Force has established Air and Space Operations Centers (AOCs) aligned with each geographical Combatant Commander to integrate air, space, cyber and missile defense capabilities into Joint operations. We have also improved our Tactical Air Control System (TACS) to account for increasingly distributed air-ground operations in Iraq and Afghanistan. Our restructured Air Liaison Officer program offers these Airmen a viable career path. We are also training additional terminal air controllers and equipping them with increasingly capable, portable and flexible air strike control systems like Remote Operated Video Receiver (ROVER) version 5.

SPACE SUPERIORITY
America's ability to operate effectively across the spectrum of conflict rests heavily on our space capabilities. Recognizing this importance, our FY10 budget proposal includes $4.4B for procurement of space and related support systems.

The Joint force depends upon space capabilities provided by the Air Force, which fall into five key areas: *Early Warning; Space Situational Awareness; Military Satellite Communications; Positioning, Navigation and Timing;* and *Weather* capabilities. We will field several new satellites, including the Global Positioning System Block IIF, Advanced Extremely High Frequency (AEHF), Space Based Surveillance System (SBSS), and the Space Based Infrared System-Geostationary (SBIRS-Geo) – recapitalization programs that are important to both the United States and its Allies. The FY10 budget proposal discontinues the Transformational Satellite (TSAT) program and supports procurement of additional AEHF and Wideband Global SATCOM (WGS) satellites.

CYBERSPACE SUPERIORITY
Operating within the cyber domain has become an increasingly critical requirement for our networked force. In order to develop and institutionalize cyberspace capabilities, and to better integrate them into the Joint cyberspace structure, we are consolidating many Air Force cyberspace operations into a new 24th Air Force under Air Force Space Command. The Air Force is firmly committed to developing the necessary capabilities to defend the cyber domain, and our FY10 budget proposal includes $2.3B to grow this important Core Function.

PERSONNEL RECOVERY
Personnel Recovery (PR) remains an imperative, fulfilling our promise to never leave an American behind. Air Force PR forces are fully engaged in Iraq and Afghanistan, accomplishing crucial missions that include command and control, intelligence, CSAR, convoy support, hostage recovery and reintegration.

The FY10 budget proposal terminates the current CSAR-X program to allow for additional discussion on platform requirements and quantities across the Joint force. We will continue to sustain our HH-60 helicopter fleet, while exploring Joint solutions to ensure sufficient PR capabilities in the coming years. We are continuing to extend our current capabilities by recapitalizing our HC-130P/N fleet with newer, more capable HC-130Js to provide low-level air refueling, infiltration, exfiltration and resupply of CSAR forces. In FY10, we will invest $605M to procure an additional five HC-130Js.

BUILDING PARTNERSHIPS
The Air Force continues to seek opportunities to develop our partnerships around the world, and to enhance our long-term capabilities through security cooperation. For example, in the Central Command AOR, deployed Airmen are working with our Afghan and Iraqi partners to build a new Afghan National Army Air Corps and the Iraqi Air Force. We are also working to further partnerships with more established allies, with programs like the Joint Strike Fighter, where our allies have committed $4.5B in research and development funding. Australia's commitment to

fund a communications satellite in the WGS constellation is another example of the value and synergy of lasting partnerships.

In the recently released *Global Partnership Strategy*, we outlined a path to cultivate these key partnerships, nurturing the global relations, fortifying our geographic access, safety and security around the world. The strategy seeks to develop partners who are able to defend their respective territories while ensuring the interoperability and integration necessary for Coalition operations.

AGILE COMBAT SUPPORT

Underpinning the work of all Air Force Core Functions are the capabilities included in Agile Combat Support. As part of our FY10 budget proposal initiatives, Agile Combat Support accounts for efforts affecting our entire Air Force, from the development and training of our Airmen to revitalizing our processes in the acquisition enterprise. Agile Combat Support reflects a large portion of the Air Force budget proposal, totaling approximately $42B.

Developing and Caring for Airmen and Their Families

The Air Force remains committed to recruiting and retaining the world's highest quality force, while meeting the needs of their families. Our FY10 budget proposal enables us to recruit, train, educate and retain the right number and mix of personnel, and to provide Quality of Service worthy of our Airmen's commitment to serve in the Armed Forces of the United States and supports an end strength of 331,700 active duty personnel.

Sharpening Our Skills

Our FY10 budget proposal enables us to train Airmen to fulfill both our Core Functions and the Combatant Commander's requirements. These changes span the vast array of skill sets, from improving language and cultural instruction to accelerated training for network operators. In FY10, we will also enhance foundational training received by all enlisted personnel entering the Air Force by constructing a $32M state-of-the-art training facility at Lackland Air Force Base.

Quality of Service

The Air Force leadership is committed not only to the quality of life of our Airmen and families, but also to their *Quality of Service*—ensuring each Airman is able to perform consistently meaningful work and make a daily impact on the Air Force mission.

We also understand the burdens placed on the families of our Airmen. To meet the needs of our Airmen and their families, our FY10 budget proposal funds a range of needed Quality of Life initiatives, including expanded legal assistance, advanced educational opportunities and new family housing. For example, our FY10 budget proposal invests $20M to build two new Child Development Centers, as well as $66M to improve and modernize military family housing overseas. The Air Force is also continuing to execute its Family Housing Master Plan, which synchronizes the military construction, operations and maintenance, and privatization efforts necessary to improve our family housing. By FY10, we will have all the funds necessary to award the privatization and MILCON projects needed to eliminate all of our inadequate homes, both in the U.S. and abroad – with all projects scheduled to be completed by FY15. To this end, we are on track to award contracts to privatize 100% of Military Family Housing in the CONUS, Hawaii, Alaska and Guam by the end of FY10. For Airmen concerned about foreclosure, we provide assistance at the Airmen and Family Readiness Center at each Air Force installation. Additionally, we are working with the Department of Defense as it expands the Homeowners Assistance Program to wounded warriors/civilians, surviving spouses and eligible military members affected by permanent changes of station.

Shaping the Force
America's Air Force draws its strength from its outstanding Airmen, with over 660,000 members of our Regular, Reserve, Guard and Civilian personnel dedicated to the mission of the Air Force. In accordance with the Secretary of Defense's guidance, we will halt active duty manpower reductions at 331,700 for FY10. We will also make commensurate adjustments in the Reserve Components, with 69,500 Airmen in the Air Force Reserve and 106,700 Airmen in the Air National Guard. We will also grow our Civilian cadre to 179,152, which includes 4,200 contractor-to-civilian conversions.

Retaining quality Airmen with critical skill sets remains a top priority. For FY10, we have proposed $641.4M for retention bonuses and recruiting, which includes a $88.3M increase for recruiting and retaining health professionals. In addition, we will retrain Airmen to fill undermanned career fields to balance and shape our force in accordance with emerging requirements. Further efforts to shape our force will also include diversity initiatives designed to leverage the unique qualities of all Airmen to achieve mission excellence.

Warrior Care
As part of our commitment to Airmen, we, in collaboration with the rest of the Department of Defense, are strengthening our focus on wounded warrior care. The importance of ensuring that our wounded warriors receive the service and support they need throughout the recovery process cannot be overstated. Through specific budget proposal items, such as increased funding to bolster the size of our Recovery Care Coordinators cadre, our wounded care programs will continue to provide our Airmen the best medical and professional support possible.

Other advances in wounded warrior care are also underway including work with Interagency and local partners to create the necessary support networks to ensure success in continued military service or in the transition to civilian life. We are also reinforcing our commitment to our Air Force wounded warrior families through support programs specifically designed to help allay their burdens and honor their sacrifices.

Recapturing Acquisition Excellence
To most effectively meet the demands of our warfighters, the Air Force has made Recapturing Acquisition Excellence a top priority. We recognize the profound importance of this capability, which enables us to acquire and recapitalize platforms that provide Global Vigilance, Reach and Power. As stewards of the taxpayer's resources, the Air Force will solidify an Acquisition system that delivers the right capabilities to the warfighter in the field – on-time and within budget.

To accomplish this we have published an Acquisition Improvement Plan (AIP) that outlines the steps we will take to improve Air Force Acquisition, informed by a series of internal and external reviews. This plan focuses on five initiatives that: revitalize the Air Force acquisition workforce; improve the requirements generation process; instill budget and financial discipline; improve Air Force major systems source selection; and establish clear lines of authority and accountability within acquisition organizations.

Through this plan, the Air Force will focus on better developing our acquisition workforce to ensure that it is appropriately sized to perform essential, inherently governmental functions and flexible enough to meet continuously evolving demands. We will also work to develop requirements that meet the users' needs while, at the same time, ensuring that they can be incorporated into effective acquisition strategies that maximize competition and allow for a fair and open source selection process.

Our reviews also emphasized that establishing adequate and stable budgets continues to be critical for program success. Therefore, the AIP emphasizes realistic budgeting based on comprehensive program cost estimates. Once budget baselines are established, achieving program stability and cost control will be given the same priority as technical performance and schedule.

We also found some weaknesses in our procedures for large system acquisition source selections and shortages in the skill sets required to conduct major source selections. So we are going back to the basics; building processes to ensure that our personnel have the experience and training required to conduct source selections and, where necessary, revising our processes and policies and increasing our use of multi-functional independent review teams (MIRTs). We are also reassessing our Program Executive Officer (PEO) and wing/group/squadron organizations to determine if they are properly structured, and identifying specific actions that could be taken to improve them.

READINESS AND RESOURCING

In the past year, we have continued to see stresses on our Air Force, both in our people and in our platforms. The Air force has conducted nearly 61,000 sorties in Operation IRAQI FREEDOM and over 37,000 sorties supporting Operation ENDURING FREEDOM, delivering over 2 million passengers and 700,000 tons of cargo. In doing so, airmen averaged nearly 265 sorties per day. Tens of thousands of America's Airmen are deployed to locations across the globe, including 63 locations in the Middle East. To support the efforts of our Airmen and provide for the recruiting and retention of the highest quality Air Force, our FY10 budget proposal includes $28.6B in Military Personnel funding. It provides for an across the board 2.9 percent pay increase, a Basic Allowance for Housing increase of 5.6 percent--resulting in zero out-of-pocket housing expenses for our Airmen--and a Basic Allowance for Subsistence increase of 5.0 percent. Additionally it halts the end strength drawdown which allows for rebalancing of the total force to cover new and emerging missions and stabilizes the active component end strength at 331,700; Reserve Component end strength at 69,500 Airmen and Air National Guard end strength at 106,700 Airmen. It also funds recruiting and retention bonuses targeted at critical wartime skills, including key specialties such as command and control, public affairs, contracting, pararescue, security forces, civil engineering, explosive ordnance disposal, and special investigations.

This high operations tempo requires focused attention on readiness. We use aircraft availability as our enterprise-level metric for monitoring fleet health, and the FY10 budget proposal provides $43.4B in Operations and Maintenance funding, a $1.3B increase over our FY09 appropriation, to mitigate the stresses of continuous combat operations on our aircraft. The FY10 Operations and Maintenance appropriation funds pay and benefits for 179,000 civilian personnel, including 4,200 contractor to civilian conversions, an increase of 200 civilian acquisition professionals and a 2.0 percent pay raise. It fully funds 1.4 million flying hours, produces 1,200 pilots and sustains over 5,400 aircraft while accelerating the retirement of roughly 250 aged aircraft, producing a smaller, more capable fighting force.

Our aging air and space fleet requires focused attention. For example, we have grounded our F-15, F-16, A-10, C-130, and T-6 fleets for limited periods during the past two years. The skill and determination of our maintainers have ensured that we return aircraft to service as quickly as possible, but 2% of the fleet remains grounded and many aircraft fly restricted profiles. To ensure stable aircraft availability and mission capable rates, we continue to integrate Fleet Viability Boards into our normal life-cycle sustainment processes and strengthen centralized asset management.

Additionally, in FY10 O&M funds will be used to rebuild the nuclear infrastructure by fortifying operations, developing people and sustaining 76 B-52s for global strike capability. The AF is also increasing MQ-1 and MQ-9 ISR capability to 43 unmanned Command Air Patrols. The O&M budget request honors the AF commitment to our Airmen and their families by increasing child care availability and special programs for children of deployed parents, providing for both legal assistance and advanced educational opportunities. Dollars are also committed to dormitory initiatives, unaccompanied housing, active Warfighter/Family Support Centers and Fitness Centers while still providing for the operating expenses of 83 major installations including two space lift ranges.

Our $19.4B FY10 Budget proposal for Research, Development, Test and Evaluation (RDT&E) is an increase of $600M from FY 09. This request funds requirements for next generation weapons and platforms by maturing technologies essential to equipping our Nation to defeat near-term and forecasted threats. We continue to develop and invest in future systems such as the KC-X Tanker program, F-35 Joint Strike Fighter, and the next enhancement of the Global Positioning System. Science and technology efforts advance propulsion, space based airborne and ground sensors, directed energy and command and control for both air and space. Modernizing our current fleet initiatives will provide upgrades to legacy fighters, bombers, strategic radar and mobility requirements. Systems and technologies designed to improve space situational awareness are also critical elements of this Budget Request. Additionally we are rebalancing the portfolio towards procurement of proven and muli-role platforms.

We are committed to supporting today's warfighter while building tomorrow's weapon systems capability. The FY10 procurement budget request provides $21.7B dollars to deliver immediate and future capabilities through investments made across four specific procurement appropriations: aircraft, missiles, ammunition and other. The FY10 Budget Request supports the Irregular Warfare Mission by increasing ISR platforms while modifying the existing fleet, provides joint warfighter support funding and balances investment in advanced aircraft platforms and legacy aircraft modifications. These funds will allow for the acquisition and modification of manned and unmanned aircraft, missiles, munitions, vehicles, electronic and telecommunications equipment, satellites and launch vehicles, and support equipment.

Funding critical infrastructure projects while meeting the needs of the Air Family are critical to our mission. The $2.4B budget request for military construction, military family housing and base realignment and closure supports a $300M increase in military construction from FY09. Projects will be focused on supporting the rebalance of AF and DoD priorities. Additionally the budget request continues our emphasis on providing quality housing for Airmen and their families. Finally, the AF is on target to deliver 17 BRAC 2005 projects on time while continuing the environmental clean-up of legacy BRAC locations.

To ensure proper stewardship of our resourcing, we have designated a Deputy, Chief Management Officer (DCMO) in line with the Department of Defense Strategic Management Plan. The DCMO is responsible for continuing our momentum in refining internal processes for reducing workloads or eliminating unnecessary work. Through a culture of continuous improvement, we are further improving warfighter effectiveness through integrated processes and systems, process improvement and technology investments aligned with our priorities.

SUMMARY

We believe the Air Force's total proposed FY10 budget of $160.5B – which includes $115.6B for Air Force managed programs, $28.9B in other funded programs such as the National Foreign Intelligence, Special Operation Forces, and the Defense Health Programs, and $16B in Overseas Contingency Operations provides the balance necessary to ensure support of today's commitments, while posturing the Air Force for success against tomorrow's challenges.

AIR FORCE ACQUISITION WORKFORCE

Mr. DICKS. Thank you both for your statements. Secretary Donley, on May 4 you and General Schwartz signed a plan to improve Air Force acquisition. Included in the plan are five goals and 33 actions that ensure rigor, reliability and transparency across the Air Force acquisition enterprise.

Your first goal is to revitalize the Air Force acquisition workforce. Will you hire new personnel or retask current employees, or both?

Mr. DONLEY. Our intent is to strengthen the acquisition workforce through both internal retraining and enhanced training in critical skill sets, and also to bring in new personnel as well.

As you are probably aware, the broader intent in the Department is to make changes in civilian personnel which will bring more work now performed by contractors back into the government. That pendulum of contracting out some of our important functions is swinging back toward a definite bias among the current leadership to get more of this capability back into our organic workforce. So our goal——

Mr. DICKS. Were we using contractors to actually do the acquisition work?

Mr. DONLEY. Contractors are definitely supporting our acquisition work. I am not sure that they were—they were not in charge of our acquisition decision process. But no question that contractors have been part of that.

As we go forward, our target for contractor-to-civilian conversions is about 4,000 in fiscal year 2010, of which about half are focused on our acquisition workforce. So we anticipate beefing up our acquisition workforce by about 2,000.

Mr. DICKS. What was the number again, 10,000?

Mr. DONLEY. Two thousand. And this is across a number of skill sets: systems engineering, contracts, cost estimators, all the different functions and supporting expertise that supports the acquisition process.

Mr. DICKS. Will they mainly be civilians or will they be civilians and military?

Mr. DONLEY. Mostly civilians.

Mr. DICKS. How will you improve the requirements generation process? I mean, one of the things we have talked about over the years is the fact that we have this requirements creep that drives up the cost. How are we going to try to get that under control?

Mr. DONLEY. Our focus in the Air Force on this subject is getting better visibility on requirements in the acquisition process and getting better understanding of the acquisition process in the requirements process up front. So we are undertaking procedures internally which require the requirements being developed by the warfighter to be reviewed by the acquisition process so we know those requirements can be translated into deliverables, contract deliverables, that we know can be accomplished; and to get acquisition professionals to sign off on those requirements so that they are written in such a way that they can be translated into contracts. And then, as the requirements move into the acquisition process, that as we write the contracts and as we translate those require-

ments into acquisition activities, that the warfighter who set the requirements signs off on those. So it is really cross-checking between requirements and acquisition.

KC–X PROCUREMENT PROGRAM

Mr. DICKS. Secretary Donley, what is the status of the KC–X procurement program and when will you release the latest RFP?

Mr. DONLEY. As you know, Mr. Chairman, I have been in dialogue with the new Under Secretary for Acquisition, Dr. Carter, and the Deputy Secretary of Defense and our acquisition officials on a regular basis over the last couple of months. We hope to take the work that we have developed thus far to the Secretary very soon and to have him give us his direction on how to proceed. We are hopeful that that new request for proposal will be out on the street this summer.

Mr. DICKS. How much funding is requested for the KC–X in the 2010 budget?

Mr. DONLEY. I would have to check, sir. I believe it is in the neighborhood of $600 to $800 million. I would have to double-check.

Mr. DICKS. I think we have the number. We think it is 439.

Mr. DONLEY. 439, right.

Mr. DICKS. But this year is going to be mainly the competition, and we hope it will be a fair and open transparent competition, which Secretary Gates has promised. And also I want to—and I want to say this on the record—encourage dialogue between the two competing sides. I think that is very important and was one of the issues, by the way, in the GAO report was that there was unfairness toward one side in the previous competition.

So transparency, openness and, I would hope, trying to keep both sides on the political side to let you guys—let the professionals make this decision without political interference, which I am afraid did mar this somewhat in the previous competition.

And then we understand also that the KC–X requirement was briefed at the Joint Requirements Oversight Council. And what was the outcome of that, do you know?

Mr. DONLEY. The general work done earlier this year was to revalidate that the requirements for the KC–X are and remain as they had been approved previously. So they were revalidated this year.

Mr. DICKS. We also understand that there has been a significant reduction in the 800 previous requests for proposals and the requirements in the previous request. Is that accurate as well?

Mr. DONLEY. We have been working to reduce, to streamline, to consolidate requirements, to write them as clearly as we can going forward; so that that has been part of our process this winter.

Mr. DICKS. One final question, and I am going to yield to Ms. Granger. The last competition was based on the best value, yet we understand that the Air Force may be considering low cost in the next competition. How do you differentiate these two concepts, best value and low cost?

Mr. DONLEY. Well, performance and cost are always part of our trade space in contract—in source selections. And I believe they will be part of our trade space going forward. I can't describe for you here yet exactly how that will be balanced out as we finalize

the Request for Proposal (RFP). But I think in some cases there is a tendency to polarize these concepts, whereas they are always part of our mix.

Mr. DICKS. The source selection authority has not yet been decided, is that correct, between the Air Force and DOD?

Mr. DONLEY. That is correct.

Mr. DICKS. Thank you. Ms. Granger.

JOINT STRIKE FIGHTER

Ms. GRANGER. Thank you. Thank you both for being here and thank you for your service.

I had a question for the General having to do with the Joint Strike Fighter, not surprisingly. I would like to know what impact there would be on reducing the procurement of the Joint Strike Fighter on your modernization plans. We have heard year after year how important reform and modernization is. And so my first question would be, what effect would it have? And given that, are there any plans to increase your buy from 80 to 110 per year, since that was the original plan?

General SCHWARTZ. Ma'am, clearly—and this not just for the Air Force; certainly the United States Navy, the United States Marine Corps and a number of international partners are highly dependent on delivery of the F–35, and that is certainly true for your Air Force.

We need to have very substantial rates of production for the F–35 to accomplish a couple of things for us. The most pressing has to do with the fact that much of our inventory is aging. I mean all of it is. But many of the machines that were bought during the Reagan buildup in the eighties are approaching the end of their service life, some of which we are going to retire early in order to get us on the ramp that we need to be on for high rates of production for the F–35.

And if we have those high rates of production, not less than 80 a year, and hopefully more as you indicated, we will be able to manage the retirements of remaining aircraft in our fleet, upgrade those that will last a bit longer time and, again, provide the overall tactical air capability that the Department requires of us. So in short as I see it, 80 is the minimum, it is the floor, it is not the ceiling, and that it is very important that this program deliver on time and on cost.

Ms. GRANGER. Thank you. I want to follow up on that to both of you. Given the fact that your requirement for 1,763 Joint Strike Fighters was predicated on the F–22 force of 381 aircraft, will there be an effort on your part in the Quadrennial Defense Review to make a case for the F–35 force structure to compensate for not having 381 F–22s?

General SCHWARTZ. Ma'am, it depends, frankly, on what the analysis that is currently underway with the Quadrennial Defense Review, what it comes up with. All of this is highly dependent on the scenarios we use to conduct the analysis with one warfight, two warfights, how close those warfights might be in terms of simultaneity. All of this affects both the size of the force and the mix of the force. And more broadly it is the joint team, but in the fighter area, as you indicated for us, the F–35, F–22 and some number of

legacy platforms. I think it is not yet clear what the top line will be for the Department. For us it has been 2,250 fighter strike-type aircraft for some number of years. It could end up being less. And if that is the case, we will still have a predominantly F–35-populated force. We will have the 187 F–22s, we will have well over 1,500 F–35s, and then some number of legacy airplanes. That will be the mix. It remains to be seen what the top line is, however, based on the analysis.

Ms. GRANGER. Mr. Secretary.

Mr. DONLEY. Ma'am, I would add one other item in addition to what the General has mentioned, and that is that as the Department looks at its tactical fighter and its air-to-ground capabilities in particular, the Reaper and armed Predator capabilities that the Department has been building the past several years to support the warfighter are coming into view as substantial assets for the Department in terms of air-to-ground capability.

So as we think about total tactical fighter strike inventories, we are starting to include these armed unmanned aerial system (UAS) capabilities in that mix as well. They are certainly not—they don't have air-to-air fighter capability, but they are certainly providing air-to-ground strike. And it is making that tactical Air Force more effective at the low end of the conflict spectrum.

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

Mr. DICKS. Mr. Boyd.

AIR FORCE COMBAT STRUCTURE

Mr. BOYD. Thank you, Mr. Chairman.

Secretary Donley, General Schwartz, welcome, and thank both of you for the time you have given me to work through some of the issues that we have a common interest in. And also I look forward to your visit to Tyndall Air Force Base on June 22nd, and I thank you for that commitment to come.

Secretary Donley, General Schwartz, last year the Air Force briefed this committee and other committees of Congress on combat Air Force structure. And basically that briefing concluded that we were in a real deficit in terms of air structure, tactical Air Force structure.

On May 9th of this year, you briefed this committee staff on the combat Air Force's restructure that is proposed in the fiscal year 2010 budget. And that includes retiring approximately 250 F–15s, F–16s, and A–10s in 2010. So it is a very radical fast-forwarding of what was in the BRAC documents that were put in place a couple of years ago.

Can you explain to the committee what, in your mind, has changed in the last 12 months that has gotten us to this point?

General SCHWARTZ. Sir, I think it is a couple of things. Clearly there are budgetary pressures that we are dealing with. That is one aspect.

A significant aspect has to do with the demands that are being placed on us by our joint commanders, which is to expand, amplify, certain aspects of the force; in other words, intelligence, surveillance and reconnaissance, reinvestment in the nuclear mission.

There are a number of areas where we had to expand or do more. And the issue for us was how do we bridge ourselves from the cur-

rent position that we are with the legacy fighter force to the one that we know we need to have, which will be a predominantly generation five kind of force. And it was our judgment, looking at this fresh this year, that it was not without risk, but that it was an opportunity to retire some of the legacy force structure sooner, several years sooner than they would otherwise have retired, take those resources, both dollars and manpower, in order to address some of those needs that we spoke to—invest in the remaining fourth-generation fighter fleet, radars, infrared search-and-track capability and so on, and then have the resources to leap to the high production rates of F–35 that we know we have to have. It is a difficult choice but one we think is needed, sir.

REASSIGNMENT OF MANPOWER POSITIONS

Mr. BOYD. Obviously this is a long thought-out process action and one that, as you know, became public in the Tyndall Air Force Base area and around the Air Force community much before you—or weeks before you intended it to. But the May 9th briefing was about 4 weeks ago. And to this point, there has been no plan for reassigning personnel, there has been no plan for the retirement, particular retirement dates of the aircraft. We can't really seem to get any meat on the bones here. And obviously from an operational standpoint and from a parochial standpoint for the communities we represent, that is a very—you know, that is a very serious subject.

So can you help me a little bit here about the reassignment of 4,000 manpower positions, civilian and military, where will they be reassigned, what about all your 2,500 Air National Guard folks? You have got two schoolhouses for F–15s in the country, I understand; you have got Klamath Falls and you got Tyndall Air Force Base, and you are going to transfer all of those to Klamath Falls under your plan.

Why would you do that? What about the military construction requirements? I haven't been to Klamath Falls, but I have spent a lot of time around Tyndall Air Force Base. You need to talk to us a little bit about those things.

General SCHWARTZ. Sir, this an example of thinning out the fighter fleet. Whether we need to have two schoolhouses in order to sustain the long-term F–15 population——

Mr. BOYD. Okay, granted you go to one schoolhouse.

General SCHWARTZ. Right.

Mr. BOYD. Talk to me about the choice.

General SCHWARTZ. This is a mission which is well-suited to the Air National Guard, and one which has performed not just in the F–15 community but the F–16 community in Tucson as well. The bottom line is those remaining F–15 units will be operational combat-coded kinds of units. And the training will occur by our partners who are full-up round in the Air National Guard, and have no reservations about that, sir, at all.

With regard to the reallocation of manpower, some of these folks no doubt will be reassigned in their current disciplines. Perhaps an F–15 crew chief from Tyndall Air Force Base might become an F–16 crew chief at Hill Air Force Base. But fundamentally folks will be reassigned, to a great degree, in their current disciplines.

Some of these folks, however, will be retrained into these growth areas, one of which the Secretary mentions, which is unmanned aerial vehicles. We are putting roughly 4,000 spaces overall—not just out of the combat air patrol (CAP) adjustment, but also out of the growth of our head space—into intelligence surveillance and reconnaissance. While we call them unmanned vehicles, sir, they are hardly unmanned. The truth is that there are a lot of folks that operate them and also digest the data that comes from the platforms and turn it into actionable intelligence.

Mr. BOYD. Mr. Chairman, I have got many other questions, so I would like to go maybe to the second round and hold those questions. But I would ask one final point, is that when can you give us a timetable or a schedule for retirement of particular aircraft and reassignment and when will we have a little meat on the bones here with this?

General SCHWARTZ. Sir, you will have insight into that before the end of the month.

Mr. BOYD. Okay. And I would hold, Mr. Chairman, my other questions to the second round.

Mr. DICKS. We appreciate your questions and we will have a second round. Mr. Bishop.

PERSONNEL TEMPO

Mr. BISHOP. Thank you very much. I would like to welcome you gentlemen, but I want to focus on personnel tempo, if you will. The increase in deployments over the past few years for domestic disasters, contingency operations, military operations other than war, has stressed military personnel and their families.

What is the average time that airmen are away from home doing your training exercises and deployments, other than Iraq and Afghanistan? And Secretary Donley, would you talk to us about how the Air Force manages the personnel tempo so that it doesn't have an adverse impact on individual unit readiness and training, and what systems you have in place to track that personnel tempo information?

Mr. DONLEY. Sir, I can give you a partial answer and let the Chief follow up a little bit. In the last year we have begun to band our Air Expeditionary Forces (AEFs), our AEF deployments, into various bands of activity. So personnel assigned to various functions and jobs understand what kind of a rotation they will be in, depending on which band they are in.

The Air Force has a broad range of deployment lengths of tours for its personnel, and this is a way in which we have spread the load across our Air Force. So if you are—you can be a medical professional in Yokota Air Base, Japan, and know that you are going to deploy to Iraq or Afghanistan on sort of a regular basis. But the medical community has its own—for example, the medical community has its own deployment——

Mr. BISHOP. Search and rescue, for example.

General SCHWARTZ. Sir, just to give you broad numbers, about half of our deployments are 179-day, 6-month tours. About a third are less than that, up to 120 days. And maybe 10 percent or so are 1-year duration deployments. In the case of, search and rescue, those are typically 120 to 179 days. A case in point is we have 12

combat search-and-rescue helicopters serving in Afghanistan now doing both the search-and-rescue mission, combat search-and-rescue mission and the aeromedical evacuation.

Mr. BISHOP. Are there certain units or mission skills that are being continually stressed with either the normal deployments for training exercises or contingency operations; and if so, which of those skill sets or units are being stretched thin?

General SCHWARTZ. Sir, there are several. Certainly the intelligence field is stressed, the security forces career field is stressed, contracting is another high-demand career field. They are essentially on a 1-to-1 deployment to at-home ratio.

Mr. BISHOP. And these are Air Force contract——

General SCHWARTZ. Air Force contracting personnel who are supporting the joint fight, who are in joint assignments.

Mr. BISHOP. Because I understand that you have reduced your contracting significantly.

General SCHWARTZ. That is another area, as the Secretary mentioned, that we will robust over time. In addition, as you are aware I am sure, we have also included incentives for these personnel who are in high-demand career fields in order to help compensate in some way for the demands on themselves and their families.

Mr. BISHOP. Has that been effective? How much of the budget for 2010 is being allocated for the retention in these high-stress skill sets, and has that been successful? Because I think there are some areas where you have met your goals, but other areas where you have not.

General SCHWARTZ. Yes, sir. I am sure the Secretary will want to lean into this. But, in short, I think the number overall for incentives and bonuses and so on is in the neighborhood of $700 million. It is substantial money, which is largely targeted to the high-stress career fields. We have seen adequate results.

We still—you know, we are on the bubble in a couple of the career fields like contracting, for example. And another one that is very interesting is the medical career field. We have had some difficulty in meeting our goals both on recruiting and retention in the medical disciplines. But interestingly, this is not just an issue for the Air Force; it is an issue for the other Services and in the civilian posture as well.

RESERVE COMPONENT PERSONNEL ON ACTIVE DUTY

Mr. BISHOP. One final question Secretary Donley. According to the Office of Assistant Secretary of Defense for Reserve Affairs, reservists contributed about a million man days per year to their respective services between fiscal years 1986 and 1989. In fiscal year 2007, reservists contributed 45.8 million days.

What is the number of Air National Guard and Air Force Reserve personnel that are currently on active duty in support of ongoing operations, and what is the Air Force's current mobilization cap?

Mr. DONLEY. Sir, I will have to get back to you on the record for that to get those numbers.

Mr. BISHOP. Okay.

Mr. DICKS. General, do you have any idea?

General SCHWARTZ. Sir, we have roughly 38,000 people deployed, about 8,000 of which, if I recall correctly, are Guard and Reserve.

[The information follows:]

The Air National Guard and the Air Force Reserve have 6,745 and 2,141 personnel, respectively, currently on active duty supporting ongoing contingency operations. The Air Force's current mobilization cap is 72,607.

Mr. DICKS. Ms. Kilpatrick.

EDUCATION PROGRAMS

Ms. KILPATRICK. Thank you, Mr. Chairman, General, Secretary—I should say it the other way around. Secretary and General, thank you for your service. Along that same lines kind of—first of all, congratulations on a successful graduation from the Academy. I understand the numbers—was it the highest ever, and what was that number?

General SCHWARTZ. It was 1,046, ma'am. It was a very large class, and we shook quite a number of hands that day.

Ms. KILPATRICK. Okay. Thank you very much for that, and for the young men and women who serve in the Air Force and the service, who are children who commit their lives. I believe that we in this committee, and certainly our Chairman, is totally committed to the force and people who serve.

Along that same line, education is where I want to go. I know that your Air Reserves, as well as your Active Duty Air Guard numbers are up. And in the retention of the Air Force, the numbers are down just a bit. I read somewhere you expect with the economy that those may increase as well.

What kind of programs do you have, in K–12 particularly and others, that would help increase those numbers and lead people, young people, into the fields of military? Are there currently those education programs; do you partner with anyone; are we looking for certain types of students? I know you have recruiters all over the country. Can you talk a little bit about it?

General SCHWARTZ. There are a number of programs that help, I think, to grow good citizens. I think that is fundamentally what they are about. And they have the side benefit of perhaps increasing the propensity of the young to serve in the Armed Forces or elsewhere in public service.

Civil Air Patrol is one, junior ROTC at the high schools is another, both of which are excellent programs, I think, that focus on citizenship but increase the propensity to serve. Naturally, it is a competitive arena out there. And while the economy is suffering, and that has improved our recruiting performance of late, we know that we have to keep at it. This is a constant effort. And one thing I would just say, ma'am, is that it is very important that the influencers, like you, like the other members of this committee, certainly parents and other influential folks, remind our youth that public service is a worthy undertaking. And that would certainly be helpful.

Ms. KILPATRICK. I do participate in our own Civil Air Patrol, as well as ROTC. I think those are good feeders as we move to the military. It is important to me that young people have that kind of discipline and responsibility even as they move forward, whatever career that they choose.

Mr. DONLEY. Can I just add one other aspect that is important to our Air Force? And that is continuing to encourage our partnerships with academia and various schools and organizations on science, technology, engineering and math, what we call STEM education. Very important to the future of our Nation, regardless of whether young people come into the United States Air Force. And we have partnered—I just partnered with the Aerospace Industries Association a few weeks ago, and the American Rocketry Club, which sponsors events for young people around the country to get them interested in this important work.

Ms. KILPATRICK. Funny you should mention that. Former Congressman Lou Stokes brought together a program partnering with NASA, STEM-related, and we put together one at Wayne State University and they are phenomenal. Our team, and it is called SEMAA—Science, Engineering, Mathematics Aerospace Academy. Our team from Michigan competed around the world—excuse me, around the country—in rocketry and came here to D.C. to compete and placed kind of high. So we know that STEM is the future. I would like to work with you on that because that is very important.

SHIFT OF EMPHASIS FROM IRAQ TO AFGHANISTAN

And finally I will wait for the second round. Afghanistan, Iraq moving, I guess shifting up in the other. What are some of your concerns and are you ready for that challenge?

Mr. DONLEY. Well, the Air Force has been working with the joint community for many months on the shift of emphasis from Iraq to Afghanistan. I will let the Chief go into some of the operational details, but I will just mention a couple.

One is that certainly our mobility community, led by the United States Transportation Command and the Air Mobility Command, have been working very hard on logistical support to Afghanistan, developing alternative routes for supplies and transportation to support this shift and to support a higher tempo of operations in that part of the world. That has been a great focus. And also our construction and engineering units and organizations have been deeply involved.

Congress has been very supportive in supporting our military construction (MILCON) requirements down range. As you appreciate, Afghanistan has much less infrastructure in that country and needs much more development of air bases and other infrastructure as we build up our capability, so we have been working very hard on that for many months.

Ms. KILPATRICK. Thank you, Secretary.

General SCHWARTZ. I would only amplify by saying that we currently have 5,000 Air Force personnel in Afghanistan supporting the joint team, part of the joint team. It will increase, probably, to in the neighborhood of 6,500 or so by the time all the additional troops have been authorized by the President or arrive there to assume their new missions.

Ms. KILPATRICK. Thank you, General. Thank you, Mr. Chairman.

NEXT GENERATION BOMBER

Mr. DICKS. Mr. Secretary, General Schwartz, over the last couple of years many of us have been briefed on the Next Generation

Bomber. And one of Mr. Secretary Gates' decisions was to terminate this program. You know, at some point we only have 20 stealthy B–2 bombers. And that is 1980s, 1970s, actually, technology—1970s and 1980s technology, which we have modernized.

Can you give us kind of the status where we are on the Next Generation Bomber? And I understand that there in your unfunded list, there is a request for $140 million to keep some level of effort going, which I personally would support. But can you fill us in on this?

Mr. DONLEY. Well, sir, I think the short story on Next Generation Bomber is that our plans in that area were probably running out ahead of the political consensus inside the Department of Defense on what was needed for that capability going forward. Well, we had significant resources put against this. We had not yet worked through the basic parameters of the program. I will let the Chief address those in a moment. But in addition to the programmatic detail, I take your point that we do need to be attentive to the kinds of technology integration support in this very sensitive area where we are combining many different technologies. And we do think it is important as we go forward to look at this more closely in the QDR and develop a new way ahead, that we do bridge this period of time where we do not have the Next Generation Bomber (NGB). That program is being canceled.

Mr. DICKS. General, before you start, I want to read to you a statement that was made before a committee in the other body. Barry Watts of the Center for Strategic and Budgetary Assessment replied to a question on Next Generation Bomber requirements. We have studied the NGB issue to death. The need, the requirement and the technology are in hand and reasonably well understood. Would you address that as you address your answer?

General SCHWARTZ. Yes, sir. The bottom line was that I don't think that our Secretary of Defense was comfortable with how the Air Force had defined the parameters of this platform. I do not believe that he has misgivings about the fundamental mission of long-range strike. This was a question about whether we had this thing right. Did we have the right range, did we have the right payload, did we know whether this should be supersonic or subsonic, should it be low observable or very low observable, should it be nuclear or nonnuclear capable, should it be manned or unmanned?

These were questions that we did not have the Secretary of Defense in his comfort zone. And this is what we will do over the next cycle, is to make sure that he in fact is comfortable.

Mr. DICKS. Wasn't that exactly what the Next Generation Bomber program was doing, was analyzing all of those issues so that the decision—it sounds to me we know what the options are. It is just a failure of decision-making here. We couldn't make a decision, we couldn't decide let's go do it, and we are going to go one way or the other.

General SCHWARTZ. Mr. Chairman, I think the bottom line was that what he wanted to make sure was that he did not get son-of-NGB as the answer to this near-term process that we have underway. He wanted this to be a thorough, no holds barred review of parameters and that he would get a truly fresh look. That is

what I believe was behind the programmatics which came out that we have discussed.

The key thing about this is that, in my view, Barry Watts certainly respects him, numerous studies have been done, but you have to get the decision-maker comfortable with your proposal and your program. That is something we have not done effectively, but we will do that.

Mr. DONLEY. If I could add one more item to that, Mr. Chairman. This is a very significant program for the Air Force and potentially a very large and highly complex program. We need to make sure that as we go forward we can make this a successful acquisition program for the Air Force.

And I will tell you that I am concerned about how we do that. We do not have a good track record in our last two bombers in terms of developing a program, a program of record, which we are able to sustain financially over time to get done what we say initially we think needs to be done. We planned on buying a few hundred B-1 bombers. We ended up with——

Mr. DICKS. You mean B–2s.

Mr. DONLEY. B–1s, a few hundred.

Mr. DICKS. We got 100.

Mr. DONLEY. And we got 100.

Mr. DICKS. And B–2s were way up there, too.

Mr. DONLEY. It is 175, I think.

Mr. DICKS. And we got 20.

Mr. DONLEY. We got 20. That makes those airplanes very expensive. And I do not want to repeat that process going forward.

C–5A RETIREMENTS

Mr. DICKS. I understand that. I can understand the budgetary implication. But I still think—and I am glad to see you got some money in the unfunded—that we have got to have an office and keep this thing going. The Secretary isn't going to learn anything if we don't have any work being done on this issue anywhere in the government. So it seems to me that we have to correct this flaw.

Now, the other thing, quickly. On the C–5A retirements, where do we stand on this? As far as I am concerned, I have supported you every step of the way. I think we are trying to do something in the supplemental, I am told, on this issue. I mean, can't we save a lot of money by retiring these older airplanes; and when we are so stressed, you know, so short of money to do all these important things, isn't it imperative that we deal with this issue?

General SCHWARTZ. Sir, here is the bottom line. Sometimes too much aluminum is as bad as not enough. And too many airplanes, excess capacity, if you will, as you suggest, competes with other needs. And our view is if it is the Congress' determination to continue to acquire C–17 platforms beyond the 205 that we have indicated we think is the proper force size, then we need to make adjustments elsewhere in the fleet mix, and that means C–5A retirements.

Now, there is a debate about what the floor should be on that. And from a former mobility capability study, circa 2005, that floor was at 292. There has been more recent legislation over the years that established the floor at 299. We currently are at 316. That is

slightly above what we believe is the minimum requirement that was certified during the Nunn-McCurdy action related to the C-5 re-engining. That was 33.95 million ton miles per day. So there is some space to reduce.

And my recommendation, my best military advice to the Secretary, is if there are X number of C–17s either in the supplemental or the authorization going forward, that we should retire C–5As in like number on a one-for-one basis. That would be my best military advice.

NEW MILITARY MOBILITY REQUIREMENT STUDY

Mr. DICKS. Mr. Secretary, do you have anything to add on that, or do you just want to stand with that?

Mr. DONLEY. Well, I do think, as you know, Mr. Chairman, we do have a new military mobility requirement study going on now that delivers toward the end of this year. My hope is that we will get that in sync with the QDR conclusion so that we can provide the Congress, again, sort of the next best, the best benchmark for what the strategic airlift requirements are.

Mr. DICKS. And I am with you on that. It also says to me, do we really want to shut down the C–17 line until we get the study? I mean, wouldn't it be a good idea to get the study in to see if in fact the assumptions we are making now are validated by the study?

Mr. DONLEY. We understand that perspective, but we think there is enough flex in the 316 that the General referred to, to add some marginal capability within the existing fleet by making other changes. We still have opportunities to do more re-engining and modernization of the C–5Bs. That program had been truncated during the Nunn-McCurdy decisions, but we can do that.

CIVIL RESERVE AIRLIFT FLEET

We have other options that have not been pursued. We have two or three things we can do that are cheaper than buying new C–17s, as good an airplane as that is.

Mr. DICKS. Ms. Granger.

UNMANNED AERIAL SYSTEMS

Ms. GRANGER. I want to turn briefly to the unmanned aerial systems. Give us a little more detail about your vision for the future in unmanned aerial systems in counterinsurgency; and in particular, are we short of those in places like Iraq, Afghanistan, Korea, our hot spots?

General SCHWARTZ. Ma'am, the way—we will grow to 50 orbits of unmanned systems by 2011. We are currently at 34, 31 of which are the smaller Predator, three of which are the larger Reaper, and then the yet larger, more strategic platform of Global Hawk more in orbit. We have approximately 120 Predators in the inventory, about 30 Reapers and about 15 of the Global Hawks. This is a trend which will continue, ma'am.

It is clear that we will become over time a more unmanned force. These are very useful assets, particularly in those cases where you need persistence, where 24/7 coverage is what is required to get the

mission done. And there are very efficient ways to perform that kind of mission: particularly intelligence, surveillance and reconnaissance, some quick reaction strike and so on. This will be a significant portion of our portfolio going forward.

And the 24 Reapers that are in this fiscal year's budget request are a manifestation of that. I don't think that we will ever end up being a completely unmanned force. There are some missions in my view that require a man in the cockpit, or a woman in the cockpit.

For example, a nuclear bomber like the B–2. I am not sure that I would be comfortable making that an unmanned platform. Nonetheless, the plan will be to expand the population of unmanned vehicles certainly to the 50-orbit level. That is our current target. And we will see what the demand signal looks like out of QDR and so on.

The last thing I would like to mention to you, ma'am, is that it is important to recognize that UASs are not any time/any place machines. They have a wonderful application but they need to be utilized largely in benign airspace. In other words, if it is denied airspace, they cannot protect themselves, they do not have the natural capacities to avoid attack. And they are vulnerable.

In fact, as you may recall in the news, we shot down an Iranian UAV in Iraq some months back. So we need, again, to think about this in terms of the whole concept of operations, where do they apply, where are they less applicable. Maybe they don't go in right away, but they follow the F–35s and the F–22s, that sort of thing. This is a package, and that is really the genius of this, being able to package this in a good way.

Mr. DICKS. What about the Special Forces? Are you talking about—when you talk about these various orbits and how many of these you have, are you also including the fact that you are doing this for SOCOM as well?

General SCHWARTZ. Mr. Chairman, yes, indeed. Of those 34 orbits that are currently performing, I would say probably half of those are dedicated to Special Operations teams on the ground and half to more conventional forces.

Mr. DICKS. All right. Do you have a third question?

Ms. GRANGER. No, I don't. Thank you.

Mr. DICKS. Mr. Boyd.

Mr. BOYD. Thank you, Mr. Chairman.

PROPOSED PLAN FOR AIRCRAFT RETIREMENTS

Secretary Donley, I want to go back to the proposed plan of the retirement of the 15s, 16s and A–10s.

As you know, Mr. Secretary, the Air Force does not have a particularly good track record when it comes to proposed cost savings versus actual cost savings, and I think many of us on this committee would be somewhat suspicious of proposed cost savings until we saw some thorough analysis of what those would be and how you would achieve that $3.5 billion over the next 5 years.

Can you speak to that and when we might see that analysis and in what detail.

Mr. DONLEY. I am open to briefing that to the Committee. There are some sensitivities with it with respect to outyear funding. We have not yet—the Department has not yet provided a 5-year plan

of detail to the Congress as is normally the case by this time of year because the outyear work just hasn't been done. But I think the main message, sir, is the one that the Chief indicated earlier.

This was not just a budgetary and a savings drill. We reinvested the resources elsewhere in the Air Force program, and we have a good briefing and a good track record of where we put the money. Back in 4th Generation modifications we put it in air-to-ground munitions, air-to-air munitions and very specific movements of dollars from one account to another; and we have a very specific track on what we did with the people which, as the Secretary mentioned, is just as important.

We needed additional personnel to be reinvested in higher priority mission areas and to get that done as soon as possible. So these were the factors behind the decision. I think we have a good trail on the dollars and the people.

Mr. BOYD. I think we understand the intent, of course, to reduce cost in one account and transfer it to another account. But before you can transfer it, you have to reduce it in one account, and I think that is where the track record hasn't been very good. So we look forward to getting those briefings and seeing that detailed analysis.

What would be the MILCON requirements for Klamath Falls in this particular scenario?

General SCHWARTZ. Sir, I don't know the answer to that. I would like to take that for the record and get back to you.

Mr. BOYD. I assume there would be some.

General SCHWARTZ. I am not certain that is the case. They currently have a schoolhouse operation, and the resized force, that may not be true, but I need to confirm that for you.

[The information follows:]

The Air Force has no military construction requirements at Klamath Falls, Oregon through fiscal year 2013.

HC-07-001 - Klamath Falls Military Construction Requirements

Coordination Table

Action Officer Information					
Action Officer's Name and Phone					**Office Symbol**
Mr. Carl A. Glad 703-607-5352					**NGB-LL**
Coordination					
Office Symbol	**Action**	**Name**	**Phone**	**Date**	**Comments**
NGB/A7	Coord	Col. William Albro	301-836-8060	15 June 09	
NGB/A4M	Coord	Lt. Col. Jeffery Combs	301-278-8410	16 June 09	
NGB/CFX	Approve	Mr. J.R. Darby	703-607-3492	22 June 09	

Mr. BOYD. Okay. Thank you.

PERSONNEL AND FUNDING IMPACT TO TYNDALL A.F.B.

Can you speak to the specific personnel and funding impact to Tyndall Air Force Base, General.

General SCHWARTZ. Sir, as you are aware, the intent is to draw down to an F–22-only—at the moment, F–22-only scenario. So you will end up losing the F–15s that are currently there and the folks that are associated with that mission; and again, I will be happy to give you the precise numbers, and we will certainly have that for you on the 22nd.

Mr. BOYD. Thank you, sir.

Now, in your report or when you briefed the committee earlier, you said that this plan would free up nationwide some 266 full-time and 2,426 part-time Air National Guard personnel. Can you talk to us about where those personnel will be? Will they be reassigned?

General SCHWARTZ. This is really an issue for the Air National Guard and National Guard Bureau, and we will certainly get that information to you as well. As you know, active duty we can reassign to other missions in other locations. This is not as easy to do with regard to the National Guard and we are working those adjustments with the Air National Guard and General McKinley at the National Guard Bureau.

Mr. BOYD. I think that was the point, and what I wanted to hear you say is, you have got 2,700 Air National Guard, many of them part-time.

It seems to me that—how do you reassign a part-time Air National Guardsman from one community to another across the Nation? I think that is a very difficult—you probably can't do it. So all of these questions that we have talked about in the two rounds that I have had, I know you have told me a lot, that you will give us the reports, give us the briefings, and we will have that before the end of the month.

General SCHWARTZ. You bet.

Mr. BOYD. Okay.

Mr. Chairman.

Mr. DICKS. Good questions.

Mr. BOYD. Thank you.

Mr. DICKS. Mr. Tiahrt.

TANKER REPLACEMENT

Mr. TIAHRT. Thank you, Mr. Chairman.

Mr. Donley and General Schwartz, thanks for your service to the country, and I appreciate your time here.

I just want to briefly go over the tanker replacement. We have an RFP that was clearly to replace a medium-sized tanker with a single platform; and there is no plan to change that concept of a single platform in the Air Force's revision of the RFP, is there?

Mr. DONLEY. Sir, our view is, we ought to go ahead with a source selection for a single airplane.

Mr. TIAHRT. I thought the RFP was very clear last time about that, but we had some significant political influence where the RFP became modified so much that it resulted in a GAO study. It

seemed like the Joint Strike Fighter had Euro participation so we tried to reciprocate by modifying the RFP to accommodate a mega medium-sized tanker, and I hope that doesn't occur this time, that the political influence is excluded from the RFP.

As you know, the results of the GAO study brought to light that some of these changes were just way beyond the pale, and it resulted in a cancellation of the decision. So as we move forward, I am hoping that we can keep the political influence out of it, that we look at the actual cost, the long-term cost, as well as the other significant requirements and come up with a good decision this time that is not influenced by politics.

PROJECT LIBERTY (MC–12 PROGRAM)

There is another program called Project Liberty. It is an ISR platform and it seems to be held up right now. Can you tell me right now the status of the MC–12 program, Project Liberty?

General SCHWARTZ. Sir, the first aircraft deployed for Iraq on the 1st, and it will arrive Friday. So you know that we have had training operation going on in Mississippi, the temporary location, so that we can train the crews and man these, that we are going to push the aircraft forward. There will only be several training birds left in the States. Everything else will go forward.

And this in a way also addresses Congresswoman Granger's earlier question about ISR capacity, that the MC–12s are an important part of that. They have much the same kind of capability, at least in the video area, that the Predators and the Reapers do, and they will provide support to the ground forces that are required both in Iraq and ultimately in Afghanistan.

So the program is slightly behind schedule based on efforts by the prime contractor, L–3. We originally anticipated deployments in April. We just got deployments this week, and we will continue to press on that.

Mr. TIAHRT. Is it an integration problem or a hardware problem-software problem?

Mr. DONLEY. Sir, I think this is just sort of underestimating some of the engineering demands that have been placed on this program. It was a very aggressive schedule to begin with. As you may recall, the first—the plan was to buy the first eight aircraft from commercial sales and the used aircraft market. As we bought those airplanes, we ended up with seven or eight different configured airplanes. So the engineering integration had to be done differently seven times for those initial airplanes. For the Block 2 aircraft, we have, working with the Office of the Secretary of Defense, with USCENTCOM and others, have been adding capabilities to these aircraft to ensure that they have the ISR capabilities that the combatant commander wants and needs in the theater. And as we have done that, we have added engineering time again into that process. So those I think are the reasons really for the delay. The contractor is on it and they are working 24/7 to meet the contract schedule.

General SCHWARTZ. Congressman, I will only add that the first delivery was seven months after contract award. So this was not sort of business as usual on anybody's part.

Mr. TIAHRT. That is a pretty short stroke. When we spoke last time, there was a problem with the AT–6C program and it was an engine problem with the prop sleeve, and I think that has been resolved.

But how are we doing to ensure that the Iraqis are fielding them properly and are working them, as well as the trainers, the trainer version of it.

General SCHWARTZ. Sir, the trainers have not been delivered to the Iraqi forces yet. That is still ahead of us. The prop sleeve touchdown problem with the engine, we still have 64 airplanes that are grounded pending certification of the fix. Certainly Pratt & Whitney believes they have the fix, and we are in the midst of phase one test to confirm that before we take the machines back airborne. Assuming that comes through as advertised, we will be okay with regard to the schedule for delivery to the Iraqi air force of the trainers.

IRAQI BUDGET

Mr. TIAHRT. Are you aware of the state of the Iraqi budget as far as the funding? Are they in good shape?

Mr. DONLEY. The Iraqis have had a couple of ups and downs in their budget planning, including national defense for them, based on the price of oil. So their budgeting process is very dependent on the price of oil. We understand the Minister of Defense is being briefed this week by their Air Chief and they are working through the various programs and priorities that they have set for the new Iraqi air force and we have advisors as part of that process continue to be directly involved with their leadership in watching the schedules and the performance of the programs that have been set in place to support the buildup of that, but they are definitely under resource constraints and remain heavily dependent on U.S. support.

B–52'S RE-ENGINING

Mr. TIAHRT. Mr. Dicks was talking about the next generation bomber, which seems like it is some ways downstream and we have a limited inventory of other bombers available today.

Is there a program office for re-engining the B–52s in existence today and would you consider that?

General SCHWARTZ. Congressman, we have looked at that a number of times over the years. The TF–33 engine is sustainable through the airframe life of the platform, so at the moment there is no consideration of re-engining the B–52, sir.

Mr. TIAHRT. The current fuel costs, it always varies, but it looks like it is going no place but up. Have you recalculated based on current fuel costs and how they are projected in the future? Because it seems like there is a significant fuel savings with the re-engining program.

General SCHWARTZ. We have looked at the business case, and it has not risen to a level of priority which would suggest that we would preempt something else in order to re-engine the B–52.

For example, candidly we wouldn't interfere with F–35 or KC–X procurement to re-engine the B–52. We think those two other items and others are a higher priority.

Mr. TIAHRT. Thank you, Mr. Chairman.
Mr. DICKS. Mr. Bishop.

AIR FORCE MISSIONS AND REQUIREMENTS

Mr. BISHOP. Thank you very much. I would like to turn my attention to general Air Force missions and requirements.

Now the Air Force is really embracing a collaborative and supportive role in the types of operations that have been conducted in Iraq and Afghanistan and, in general, attempting to change the service's culture to meet these new challenges. Of course, the Air Force has always provided mission support in the struggle against extremism, which you designated as in lieu of, and now "in lieu of" has been defined as a standard force and equipment that is supplied to execute missions and tasks outside of your core competencies of core responsibilities.

Now, the Air Force views these responsibilities and refers to them as Joint Expeditionary Tasking, JETs, but to support that there are some realities that you have got to deal with—increased deployment tempo and requirements—and they are done at the expense of your traditional missions.

General Schwartz, I think you stated you want to change the Air Force's culture. What types of changes can we expect to see in the Air Force?

And Secretary Donley, will there be any overall policy changes to reflect such a shift in the fiscal year 2010?

General SCHWARTZ. Congressman, I think the way to start this—and I know the Secretary will wrap—the Nation is at war, and there are demands on the joint team, writ large, to be successful in Iraq and Afghanistan. And if there is a need and if the Air Force can fill a need, it was our view, the leadership's view, that in a time of war we will do whatever is necessary wherever it is needed for however long it is needed.

Now, our commitment to our youngsters is that they will be trained to do what we ask them to do, and I think we have been very rigorous in that regard. But, yes, we have some people who are doing nontraditional things, but I think we should celebrate that. It doesn't diminish us at all.

The truth is that—and I just met with 60 folks or so that are doing convoy work at Camp Arifjan in Kuwait and sustaining our forces in Iraq, including Air Force youngsters, and these Airmen will be better Chief Master Sergeants when they grow up as a result of this experience.

So, in short, sir, I do not apologize for our folks filling legitimate combat requirements for the joint team. We just simply need to recognize their contribution, honor their contribution, make sure that they are properly trained and that they are rewarded for their work.

Mr. BISHOP. Is that going to result in a shortfall of the traditional missions for training as well as execution if you do that? And how many of those functions were performed by the Army and Marine Corps?

General SCHWARTZ. Sir, it means that the folks that remain in those disciplines where we drew folks for nontraditional tasks will

work harder. It means the entire team works harder. That is the reality.

But, again, I would put this in context. This is not peacetime, and people are dying, and so we are not going to stand by and argue about it is not our job. That is not what we are about.

Mr. DONLEY. I would echo exactly what the Chief has said, that we are all in. Whatever we are asked to do, we will do.

I think another aspect of our joint work together over the last year has been to broaden the appreciation with both outside and inside communities in our Air Force of the extent to which we are all participating in this fight whether we are deployed downrange or not. We have logisticians; we have mobility forces that are back and forth from the theater on a regular basis that are not necessarily deployed there; we have all the UAS support work, the intelligence work that backs up all that data collection that is done in other parts of the world, not just in CONUS.

Some of it is done in Europe; some of it is done elsewhere. Our Air Force is committed to these fights from—geographically from, basically from all around the world and in all of our different functions.

Mr. BISHOP. How many of them in the Central Command area of responsibility?

Mr. DONLEY. About 26,000 at any given time of our 37,000 deployed abroad are in the USCENTCOM AOR.

Mr. BISHOP. Are you experiencing any difficulty filling those deployment missions?

General SCHWARTZ. It is interesting, sir. We—and I will give you an example.

We just lost two people on a provincial reconstruction team mission in Afghanistan last week, one officer and one young Airman, both of whom were volunteers. And this is the reality. The people understand the value of the work and they have volunteered. Thus far, we are fulfilling the requirements that have been levied on us.

Mr. BISHOP. As I understand it, the Air Force is currently playing a critical role in the mission that is expected to continue expanding to match 50 unmanned combat air patrols. Will this expanded role affect ISR manning requirements, and if so, how does the 2010 budget request address those needs?

Mr. DONLEY. Sir, we have been very attentive to making sure that as we add ISR collection assets, as the unmanned aerial systems and other ISR assets increase, that we also back it up with the necessary intelligence personnel to do that, sir. We have done that in the 2010 budget.

We can get you more detail as you would like.

NUCLEAR MANNING REQUIREMENTS

Mr. BISHOP. Finally, what are the nuclear manning requirements and how does your 2010 budget address those needs? And are you able to source all your requirements in the nuclear field, and if not, what shortfalls do you have and how can we help in that regard?

General SCHWARTZ. We are on a glide path, Congressman, with regard to reinvigorating the nuclear discipline in our Air Force, so in some areas we don't have the numbers or the depth of expertise

we would like. That is part of our plan for recapturing excellence in this area.

We are putting, for example, about 1,000 spaces back into the nuclear enterprise in order to serve that mission well. Some of that is in the new headquarters, the Global Strike Command. Some of that is in the 4th B–52 Squadron that will be moving to Minot Air Force Base in North Dakota, and it is in the 2010 program.

Mr. BISHOP. It is in the 2010 program.

Thank you, Mr. Chairman.

Mr. DICKS. Mr. Rogers.

NUCLEAR OVERSIGHT BOARD

Mr. ROGERS. Thank you, Mr. Chairman.

Good morning, gentlemen. Thanks for your service to our country to all of you in the room.

Let me quickly ask about the two high-profile nuclear security incidents in the past few years, Minot and Taiwan. You have taken severe—I guess is the word—steps to try to correct those problems.

Are you satisfied, both of you, with what you have done, that our nuclear capability is kept secure at all times?

General SCHWARTZ. I can speak from the operational side.

I think we took the necessary actions, some of which included disciplining officers and NCOs, some of which entailed reorganizing the way we had responsibilities distributed around the Air Force in a number of commands and concentrating that operationally in one command and on a sustainment side in one command, one accountable officer.

We likewise have given focus to the policy side of this, which is not trivial, as well, and that activity, of course, works for the Secretary.

My view is, we are on exactly the right path, the needed path. In fact, this Saturday we will have what we call the Nuclear Oversight Board. We meet periodically to address progress along with our nuclear road map, those remedies that we have put in place, and I am persuaded that we are on the right path, sir.

Mr. DONLEY. Likewise, I think we have put together a strong road map to get back the level of expertise and discipline that we need in this very important area.

But I would tell you, this is a work in progress, that it will not come back quickly and it needs continued attention in the next several years as we build back the necessary expertise.

We have had since October, I believe about 19 inspections across our nuclear enterprise of which 17 resulted in satisfactory or excellent ratings. Two were unsatisfactory and had to be retested at a later date, which they passed. But this continues to be a work in progress.

The Chief mentioned the Nuclear Oversight Board that we have established. This will be our third meeting at the end of this week.

Just this last weekend, we were back at Ogden Air Logistics Center reviewing the progress made there over the past year in the handling of nuclear-related materials. They have made progress there, but there is more to do. We do not have in place all the automated systems and such that we should have that would help us with end-to-end accountability and get us out of the paper environ-

ment. So we have a lot of work to do to build back, but we have a good program and we are putting the resources in place to do it.

So I am very pleased with the progress we have made over the last year.

Mr. ROGERS. Well, I need not remind us all it just takes one simple mistake to do a lot of damage.

Well, on February 4, the Washington Times and other agencies reported that Air Force nuclear units have failed two surety inspections in the past 3 months. Are those the ones that you mentioned a moment ago?

Mr. DONLEY. I believe they are, sir.

Mr. ROGERS. Well, again, are you positive that we have solved the problem, given those lapses that we have just mentioned?

General SCHWARTZ. Sir, in the end, you know, this is discipline, it is compliance with procedures, and there will be some human error; so that is why we do two-man or two-woman kinds of processes to assure that we mitigate that risk.

But with respect to the inspections, I don't think that 100 percent pass on inspections is necessarily the thing we want to see. We consciously turn the dial up on the inspection process to make sure that it was rigorous, to make sure that it was more invasive, to make sure that it actually told commanders where they had problems.

And that was one of the dilemmas we had. Frankly, I think the inspection process became too easy and so that has been part of the corrective action. And if we see failures, I think that is a reflection of rigor and not necessarily a situation over which we should be alarmed, too alarmed in any event.

Mr. ROGERS. All right. Thank you.

Mr. DICKS. Ms. Kilpatrick.

NUCLEAR REQUIREMENTS

Ms. KILPATRICK. Thank you, Mr. Chairman. Those were exactly where I was going with regard to the nuclear.

But one thing as it relates to the 2010 budget—and I thank you for all you said, and Senator Gates coming in and changing the command, and the two of you assuming new positions and carrying out what we just discussed in the last questioning. Does the 2010 budget fully source all your requirements for the field? Do you have what you need? And I think I asked you that before. Are there any shortfalls we should look at at this time?

General SCHWARTZ. Trust me, ma'am. We made sure that all the nuclear requirements were addressed at 100 percent.

Ms. KILPATRICK. So as this committee goes through its due diligence after you have gone back to the base and all that, you want to leave us with that point?

General SCHWARTZ. Yes, ma'am. The key thing is, you won't see any nuclear items on the unfunded list.

HEALTH CARE

Ms. KILPATRICK. Thank you very much.

Let's go to health care. We didn't talk about that very much this morning.

General, you did mention that is one of your short staffing falls. I don't know if you have the people that would require—the needs that we have as we go forth to Afghanistan and really the domestic and around the world needs. What kind of assistance do you need? I am talking more positions and dollars, enlisted or not.

I just left a hearing where Congresswoman Nita Lowey was introducing a bill that the medical profession's nurses who performed in World War II are not—they don't get pensions. Her bill was trying to get them pensions and make them a part of the military, which I strongly support, and those who now commit their lives and follow the troops around and care for them and keep them safe and healthy.

Talk a little bit about health care as it relates to the mission in theater and the overall Air Force.

General SCHWARTZ. Clearly, one of the great successes of this period of conflict that we have been in is how the medical community has performed. When I first came into the Armed Forces, we were in the midst of the Vietnam conflict, and I remember vividly how it took weeks to get wounded back from Vietnam to hospitals in the States, maybe longer. Now it takes hours, literally.

And as you are aware, ma'am, the survival rate of our troops, our Airmen, Marines, Sailors, who are wounded on the battlefield is well in excess of 95 percent, higher than it has ever been because of the casualty evacuation capability, of the field medical capability, and the strategic efforts that we have to move folks from one theater to the next back to the U.S. for definitive care. I think it is a wonderful example of how the Armed Forces take care of their own.

This is not to say that there are not difficulties with respect to certain specialties in the medical area. One of the—the truth is, though, that we have had greater success in recruiting surgeons of late than perhaps we did before. We typically were a very healthy force in peacetime, so you only did geriatric surgery, if you will. But this is the real deal now, and certainly trauma surgeons know that the Armed Forces are a place where their skills can be put to very good use.

So the bottom line is, we compete in the civil market for talent. We need to have incentives that allow people to have a fair standard of living along with the rewards that come with military service.

Ms. KILPATRICK. When you talked about the shortage in health care, were you talking about the surgeons specifically, or the other professionals in that field?

General SCHWARTZ. An area where we have had difficulty because they are in short supply is mental health. And we have—for example, we have hired 100 mental health professionals in the Air Force, and this is a relatively small number compared with what the Army has done; but there is keen competition for mental health professionals.

Ms. KILPATRICK. In the domestic world——

General SCHWARTZ. Exactly. And that is my point.

So this is a difficult area, and it is one where, after folks return home, there are still mental health needs, and that is an area where incentives and so on are certainly required.

Mr. DONLEY. As the Chief mentioned earlier, we have put about $645 million against incentives and bonuses for recruiting and retention generally. Of that amount, about 88 million or so is targeted at health care professionals. So I think we have—as the Chief suggested, I think we have addressed the requirements issues and we have established where we need additional personnel positions. I mean, we have done that internally. The shortage is in the bodies and getting them in and retaining them; that is a common problem across the Armed Forces right now.

Ms. KILPATRICK. Finally, along that same line, the wounded warriors who come home and their families, adequate health care resources?

General SCHWARTZ. For the Air Force, we do. We have had far fewer numbers of casualties than have the other services. But we have been focused on this and we are okay with regard to assuring that our commitments to our wounded warriors are fulfilled.

Ms. KILPATRICK. And their families?

General SCHWARTZ. Certainly, and their families. Yes, ma'am, forgive me for——

Ms. KILPATRICK. Thank you.

Mr. DICKS. Let me ask you, on the ILOs, are they all volunteers?

General SCHWARTZ. Probably not all, but a large proportion certainly are, and we prefer it that way. For example, in the contracting area where we have a lot of our folks involved, they are on a one-to-one ratio as I indicated, somewhat like the security forces or the engineers. And we have had to direct people to serve and, of course, that is what we sign up to do in the Air Force or in any of the Armed Forces. But we seek volunteers first and then deal with the remainder as we need to.

JOINT CARGO AIRCRAFT

Mr. DICKS. On the joint cargo aircraft, can you explain what is going to happen here? First, this was an Army program, then it was a joint program, and now we understand it is an Air Force program. That is rather magical.

Recently the Secretary of Defense has stated that the C–130 aircraft could and should be used to carry out the mission. So tell us where we are on this.

And the Army has got eight of those planes, as I understand it. How are you going to get those back? What is the story here? And we hope this is the final chapter.

General SCHWARTZ. Sir, nothing happens instantaneously in this, and it would be foolish to do so.

The Army program office will remain in the lead until well into 2010. They will have—they currently have Air Force people in the office, but there will be more folks assigned and attached now that the transfer has been directed and that we will migrate the program from Army supervision and management to Air Force supervision and management over the next year.

A key factor in this is that there is a deployment of four aircraft that are required to go to the U.S. Central Command area of responsibility late in 2010. So that is the mark on the wall. We will fulfill that commitment. And it may be with some Army crews and some Air Force crews; it will probably be a mix. We are getting the

plan together now on how we will man this and likewise how we will operate this mission downrange. Still a lot of work to do.

I think that at the strategic level, Mr. Chairman, the issue was, how many C–27s do we need? And I believe that the Secretary was concerned that perhaps we were not getting as much utilization out of our C–130 fleet as he thought appropriate.

Just again as background, about two-thirds of our C–130 fleet is in either the Air National Guard or the Air Force Reserve, and because of availability management issues related to that, they are not quite as available for deployment as our active duty, and this is the nature of things.

We need to get the Secretary settled on what the right mix is, and clearly that will be an outcome of the Quadrennial Defense Review. It might mean more than 38 JCAs. That is an open question. I think 38 is the floor; it could be more. We will have to satisfy his inquiry related to the applicability of available C–130 capacity to do that mission.

Mr. DICKS. What I have a hard time understanding is, if the Air Force is going to take this program over, why wouldn't it be Air Force crews? Why would you do mixed crews? Why not deal with this once and get it over with?

General SCHWARTZ. I agree, sir. And that will be the end game. But the problem is, we have a near-term deployment requirement, and to get people trained and certified and so on may require a mix before the total migration occurs.

And so this is something we are working out. We probably won't have mixed crews, but it is conceivable that you would have Army—a coherent Army crew, coherent Air Force crew that would operate the aircraft using the same rules.

Mr. DONLEY. Just to follow up, Mr. Chairman, there are many moving parts to this: the program management piece, the training piece, the Guard, the basing issues, the deployment commitments that have been made.

The Army and the Air Force and the National Guard Bureau together are working this very hard. I think it is going to take several months before we get a real firm handle on how all the details of this will spin out. So there is a lot of work here.

I think the strategic level decision that the Secretary took is that the direct support mission can move, should move from the Army to the Air Force. That was the strategic level decision, not just the JCA program.

So there is a lot of work that needs to be done and—to the concepts of operations and how Army needs to be supported and making sure that the Air Force prepares itself to do that correctly. So, many moving parts. The clutch here will operate probably for a year or two as we make this transition; it is a significant one.

KCX COMPETITION

Mr. DICKS. Going back to the KCX competition, one of the things that really bothered me in this is the fact that the Air Force leadership, as I understand it, by statute, is precluded from being involved in the decisionmaking.

Is that accurate as it relates to the acquisition part of this program, that the acquisition people do this, or is that inaccurate?

Mr. DONLEY. Source selection decisions are closely held and are limited to those individuals who have been assigned that responsibility, so we do not share source selection information outside of the select—source selection team.

Mr. DICKS. So we have people in the source selection group who are going to take into account—who take into account the industrial base issues?

Who takes into account key issues that affect the country here in terms of industrial base and where this thing is going to be built and the whole thing? I mean, those kinds of issues, who takes those kinds of issues into account?

Mr. DONLEY. Well, the source selection authority is responsible for ensuring that——

Mr. DICKS. That those things have been looked at.

Mr. DONLEY [continuing]. That those things have been looked at, that the law has been fulfilled in every respect—regulations, et cetera.

Mr. DICKS. There is a provision in Title 10 that says you have to look at industrial base. We don't think that was done on this program the last go-round, and we raised this with Secretary Young before his departure.

So we would like you to look and make sure that we have looked at—and that is supposed to be done to make sure we have evaluated the effect on the industrial base. We can get you the citation. It is in Title 10.

The other thing is, there were some changes made in the model, the CMARP, that in order to allow the Airbus aircraft, the EADS Airbus aircraft, Northrup Grumman, to be able to compete. Now, when we start this process over again, are those same changes in the CMARP going to be allowed or are they going to be reevaluated, or do you know?

Mr. DONLEY. I can't speak to the specific issue you are raising here. All I can assure you is that we are going through this process with a fine tooth comb to make sure that we have established all the requirements for the program in ways that can be understood and written into a good proposal—clear proposal, measurable requirements—and that we have good oversight of this program going forward.

We have made internal changes to the Air Force to strengthen that source selection process. We have increased the seniority of the team. We have done sort of remedial training, if you will. We have moved contracting responsibilities and oversight to a higher level in the Air Force.

So we have taken a number of steps since last summer to strengthen our preparedness to get back into this RFP this summer and to go through a fair and open competition and to make sure that we can withstand scrutiny that we know will come, and should come, from the Congress and those overseeing us.

Mr. DICKS. We have had this discussion, but I want to say this on the record:

I would hope that they would go back and reevaluate the changes that were made in the model, the CMARP, in order to make certain that that was in the best interest of the Air Force and the operation of the Air Force. I have doubts about that my-

self, that those changes should have been made. They were done so that one company would be able to compete because they said they were going to withdraw from the competition if changes weren't made.

The other thing is, in the GAO report there were two requirements: Now they have to meet the requirements. Two of the requirements were not met. One was on the organic—having an organic maintenance site within 2 years and the other was the ability to refuel all Air Force aircraft. Those were not met, and I want to know whether in the next go-round if a competitor doesn't meet the requirements, stated requirements, that they will be disqualified, which they should have been under the law.

And those are two things that I think are fundamental.

And the third thing is to do a valid cost comparison on life-cycle costs. I mean, I think Congress is—we want to know the difference in life-cycle costs between the planes that are competing; and that was not, in my judgment and in the judgment of many others, properly evaluated in the first go-round.

So those three things we would like an answer to, how you are going to approach those things.

Mr. Tiahrt.

Mr. TIAHRT. Mr. Chairman, you are referring to Title 10, U.S. Code. It is section 2440 just to be specific.

And if I might add, there are also some Defense Federal Acquisition Regulations, DFARs, that waive regulations for some of our allies, particularly the International Traffic in Arms Regulations, the Foreign Corrupt Practices Act, along with other cost accounting procedures that are demanded upon our American contractors and not our European allies that I think need to be reevaluated for a fair and level playing field.

I have an additional question if we have time.

Mr. DICKS. I yield to you.

INDEPENDENT COST REQUIREMENT

Mr. TIAHRT. Thank you, Mr. Chairman.

In the process of every major program, there is a requirement for the Air Force to conduct an independent cost estimate, and in that independent cost estimate—which is a difficult task, by the way; whether you use parametrics or some similar programs, it is always hard to estimate what new technology is going to be and how you get there.

But once that has been established and there is some degree of confidence, there has been a tendency within the Air Force in the past to underbudget those programs. They are trying to cram more program into the budget by number of aircraft by lowering the independent cost estimate or adjusting it downward. And the tendency is in doing that—the result, I should say, in doing that is that we end up later on with program overruns; and then we go through these machinations of trying to catch up on the funding on very essential programs.

I assume you will have to keep continuing on the independent cost estimates. But I think it is important that we keep in mind that once you establish a dollar figure for a program, that it is fully included in the budget because the harder it goes, later on, by try-

ing to cram 10 pounds of sand into a 5-pound bag, eventually it is going to spill out; and that spilling out is where we run into a lot of trouble with our budgeting process, our funding process, as well as your having to go through all of these hearings.

So I would encourage you in the future, when you get an independent cost estimate, that is what your budgetary number ought to be. Can I get some agreement on that?

Mr. DONLEY. The use of independent cost estimates is a very important tool to the leadership, no question; inside the Air Force and inside the DOD leadership, this carries weight with us. As we look toward improving the acquisition workforce, we are adding cost estimators. That is—part of our plan is to beef up that part of our workforce that supports this aspect of the acquisition process.

I would say, as the chairman and I were discussing earlier, we have seen a lot of acquisition reform in our time here in Washington, DC over 30 years. I would summarize it a little bit as you did, perhaps a little bit more bluntly. Those who want to add capability to programs usually underestimate the cost and the impact on schedule. Those that want to take money from programs usually underestimate the impact on capability and schedule when they do that, and we have people in this town for various programs—all of us are participating in this process who want to add capability or who want to cut dollars from programs; it just depends on the program.

So we put our program managers in a very difficult situation. There are only certain aspects of programs that they really have control over, because the leadership in the Pentagon, the Air Force, the Office of Secretary of Defense, many different competing pressures on programs, and also, obviously, in Congress with multiple committees marking and funding programs at different levels with different goals, different objectives, different capabilities. We are all working around the edges of these programs.

So maintaining stability both in content and in funding is a very significant challenge for all of us and continues to be going forward and requires a lot of discipline on our part to know when to intervene and when to leave it alone.

Mr. TIAHRT. I know that some people are always a little bit surprised that there are politics in Washington, D.C. And I know it doesn't end at the Potomac; I know it occurs the across the river as well. But I think in this process, if we can have some stability in abiding by these independent cost estimates, it will help us avoid some future overruns, which politically are difficult to live through for both you and ourselves.

Thank you, Mr. Chairman.

Mr. DICKS. Mr. Bishop.

NEW MILITARY SATELLITE COMMUNICATION ARCHITECTURE

Mr. BISHOP. Thank you very much.

As part of the fiscal year 2010 budget development, Secretary Gates cancelled the Next Generation Military Satellite Communications Program, TSAT. TSAT would have provided anti-jam, high-data rate MILSAT communications and Internet-like services to military users, such as the future combat systems and the intelligence, surveillance, and reconnaissance assets.

With the cancellation of TSAT, the restructure of FCS and the addition of 50 Predator orbits, it is not clear whether or not the current satellite communications architecture is capable of supporting force projection assets. And, of course, last week DOD issued the stop order on the TSAT program.

What are your plans, Secretary Donley, for the new military satellite communication architecture, and when will you make those plans available to Congress? And could you tell me whether or not you are going to migrate the TSAT capabilities onto the advanced, extremely high-frequency satellite system? Would you address that for me?

Mr. DONLEY. As you indicated, the Secretary made a strategic level decision to reduce the risk in our MILSATCOM programs that was perceived to be associated with the TSAT program. It had forecast significant increases in capability across a broad range of functions and aspects for MILSATCOM. It protected communications on the move, et cetera. These were viewed as very desirable by the combatant commanders, but also very high risk and potentially high cost.

The Secretary's decision was to take risk out of our program by continuing to add MILSATCOM capability by extending the Wide-Band Global System another two satellites, by extending the AEHF system that you referred to by another two satellites.

At the same time, the decision recognized that at some point in the future we would want to continue the R&D work necessary to develop the advance MILSATCOM capabilities that we hope would be available in the future from a TSAT-like capability and decide whether those capabilities ought to be migrated into our MILSATCOM structure.

So we owe a plan to the Office of the Secretary of Defense as part of the TSAT cancellation, that develops a plan—Air Force working with combatant commanders and other users in the system—to continue to evaluate the technology and to determine when that technology is ready to be inserted into the MILSATCOM—future MILSATCOM architecture.

So the details of that have not been worked, but it is probably at AEH–6 or beyond.

Mr. BISHOP. How are you trading off the commercial lease satellite communications systems with the military satellite communications systems in your future architecture analysis?

Mr. DONLEY. We are big users of commercial SATCOM today and depend on our commercial partners to support ongoing operations in the theater. They bear a significant part of our requirement today.

I believe they will continue to be part of our MILSATCOM architecture in the future. We will have further internal debates on how much and what kind——

Mr. BISHOP. I was going to ask you what the balance was going to be.

Mr. DONLEY. Right. And we will continue to work that going forward.

There is no question in my mind that it is recognized within the space and MILSATCOM community that commercial partners are a part of our MILSATCOM—part of our SATCOM architecture

going forward. They will be meeting part of our needs going forward, no question.

Mr. BISHOP. Thank you very much, gentlemen.

And thank you, Mr. Chairman. I would like to at the close of the hearing have a moment with General Schwartz, if you don't mind——

General SCHWARTZ. Yes, sir.

Mr. BISHOP [continuing]. Regarding a constituent matter.

Thank you, Mr. Chairman.

ALTERNATE ENGINE FOR JOINT STRIKE FIGHTER

Mr. DICKS. Can you give me kind of the newest update on the alternate engine on the Joint Strike Fighter, what the administration's position on this is?

Mr. DONLEY. Sir, the administration's position remains that the second engine for the F–35 would not be in the best interest of the F–35 program going forward. So there is—at the moment, there is no change in the Administration's position on that subject.

Mr. DICKS. We understand that the Congress has added $2.5 billion. A lot of this comes from the—I think it is the F–100 competition; and our analysis up here is that over the life cycle that—even in the worst case, this would only cost $300 million. And that with competition there, it keeps both competitors' prices down.

So, anyway, I just want to make that point because I am pretty confident Congress is going to stay with their position on this.

General SCHWARTZ. Mr. Chairman, if I could, if you would allow me just to say that I think we understand that argument. I would only ask that if that is the case, if we are going to proceed, that Congress directs that we proceed with the alternate engine, that we all do our best not to have that decision impact the production rate of our F–35 platforms.

If the trade is fewer airplanes for more engines, from an operator's point of view, that is less than ideal.

COMBAT SEARCH AND RESCUE HELICOPTER PROGRAM

Mr. DICKS. That is a valid point and noted.

On April 6, Secretary Gates announced the termination of the Air Force Combat Search and Rescue helicopter program due to a concern over the acquisition history and questions whether the mission can only be accomplished by yet another single-service solution with a single-purpose aircraft.

Secretary Gates further stated that he would take a fresh look at the requirement behind the program and develop a more sustainable approach.

Later in the month, at Maxwell Air Force Base, he stated, frankly, the notion of an unarmed helicopter going 250 miles by itself to rescue somebody did not seem to be a realistic operational concept.

What is in the budget to address this critical capability? Anything?

General SCHWARTZ. Sir, the decision to cancel the CSAR-X solicitation did not remove all the dollars that were associated with that effort. In fact, there is a fair amount of money left in the personnel recovery search and rescue line; and what we will end up doing,

I think—the bottom line is I think the Secretary's view was that we had over spec'd the requirement and that there are less expensive capabilities that can help satisfy this mission, and what we will end up doing is procuring airplanes currently in production that are either supporting the Army or the Special Operations Forces.

Mr. BISHOP. These airplanes, are you talking about helicopters?

General SCHWARTZ. Yes, sir, helicopters.

Mr. BISHOP. Rotary wing?

General SCHWARTZ. Rotary wing, helicopters, yes. UH–60M variance.

Mr. DICKS. What about the idea of purchasing two H2M helicopters to be modified to a CSAR configuration?

General SCHWARTZ. Sir, could you repeat that?

Mr. DICKS. What about the—there is one option of purchasing two H–60M helicopters to be modified to a CSAR configuration.

General SCHWARTZ. Yes, that is the Department's position, sir.

Mr. DICKS. That is what you are going to do.

Mr. DONLEY. I don't think that has been completely decided.

What I think you saw and have seen in the 2010 budget, first of all, there are dollars—as the Chief indicated, there are dollars left behind from the CSAR program cancelation that we intend to put into a different capability going forward. But at the same time that decision was made we also made what I will call some clean-up decisions.

Since we knew we were not going to have CSAR procured in the near future to do some loss replacement for helicopters, we put in some dollars for MC–130 for additional tanking. We did some additional modification dollars on H–60s as well, adding clear capabilities and some other functions that would be helpful in the CSAR in the personnel recovery missionary.

These were short-term, band-aid budget adjustments made to compensate in the immediate near term for the CSAR cancelation. We need to reconstitute a future program that needs to be defined here in the QDR going forward.

Mr. BISHOP. Will the gentleman yield?

Mr. DICKS. Yeah, I yield.

Mr. BISHOP. The CSARs that you are talking about, will they be armed so that when they go in on the missions that they have some protection? And, if so, will that reduce the available space for MediVac and the number of casualty victims that can be extracted?

General SCHWARTZ. They will be armed, as ours are today, either with light machine guns or 50-caliber weapons is the typical configuration. And, yes, there is a tradeoff between payload in space with regard to what you put on to protect the airplane, how much gas you carry, how far you can go versus how many people you can pick up and return and so on.

But the bottom line is that these aircraft do have self-protection capability, and the aircraft that we are talking about procuring will likewise have that capability.

Mr. DICKS. Mr. Tiahrt.

TANKER

Mr. TIAHRT. Thank you, Mr. Chairman.

General Handy has been talking about a duel buy on the tankers, and what is the plan on the KC–10 replacement? Is it on the radar screen yet.

Mr. DONLEY. No.

Mr. TIAHRT. It is still long term out? He was talking about the lower cost paragraph, if you replace them up front. But it just seems they are not in the budget now.

Mr. DICKS. Would you yield on that?

As I understood what the Air Force's position was, we are going to buy 179 in the first tranche of medium-size aircraft, 179 in the second tranche, and then a third tranche of 179, which could be a larger airplane. That was the original plan; and that would take a long, long time. I know Mr. Murtha feels that whatever we do we should accelerate this to try to get the unit cost down and get these tankers sooner, but is that not still the plan?

Mr. DONLEY. You are exactly right, Mr. Chairman. The broad intent is to do this in three increments. We have over 400 tankers involved, KC–135 replacements, if you will, to effect over the next 15 to 20 to 25 years.

Mr. DICKS. This was over 45 years.

Mr. DONLEY. This is going to take time. This is going to take time. And we had not looked at the exact content of all that.

The main purpose behind these increments was to give us way points, if you will, decision making points to understand where the future technologies and what the future commercial air frames might be 10 years or 15 years out so that we don't commit to an air frame now that may be passed by technology advancements or new commercial aircraft available 20 or 30 years from now.

Mr. DICKS. General, do you want to make a comment?

General SCHWARTZ. I would just say that KC–10 was really KCZ.

Mr. DICKS. That's right, XYZ.

General SCHWARTZ. It was the third increment. And so notionally, conceptually it is out there, but it is not programmatic yet.

Mr. DICKS. But it is still the administration's position that you are against a split buy, isn't that correct?

Mr. DONLEY. Yes.

Mr. DICKS. And can you give us some of the reasoning why you are?

Mr. DONLEY. Well, the split buy would require us really to fully develop two aircraft going forward. In addition to fully developing those aircraft, we would end up with two logistics and support trains that go with those aircraft. A third consideration from our point of view is that the minimum buy to support two production facilities, if you will, is probably a minimum of about 12 each.

So our plan going forward assumed that the Air Force would be buying about 15 airplanes a year into the future, and that was roughly what we thought we could afford with our procurement accounts going forward. If we end up with a split buy, the minimum for each is 12. That means a buy of 24 airplanes a year.

There is goodness in that. From one point of view, it is sort of a more robust industrial base kind of situation. You get them faster. The KC–135s come out faster. However, we think it is probably more expensive in the long run to support that; and it requires that, instead of buying 15 per year, we would buy 24 per year. So

the impact on our budget is significant. We end up spending a lot more on tankers, and that crowds out other programs.

Mr. DICKS. And there is a very definite increase in the development cost, as we understand it. I think Secretary Gates has said, or somebody, at least $7 billion more in development costs in the near term. So that also has an effect, would have an adverse effect on the Air Force budget.

Mr. Tiahrt.

REQUIREMENTS FOR AIRLIFT CAPABILITY

Mr. TIAHRT. In your questioning, Mr. Chairman, you were talking about a study of requirements for the airlift capability.

Mr. DICKS. Right.

Mr. TIAHRT. And when we think of the current situation in Afghanistan we are pretty easy to be landlocked. We have the Russians trying to influence the northern side of it. We have Iran to the west, Pakistan's uncertainty to the east and south. And that really brings a high emphasis to the ability to get equipment and supplies and personnel in and out of Afghanistan.

We have been using this link through Pakistan, and we have had a lot of trouble with that. They have broken into some of the containers. You can go down in the black market just outside the air base in—was it Bagram—and buy the seals that they put on the back of the cargo containers to show they haven't been broken into. You can buy replacements for those. And so they simply bust the seal, steal what they want, and put the seal back on. And then the manifest doesn't match the cargo. So there has been a lot of trouble with going through Pakistan.

Will this be part of the plan? I mean, it seems like a near-term problem when you are doing a long-term study. But when it comes to handling cargo, we could have a huge demand almost immediately with instability in that area.

General SCHWARTZ. Congressman Tiahrt, we certainly have contingency plans to deal with either limitations on access through the southern routes, the Chaman or the Torkham gates, as they are called, in the east of Afghanistan or from the north through any number of the stans.

This really is in the U.S. Transportation Command lane. But fundamentally what we have done is establish relationships with a number of the governments.

For example, in Kyrgyzstan should have an agreement for continued access to Manas. And that is an important location because it allows us not only to do transload of personnel from commercial to military to go in country, but it also allows us to have tankers near or closer to Afghanistan to support day-to-day missions.

If we had to fall back to other locations, we could do that. We have a plan. We have a back-up. It is harder. It is more expensive. It is more asset intensive. But we are not without options with regard to maintaining support for the folks that are on the ground there.

IRREGULAR WARFARE

Mr. DICKS. Let me ask you, Secretary Donley, has irregular warfare DOD directive 3000–.07 been reflected in your 2010 budget request?

Mr. DONLEY. I believe it has. The work that the Air Force has done over the last several months has really helped to focus building partnership capacity in that our international affairs work as a core function in the Air Force. So we have stepped out to recognize the importance of this work.

As we have alluded to in a few different programs here today, if you package them together we have looked carefully at how to further develop Air Force force structure and capacity for irregular warfare sort of at the lower end of the conflict spectrum and to develop capabilities that not only are useful to the United States in its work but can be translated over to international partners who are not the same kinds of partners that we deal with in, for example, in NATO context.

So building partnership capacity at the high end with NATO partners means F–35s and high-end Rivet Joint kinds of capacity, unmanned aerial vehicles. These are the kinds of issues that we work with the British, with the Germans, and with other partners.

At the lower end, we need to have capabilities that are at the technological level, resource level, training level that fits partners facing different kinds of resource challenges, geographic challenges.

So building capabilities like the JCA, like the C–27 capability, building ISR capabilities in platforms like the MC–12 and potentially developing training airplanes like the T–6 or the Super Tucano or other kinds of aircraft in that class of airframe can help us, and it can help us teach and work with partners to build up their indigenous capability. So we have been working the IW and partnership issues very hard and continue to do so. We have more work to do there.

Mr. DICKS. Is the Air Force doing anything, General, to revise doctrine, organization, training, material leadership, personnel, and facilities to reflect a sharpened focus on irregular warfare?

General SCHWARTZ. We are. In fact, this will be a major topic for discussion in our four-star conference here this weekend. And I think what you will see——

For example, we have what we call contingency response groups in the overseas theaters. They originally were conceived to be elements with lots of different disciplines, from airfield management to engineers to services personnel support kind of capabilities to open airfields. It is an important function for us. If we are expeditionary, you need to have an airfield opening capability.

But it turns out that these organizations also have, because they are multi-disciplinary, the interesting capacity to engage other air forces in interaction related to the various disciplines, whether it is building a runway or whether it is air traffic control, whether it is medical support.

And what we will probably do—and it is an example of several initiatives—is to dual-role those organizations both to do airfield opening, but when they are not opening airfields to build partner capacity with our partners like the Afghan Army Air Corps.

The truth is that we have capacity that may have been overly focused on a particular mission set, that we can expand their view, and I think with minimal expense and minimal growth in manpower requirements actually serve the irregular warfare mission very well. And that is where we will start, sir. There will be some new stuff, as the Secretary suggested. But I think our first effort will be to make better use of what we already possess in that lower end of the spectrum.

AIR OPERATIONS

Mr. DICKS. Why is the air operations request for 2010 50 percent less than 2009?

General SCHWARTZ. I am not sure, sir, what you mean with regard to air operations.

Mr. DICKS. Basically, flying hours we are talking about. How has the Air Force training curriculum for flying hours been substantially updated since the Berlin Wall? When did it occur—yeah, when did it occur on training hours, training curriculum? Has the Air Force's training curriculum for flying hours been substantially updated since the Berlin Wall came down?

General SCHWARTZ. Certainly it has. I mean, the most graphic example of that, Mr. Chairman, is the capacity in simulation. I mean, we now—and to network simulation. Our simulators—and, of course, this is true in the commercial sector as well. And as you well know, in the commercial business, aviators are no longer qualified and actually flying the airplanes. All that is done in high fidelity simulators. The same thing is true for our aircrews.

Now, there is some things you have got to do in the air, and we certainly do that. But we are making better use of high fidelity simulation, of networking those simulators in a way that allows F–15s, let's say, to gaggle with F–16s in a virtual sense. And it isn't a complete substitute, but it has reduced our need for flying in the air, sir.

Mr. DICKS. Our staff is concerned that this may be an excuse to cut out some major programs, that we are moving to irregular warfare, therefore, we need fewer F–22s, fewer C–17s. We are shutting down a lot of programs, Next Generation Bomber. I mean, it is—you know, and what are you switching to? What does irregular warfare bring with it in terms of requests? Now, we know there is going to be Predators, Reapers, ISR, things that you have talked about. But you know——

General SCHWARTZ. Some of this is human capital, Mr. Chairman. The question is—I only speak one language, and that is not a good thing. You know, in 15 or 20 years, the next Chief of Staff you should expect to be conversing in more than one language.

And that is one of those things that really is irregular warfare. We need to make sure that our folks in our Air Force, your Air Force, both can connect with other cultures, have the sensitivity and the awareness to do that well, can communicate and so on and so forth. So part of this is human capital.

Yes, we are growing in some areas that we have talked about and shrinking in others. I think this is the reality that we face. Because the truth of the matter is that our budgets are limited, and we are going to have to make choices.

But I think what you hopefully will see is that at the strategic level we have certain things that are single purpose. For example, the missiles in North Dakota and Wyoming and so on are single purpose. They serve the deterrent mission. They are not really very applicable in the irregular warfare context.

Mr. DICKS. Right.

General SCHWARTZ. You have some things on the other end that are very mission specific that are not applicable as you move up the warfare spectrum. But that general purpose force in the middle we need to make more versatile. So we will have some dedicated to this and some dedicated to that. But I think our way ahead is to build versatility into our force so that we can swing to the needs without doing these major fluctuations of discontinuing some programs and starting new ones.

IRREGULAR WARFARE

Mr. DICKS. Just to follow up on that, what would be kind of the—in your vision of this with irregular warfare, what are the kinds of things that the Air Force will need in order to implement irregular—I mean, and equip itself with irregular warfare? Have we missed anything here? I mean, are we talking about helicopters? Are we talking about UAVs? Are we talking about—what else?

General SCHWARTZ. You are talking about mobility, you are talking about reconnaissance, you are talking about light strike, and you are talking about the management capacity to orchestrate and sustain those resources. And one of the things that your Air Force brings to the table here is to be able to train others like the Afghan Army Air Corps how to maintain and how to sustain these assets that they will have, largely non-U.S. made. Some Italian air lifters, some Russian helicopters, a mix.

But our kids need to be able to train others to use those assets; and that is something which requires, again, versatility. We build that into the force. We have people that are qualified on various platforms and that can teach. That is the way ahead, in my view.

Mr. DICKS. Mr. Secretary——

Mr. DONLEY. Just to add an additional couple of points, Mr. Chairman.

As the Chief indicated, the Secretary is not swinging in this budget, swinging a pendulum hard over to irregular warfare. He is asking the Department to look more carefully at how we can use those general purpose forces that we are building.

We are still committed to JSF. For example, our program for JSF is 1,763 airplanes, and that is going take a while, and we are deeply invested in that, and we hope to execute that. But the issue is, as we build and maintain force structure going forward, making it as useful as possible across the spectrum of conflict.

And the other thing that should be in our minds as we continue to work the irregular warfare issue is that the effectiveness of our Armed Forces jointly both in Iraq, Afghanistan, across the board in any operation today is our ability to network and work together. So it is the enabling capabilities, much of which the Air Force brings to the table in its space and ISR communications, these capabilities that are useful across the spectrum of conflict and for

which we are able to scale up and scale down to support irregular warfare, and support high intensity combat when necessary.

These enabling capabilities are critical to all the Armed Forces. We bring a lot of that to the table, and I see growth and demand in those areas. Cyber and space are the other key domains that we are focused on. Those are growth areas for I think the joint community going forward, and we have got to do the work necessary to continue to build capacity in cyber and in space.

CYBER ATTACKS

Mr. DICKS. Mentioning cyber, has the Air Force been a victim of attacks by other countries?

Mr. DONLEY. Yes.

Mr. DICKS. And I know we can't go too far here, but has it gone beyond unclassified systems into classified systems?

Mr. DONLEY. It has, and it is persistent. It is a regular part of doing business today. This is a warfare domain.

Mr. DICKS. Any further questions?

All right. The committee will stand in adjournment. Thank you very much, and we appreciate your testimony.

Also, Secretary Donley, I want to thank you personally for meeting with a group of my constituents from Tacoma. They very much enjoyed the meeting.

Mr. DONLEY. Happy to do that, Mr. Chairman.

[CLERK'S NOTE.—Questions submitted by Mr. Boyd and the answers thereto follow:]

TYNDALL AIR FORCE BASE

Question. What is the personnel and funding impact to Tyndall Air Force Base with the removal of 48 aircraft due to the early retirement of the F–15?

Answer. The combat air forces restructure reduces 48 primary aircraft from Tyndall Air Force Base, Florida and the corresponding personnel impact is a reduction of 594 total active duty authorizations (550 enlisted, 40 officers and 4 civilians). This represents a reduction of $19.7 million in personnel costs ($16.9 million for enlisted, $2.6 million for officers and $.2 million for civilians).

KINGSLEY FIELD

Question. What are the infrastructure requirements for Kingsley Field through FY 2013 that relate to F–15s, their maintenance and/or training for F–15 pilots? What are the costs associated with that military construction?

Answer. The Air National Guard operates an F–15 formal training unit at Kingsley Field, Klamath Falls, Oregon to train F–15 aircrew members. Presently, there are no military construction projects programmed to recapitalize F–15 maintenance or training facilities for F–15 pilots at this installation.

Question. What is the aircraft utilization rate (scheduled vs. actual) at Kingsley Field?

Answer. Aircraft utilization rate statistics for Kingsley Field for the current and prior fiscal year are indicated below.

For fiscal year 2009 (thru May): scheduled 23.2; actual 20.3 and attrition 12.2 based on cancellations (maintenance, operations, weather, etc.).

For fiscal year 2008: scheduled 20.8; actual 15.9 and attrition 23.2 based on cancellations (maintenance, operations, weather, etc.).

Question. What is the maintenance non-delivery rate at Kingsley Field?

Answer. For fiscal year 2008 the maintenance non-delivery rate at Kingsley Field was 2.1 percent. For fiscal year 2009 the rate is 1.3 percent (maintenance cancellations/sorties flown).

Question. How many classrooms are available at Kingsley Field?

Answer. There are 20 classrooms at Kingsley Field.

Question. Is ACMI range access available at Kingsley Field for F–15 training?

Answer. Yes. However, the air combat maneuvering instrumentation (ACMI) pods used at Kingsley Field and other Air National Guard (ANG) locations are not associated with the specific ANG facility. The ANG centrally manages their ACMI capabilities at four combat readiness training centers to minimize operations and maintenance costs. The only ANG location that owns their pods is Montana, who acquired eighteen P5 pods through congressional action. But even in that case, the pods are being maintained by the Savannah combat readiness training centers. Through this centralized management construct, Kingsley Field has ACMI capability on a full-time basis including full de-brief capability.

F–35S

Question. The number of F–35 aircraft requested in the fiscal year 2010 budget was reduced from what was projected for fiscal year 2010 in last year's budget request. With the looming aircraft shortfall the Air Force is facing, how do you rationalize the reduced procurement of F–35 aircraft?

Answer. The Air Force supports Secretary Gates' decision to reduce the fiscal year 2010 Air Force procurement of F–35A aircraft from 12 to 10 as it allows the Marine Corps to correspondingly increase their fiscal year 2010 procurement by two F–35B STOVL variants. This enables the Marines to reach their planned initial operational capability in fiscal year 2012. The reduction of two F–35s in fiscal year 2010 for the Air Force does not impact our planned initial operational capability date of fiscal year 2013.

Question. The platform that will provide the most relief for the tactical fighter shortfall is the F–35 (Joint Strike Fighter). As with the majority of complex, new weapon systems, this program has seen its share of problems and is likely not out of the woods yet. In fact, the Marine Corps variant has been delayed from its original schedule due to engine problems.

Do you anticipate the Joint Strike Fighter becoming operational in time to help with the shortfall or will continued delays make it worse? Does the department have a contingency plan to mitigate the aircraft shortfall should the Joint Strike Fighter continue to slip?

Answer. The Air Force's variant of the Joint Strike Fighter is currently scheduled for initial operational capability in late 2013. Beginning 2015, the Air Force is programmed to purchase 80 Joint Strike Fighters each year alleviating the projected fighter shortfall. In addition, the Air Force will maintain approximately 220 F–15Es and approximately 350 A–10s until unspecified retirement dates after 2030 enabling the Air Force to maintain sufficient strike assets as the F–35A comes on line. The Air Force is also taking additional steps to further evaluate the sustainability and viability of its F–16 fleet, if additional service life is required due to a significant delay in the Joint Strike Fighter's initial operational capability.

Question. What maintenance reliability lessons from the F–22 program can be applied to the F–35?

Answer. One of the key strategic efforts during and post Engineering and Manufacturing Development phase of the F–22 program has been to proactively identify reliability issues very early based upon detailed analysis of developmental/operational test data and to programmatically fund for a Reliability and Maintainability Maturation Program (RAMMP) to effect critical redesigns where needed. The RAMMP effort has led to a six-fold improvement of measured reliability from initial operational test to today. Due to this proactive approach the F–22 program is well on track to meeting or exceeding the Mean Time Between Maintenance Event Key Performance Parameter by the required 100,000 flying hour definition of maturity in the Operational Requirements Document. In fact recent data shows at least one operational base meeting and exceeding the mature requirement today, over 1.5 years ahead of expected fleet maturity at 100,000 cumulative flying hours sometime in late calendar year 2010. A key lesson from the F–22 program, for the F–35 program, is that a RAMMP or RAMMP-like program should be considered for the F–35. Additionally, the F–35 Joint Program Office meets regularly with the F–22 System Program Office and F–22 users to gain lessons learned on all F–22 and F–35 aircraft system reliability issues. The F–35 Joint Program Office has an in-depth integrated systems approach to testing F–35 components, and is flying a highly modified Boeing 737 with a full suite of F–35 avionics to find, fix, and prevent potential avionics integration problems.

F–22S

Question. The F–22 program is proposed to be completed at 187 aircraft in addition to the proposal to retire 250 Air Force fighters. These actions create a gap in capability. How do you rationalize these decisions?

Answer. To comply with the Secretary of Defense's Guidance for the Development of the Force, the Air Force analyzed its fighter force structure and determined we have a window of opportunity to take a strategic pause and build a smaller, but more flexible, capable, and lethal force as we bridge to the 5th Generation-enabled force. This analysis determined that the Air Force is faced with aging fighter aircraft during a period in history where we are not directly threatened by a near-peer competitor, ultimately assessing the risk as acceptable. Any remaining risk is mitigated in the short-term through a combination of permanently based and rotational forces. It is part of a global resource allocation process that makes strategic sense.

As we developed this combat air forces restructuring plan over the last year, we were successful in balancing planned force reductions across our active duty, Guard, and Reserve components, as well as in the States and overseas locations. We carefully analyzed the missions across our units in all the Air Force components to achieve the force mix that made the most strategic sense. The changes in this plan were closely coordinated with our Air National Guard and Air Force Reserve partners, as well as our major commands and affected regional combatant commanders.

Secretary Gates agreed with the Air Force's assessment and approved the restructuring plan. The retirement of approximately 250 fighter aircraft in fiscal year 2010 will not affect the potential fighter shortfall identified last year. That shortfall referenced the year 2024, by which time all of the 250 aircraft would have previously exceeded the end of their programmed service lives.

Question. Has F–22 system reliability improved?

Answer. The F–22 system reliability has dramatically improved over six-fold from the completion of the Engineering and Manufacturing Development phase to present. At the end of the Engineering and Manufacturing Development, the measured reliability Mean Time Between Maintenance event was approximately 0.5. One operational base is currently measuring above the mature requirement (3.0) at 3.03 prior to fleet maturity at 100,000 flying hours expected in late calendar year 2010. Additional planned changes will ensure the design at maturity meets the Mean Time Between Maintenance key performance parameter of 3.0.

Question. What is the current performance in meeting the key reliability requirement of 3-hour mean time between maintenance actions?

Answer. The F–22 Operational Requirements Document key performance parameter requires the 3.0 Mean Time Between Maintenance (MTBM) event to be achieved by 100,000 cumulative flying hours. The current operational fleet average between November 2008 and April 2009 is a 1.9 MTBM. One operational base demonstrated a 3.03 MTBM in April 2009.

Question. How well are the on-board maintenance diagnostics and health management systems working?

Answer. The current F–22 operational fleet average performance between November 2008 and April 2009 is as follows: the Fault Detection percentage (FD %) metric is 68.3 percent and the Fault Isolation percentage (FI %) metric is 94.1 percent. Planned diagnostic software updates by the end of calendar year 2010 are expected to improve the metrics as the operational fleet reaches system maturity at 100,000 cumulative flying hours.

Question. What efforts remain to fully demonstrate those capabilities?

Answer. The final demonstration of the F–22 mature reliability capabilities will occur during the follow-on Operational Test and Evaluation III period scheduled for late calendar year 2010.

Question. Are they paying off in terms of reduced base-level maintenance and earlier recognition of problem areas needing inspection?

Answer. Yes. The F–22 standard (Systems Specification) Direct Maintenance Man Hour/Flying Hour (DMMH/FH) requirement is to be less than or equal to 12 at system maturity at 100,000 cumulative fleet flying hours (expected by end of calendar year 2010). At the end of the Engineering and Manufacturing Development phase in March 2004, the DMMH/FH was initially measured at 13.4 DMMH/FH. The current operational fleet DMMH/FH metric is measured at 10.48 DMMH/FH as of April 2009. This is a result of the Reliability and Maintainability Maturation Program identified improvements.

TEST AND EVALUATION SUPPORT

Question. The President's Budget request cuts PE 0605807F almost $50 million when compared to the FY 09 budget and first FY10 budget request submitted in January. A portion of this cut is simply a cut. The second element of the cut is based upon the assertion that there will be savings realized when 750 contractor and civil service positions are converted to civil service solutions.

What analysis has been done to identify what the workforce mix of contractor and civil service should be? Please provide a copy of the analysis?

Answer. The Service components received an Office of the Secretary of Defense-directed contract to Department of Defense civilian conversion targets starting in fiscal year 2010. The Air Force is in the process of identifying specific in-sourcing candidates to comply with this mandate.

Question. What is the hiring ramp-up schedule for achieving the contractor to civil service conversions? What analysis has been done to verify that OPM and AF offices can achieve the ramp-up schedule? Please provide a copy of the analysis.

Answer. The Service components received an Office of the Secretary of Defense-directed contract to Department of Defense civilian conversion targets starting in fiscal year 2010. The Air Force is in the process of identifying specific in-sourcing candidates to comply with this mandate.

Question. What analysis has been done showing the savings that will result from the conversion of contractor positions to civil service positions? Did the analysis include fully burdened costs of civil service positions similar to costs clearly visible for contractor support (i.e., overhead, G&A, material & handling, etc.)?

Answer. The Service components received an Office of the Secretary of Defense-directed contract to Department of Defense civilian conversion targets starting in fiscal year 2010. The associated funding reductions were based on Department of Defense's assumption of 40 percent savings. The Air Force is in the process of identifying specific in-sourcing candidates to satisfy this mandate.

[Clerk's note.—End of questions submitted by Mr. Boyd. Question submitted by Mr. Kingston and the answer thereto follows:]

OPERATIONALLY RESPONSIVE SPACE

Question. The Operationally Responsive Space (ORS) program was initiated in 2007 by the Air Force to develop test and field satellites for meeting military requirements particularly in forward deployed areas. ORS continues to bring to maturity space-borne sensors and put in the field tactical satellites targeted to specific theater needs. We desire to fund cost-reducing programs and initiatives that modernize space operations including ground support for satellites and spacecraft development and construction.

How helpful would programs that provide rapid spacecraft prototyping and mission performance and analysis be for the ORS activity? How much collaboration is there between Air Force and industry on developing relatively low cost prototyping for programs such as ORS?

Answer. The vision for Operationally Responsive Space (ORS) is to provide operational mission capability for combatant commanders quickly and one aspect of that is the ability to rapidly analyze alternative solutions. ORS is investigating and evaluating tools from industry that can demonstrate these capabilities. These tools are a key enabler for the rapid response space capability that ORS is developing. It's uncertain at this time if there is a role for rapid prototyping in developing operational ORS spacecraft on the timelines required for responding to urgent military requirements.

[Clerk's note.—End of question submitted by Mr. Kingston.]

WEDNESDAY, JUNE 3, 2009.

NAVY AND MARINE CORPS POSTURE

WITNESSES

HON. RAY MABUS, SECRETARY OF THE NAVY

ADMIRAL GARY ROUGHEAD, CHIEF OF NAVAL OPERATIONS

GENERAL JAMES CONWAY, COMMANDANT OF THE MARINE CORPS

OPENING STATEMENT

Mr. MURTHA. The committee will come to order.

I want to welcome these three distinguished gentlemen. I want to say Bill we were talking about Jamie Whiten. Of course, the Secretary is from Mississippi and he was Governor when Jamie was the chairman. So he remembers him well. And he reminded me, told me that Jamie and his uncle were in the 1932 convention and Mississippi went by one vote for Roosevelt. Jamie used to tell me that story all the time.

But we welcome you gentlemen to the committee, and we appreciate your distinguished careers and look forward to your statements. If you will summarize them and then we will ask some questions.

Mr. Young.

Mr. YOUNG. Mr. Chairman, I just want to agree with what you said. We appreciate the very distinguished careers of the witnesses and their support teams. We are looking forward to being supportive of the needs of our Sailors and our Marines.

Mr. MURTHA. Bill, I want you to know that the Secretary, and I said we wouldn't hold it against him, he graduated from Harvard Law School. He said he couldn't get into the University of Mississippi. That's what he said.

Mr. Secretary.

SUMMARY STATEMENT OF SECRETARY MABUS

Mr. MABUS. Mr. Chairman, thank you very much, Congressman Young, distinguished members of committee, it is an honor to be here with Admiral Roughead and General Conway on behalf of our Sailors, Marines, and their families.

Two weeks ago, I assumed the responsibility as the Secretary of the Navy. In this very short period of time, it has been my privilege to gain firsthand insight into our Nation's exceptional Navy and Marine Corps. This naval force serves today around the world providing a wide range of missions in support of our Nation's interests. I am here today to discuss with you the fiscal year 2010 budget, the various missions of the Navy and Marine Corps, and some priorities of our Department.

The Navy Department's fiscal year 2010 budget reflects a commitment to our people, shaping our force, providing adequate infrastructure, sustaining and developing the right capabilities for the future. The ongoing Quadrennial Defense Review will also aid in shaping the department's contribution to the national effort in the future.

As I have taken on these new duties, my first priority is to ensure we take care of our people: Sailors, Marines, civilians, and their families. Thousands of brave Marines and Sailors are currently engaged in Iraq and Afghanistan, and thousands more are carrying out other hazardous duties around the world. These inspirational Americans volunteered to serve, and they are protecting us and our way of life with unwavering commitment. We have to show them the same level of commitment when providing for their health and welfare and that of their families.

Last week I went to the National Naval Medical Center in Bethesda and visited with our wounded. It was both a humbling and inspirational experience, reinforcing the enduring commitment we owe them in terms of treatment, transition, and support. Programs like the Marine Corps Wounded Warrior Regiment, the Navy's Safe Harbor Program, advances in treatment and traumatic brain injuries, and programs that offer training and support and stress control must continue to be our priorities.

Today our Sailors and Marines are serving and responding to a wide variety of missions from combat operations to humanitarian assistance and maritime interdiction. The Navy has 13,000 Sailors ashore and 9,500 Sailors at sea in Central Command's Area Of Responsibility (AOR). More than 25,000 Marines are deployed in Iraq and Afghanistan. Our civilian force is also heavily engaged in supporting these operational efforts. We have to ensure that the Department of the Navy will continue to meet these missions while investing in capabilities that provide the right naval force for future challenges.

Real acquisition reform too has to be a priority. The Department of Navy has begun to implement the Weapons Systems Acquisition Reform Act and is ready to use this Act and other tools to try to ensure we get the right capabilities on time and at an affordable cost. The Department of the Navy and I, in particular, look forward to working together with you in our shared commitment to our Nation, our Marines, our Sailors, civilians, and their families. On behalf of all of them, and very importantly, thank you and this committee for your unwavering support, for your continued stance of providing these Sailors, Marines, civilians, and their families with the tools they need with the assistance they deserve. Thank you on behalf of all of them.

I look forward to your questions.

[The statement of Secretary Mabus follows:]

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HOUSE COMMITTEE ON
APPROPRIATIONS
SUBCOMMITTEE ON DEFENSE

STATEMENT OF

HONORABLE RAY MABUS

SECRETARY OF THE NAVY

BEFORE THE

HOUSE COMMITTEE ON APPROPRIATIONS
SUBCOMMITTEE ON DEFENSE

ON

FY10 DEPARTMENT OF NAVY POSTURE

3 JUNE 2009

NOT FOR PUBLICATION
UNTIL RELEASED BY THE
HOUSE COMMITTEE ON APPROPRIATIONS
SUBCOMMITTEE ON DEFENSE

The Navy-Marine Corps Team—Prevailing Today, Preparing for Tomorrow

Chairman Murtha, Representative Young, and Members of the Committee, thank you for the opportunity to appear before you today as the seventy-fifth Secretary of the Navy. It is my great honor to serve with and represent the over 800,000 men and women of the United States Navy and Marine Corps—active, reserve, and civilian and their families. I am committed to ensuring that the Naval Force remains the preeminent sea power, ready to meet both current and future challenges.

I assumed my duties as Secretary of the Navy very recently. I am humbled by and proud of the responsibility of representing the wonderful men and women of our Navy and Marine Corps.

Our enduring seapower has been essential to furthering America's interests worldwide. Its importance cannot be overstated, over 70% of the planet is covered by water, 80% of the world's inhabitants live near the oceans, and 90% of global commerce is transported by sea. By maintaining U.S. maritime dominance, our Sailors and Marines promote security, stability, and trust around the world. Together, we provide a persistent forward presence, power projection abroad, and protection of the world's sea lanes. Our Sailors and Marines, in cooperation with our foreign partners and allies, continue to provide training, deliver humanitarian aid, disaster relief and other assistance throughout the globe.

Our naval forces are uniquely postured to deter aggression and prevent escalations. Should deterrence fail, we stand ready to fight America's wars and defeat our adversaries. In times of crisis, Navy and Marine Corps units are often already on the scene or the first U.S. assets to arrive in force. And they accomplish this all as a seaborne force with a minimum footprint.

To ensure and sustain an effective Navy and Marine Corps in an increasingly complex security environment, we must emphasize and promote a number of essential priorities.

First, we must ensure the proper care for our forces and their families. America's greatest military assets are the dedicated men and women who wear the uniform. Thousands of brave Sailors and Marines are currently engaged in Iraq and Afghanistan; thousands more carry out hazardous duties around the globe. Every one of these incredible Americans volunteered to serve, and they are protecting us and our way of life with unwavering commitment. As we drawdown in Iraq and increase our strength in Afghanistan, they once again stand ready to answer our Nation's call. We must show them the same level of commitment when providing for their health and welfare and that of their families.

Second, we must ensure that the Department of the Navy continues to meet our many missions of today, while preparing for the unknowable but inevitably complex challenges of tomorrow.

Third, we must continue to balance the Department of the Navy's programs, choosing to maintain or establish only those that are achievable, affordable, and responsive to our Nation's needs. We are committed to refining fiscal and budgetary discipline, tackling waste and cost overruns, and building our acquisition workforce. I look forward to working with you to make sure that the Department of the Navy does not shortchange our Sailors, Marines or our taxpayers.

I. TAKE CARE OF OUR SAILORS AND MARINES AND THEIR FAMILIES

The Department continues to shape the force to balance today's missions and to provide flexibility for the future. The Marine Corps has accomplished its goal of growing the force to 202,000 Marines. This will help to provide our Marines greater dwell time and will provide the opportunity to address other training and missions that have not been accomplished in our recent history. The Navy force has stabilized. Both the Navy and Marine Corps are meeting their recruiting goals both in numbers and quality. Our reserves continue to play a key role as part of the Total Force and our civilians are a bedrock providing support around the globe to our warfighters and to our naval capabilities. Together, we thank you for your support in sustaining the people who stand in our ranks - military and civilian.

We must support and strive to find ways to improve the initiatives that provide for their physical and mental welfare. The following programs exemplify some of the actions we are taking.

Wounded Warrior Medical Care

We as a nation have no higher obligation than to care for our wounded heroes who have sacrificed so much to serve our nation. We have a solemn duty to ensure that when our forces go into harm's way, there is an excellent, comprehensive and sustainable plan for the care of our wounded, ill, or injured. The budget request reflects the Department of the Navy's commitment to this highest priority, providing exceptional, individually tailored assistance to our wounded warriors, with a comprehensive approach designed to optimize their recovery, rehabilitation, and reintegration. The Navy Safe Harbor Program and the Marine Corps Wounded Warrior Regiment extend this assistance to the wounded, ill, and injured warriors and their families. The Navy Department is also collaborating with the Department of Defense (DoD) and the Department of Veterans Affairs (VA) to foster continuity of care across all systems and facilitate efficient and effective transitions.

Traumatic Brain Injury

Traumatic Brain Injury is the defining wound of Operation Iraqi Freedom. The National Naval Medical Center Bethesda has a new state-of-the-art Unit to treat Traumatic Brain Injury. I recently had the opportunity to visit this unit and was deeply impressed both by the staff and the facilities. This clinic provides unsurpassed inpatient care for polytrauma patients with TBI, serving all blast-exposed or head-injured casualties medically evacuated from theater. The medical professionals are highly trained and actively

manage symptomatic patients and evaluate complex cases to fashion appropriate, individual treatment and rehabilitation plans.

To increase TBI detection during deployments, the Department of the Navy has implemented a strategy of lowering the index of suspicion for TBI symptoms and improving screening, detection, and treatment coordination between line and medical leaders.

The Department of the Navy has also expanded TBI research. Navy Medical Research Command is using new techniques to identify transmissibility of blast-wave energy into the brain, focusing on the nexus between the blast-wave energy transmission and the resulting brain pathology.

Psychological Health

To address Post Traumatic Stress Disorder (PTSD) and other psychological conditions that effect more and more of our force, the Navy and the Marine Corps continue to improve their Operational Stress Control (OSC) programs. This comprehensive approach seeks to not only promote psychological resilience, but also a culture of psychological health among Sailors and Marines and their families. I am committed to removing any stigma associated with seeking help for mental health. To address this, the Bureau of Medicine and Surgery has established a centralized and comprehensive OSC program to indoctrinate psychological health-stigma reduction into the broader Navy-Marine Corps culture. This includes training and tools that line leadership can use from the newest accessions to flag and general officers. OSC is targeting perceptions within individuals and command leadership, as well as working to help care-givers overcome barriers to psychological health care.

Navy Medicine has established seventeen Deployment Health Clinics as portals of care for service members, staffed with primary-care medical and psychological health providers who support early recognition and treatment of deployment-related psychological health issues within the primary care setting. These examples are not all inclusive. Thank you for your continued support of these programs that are so vital to the overall strength of the Department.

Housing and Child Care

The world's finest naval force deserves the world's finest family support programs, including community and health care services and access to quality, affordable child care. The budget request demonstrates a commitment to our Navy and Marine Corps families by investing in family programs, housing, and infrastructure.

II. Meeting the Missions of Today

While naval forces are conducting combat and combat-support missions in Iraq and Afghanistan, the Navy and the Marine Corps also stand ready to answer our Nation's call across the full spectrum of military operations. Despite a high operational tempo, our naval forces remain resilient and motivated, and they are performing superbly around the

globe. We will work to continue their proud tradition of readiness and to ensure that they are fully trained and equipped for their assigned missions.

Today our Marines and Sailors are undertaking a myriad of missions, from combat operations in the mountains of Afghanistan, to humanitarian assistance in Africa. The Navy has over 9,900 Individual Augmentees and more then 6,600 reservists deployed on the ground around the world in support of Overseas Contingency Operations. Nearly half of the combat air missions over Afghanistan are flown by naval air forces. There are 283 active ships in service - 76 percent of these ships, including four aircraft carriers and two large-deck amphibious ships, are underway. Over 50 percent of our attack submarines are underway, with nearly forty percent of our submarine force on deployment.

More than 25,000 Marines are deployed in support of Operations IRAQI FREEDOM (OIF) and ENDURING FREEDOM (OEF). The large majority are in Iraq; however, the process has begun drawing down those forces and increasing the number of Marines in Afghanistan. Nearly 5,700 Marines are deployed to various regions throughout Afghanistan — either as part of the Special Purpose Marine Air Ground Task Force, Afghanistan, or in the 2d Marine Expeditionary Brigade, Marine Special Operations Companies, Embedded Training Teams, or Individual Augments.

One of the most significant readiness challenges facing the Navy and the Marine Corps is balancing their current obligations to overseas contingency operations with other anticipated readiness requirements. To address these concerns, the Department of the Navy is working to expand our engagements with other nations in order to meet our common challenges.

Fostering trust and cooperative relationships with foreign partners is critical to national security, but trust cannot be simply summoned in moments of crisis. It must be developed over time. To revitalize existing relationships and create new ones, we need to show long-term commitment.

Our Naval Forces contribute significantly to cooperative security operations through forward presence and sustained, routine engagement with foreign partners and allies. We are committed to sustaining this core capability of the Maritime Strategy and ask for your continued support.

Additionally, in order to meet our readiness challenges, the Department is working to develop greater energy independence and conservation ashore and afloat. Energy costs siphon resources away from vital areas. The potential for disruption and the possible vulnerability of energy supplies could threaten our ability to perform on the battlefield.

The Department of the Navy has made good progress in increasing energy efficiency, reducing energy consumption, and capitalizing on renewable energy sources. We are the Department of Defense lead for solar, geothermal, and ocean energy, and today, 17% of our total energy requirements are provided through alternative or renewable sources.

The Navy and Marine Corps can, and should, do more. As we continue to increase conservation and develop alternative energy options, the Department of the Navy can mitigate the impact of energy volatility, use energy as a strategic resource for operational advantage, and become a leader in environmental stewardship.

III. Building and Balancing the Naval Force of the Future

The Department of the Navy will continue to meet America's current commitments worldwide, while simultaneously developing a force capable of meeting the challenges of the future. We will focus on irregular warfare and hybrid campaigns, while continuing those more conventional capabilities where our technology gives us a strategic advantage. The FY-10 budget request puts us on the path towards the goal of balancing near-term requirements with those of the next decade and beyond.

The budget request provides balanced support for deployed and non-deployed steaming days, associated flight hours, and related ship and aircraft maintenance. It works to bolster our naval forces' independence and flexibility by building on their unique ability to operate at great distance with long staying power. This budget would also fund the critical "eyes and ears" of our forces with increases to Intelligence, Reconnaissance, and Surveillance programs and Command, Control, Communications, Computers programs. The budget shows commitment to maintain key capabilities such as power projection, sea control, interdiction, deterrence, and humanitarian assistance.

In an effort to continue to shape our future contributions to the joint force and our country, I look forward to engaging in the Quadrennial Defense Review, which strives to define the best, most affordable collective military force to defend our national interests at home and abroad.

Changes to how equipment is acquired are essential to building our forces for the future. We are committed to pursuing acquisition reform and cost control measures and look forward to implementing Congressional acquisition reform, as well as working with you to continue to find ways to produce the best results out of our acquisition process.

Our Sailors and Marines are a superb fighting force which can be lethal or compassionate, patient or quick, as situations dictate. They are well-trained, proud warriors that continue to deserve the appreciation of a grateful nation. As their new Secretary, I look forward to working together with you to continue to enhance a relationship built on trust and commitment to our nation, and the Sailors, Marines, civilians and their families who sacrifice for its cause.

On behalf of the more then 800,000 dedicated men and women of the United States Navy and Marine Corps, I express our grateful appreciation to Congress for its continuing and unflagging support.

SUMMARY STATEMENT OF ADMIRAL ROUGHEAD

Mr. MURTHA. Admiral Roughead.

Admiral ROUGHEAD. Chairman Murtha, Congressman Young, distinguished members of the committee, on behalf of the 600,000 Sailors, Navy civilians, and families, I thank you for your continued support and for the opportunity to represent our Navy alongside the Secretary and General Conway.

Today we have 40,000 Sailors on station making a difference around the world. We are more versatile and agile than we have ever been with more than 13,000 Sailors serving on the ground in the Central Command. The 2010 budget balances the needs of these Sailors around the world, our current operations and needs for future Fleet in accordance with our maritime strategy. However, we are progressing at an adjusted pace. Our risk is moderate today trending toward significant because of challenges posed by our Fleet capacity, our operational requirements, manpower, maintenance and infrastructure costs. Our Navy is operating at its highest levels in recent years, and while we remain ready and capable, we are stretched in our ability to meet additional operational demands while balancing our obligation to our people and to building the future Fleet.

We require additional capacity to meet Combatant Commander demands and maintain our operational tempo. A Fleet of at least 313 ships is needed along with capabilities that include more ballistic missile defense, irregular warfare, and open ocean anti-submarine warfare (ASW) capabilities. These needs drove the decision to truncate the DDG–1000 and restart the DDG–51 with its blue water ASW capability and integrated air and missile defense capability, and also to procure in this budget three littoral combat ships.

As I articulated last year, our Navy must have a stable shipbuilding program that provides the right capability and capacity while preserving our Nation's industrial base. The balance among capability, capacity, affordability, and executability in our procurement plans, however, is not optimal. I continue to focus on the control of requirements, integration of total ownership costs into our decision making, maturing new ship designs before production and pursuing proven designs.

The use of common hull forms and components and longer production runs to control costs as we build the future Fleet are most important. To best maintain the ships we have, we have reinstituted an engineering-based approach to maintenance for our surface ships through the surface ship lifecycle management activity. Meanwhile, our board of inspection and survey teams will continue to use INSURV processes to conduct rigorous self-assessments on the condition of our ships and submarines. All that we do is made possible by our dedicated Sailors and Navy civilians.

I am committed to providing the necessary resources and shaping our personnel policies to ensure our people and their families are properly supported. We are stabilizing our force this year by seeking authorization and funding for an end strength of 328,800 Sailors, including overseas contingency operation funding for 4,400 individual augmentees who are in today's fight. We continue to pro-

vide a continuum of care that covers all aspects of individual medical, physical, psychological, and family readiness to our returning warriors and Sailors. In 2008, we added 170 care managers to our military treatment facilities and ambulatory care clinics for our 1,800 wounded warriors and their families.

In addition, we continue to move mental health providers closer to the battlefield and are actively working against the stigma of post-traumatic stress disorder. Achieving the right balance within and across my three priorities of the future fleet, current operations, and people is critical today and for the future, and I ask for your support for this 2010 budget.

Thank you for your continued support and commitment to our Navy, for all you do to make the United States Navy a force for good around the world today and tomorrow.

I look forward to your questions.

[The statement of Admiral Roughead follows:]

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RELEASED BY THE
HOUSE SUBCOMMITTEE ON DEFENSE
COMMITTEE ON APPROPRIATIONS

STATEMENT OF

ADMIRAL GARY ROUGHEAD

CHIEF OF NAVAL OPERATIONS

BEFORE THE

HOUSE SUBCOMMTTEE ON DEFENSE

COMMITTEE ON APPROPRIATIONS

ON

FY10 DEPARTMENT OF NAVY POSTURE

3 JUNE 2009

NOT FOR PUBLICATION
UNTIL RELEASED BY THE
HOUSE SUBCOMMITTEE ON DEFENSE
COMMITTEE ON APPROPRIATIONS

Navy FY 2010 Posture Statement

Chairman Murtha, Representative Young, and members of the Committee, it is an honor to appear before you today representing the more than 600,000 Sailors and civilians of the United States Navy. We are making a difference around the world. We are globally deployed, persistently forward, and actively engaged. I greatly appreciate your continued support as our Navy defends our nation and our national interests.

Last year, I came before you to lay out my priorities for our Navy, which were to build tomorrow's Navy, remain ready to fight today, and develop and support our Sailors, Navy civilians, and families. We made great progress on those priorities this past year. Sustaining our Navy's maritime dominance requires the right balance of capability and capacity for the challenges of today and those we are likely to face in the future. It demands our Navy remain agile and ready.

Our Maritime Strategy, issued by the Navy, Marine Corps, and Coast Guard over a year ago, continues to guide our efforts. The strategy recognizes the importance of naval partnerships, elevates the importance of preventing war to the ability to fight and win, and identifies six core capabilities: forward presence, deterrence, sea control, power projection, maritime security, and humanitarian assistance and disaster response (HA/DR). We have increased the breadth and depth of our global maritime partnerships. We have engaged, more than ever, in stability operations and theater security cooperation. Moreover, we are performing each of our six core capabilities as part of the joint force in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF), and across the globe.

We continue to build tomorrow's Navy. As I articulated last year, our Navy needs a stable shipbuilding program that provides the right capability and capacity for our Fleet while preserving our nation's industrial base. Since I came before you last year, ten new ships have joined our Fleet. Among them, is USS FREEDOM (LCS 1), an important addition that addresses critical warfighting gaps. We have increased oversight and are working closely with industry to lower LCS costs and meet program milestones. I am pleased to announce we have awarded fixed price, incentive fee contracts for the third and fourth LCS ship. We are aggressively working to ensure LCS is a successful and affordable program. The introduction of USS GEORGE W. BUSH (CVN 77) earlier this year also re-affirmed the strength and power of the American shipbuilder and our industrial base. I remain committed to a carrier force of 11 for the next three decades. In our drive to build the future Fleet, I continue to demand that we accurately articulate requirements and remain disciplined in our processes. As I testified last year, effective procurement requires affordable and realistic programs to deliver a balanced future Fleet.

We reached several key milestones in Navy aviation over the last year. Recently, the first P-8A Poseidon aircraft successfully completed its first flight. The P-8A will replace our aging P-3 Orion maritime patrol aircraft, which we have adapted to the fight we are in by providing critical Intelligence, Surveillance, and Reconnaissance capabilities to current operations in Iraq and Afghanistan. We also issued our first contract for the Broad Area Maritime Surveillance aircraft, which will provide capability to meet the challenges we are likely to face in the future. As I identified last year, we continue to expect a decrease in the number of our strike fighters

between 2016 and 2020 which will affect the capacity and effectiveness of our carrier air wings. The timely delivery of the F-35 Joint Strike Fighter is critical to meeting our strike fighter needs.

While we have been building our Navy for tomorrow, we have also been focused intensely on today's fight. Our Sailors are fully engaged on the ground, in the air, and at sea in support of operations in Iraq and Afghanistan. On the ground, our Navy has more than 13,000 active and reserve Sailors in Central Command supporting Navy, Joint Force, and Combatant Commander requirements. Navy Commanders are leading six of the 12 U.S.-led Provincial Reconstruction Teams in Afghanistan. Our elite teams of Navy SEALs are heavily engaged in combat operations. Navy Explosive Ordnance Disposal platoons are defusing Improvised Explosive Devices (IEDs) and landmines. Our SEABEE construction battalions are rebuilding schools and restoring critical infrastructure. Navy sealift is delivering the majority of heavy war equipment to Iraq, while Navy logisticians are ensuring materiel arrives on time. Our Navy doctors are providing medical assistance in the field and at forward operating bases. In addition, I am thankful for the support of Congress for Navy Individual Augmentees who are providing combat support and combat service support for Army and Marine Corps personnel in Iraq and Afghanistan. On the water, Navy Expeditionary Combat Command Riverine forces are working closely with the Iraqi Navy to safeguard Iraqi infrastructure and provide maritime security in key waterways. Navy forces are also intercepting smugglers and insurgents and protecting Iraqi and partner nation oil and gas infrastructure. We know the sea lanes must remain open for the transit of oil, the lifeblood of the Iraqi economy, and our ships and Sailors are making that happen.

Beyond the fight in Iraq and Afghanistan, however, we remain an expeditionary force, engaged around the world. As the dramatic capture of Maersk Alabama and subsequent rescue of Captain Richard Phillips demonstrated, we do not have the luxury to be otherwise. We are engaged in missions from the Horn of Africa, to the Caribbean and the Philippines. Our operations range from tracking attempted ballistic missile launches from North Korea, to interacting with international partners at sea, to providing medical and humanitarian assistance from the sea. Our Sailors continue to be ambassadors for our nation. This past October marked the first visit ever of a U.S. nuclear-powered ship, USS THEODORE ROOSEVELT, to South Africa, the first year Navy ships were engaged in operations on both the East and West Coasts of Africa, and the first visit ever of a U.S. CNO to South Africa. Additionally, my recent visit to China continued a dialogue with the PLA(N) that will enhance our military-to-military relationships. In total, we have more than 50,000 Sailors deployed and more than 10,500 in direct support of global Requests for Forces and Joint manning requirements.

My commitment to developing and supporting our Sailors and Navy civilians in their global operations endures. We have met overall officer and enlisted (active and reserve) recruiting goals for 2008 and are on track for success in 2009. We are also improving the diversity of our Navy through significant outreach and mentorship. We continue to provide, support, and encourage training and education for our warfighters in the form of Joint Professional Military Education, Language Regional Expertise and Cultural programs, and top-notch technical schoolhouses. In addition, to help our Sailors balance between their service to the nation and their lives at home and with their families, we have expanded access to childcare, and improved housing for families and bachelors through Public Private Ventures (PPV). We also continue to address the physical and mental needs of our Wounded and Returning Warriors and

their families, as well as the needs of all our Sailors who deploy. I appreciate the support of Congress for these incredible men and women.

My focus as CNO is to ensure we are properly balanced to answer the call now and in the decades to come. As I indicated last year, the balance among capability, capacity, affordability, and executability in our procurement plans is not optimal. This imbalance has increased our warfighting, personnel, and force structure risk in the future. Our risk is moderate today trending toward significant in the future because of challenges associated with Fleet capacity, increasing operational requirements, and growing manpower, maintenance, and infrastructure costs.

We remain a ready and capable Navy today, but the stress on our platforms and equipment is increasing. We can meet operational demands today but we are stretched in our ability to meet additional operational demands while taking care of our people, conducting essential platform maintenance to ensure our Fleet reaches its full service life, and modernizing and procuring the Navy for tomorrow. Our FY 2010 budget aligns with the path our Maritime Strategy has set; however, we are progressing at an adjusted pace. Our budget increases our baseline funding, yet our Navy continues to rely on contingency funding to meet current operational requirements and remain the nation's strategic reserve across the entire spectrum of conflict.

Achieving the right balance within and across my priorities will be critical as we meet the challenges of today and prepare for those of tomorrow. I request your full support of our FY 2010 budget request and its associated capabilities, readiness, and personnel initiatives highlighted below.

Build Tomorrow's Navy

To support our nation's global interests and responsibilities, our Navy must have the right balance of capability and capacity, across multiple regions of the world, to prevent and win in conflict today while providing a hedge against the challenges we are most likely to face tomorrow. You have provided us with a Fleet that possesses the capabilities Combatant Commanders demand. Our budget request for FY2010 increases the capacity of our Fleet to respond to those demands.

We are addressing our aviation capability and capacity by investing in both new and proven technologies. Our E/A-18 G aircraft utilize the same airframe as the F/A-18 F, which improves construction costs and efficiencies, but it is equipped for airborne electronic attack, rather than strike missions. The E/A-18G will complete operational testing this year and eventually replace our existing EA-6B Fleet. Our budget includes procurement and RDT&E funding for this aircraft and for our P-8A Multi-mission Maritime Aircraft, which will replace our aging P-3 Orion Fleet. In addition to manned aviation, our Navy is investing in unmanned aircraft, such as Firescout, which is more affordable, can be built in larger numbers, and can do the missions needed in the small wars and counterinsurgencies we are likely to face in the near to mid-term. We are also investing in the Broad Area Maritime Surveillance System (BAMS), which is the only unmanned aircraft that can provide long-range intelligence, surveillance, and

reconnaissance in the maritime environment. Our aviation programs increased by more than $4.2B from FY 2009 to FY 2010 to achieve the right balance of capability and capacity.

Our Navy's operational tempo over the past year reaffirms our need for a minimum of 313 ships. The mix of those ships has evolved in response to the changing security environment and our investments in FY 2010 support growing Combatant Commander demands for ballistic missile defense, irregular warfare, and open ocean anti-submarine warfare. We are also addressing demands for high speed and intra-theater lift, as well as a variety of missions in the littoral. Specifically, our FY 2010 budget funds eight ships: the 12th Virginia class submarine, three Littoral Combat Ships (LCS), two T-AKE Dry Cargo and Ammunition Ships, a second Joint High Speed Vessel (JHSV) for the Navy, and an advanced Arleigh Burke Class Destroyer that will restart the DDG 51 program. The budget also funds the balance of LPD 26 and DDG 1002 construction, and provides third-year funding for CVN 78.

American shipbuilding is not broken, but improvements are needed. Since becoming CNO, I have focused on our need to address and control procurement and total ownership costs. Shipbuilding costs have been increasing as a result of reductions in number of ships procured, overtime costs, and challenges associated with the introduction of new technologies and sophisticated systems. We are addressing these costs by maturing new ship designs to adequate levels before commencing production, and by pursuing common hull forms, common components, proven designs, and repeat builds of ships and aircraft to permit longer production runs and lower construction costs. Additionally, our shipbuilding plans incorporate open architecture for hardware and software systems and increasingly use system modularity. These initiatives reduce costs from inception to decommissioning and allow ease of modernization in response to evolving threats.

In 2008, we introduced a more comprehensive acquisition governance process to better link requirements and costs throughout the procurement process. I will work closely with the Secretary of the Navy to grow our acquisition workforce and enhance our ability to properly staff and manage our acquisition programs. I also enthusiastically support reviewing the overall acquisition and procurement processes to determine how the Services can best address costs and accountability.

A solid and viable industrial base is essential to national security and our future Navy, and is a significant contributor to economic prosperity. Shipbuilding alone is a capital investment that directly supports more than 97,000 American jobs and indirectly supports thousands more in almost every U.S. state. Similarly, aircraft manufacturing provides extraordinary and unique employment opportunities for American workers. Like the manufacturing base in other sectors of our economy, the shipbuilding and aircraft industries depend upon stable and predictable workloads to stabilize their workforce and maximize efficiencies. Level loading of ship and aircraft procurements helps retain critical skills and promotes a healthy U.S. shipbuilding and aircraft industrial base.

I seek your support for the following initiatives and programs:

Aircraft Carrier Force Structure

The Navy remains committed to a force of 11 carriers for the next three decades that can respond to national crises and provide options when access is not assured. Our carrier force provides the nation the unique ability to overcome political and geographic barriers to access critical areas and project power ashore without the need for host nation ports or airfields.

The 11-carrier requirement is based on a combined need for world-wide presence requirements, surge availability, training and exercises, and maintenance. During the period between the planned 2012 inactivation of USS ENTERPRISE (CVN 65) and the 2015 delivery of GERALD R. FORD (CVN 78), however, legislative relief is needed to temporarily reduce the operational carrier force to 10. Extending ENTERPRISE beyond 2012 involves significant technical risk, challenges manpower and the industrial base, and requires expenditures in excess of $2.8B with a minimal operational return on this significant investment. Extending ENTERPRISE would result in only a minor gain in carrier operational availability and adversely impact carrier maintenance periods and operational availability of the force in the future. The temporary reduction to 10 carriers can be mitigated by adjustments to deployments and maintenance availabilities. I request your approval of this legislative proposal.

F/A-18 and Joint Strike Fighter (JSF)

Navy and Marine Corps carrier-based F/A-18 aircraft are providing precision strike in support of forces on the ground in Iraq and Afghanistan. The F/A-18 E/F is the aviation backbone of our Navy's ability to project power ashore without bases that infringe on a foreign nation's sovereign territory. At the rate we are operating these aircraft, the number of our carrier-capable strike fighters will decrease between 2016 and 2020, which will affect our air wing capacity and effectiveness. The F-35 Joint Strike Fighter (JSF) is essential to addressing the Navy's strike fighter needs. Stable funding of JSF will facilitate the on-time and within budget delivery of the aircraft to our Fleet. I also appreciate the support of Congress for our FY 10 request that continues to fund F/A-18 E/F production while transitioning to JSF.

Littoral Combat Ship (LCS)

LCS is a fast, agile, and networked surface combatant with capabilities optimized to support naval and joint force operations in littoral regions. LCS fills warfighting gaps in support of maintaining dominance in the littorals and strategic choke points around the world. It will operate with focused-mission packages, which will include manned and unmanned vehicles, to execute a variety of missions, primarily anti-submarine warfare (ASW), anti-surface warfare (SUW), and mine countermeasures (MCM).

LCS' inherent characteristics of speed, agility, shallow draft, payload capacity, reconfigurable mission spaces, and air/water craft capabilities, combined with its core Command, Control, Communications, Computers and Intelligence, sensors, and weapons systems, make it an ideal platform for engaging in irregular warfare and maritime security operations, to include counter-piracy missions.

I am pleased to report that USS FREEDOM (LCS 1) is at sea and INDEPENDENCE (LCS 2) will deliver later this year. We have issued fixed-price incentive fee contracts for

construction of the next two LCS ships based on a limited competition between the current LCS seaframe prime contractors.

The Navy is aggressively pursuing cost reduction measures to ensure delivery of future ships on a schedule that affordably paces evolving threats. We are applying lessons learned from the construction and test and evaluation periods of the current ships, and we are matching required capabilities to a review of warfighting requirements. I am committed to procuring 55 LCS, however legislative relief may be required regarding the LCS cost-cap until manufacturing efficiencies can be achieved. Our FY 2010 budget includes funding for three additional LCS seaframes.

DDG-1000 / DDG-51

Ballistic missile capability is rapidly proliferating and, since 1990, the pace of that proliferation has increased markedly. Non-state actors are also acquiring advanced weapons, as demonstrated in 2006 when Hezbollah launched a sophisticated anti-ship missile against an Israeli ship. In addition, while DDG 1000 has been optimized for littoral anti-submarine warfare, the number of capable submarines worldwide does not allow us to diminish our deep-water capabilities. The world has changed significantly since we began the march to DDG 1000 in the early 1990's and, today, Combatant Commander demands are for Ballistic Missile Defense, Integrated Air and Missile Defense, and Anti-Submarine Warfare.

To align our surface combatant investment strategy to meet these demands, we are truncating the DDG 1000 program at three ships and appropriately restarting the DDG 51 production line. The technologies resident in the DDG 51 provide extended range air defense now, and when coupled with open architecture initiatives, will best bridge the transition to the enhanced ballistic missile defense and integrated air and missile defense capability envisioned in the next generation cruiser. In our revised plan, we are addressing the changing security environment and the dynamic capability requirements of the Fleet, while providing maximum stability for the industrial base.

Our FY 2010 budget requests $1.084 billion to provide the balance of incremental funding for the third ship of the DDG 1000 class authorized in 2009. In addition, $2.241 billion is requested to re-start the DDG 51 program. The SWAP II Memorandum of Agreement (MOA) will align construction responsibilities to ensure shipyard workload stability, stabilize and minimize cost risk for the DDG 1000 program, and efficiently re-start DDG 51 construction. Research, development, test and evaluation efforts for the DDG 1000 program, will continue in order to deliver the necessary technology to complete the DDG 1000 class ships and support the CVN 78 Class.

Ballistic Missile Defense

The increasing development and proliferation of ballistic missiles threatens our homeland, our allies, and our military operations. Current trends indicate adversary ballistic missile systems are becoming more flexible, mobile, survivable, reliable, accurate, and possess greater range. Threats posed by ballistic missile delivery are likely to increase and become more complex over the next decade.

Our Navy is on station today performing ballistic missile defense (BMD) as a core mission. Maritime BMD is a joint warfighting enabler. Aegis BMD contributes to homeland defense through long range surveillance and tracking and Aegis BMD ships can conduct organic midcourse engagements of short and medium range ballistic missiles in support of regional and theater defense. Our Navy and partner nation Aegis BMD capability, proven and deployed around the world, has an impressive record of success: 18 of 22 direct hits on target, of which 3 of 3 were successful engagements within the earth's endo-atmosphere.

Today, Navy Aegis BMD capability is currently installed on 18 ships: three guided missile cruisers and 15 guided missile destroyers. In response to an urgent Combatant Commander demand, the Defense Department budget requests $200 million to fund conversion of six additional Aegis ships to provide BMD capability. Ultimately, our plan is to equip the entire Aegis fleet with BMD capability, to provide Joint Commanders an in-stride BMD capability with regularly deploying surface combatants. While development and procurement funding is covered under the Missile Defense Agency budget, Navy has committed $14.5 million in FY 2010 for operations and sustainment of Aegis BMD systems and missiles that have transferred to the Navy.

Modernizing Cruisers and Destroyers

Our Cruiser and Destroyer modernization programs provide vital mid-life upgrades to the combat systems and hull, mechanical, and engineering systems. These upgrades complement our engineered ship life-cycle maintenance efforts, which are necessary to ensure our ships maintain their full service life. Combat systems upgrades, in particular, reduce technology risk for future surface combatants and provide a rapid and affordable capability insertion process. Maintaining the stability of the Cruiser and Destroyer modernization programs will be critical to our future Navy capability and capacity. Our FY 2010 budget includes funds to modernize two Cruisers and two Destroyers.

Joint High Speed Vessel (JHSV)

Intra-theater lift is key to enabling the United States to rapidly project, maneuver, and sustain military forces in distant, anti-access or area-denial environments. The Joint High Speed Vessel (JHSV) program is an Army and Navy joint program to deliver a high-speed, shallow draft surface ship capable of rapid transport of medium payloads of cargo and personnel within a theater to austere ports without reliance on port infrastructure for load/offload. The detail design and lead ship construction contract was awarded to Austal USA on November 13, 2008, and includes contract options for nine additional ships for the Army and Navy. Delivery of the first vessel will be to the Army and is expected in 2011. Our FY 2010 budget includes $178 million for the construction of the Navy's second JHSV. Navy will oversee procurement of the second Army funded vessel.

LPD 17 Class Amphibious Warfare Ship

The LPD 17 Class of amphibious warfare ships represents the Navy's commitment to a modern expeditionary power projection Fleet that will enable our naval force to operate across the spectrum of warfare. The class will have a 40-year expected service life and serve as the replacement for four classes of older ships: the LKA, LST, LSD 36, and the LPD 4. SAN ANTONIO Class ships will play a key role in supporting ongoing overseas operations by

forwardly deploying Marines and their equipment to respond to global crises. USS GREEN BAY (LPD 20) was commissioned in January 2009 and USS NEW ORLEANS (LPD 18) deployed the same month. New York (LPD 21) is planned to deliver this fall. LPDs 22-25 are in various stages of construction. Our FY 2010 budget requests $872 million for the balance of the funding for LPD 26, which was authorized in 2009. Further, we request $185 million of advance procurement for LPD 27 to leverage production efficiencies of the existing LPD 17 class production line. Amphibious lift will have my highest attention as we address it in the ongoing Quadrennial Defense Review.

P-3 Orion and P-8 Multi-mission Maritime Aircraft

Your continued support of the P-3 and P-8A force remains essential. The legacy P-3 Orion, is providing critical intelligence, surveillance and reconnaissance (ISR) to the current fight and it is a key enabler in the execution of our Maritime Strategy. An airframe in very high demand, the P-3 supports the joint warfighter with time-critical ISR, contributes directly to our maritime domain awareness across the globe, and is our nation's pre-eminent airborne deterrent to an increasing submarine threat. Thirty-nine P-3s were grounded in December 2007 due to airframe fatigue. I thank Congress for providing $289.3 million to our Navy in the FY 2008 Supplemental to fund the initial phase of the recovery program.

Boeing has resolved labor issues with their workforce and is implementing a recovery plan for the P-8A within fiscal resources that will restore the program schedule from delays caused by last year's strike.

The P-8A Poseidon will start to fill the P-3 capability in 2013. I am pleased to report the program reached a critical milestone this April when the first P-8A test aircraft successfully completed its first flight. I request your support of our FY10 budget request for six P-8A aircraft.

E-2D Advanced Hawkeye

The E-2D Advanced Hawkeye aircraft replaces the E-2C Hawkeye aircraft. The aircraft's APY-9 radar is a two-generation leap in airborne surveillance radar capability, significantly improving detection and tracking of small targets in the overland and littoral environment when compared to the E-2C. The E-2D improves nearly every facet of tactical air operations, maintains open ocean capability, and adds overland and littoral surveillance to support Theater Air and Missile Defense capabilities against air threats in high clutter, electro-magnetic interference, and jamming environments. I ask Congress to support our FY 2010 budget request for two E-2D Hawkeye aircraft.

Unmanned Aerial Systems

We are investing in unmanned systems to enhance our capacity to meet increasing global demands for Intelligence, Surveillance and Reconnaissance (ISR) capability. The Broad Area Maritime Surveillance (BAMS) UAS enhances situational awareness of the operational environment and shortens the sensor-to-shooter kill chain by providing persistent, multiple-sensor ISR to Fleet Commanders and coalition and joint forces. Our FY 2010 budget requests funding for continued research and development of BAMS. We are also requesting funding for the procurement of five MQ-8 Vertical Takeoff and Landing Tactical UAVs (VTUAV). The MQ-8 supports LCS core mission areas of ASW, Mine Warfare, and SUW. It can operate from

all air-capable ships and carry modular mission payloads to provide day and night real time reconnaissance, surveillance and target acquisition capabilities. VTUAV began operational testing this March aboard USS MCINERNY (FFG 8).

MH-60R/S Multi-Mission Helicopter

The MH-60R multi-mission helicopter program will replace the surface combatant-based SH-60B and carrier-based SH-60F with a newly manufactured airframe and enhanced mission systems. The MH-60R provides forward-deployed capabilities, including Surface Warfare, and Anti-Submarine Warfare, to defeat area-denial strategies, which will enhance the ability of the joint force to project and sustain power. MH-60R deployed for the first time in January 2009 with the USS JOHN C. STENNIS. Our FY 2010 budget requests funding to procure 24 MH-60R helicopters.

The MH-60S will support deployed forces with combat logistics, search and rescue, air ambulance, vertical replenishment, anti-surface warfare, airborne mine counter-measures, and naval special warfare mission areas. Our FY 2010 budget requests funding to procure 18 MH-60S helicopters.

Virginia Class SSN

The VIRGINIA Class submarine is a multi-mission submarine that dominates in the littorals and open oceans. Now in its 10th year of construction, the VIRGINIA program is demonstrating that this critical undersea capability can be delivered affordably and on time. We have aggressively reduced construction costs of the VIRGINIA Class to $2 billion per submarine, as measured in FY 2005 dollars, through construction performance improvements, redesign for affordability, and a multi-year procurement contract, which provides an assured build rate for shipyards and vendors and offers incentives for cost, schedule, and capital expenditure for facility improvements. Not only are these submarines coming in within budget and ahead of schedule, their performance is exceeding expectations and continues to improve with each ship delivered. I consider Virginia Class cost reduction efforts a model for all our ships, submarines, and aircraft.

SSBN

Our Navy supports the nation's nuclear deterrence capability with a credible and survivable fleet of 14 Ohio Class ballistic missile submarines (SSBN). Originally designed for a 30-year service life, this class will start retiring in 2027 after over 40 years of service life.

As long as we live in a world with nuclear weapons, the United States will need a reliable and survivable sea-based strategic deterrent. Our FY 2010 budget requests research and development funds for the Ohio Class Replacement, to enable the start of construction of the first ship in FY 2019. The United States will achieve significant program benefits by aligning our efforts with those of the United Kingdom's Vanguard SSBN replacement program. The US and UK are finalizing a cost sharing agreement.

Foreign Military Sales

Our Navy also supports the development of partner capability and capacity through a robust Foreign Military Sales (FMS) program. FMS is an important aspect of security cooperation programs designed to improve interoperability, military-to-military relations, and global security. Navy uses the FMS program to help build partner nation maritime security capabilities through transfers of ships, weapon systems, communication equipment, and a variety of training programs. Sales and follow-on support opportunities may also result in production line efficiencies and economies of scale to help reduce USN costs. In the past year, Navy FMS has worked with over 147 nations and international organizations, coordinating 2 ship transfers and twenty five ship transfer requests, providing military training to over 12,000 international military members, with total foreign military sales of roughly $6.8 billion. Congressional support is key to the successful transfer of U.S. equipment to our partners. I thank you for your continued support in this area.

Next Generation Enterprise Network (NGEN)

To pace the complex and adaptive techniques of potential adversaries, we need survivable and persistent network communications that enable secure and robust means to command and control our assets, and to use, manage, and exploit the information they provide. These functions come together in cyberspace, a communication and warfighting domain that includes fiber optic cables on the ocean floor, wireless networks, satellite communications, computer systems, databases, Internet, and most importantly, properly trained cyber personnel to execute cyberspace effects. Cyberspace presents enormous challenges and unprecedented opportunities to shape and control the battlespace. Recent activities, such as the cyber attacks on Georgia and Estonia last year, highlight the complex and dynamic nature of cyber threats.

Our Navy has provided cyber capabilities to the joint force for more than 11 years and we continue to make security and operations in the cyberspace domain a warfighting priority. The challenge we face today is balancing our need to collect and share information with our need to protect against 21st century cyber threats. We are taking steps to effectively organize, man, train, and equip our Navy for cyber warfare, network operations, and information assurance. We are also working closely with Joint and interagency partners to develop offensive and defensive cyberspace capabilities, infrastructure, experience, and access, rather than developing independent, Navy-only capabilities.

As we move from the Navy-Marine Corps Intranet (NMCI) to the Next Generation Enterprise Network (NGEN), the sophistication, speed, and persistence of cyber threats we observe today makes it imperative that we continually improve our network capabilities, improve our flexibility to adapt to changing environment, and maintain complete operational control of the network. NGEN Block 1 is the follow-on to the existing NMCI contract that expires 30 September 2010. It replaces the services currently provided by NMCI and takes advantage of lessons learned from that network. Future NGEN Blocks will upgrade services provided by NMCI and the OCONUS Navy Enterprise Network. NGEN will also integrate with shipboard and Marine Corps networks to form a globally integrated, Naval Network Environment to support network operations. NGEN will leverage the Global Information Grid (GIG) and, where possible, utilize DoD enterprise services. A comprehensive transition strategy is currently being

developed to detail the approach for transition from NMCI to NGEN. I appreciate the support of Congress as we execute a Continuity of Services Contract to assist in this transition.

Remain Ready to Fight Today

Our Navy is operating at its highest levels in recent years. As I testified last year, even as our nation shifts its focus from Iraq to Afghanistan, our Navy's posture, positioning, and frequency of deployment remain high. Combatant Commanders recognize the value of Navy forces to the current fight and to operations world-wide. We are meeting new needs for ballistic missile defense in Europe and the Pacific, counter-piracy and maritime security in Africa and South America, and humanitarian assistance in the Caribbean and Southeast Asia. Many of these demands started as one-time sourcing requests and have evolved into enduring requirements for Navy forces. As a result, we have experienced a significant difference between our budgeted and actual Fleet operations from year to year, as well as an increase in maintenance requirements for our Fleet as a result of its increased operational tempo.

We have been able to meet these requirements by relying on a combination of base budget and contingency funding and the continuous readiness of our force generated by the Fleet Response Plan (FRP). FRP allows us to provide continuous availability of Navy forces that are physically well-maintained, properly manned, and appropriately trained to deploy for ongoing and surge missions. Any future funding reductions or increased restrictions limit our Navy's ability to respond with as much flexibility to increased Combatant Commander demands world-wide.

Our bases and infrastructure enable our operational and combat readiness and are essential to the quality of life of our Sailors, Navy civilians, and their families. I appreciate greatly your enthusiastic support and confidence in the Navy through the inclusion of Navy projects in the American Reinvestment and Recovery Act. The funding provided through the Recovery Act addresses some of our most pressing needs for Child Development Centers, barracks, and energy improvements. Our projects are prioritized to make the greatest impact on mission requirements and quality of life. All of our Recovery Act projects meet Congress' intent to create jobs in the local economy and address critical requirements. These projects are being quickly and prudently executed to inject capital into local communities while improving mission readiness and quality of work and life for our Sailors and families.

I appreciate your support for the following initiatives:

Training Readiness

The proliferation of advanced, stealthy, nuclear and non-nuclear submarines, equipped with anti-ship weapons of increasing range and lethality, challenge our Navy's ability to guarantee the access and safety of joint forces. Effective Anti-Submarine Warfare (ASW) remains a remarkably and increasingly complex, high-risk warfare area that will require continued investment in research and development to counter the capabilities of current and future adversaries.

Active sonar systems, particularly medium frequency active (MFA) sonar, are key enablers of our ability to conduct effective ASW. MFA sonar is the Navy's most effective tool for locating and tracking submarines at distances that preclude effective attack on our ships. We must conduct extensive integrated training, to include the use of active sonar, which mirrors the intricate operating environment present in hostile waters, particularly the littorals. This is of the highest importance to our national security and the safety of our Sailors and Marines.

Over the past five years, Navy has expended significant effort and resources preparing comprehensive environmental planning documentation for our at sea training and combat certification activities. The Navy remains a world leader in marine mammal research, and we will continue our robust investment in this research in FY 2010 and beyond. Through such efforts, and in full consultation and cooperation with our sister federal agencies, Navy has developed effective measures that safely protect marine mammals and the ocean environment from adverse impacts of MFA sonar while not impeding vital naval training.

In overruling attempts to unduly restrain Navy's use of MFA sonar in Southern California training ranges, the Supreme Court cited President Teddy Roosevelt's quote "the only way in which a navy can ever be made efficient is by practice at sea, under all conditions which would have to be met if war existed." We can and do balance our responsibility to prepare naval forces for deployment and combat operations with our responsibility to be good stewards of the marine environment.

Depot Level Maintenance

Optimum employment of our depot level maintenance capability and capacity is essential to our ships and aircraft reaching their expected service life. Depot maintenance is critical to the safety of our Sailors and it reduces risk caused by extension of ships and aircraft past their engineered maintenance periodicity. Effective and timely depot level maintenance allows each ship and aircraft to reach its Expected Service Life, preserving our existing force structure and enabling us to achieve our required capacity.

I have taken steps to enhance the state of maintenance of our surface combatants. In addition to our rigorous self-assessment processes that identify maintenance and readiness issues before our ships and aircraft deploy, I directed the Commander, Naval Sea Systems Command to reinstate an engineered approach to surface combatant maintenance strategies and class maintenance plans with the goal of improving the overall condition of these ships. Our Surface Ship Life Cycle Maintenance Activity will provide the same type of planning to address surface ship maintenance as we currently have for carriers and submarines.

Consistent, long term agreements and stable workload in both the public and private sector are necessary for the efficient utilization of depots, and it is the most cost effective way to keep our ships and aircraft at the highest possible state of readiness. Consistent with my intent to drive our Navy to better articulate requirements and costs in all we do, we have rigorously updated the quantitative models we use to develop our maintenance budgets, increasing their overall fidelity. These initial editions of the revised maintenance plans have resulted in increased maintenance requirements and additional costs. Our combined FY10 budget funds 96 percent of the projected depot ship maintenance requirements necessary to sustain our Navy's global

presence. Our budget funds aviation depot maintenance at 100 percent for deployed squadrons and at 87 percent for aviation maintenance requirements overall. I request the support of Congress to fully support our baseline and contingency funding requests for our operations and maintenance to ensure the safety of our Sailors and the longevity of our existing ships and aircraft.

Shore Readiness

Our shore infrastructure enables our operational and combat readiness and is essential to the quality of life and quality of work for our Sailors, Navy civilians, and their families. For years, increased operational demand, rising manpower costs, and an aging Fleet have led our Navy to underfund shore readiness and, instead, invest in our people, afloat readiness, and future force structure. As a result, maintenance and recapitalization requirements have grown and the cost of ownership for our shore infrastructure has increased. At current investment levels, our future shore readiness, particularly recapitalization of our facilities infrastructure, is at risk.

In an effort to mitigate this risk in a constrained fiscal environment, we are executing a Shore Investment Strategy that uses informed, capabilities-based investment decisions to target our shore investments where they will have the greatest impact to our strategic and operational objectives. I appreciate the enthusiastic support and confidence of Congress in the Navy through the inclusion of Navy projects in the American Reinvestment and Recovery Act. Through the Recovery Act, you allowed our Navy to address some of our most pressing needs for Child Development Centers, barracks, dry dock repairs, and energy improvements. These Navy projects are located in 22 states and territories and fully support the President's objectives of rapid and pervasive stimulus efforts in local economies. I am committed to further improvements in our shore infrastructure but our Navy must balance this need against our priorities of sustaining force structure and manpower levels.

Energy

Our Navy is actively pursuing ways to reduce our energy consumption and improve energy efficiency in our operations and at our shore installations. Our emerging Navy Energy Strategy spans three key areas, afloat and on shore: 1) an energy security strategy to make certain of an adequate, reliable and sustainable supply; 2) a robust investment strategy in alternative renewable sources of energy and energy conservation technologies; and 3) policy and doctrine changes that are aimed at changing behavior to reduce consumption.

I will be proposing goals to the Secretary of the Navy to increase energy independence in our shore installations, increase use of alternative fuels afloat and reduce tactical petroleum consumption, and to reduce our carbon footprint and green house gas emissions. We are leveraging available investment dollars and current technological advances to employ technology that reduces energy demand and increases our ability to use alternative and renewable forms of energy for shore facilities and in our logistics processes. This technology improves energy options for our Navy today and in the future. Our initial interactions with industry and academic institutions in public symposia over the past few months have generated an enthusiastic response to our emerging strategy.

United Nations Convention on the Law of the Sea

The Law of the Sea Convention codifies navigation and overflight rights and high seas freedoms that are essential for the global mobility of our armed forces. It directly supports our National Security interests. Our current non-party status constrains efforts to develop enduring maritime partnerships, inhibits efforts to expand the Proliferation Security Initiative, and elevates the level of risk for our Sailors as they undertake operations to preserve navigation rights and freedoms, particularly in areas such as the Strait of Hormuz and Arabian Gulf, and the East and South China Seas. Accession to the Law of the Sea Convention remains a priority for our Navy.

Develop and Support Our Sailors and Navy Civilians

Our talented and dedicated Sailors and Navy civilians are the critical component to the Navy's Maritime Strategy. I am committed to providing the necessary resources and shaping our personnel policies to ensure our people are personally and professionally supported in their service to our nation.

Since 2003, the Navy's end strength has declined by approximately 10,000 per year aiming for a target of 322,000 Active Component (AC) and 66,700 Reserve Component (RC) Sailors. While end strength declined, we have increased operational availability through the Fleet Response Plan, supported new missions for the joint force, and introduced the Maritime Strategy. This increased demand includes maritime interdiction, riverine warfare, irregular and cyber warfare, humanitarian and disaster relief, an extended individual augmentee requirement in support of the joint force, and now, counter-piracy.

To meet increased demands, maintain required Fleet manning levels with minimal risk, and minimize stress on the force, we have transitioned from a posture of reducing end strength to one of stabilizing the force. We anticipate that we will finish this fiscal year within two percent above our authorized level.

The FY10 budget request supports an active component end strength of 328,800. This includes 324,400 in the baseline budget to support Fleet requirements, as well as increased capacity to support the individual augmentee missions. The budget also supports the reversal of the Defense Health Program military-to-civilian conversions as directed by the Congress. The FY 2010 budget also requests contingency funding for individual augmentees supporting the joint force in non-traditional Navy missions. To maintain Fleet readiness, support Combatant Commanders, and to minimize the stress on the force, our Navy must be appropriately resourced to support this operational demand.

I urge Congress to support the following manpower and personnel initiatives:

Recruiting and Retention

Navy has been successful in attracting, recruiting, and retaining a highly-skilled workforce this fiscal year. The FY10 budget positions us to continue that success through FY10. We expect to meet our overall officer and enlisted recruiting and retention goals, though we remain focused on critical skills sets, such as health professionals and nuclear operators.

As demand for a professional and technically-trained workforce increases in the private sector, Navy must remain competitive in the marketplace through monetary and non-monetary incentives. Within the health professions, Navy increased several special and incentives pays, and implemented others, targeting critical specialties, including clinical psychology, social work, physician assistant, and mental health nurse practitioners. We are also offering mobilization deferments for officers who immediately transition from active to reserve status. We have increased bonuses and other incentives for nuclear trained personnel to address an increasing demand for these highly-trained and specialized professionals in the private sector.

We continually assess our recruiting and retention initiatives, taking a targeted investment approach, to attract and retain high-performing Sailors. We appreciate Congressional support for the Post-9/11 GI Bill. Navy's goal is to maintain a balanced force, in which seniority, experience, and skills are matched to requirements.

Total Force Integration

Navy continues to invest in Navy Reserve recruiting, retention and training while achieving Total Force integration between active and reserve components. The Navy Reserve Force provides mission capable units and individuals to the Navy and Marine Corps team through a full range of operations. Navy's goal is to become a better aligned Total Force in keeping with Department of Defense and Department of the Navy strategic guidance, while providing fully integrated operational support to the Fleet. Navy continues to validate new mission requirements and an associated Reserve Force billet structure to meet future capability requirements. Navy has leveraged incentives to best recruit Sailors within the Total Force and is developing and improving programs and policies that promote a continuum of service through Navy Reserve affiliation upon separating from the active component. Navy is removing barriers to ease transition between active and reserve components and is developing flexible service options and levels of participation to meet individual Sailor ability to serve the Navy throughout a lifetime of service.

Sailor and Family Continuum of Care

Navy continues to provide support to Sailors and their families, through a "continuum of care" that covers all aspects of individual medical, physical, psychological, and family readiness. Through an integrated effort between Navy Medicine and Personnel headquarters activities and through the chain of command, our goal is reintegrating the individual Sailor with his or her command, family, and community.

Our Navy and Coast Guard recently signed a memorandum of agreement for the Coast Guard to share the services provided by the Navy Safe Harbor Program. The program is currently comprised of approximately 375 lifetime enrollees and 217 individuals receiving personally-tailored care management. It provides recovery coordination and advocacy for seriously wounded, ill, and injured Sailors and Coast Guardsmen, as well as a support network for their families. We have established a headquarters support element comprised of subject matter expert teams of non-medical care managers and recovery care coordinators, and Reserve surge support to supplement field teams in mass casualty situations.

We have also developed the Anchor Program, which leverages the volunteer services of Navy Reserve members and retirees who assist Sailors in reintegrating with family and community. Navy recently institutionalized our Operational Stress Control (OSC) Program which provides an array of initiatives designed to proactively promote psychological resilience and sustain a culture of psychological health among Sailors and their families. We are developing a formal curriculum which will be integrated into the career training continuum for all Sailors throughout their Navy careers.

Active and Reserve Wounded, Ill and Injured

Navy Medicine continues to assess the needs of wounded, ill and injured service members and their families. In 2008, Navy Medicine consolidated all wounded, ill and injured warrior healthcare support with the goal of offering comprehensive implementation guidance, the highest quality and most compassionate care to service members and their families. As of October 2008, 170 additional clinical care managers were assigned to military treatment facilities (MTFs) and ambulatory care clinics caring for approximately 1800 OIF/OEF casualties. Over 150 clinical medical case managers at Navy MTFs advocate on behalf of wounded warriors and their family members by working directly with the multi-disciplinary medical team caring for the patient.

The Navy recognizes the unique medical and administrative challenges faced by our Reserve Wounded Sailors when they return from deployment, and we know their care cannot end at the Military Treatment Facility (MTF). In 2008, we established two Medical Hold Units responsible for managing all aspects of care for Reserve Sailors in a Medical Hold (MEDHOLD) status. Co-located with MTFs in Norfolk and San Diego, these units are led by Line Officers with Senior Medical Officers supporting for medical issues. Under their leadership, case managers serve as advocates who proactively handle each Sailor's individualized plan of care until all medical and non-medical issues are resolved. We have reduced the numbers of Sailors in the MEDHOLD process and the length of time required to resolve their cases. The RC MEDHOLD program has become the single, overarching program for providing prompt, appropriate care for our Reserve Wounded Sailors.

Traumatic Brain Injury (TBI)

TBI represents the defining wound of OIF/OEF due to the proliferation of improvised explosive devices (IED). The Department of the Navy has implemented a three-pronged strategy to increase detection of TBI throughout the deployment span, which includes mental health stigma reduction efforts, lowering the index of suspicion for TBI symptoms and improving seamless coordination of screening, detection and treatment among line and medical leaders. Navy Medicine continues to expand its efforts to identify, diagnosis and treat TBI. The traumatic stress and brain injury programs at National Naval Medical Center (NNMC) Bethesda, Naval Medical Center San Diego (NMCSD), Naval Hospital (NH) Camp Pendleton, and NH Camp Lejeune are collaborating to identify and treat service members who have had blast exposure. Furthermore, Navy Medicine has partnered with the Line community to identify specific populations at risk for brain injury such as front line units, SEALS, and Navy Explosive Ordinance disposal units.

Psychological Health

The number of new cases of Post Traumatic Stress Disorder (PTSD) in the Navy has increased in the last year, from 1,618 in FY 2007 to 1,788 in FY 2008 and we have expanded our efforts to reach out to service members. We continue to move mental health providers closer to the battlefield and remain supportive of the Psychologist-at Sea program. Incentives for military mental health providers have also increased to ensure the right providers are available. We are actively working to reduce the stigma associated with seeking help for mental health. Our recently established Operational Stress Control (OSC) program implements training and tools that line leadership can use to address stigma. Since inception, OSC Awareness Training, which included mental health stigma reduction, has been provided to over 900 non-mental health care givers and 16,000 Sailors including over 1,395 at Navy's Command Leadership School and Senior Enlisted Academy.

Diversity

We have had great success in increasing our diversity outreach and improving diversity accessions in our ranks. We are committed to a Navy that reflects the diversity of the nation in all specialties and ranks by 2037. Through our outreach efforts, we have observed an increase in NROTC applications and have increased diverse NROTC scholarship offers by 28 percent. The NROTC class of 2012 is the most diverse class in history and, with your help through nominations, the U.S. Naval Academy class of 2012 is the Academy's most diverse class in history. Our Navy is engaging diversity affinity groups such as the National Society of Black Engineers, Thurgood Marshall College Fund, Society of Hispanic Professional Engineers, American Indian Science and Engineering Society, Mexican American Engineering Society, and the Asian Pacific Islander American Scholarship Fund to increase awareness of the opportunities for service in the Navy. Our engagement includes Flag attendance, junior officer participation, recruiting assets such as the Blue Angels, direct Fleet interaction. We have also established Regional Outreach Coordinators in Atlanta, Chicago, Houston, Los Angeles, and Miami to build Navy awareness in diverse markets.

As we continue to meet the challenges of a new generation, the Navy is already being recognized for our efforts through receipt of the Work Life Legacy Award (Families and Work Institute), the Work Life Excellence Award (Working Mother Media), Most Admired Employer (U.S. Black Engineer and Hispanic Engineer Magazine), and Best Diversity Company (Diversity/Careers in Engineering and IT).

Life-Work Integration

Thank you for your support of our Navy's efforts to balance work and life for our Sailors and their families. You included two important life-work integration initiatives in the FY 2009 National Defense Authorization Act (NDAA) in which our Sailors have consistently expressed strong interest. The NDAA authorized 10 days of paternity leave for a married, active duty Sailor whose wife gives birth to a child, establishing a benefit similar to that available for mothers who receive maternity leave and for parents who adopt a child. The NDAA also included a career intermission pilot program, allowing participating Sailors to leave active duty for up to three years to pursue personal and professional needs, while maintaining eligibility for certain medical, dental, commissary, travel and transportation benefits and a portion of basic pay. In addition to these new authorities, Navy is also exploring other life-work integration initiatives, such as

flexible work schedules and telework in non-operational billets through use of available technologies such as Outlook Web Access for e-mail, Defense Connect Online, and Defense Knowledge Online for document storage and virtual meetings. The Virtual Command Pilot, implemented within the Total Force Domain for an initial group of officers, will allow individuals to remain in their current geographic locations while working for parent commands located elsewhere within the U.S.

Education

We recognize the importance both to the individual and to our mission of providing a life-long continuum of learning and development. Education remains a critical component of this continuum. The Navy's Professional Military Education Continuum, with an embedded Joint Professional Military Education (JPME) component, produces leaders skilled in maritime and joint planning. Additionally, we offer several college-focused incentives. Tuition assistance provides funds to individuals to pay for college while serving. The Navy College Fund provides money for college whenever the Sailor decides to end his or her Navy career. The Navy College Program Afloat College Education (NCPACE) provides educational opportunities for Sailors while deployed. Furthermore, officers are afforded the opportunity to pursue advanced education through the Naval Postgraduate School (NPS), NPS distance learning programs, the Naval War College, and several Navy fellowship programs. In addition, our Loan Repayment Program allows us to offer debt relief up to $65,000 to recruits who enlist after already earning an advanced degree. The Advanced Education Voucher (AEV) program provides undergraduate and graduate off-duty education opportunities to selected senior enlisted personnel as they pursue Navy-relevant degrees. The Accelerate to Excellence (A2E) program, currently in the second year of a three-year pilot, combines two semesters of education completed while in the Delayed Entry Program, one semester of full-time education taken after boot camp, and college credit earned upon completion of "A" school to complete an Associates Degree. The Navy Credentialing Opportunities Online (COOL) program matches rate training and experience with civilian credentials, and funds the costs of credentialing and licensing exams. As of the end of March 2009, there have been more than 35 million visits to the COOL web site, with more than 13,000 certification exams funded and approximately 8,500 civilian certifications attained.

Conclusion

Despite the challenges we face, I remain optimistic about the future. The men and women, active and reserve, Sailor and civilian, of our Navy are extraordinarily capable, motivated, and dedicated to preserving our national security and prosperity. We are fully committed to the current fight and to ensuring continued US global leadership in a cooperative world. We look forward to the upcoming Quadrennial Defense Review, which will address how we can best use our military forces to meet the complex and dynamic challenges our nation faces today and will face in the future. We have seen more challenging times and emerged prosperous, secure, and free. I ask Congress to fully support our FY 2010 budget and identified priorities. Thank you for your continued support and commitment to our Navy, and for all you do to make the United States Navy a force for good today and in the future.

Mr. MURTHA. Before I acknowledge the Commandant, I want you to know I had three brothers in the Marine Corps, and the committee has heard this story before, but when I enlisted it was 1952 in the Korean War. My mother cried all through my enlistment. My second brother joined the Marine Corps. My third brother joined the Marine Corps. I was going to go into the Army. The reason I am reminded of this is when I see these public relations guys in front of you guys, it makes me realize why my mother was so upset when she thought I couldn't join the Army because of all that information you send out to the families to make sure they know how good a job we are doing in the Marine Corps.

Commandant.

SUMMARY STATEMENT OF GENERAL CONWAY

General CONWAY. Mr. Chairman, Congressman Young and distinguished members of the committee, thank you for the opportunity to report to you on the posture of your Marine Corps. My pledge, as always, is to provide you with a candid and honest assessment and it is in that spirit that I appear before you today.

Our number one priority remains your Marines in combat. Since testimony before your committee last year, progress in the Al Anbar province in Iraq continues to be significant. Indeed, our Marines are in the early phases of the most long awaited phase of operations, redeployment of the force, and a reset of our equipment. Having recently returned from a trip to theater, I am pleased to report to you that the magnificent performance of our Marines and Sailors in Anbar continues across a whole spectrum of tasks and responsibilities.

In Afghanistan, we have substantially another story as thus far in 2009 the Taliban have again increased their activity. The 2nd Marine Expeditionary Brigade and Air Ground Task Force numbering more than 10,000 Marines and Sailors has just assumed responsibility for its battle space under Regional Command South. They are operating primarily in the Helmand Province, where 93 percent of the country's opium is harvested and where the Taliban have been most active. We are maintaining an effort to get every Marine to the fight and today more than 70 percent of your Marine Corps has done so. Yet our force remains resilient in spite of an average deployment to dwell that is slightly better than one to one in most occupational specialties. We believe retention is a great indicator of the morale of the force and the support of our families. By the halfway point of this fiscal year, we had already met our retention goals for our first-term Marines and for our career force.

Our growth in the active component by 27,000 additional Marines has proceeded 2½ years ahead of schedule with no change to our standards. We have reached the level of 202,100 Marines and have found it necessary to throttle back our recruiting efforts. We attribute our accelerated growth to four factors: quality recruiting, exceptional retention levels, reduced attrition, and not least a great generation of young Americans who wish to serve their country in wartime. Our Corps is deeply committed to the care and welfare of the wounded and their families. The Wounded Warrior Regiment reflects this commitment. We seek through all phases of recovery to assist in the rehabilitation and transition of our wounded, in-

jured and ill, and their families. I would also like to thank those of you on the committee who have set aside your personal time to visit with our wounded warriors.

Secretary Gates seeks to create a balanced U.S. Military through the efforts of the Quadrennial Defense Review. We have always believed that the Marine Corps has to be able to play both ways, to be a two-fisted fighter. Our equipment and major programs reflect our equipment to be flexible in the face of uncertainty, that is to say 100 percent of USMC procurement can be employed either in a hybrid conflict or in major combat. If this Nation decides through the QDR that it still needs a forcible entry capability, and we tend to think that it does, then we believe based on the threat and risk to the ships of the United States Navy that the requirement for a platform with the capabilities of the expeditionary fighting vehicle is absolutely essential. And it has my personal attention, sir.

The future posture of our Corps includes a realignment of Marine forces in the Pacific. As part of the agreement between Tokyo and Washington, we are planning the movement of 8,000 Marines off Okinawa to Guam. We support this move. However, we believe the development of training areas and ranges on Guam and the adjoining islands in the Marianas are key prerequisites for the realignment of our forces. We are actively working within the Department of Defense to align USMC requirements with ongoing environmental assessments and political agreements.

On behalf of your Marine Corps, I extend my gratitude for the support that we have received to date. Our great young patriots have performed magnificently and have written their own page in history. They know as they go into harm's way that their fellow Americans are behind them. On their behalf, I thank you for your enduring support. We pledge to spend wisely every dollar you generously provide in ways that contribute to the defense of this great land.

Thank you once again for the opportunity to report to you today, sir, and I look forward to your questions.

[The statement of General Conway follows:]

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STATEMENT OF

GENERAL JAMES T. CONWAY
COMMANDANT OF THE MARINE CORPS

BEFORE

THE HOUSE APPROPRIATIONS COMMITTEE
SUBCOMMITTEE ON DEFENSE

THE POSTURE OF THE UNITED STATES MARINE CORPS

3 JUNE 2009

Not public until
Released by the HAC-D

General James T. Conway

Commandant of the Marine Corps

General Conway was born in Walnut Ridge, Arkansas and is a graduate of Southeast Missouri State University. He was commissioned in 1970 as an infantry officer. His company grade assignments included multiple platoon and company commander billets with both the 1st and 2nd Marine Divisions; Executive Officer of the Marine Detachment aboard the USS *Kitty Hawk* (CVA-63); series and company commander at the Marine Corps Recruit Depot in San Diego; aide to the Commanding General, and Director, Sea School.

As a field grade officer, he commanded two companies of officer students and taught tactics at The Basic School; he also served as operations officer for the 31st Marine Amphibious Unit to include contingency operations off Beirut, Lebanon; and as Senior Aide to the Chairman, Joint Chiefs of Staff. Promoted to Lieutenant Colonel, he was reassigned to the 2d Marine Division as Division G-3 Operations Officer.

He commanded Battalion Landing Team 3/2 during Operations DESERT SHIELD and DESERT STORM. Selected for colonel, he served as the Ground Colonels' Monitor, and as Commanding Officer of The Basic School. His general officer duties included Deputy Director of Operations, J-34, Combating Terrorism, Joint Staff, Washington, D.C.; and President, Marine Corps University at Quantico, Virginia. After promotion to Major General, he assumed command of the 1st Marine Division. In November 2002, Major General Conway was promoted to Lieutenant General and assumed command of the I Marine Expeditionary Force. During 2003-2004, he commanded I Marine Expeditionary Force through two combat tours in Iraq. In late 2004, he was reassigned as the Director of Operations, J-3, Joint Staff, in Washington, D.C.

General Conway graduated with honors from The Basic School, the U.S. Army Infantry Officers' Advanced Course, the Marine Corps Command and Staff College and the Air War College.

Introduction

Chairman Murtha, Congressman Young, and distinguished Members of the Committee; my pledge to you remains the same — to always provide my forthright and honest assessment of your Marine Corps. The following pages detail my assessment of the current state of our Corps and my vision for its future.

First and foremost, on behalf of all Marines, I extend deep appreciation for your magnificent support of the Marine Corps and our families — especially those warriors currently engaged in Iraq and Afghanistan. Extremists started this war just over 25 years ago in Beirut, Lebanon. Since then, our country has been attacked and surprised repeatedly, at home and abroad, by murderers following an extreme and violent ideology. I am convinced, given the chance, they will continue to kill innocent Americans at every opportunity. Make no mistake, your Marines are honored and committed to stand between this great Nation and any enemy today and in the future. Whether through soft or hard power, we will continue to fight the enemy on their land, in their safe havens, or wherever they choose to hide.

A selfless generation, today's Marines have raised the bar in sacrifice and quality. They know they will repeatedly go into harm's way, and despite this, they have joined and reenlisted at exceptional rates. Exceeding both the Department of Defense and our own high school graduate standards, more than 96 percent of our enlistees in Fiscal Year 2008 had earned their high school diploma. Furthermore, based on a recent study from the Center for Naval Analyses, we are also retaining higher quality Marines.

The success in Al Anbar directly relates to the quality of our Marines. Several years ago, few would have thought that the conditions we see in Al Anbar today were possible, but rotation after rotation of Marines, Sailors, Soldiers, and Airmen practiced patience, perseverance, and trigger control until the Sunni leadership realized that we were not the enemy. Now, the vast majority of our actions in Al Anbar deal with political and economic issues — the Corps looks forward to successfully completing our part in this initial battle of the Long War.

However, our Marines are professionals and understand there is still much work to be done. As we increase our strength in Afghanistan, Marines and their families are resolved to answer their Nation's call. There are many challenges and hardships that lie ahead, but our Marines embrace the chance to make a difference. For that, we owe them the full resources required to complete the tasks ahead — to fight today's battles, prepare for tomorrow's challenges, and fulfill our commitment to our Marine families.

Our Marines and Sailors in combat remain my number one priority. The resiliency of our Marines is absolutely amazing. Their performance this past year in Iraq and Afghanistan has been magnificent, and we could not be more proud of their willingness to serve our great Nation at such a critical time. Our concerns are with our families; they are the brittle part of the equation, yet through it all, they have continued to support their loved ones with the quiet strength for which we are so grateful.

To fulfill the Marine Corps' commitment to the defense of this Nation, and always mindful of the sacrifices of our Marines and their families that make it possible, our priorities will remain steadfast. These priorities will guide the Corps through the battles of today and the certain challenges and crises in our Nation's future. Our budget request is designed to support the following priorities:

- **Right-size the Marine Corps for today's conflict and tomorrow's uncertainty**
- **Reset the force and prepare for the next contingency**
- **Modernize for tomorrow to be "the most ready when the Nation is least ready"**
- **Provide our Nation a naval force fully prepared for employment as a Marine Air Ground Task Force across the spectrum of conflict**
- **Take care of our Marines and their families**
- **Posture the Marine Corps for the future**

Your support is critical as we continue to reset the force for today and adapt for tomorrow. As prudent stewards of the Nation's resources, we are committed to providing the American taxpayer the largest return on investment. The future is uncertain and invariably full of surprises, but continued support by Congress will ensure a balanced Marine Corps — increasingly agile and capable — ready to meet the needs of our Nation and a broadening set of missions. From humanitarian assistance to large-scale conventional operations, your Marines have never failed this great Nation, and thanks to your steadfast support, they never will.

Our Marines and Sailors in Combat

Our Corps' most sacred resource is the individual Marine. It is imperative to the long-term success of the institution that we keep their well being as our number one priority. Over the past several years, sustained deployments in Iraq, Afghanistan, and across the globe have kept many Marines and Sailors in the operating forces deployed as much as they have been at home station. They have shouldered our Nation's burden and done so with amazing resiliency. Marines understand what is required of the Nation's elite warrior class — to stand up and be counted when the Nation needs them the most. For this, we owe them our unending gratitude.

Marines and their families know that their sacrifices are making a difference, that they are part of something much larger than themselves, and that their Nation stands behind them. Thanks to the continued support of Congress, your Marines will stay resolved to fight and defeat any foe today or in the future.

USMC Operational Commitments

The Marine Corps is fully engaged in a generational, multi-faceted Long War that cannot be won in one battle, in one country, or by one method. Our commitment to the Long War is characterized by campaigns in Iraq and Afghanistan as well as diverse and persistent engagements around the globe. As of 6 May 2009, there are more than 25,000 Marines deployed to the U.S. Central Command's Area of Responsibility in support of Operations IRAQI FREEDOM (OIF) and ENDURING FREEDOM (OEF). The vast majority are in Iraq; however, we are in the process of drawing down those forces and increasing the number of Marines in Afghanistan.

In Afghanistan, we face an enemy and operating environment that is different than that in Iraq. We are adapting accordingly. Nearly 5,700 Marines are deployed to various regions throughout Afghanistan — either as part of Special Purpose Marine Air Ground Task Force (SPMAGTF) – Afghanistan, 2d Marine Expeditionary Brigade, Marine Special Operations Companies, Embedded Training Teams, or Individual Augments and those numbers will grow substantially. The Embedded Training Teams live and work with the Afghan National Army and continue to increase the Afghan National Army's capabilities as they grow capacity. Other missions outside Afghanistan are primarily in the broader Middle East area, with nearly 2,800 Marines, to include the 13th Marine Expeditionary Unit.

While we recognize the heavy demand in Iraq and Afghanistan, the Marine Corps is very conscious of the need for deployed forces throughout the rest of the globe. As of 6 May 2009, there are roughly 2,800 Marines deployed in the U.S. Pacific Command's Area of Responsibility alone, to include the 31st Marine Expeditionary Unit and a 62-man detachment in the Philippines. More than 100 Marines are deployed in support of Combined Joint Task Force – Horn of Africa in Djibouti. Additionally, the Marine Corps has participated in more than 200 Theater Security Cooperation events, ranging from small mobile training teams to MAGTF exercises in Latin America, Africa, Eastern Europe, and the Pacific.

Right-size the Marine Corps

The needs of a nation at war demanded the growth of our active component by 27,000 Marines. We have had great success and will reach our goal of 202,000 Marines during Fiscal Year 2009 — more than two years earlier than originally forecasted. Solid planning and your continued support will ensure we meet the training, infrastructure, and equipment requirements resulting from this growth. This growth will significantly improve the ability of your Corps to train to the full range of military operations. It will also increase our capacity to deploy forces in response to contingencies and to support security cooperation with our partners, ultimately reducing operational risk and posturing the Corps for continued success in the future.

Before we were funded to grow our force, we were forced into an almost singular focus on preparing units for future rotations and counterinsurgency operations. This narrowed focus and the intense deployment rate of many units weakened our ability to maintain traditional skills, such as amphibious operations, combined-arms maneuver, and mountain warfare. Congressionally-mandated to be "the most ready when the Nation is least ready," this growth is an essential factor to improve our current deployment-to-dwell ratio and allow our Corps to maintain the sophisticated skills-sets required for today and the future.

In Fiscal Year 2008, we activated another infantry battalion and increased capacity in our artillery, reconnaissance, engineer, military police, civil affairs, intelligence, and multiple other key units that have seen a significantly high deployment tempo. With your continued support, we will continue to build capacity according to our planned growth.

Improving the deployment-to-dwell ratio for our operating forces will also reduce stress on our Marines and their families. Achieving our goal of a 1:2 deployment-to-dwell ratio for active duty and a 1:5 ratio for Reserves is crucial to the health of our force and our families during this Long War. Our peacetime goal for active duty remains a 1:3 deployment-to-dwell ratio.

Achieving and Sustaining a Marine Corps of 202,000

The Marine Corps grew by more than 12,000 Marines in Fiscal Year 2008 and is on pace to reach an active duty end strength of 202,000 by the end of Fiscal Year 2009 — more than two years ahead of schedule. We attribute our accelerated growth to four factors: quality recruiting, exceptional retention levels, reduced attrition, and — not least — an incredible generation of young Americans who welcome the opportunity to fight for their country. Our standards remain high, and we are currently ahead of our Fiscal Year 2009 goal in first term enlistments and are on track with our career reenlistments. Attrition levels are projected to remain at or below Fiscal Year 2008 rates.

Recruiting

Recruiting is the strategic first step in making Marines and growing the Corps. With first-term enlistments accounting for more than 70 percent of our end strength increase, our recruiting efforts must not only focus on our overall growth, but also on attracting young men and women with the right character, commitment, and drive to become Marines.

We continue to exceed Department of Defense quality standards and recruit the best of America into our ranks. The Marine Corps achieved over 100 percent of the Active Component accession goal for both officer and enlisted in Fiscal Year 2008. We also achieved 100 percent of our Reserve component recruiting goals.

Retention

Retention is a vital complement to recruiting and an indicator of the resiliency of our force. In Fiscal Year 2008, the Marine Corps achieved an unprecedented number of reenlistments with both the First Term and Career Force. We established the most aggressive retention goals in our history, and our achievement was exceptional. Our 16,696 reenlistments equated to a first-term retention rate of almost 36 percent and a Career Marine retention rate of 77 percent. Through 17 March 2009:

- 7,453 first-term Marines reenlisted, meeting 101.6 percent of our goal. This represents the fastest attainment of a fiscal year first-term reenlistment goal in our history and equates to a retention rate of 31.4 percent retention rate; traditional reenlistments average 6,000 or a retention rate of 24 percent.

- 7,329 Marines who have completed at least two enlistment contracts chose to reenlist again. This number represents 98.2 percent of our goal of 7,464 reenlistments, and a 72.2 percent retention rate among the eligible population.

Our retention success may be attributed to several important enduring themes. First, Marines are motivated to "stay Marine" because they are doing what they signed up to do — fighting for and protecting our Nation. Second, they understand that the Marine Corps culture is one that rewards proven performance. Third, our reenlistment incentives are designed to retain top quality Marines with the most relevant skill sets. The continued support of Congress will ensure continued success.

The Marine Corps Reserve

Our Reserves continue to make essential contributions to our Total Force efforts in The Long War, particularly in Iraq and Afghanistan. As we accelerated our build to 202,000 Active Component Marines, we understood that we would take some risk in regards to obtaining our Reserve Component end strength of 39,600. During the 202,000 build-up, we adjusted our accession plans and encouraged our experienced and combat-tested Reserve Marines to transition back to active duty in support of these efforts. They responded in force, and as a result, we came in under our authorized Reserve Component end strength limit by 2,077. As a Total Force Marine Corps, we rely heavily upon the essential augmentation and reinforcement provided by our Reserve Marines. We believe our authorized end strength of 39,600 is appropriate and provides us with the Marines we require to support the force and to achieve our goal of a 1:5 deployment-to-dwell ratio. With the achievement of the 202,000 active duty force, we will refocus our recruiting and retention efforts to achieve our authorized Reserve Component end strength. The bonus and incentives provided by Congress, specifically the authorization to reimburse travel expenses to select members attending drill, will be key tools in helping us accomplish this goal.

Infrastructure

The Marine Corps remains on track with installation development in support of our personnel growth. With the continued support of Congress, we will ensure sufficient temporary facilities or other solutions are in place until permanent construction can be completed.

Military Construction: Bachelor Housing

Due to previous fiscal constraints, the Marine Corps has routinely focused on critical operational concerns, and therefore we have not built barracks. With your support, we have recently been able to expand our construction efforts and have established a program that will provide adequate bachelor housing for our entire force by 2014. Additional support is required for our Fiscal Year 2010 program to provide 3,000 new barracks spaces and meet our 2014 goal. We are also committed to funding the replacement of barracks' furnishings on a seven-year cycle as well as the repair and maintenance of existing barracks to improve the quality of life of our Marines.

We are constructing our barracks to a two-person room configuration and assigning our junior personnel (pay grades E1-E3) at two Marines per room. We are a young Service; the majority of our junior Marines are 18-21 years old, and assigning them at two per room helps assimilate them into the Marine Corps culture, while fostering camaraderie and building unit cohesion. As Marines progress to noncommissioned officer rank and take on the added responsibilities of corporal (E4) and sergeant (E5), our intent is to assign them one per room.

Public Private Venture (PPV) Housing

The Marine Corps supports the privatization of family housing. To date, the Public Private Venture (PPV) program has been a success story. We have benefited from the construction of quality homes and community support facilities, as well the vast improvement in maintenance services. PPV has had a positive impact on the quality of life for our Marines and families. The feedback we have received has been overwhelmingly positive.

PPV has been integral to accommodating existing requirements and the additional family housing requirements associated with the growth of our force. By the end of Fiscal Year 2007, with the support of Congress, the Marine Corps privatized 96 percent of its worldwide family housing inventory. By the end of Fiscal Year 2010, we expect to complete our plan to privatize 97 percent of our existing worldwide family housing inventory.

We again thank the Congress for its generous support in this area. In Fiscal Years 2008 and 2009, you provided the funding to construct or acquire nearly 3,000 additional homes and two related Department of Defense Dependent Schools through this program; and by 2014, PPV will result in all of our families being able to vacate inadequate family housing.

Reset the Force

Operations in Iraq and Afghanistan have placed an unprecedented demand on ground weapons systems, aviation assets, and support equipment. These assets have experienced accelerated wear and tear due to the harsh operating environments and have far exceeded the planned peacetime usage rates. Additionally, many equipment items have been destroyed or damaged beyond economical repair. High rates of degraded material condition require the Marine Corps to undergo significant equipment reset for our operational forces and our prepositioning programs. Reset will involve all actions required to repair, replace, or modernize the equipment and weapons systems that will ensure the Nation's expeditionary force in readiness is well prepared for future missions. We appreciate the generous support of Congress to ensure that Marines have the equipment and maintenance resources they need to meet mission requirements. It is our pledge to be good stewards of the resources you so generously provide.

Reset Costs

Costs categorized as "reset" meet one of the following criteria: maintenance and supply activities that restore and enhance combat capability to unit and prepositioned equipment; replace or repair equipment destroyed, damaged, stressed, or worn out beyond economic repair; or enhance capabilities, where applicable, with the most up-to-date technology.

Congressional support has been outstanding. Thus far, you have provided more than $12 billion toward reset. We thank you for this funding; it will help ensure that Marines have the equipment they need to properly train for and conduct combat operations.

Equipment Readiness

Sustained operations have subjected our equipment to more than a lifetime's worth of wear and tear stemming from mileage, operating hours, and harsh environmental conditions. The additional weight associated with armor plating further exacerbates the challenge of maintaining high equipment readiness. Current Marine Corps policy dictates that as forces rotate in and out of theater, their equipment remains in place. This policy action was accompanied by an increased maintenance presence in theater and has paid great dividends as our deployed ground force readiness remains above 90 percent. While we have witnessed a decrease in supply readiness rates for home station units, the delivery of supplemental procurements is beginning to bear fruit and we expect our readiness rates in supply to rise steadily.

Aviation Equipment and Readiness

Marine Corps Aviation supports our Marines in combat today while continuing to plan for crisis and contingency operations of tomorrow. Our legacy aircraft are aging, and we face the challenge of maintaining current airframes that have been subjected to heavy use in harsh, austere environments while we transition to new aircraft. Our aircraft have been flying at rates well above those for which they were designed; however, despite the challenge of operating in two theaters, our maintenance and support personnel have sustained a 74.5 percent aviation mission-capable rate for all Marine aircraft over the past 12 months. We must continue to overuse these aging airplanes in harsh environments as we transition forces from Iraq to Afghanistan.

To maintain sufficient numbers of aircraft in squadrons deployed overseas, our non-deployed squadrons have taken significant cuts in available aircraft and parts. Reset and supplemental funding have partially alleviated this strain, but we need steady funding for our legacy airframes as age, attrition, and wartime losses take their toll on our aircraft inventory.

Prepositioning Programs

Comprised of three Maritime Prepositioning Ships Squadrons (MPSRON) and other strategic reserves, the Marine Corps' prepositioning programs are a critical part of our ability to respond to current and future contingency operations and mitigate risk for the Nation. Each MPSRON, when married with a fly in echelon, provides the equipment and sustainment of a 17,000 man Marine Expeditionary Brigade for employment across the full range of military operations. Withdrawal of equipment from our strategic programs has been a key element in supporting combat operations, growth of the Marine Corps, and other operational priorities. Generous support from the Congress has enabled long-term equipment solutions, and as a result, shortfalls within our strategic programs will be reset as equipment becomes available from industry.

Maritime Prepositioning Squadrons (MPSRON)

Our MPSRONs will be reset with the most capable equipment possible, and we have begun loading them with capabilities that support lower spectrum operations while still maintaining the ability to generate Marine Expeditionary Brigades capable of conducting major combat operations. The MPSRONs are currently rotating through Maritime Prepositioning Force Maintenance Cycle–9. MPSRON-1 completed MPF Maintenance Cycle-9 in September 2008 and is currently at 86 percent of its full equipment set. As I addressed in my 2008 report,

equipment from MPSRON-1 was required to outfit new units standing up in Fiscal Year 2007 and Fiscal Year 2008 as part of our end strength increase to 202,000. MPSRON-1 is expected to be fully reset at the completion of its next maintenance cycle in 2011.

MPSRON-2 is currently undergoing its rotation through MPF Maintenance Cycle–9. Equipment from MPSRON-2 was offloaded to support Operation IRAQI FREEDOM and much of that equipment remains committed to forward operations today. With projected deliveries from industry, MPSRON-2 will complete MPF Maintenance Cycle-9 in June 2009 with approximately 90 percent of its planned equipment set. Our intent is to finish the reset of MPSRON-2 when it completes MPF Maintenance Cycle-10 in fiscal year 2012. MPSRON-3 was reset to 100 percent of its equipment set during MPF Maintenance Cycle-8 in March 2007 and remains fully capable.

We are currently in the process of replacing the aging, leased vessels in the Maritime Prepositioning Force with newer, larger, and more flexible government owned ships from the Military Sealift Command fleet. Two decades of equipment growth and recent armor initiatives have strained the capability and capacity of our present fleet — that was designed to lift a Naval Force developed in the early 1980s. As we reset MPF, these changes are necessary to ensure we incorporate hard fought lessons from recent combat operations.

Five of the original thirteen, leased Maritime Prepositioning Ships will be returned to Military Sealift Command by July 2009. In their place, we are integrating three of Military Sealift Command's nineteen large, medium-speed, roll-on/roll-off ships (LMSR), a fuel tanker and a container ship into the MPF Program. One LMSR was integrated in September 2008 and two more are planned for January 2010 and January 2011. The fuel tanker and container ship will be incorporated in June 2009. These vessels will significantly expand MPF's capacity and flexibility and will allow us to reset and optimize to meet current and emerging requirements. When paired with our amphibious ships and landing craft, the LMSRs provide us with platforms from which we can develop advanced seabasing doctrine and tactics, techniques, and procedures for utilization by the Maritime Prepositioning Force (Future) program.

Marine Corps Prepositioning Program: Norway

The Marine Corps Prepositioning Program – Norway (MCPP-N) was also used to source equipment in support of current operations in both Operations Iraqi and Enduring Freedom and to provide humanitarian assistance in Georgia. The Marine Corps continues to reset MCPP-N in accordance with our operational priorities while also exploring other locations for geographic prepositioning that will enable combat and theater security cooperation operations in support of forward deployed Naval Forces.

Modernize for Tomorrow

Surprise is inevitable; however, its potentially disastrous effects can be mitigated by a well-trained, well-equipped, and disciplined force — always prepared for the crises that will arise. To that end and taking into account the changing security environment and hard lessons learned from seven years of combat, the Marine Corps recently completed an initial review of its Operating Forces' ground equipment requirements. Recognizing that our unit Tables of Equipment (T/E) did not reflect the challenges and realities of the 21st century battlefield, the Corps adopted new T/Es for our operating units. This review was synchronized with our modernization plans and programs, and provided for enhanced mobility, lethality, sustainment,

and command and control across the MAGTF. They reflect the capabilities required not only for the Corps' current mission, but for its future employment across the range of military operations, against a variety of threats, and in diverse terrain and conditions. The MAGTF T/E review is an integral part of the critical work being done to reset, reconstitute, and revitalize the Marine Corps.

Additionally, we recently published the *Marine Corps Vision and Strategy 2025*, which guides our development efforts over the next two decades. Programs such as the Expeditionary Fighting Vehicle and the Joint Strike Fighter are critical to our future preparedness. Congressionally-mandated to be "the most ready when the Nation is least ready," your multi-capable Corps will be where the Nation needs us, when the Nation needs us, and will prevail over whatever challenge we face.

Urgent Needs Process

The Marine Corps Urgent Needs Process synchronizes abbreviated requirements, resourcing, and acquisition processes in order to distribute mission-critical warfighting capabilities on accelerated timelines. Operating forces use the Urgent Universal Need Statement to identify mission-critical capability gaps and request interim warfighting solutions to these gaps. Subject to statutes and regulations, the abbreviated process is optimized for speed and involves a certain degree of risk with regard to doctrine, organization, training, materiel, leadership and education, personnel, and facilities integration and sustainment, along with other deliberate process considerations. A Web-based system expedites processing; enables stakeholder visibility and collaboration from submission through resolution; and automates staff action, documentation, and approval. This Web-based system is one of a series of process improvements that, reduced average time from receipt through Marine Requirements Oversight Council decision from 142 days (December 2005 through October 2006) to 85 days (November 2006 through October 2008).

Enhancing Individual Survivability

We are providing Marines the latest in Personal Protection Equipment (PPE) — such as the Scalable Plate Carrier, Modular Tactical Vest, Lightweight Helmet, and Flame Resistant Organizational Gear (FROG). The Scalable Plate Carrier features a smaller area of coverage to reduce weight, bulk, and heat load for operations at higher elevations like those encountered in Afghanistan. Coupled with the Modular Tactical Vest, the Scalable Plate Carrier provides commanders options to address various mission/threat requirements. Both vests use Enhanced Small Arms Protective Inserts (E-SAPI) and Side SAPI plates and provide the best protection available against a wide variety of small arms threats — including 7.62 mm ammunition.

The current Lightweight Helmet provides a high degree of protection against fragmentation threats and 9 mm bullets, and we continue to challenge industry to develop a lightweight helmet that will stop the 7.62 mm round. The lifesaving ensemble of Flame-Resistant Organizational Gear (FROG) clothing items help to mitigate potential heat and flame injuries to our Marines from improvised explosive devices.

We are also upgrading our Counter Radio-controlled Electronic Warfare (CREW) systems to meet evolving threats. Our Explosive Ordnance Disposal (EOD) equipment has been

reconfigured and modernized to be used with CREW systems and has provided EOD technicians the capability of remotely disabling IEDs.

Marine Aviation Plan

The Fiscal Year 2009 Marine Aviation Plan provides the way ahead for Marine Aviation through Fiscal Year 2018, with the ultimate long-range goal of fielding an all-short-takeoff/vertical landing aviation force by 2025. We will continue to transition from our 12 legacy aircraft models to six new airframes and expand from 64 to 69 flying squadrons while adding 565 officers and more than 4,400 enlisted Marines.

Joint Strike Fighter (JSF)

The F-35 Lightning II, Joint Strike Fighter, will provide the Marine Corps with an affordable, stealthy, high performance, multi-role jet aircraft to operate in the expeditionary campaigns of the future. The JSF acquisition program was developed using the concept of cost as an independent variable (CAIV), which demands affordability, aggressive management, and preservation of the warfighting requirement. The F-35B's cutting edge technology and STOVL design offer greater safety, reliability, and lethality than today's tactical aircraft.

This aircraft will be the centerpiece of Marine Aviation. Our program of record is to procure 420 aircraft (F-35B, STOVL). Our first flight of the STOVL variant was conducted in the summer of 2008, and the manufacture of the first 19 test aircraft is well under way, with assembly times better than planned. We will reach initial operational capability in 2012, with a standing squadron ready to deploy.

MV-22 Osprey

The MV-22 is the vanguard of revolutionary assault support capability and is currently replacing our aged CH-46E aircraft. In September 2005, the MV-22 Defense Acquisition Board approved Full Rate Production, and MV-22 Initial Operational Capability was declared on 1 June 2007, with a planned transition of two CH-46E squadrons per year thereafter. We have 90 operational aircraft, a quarter of our planned total of 360. These airframes are based at Marine Corps Air Station New River, North Carolina; and Pawtuxet River, Maryland. Recently, we welcomed back our third MV-22 squadron from combat. By the end of Fiscal Year 2009, we will have one MV-22 Fleet Replacement Training Squadron, one test squadron, and six tactical VMM squadrons.

The MV-22 program uses a block strategy in its procurement. Block A aircraft are training aircraft and Block B are operational aircraft. Block C aircraft are operational aircraft with mission enhancements that will be procured in Fiscal Year 2010 and delivered in Fiscal Year 2012.

Teaming with Special Operations Command, we are currently on contract with BAE systems for the integration and fielding of a 7.62mm, all aspect, crew served, belly mounted weapon system that will provide an enhanced defensive suppressive fire capability. Pending successful developmental and operational testing we expect to begin fielding limited numbers of this system later in 2009.

This aircraft, which can fly higher, faster, farther, and longer than the CH-46, provides dramatically improved support to the MAGTF and our Marines in combat. On deployments, the MV-22 is delivering Marines to and from the battlefield faster, ultimately saving lives with its speed and range. Operating from Al Asad, the MV-22 can cover the entire country of Iraq. The Marine Corps asked for a transformational assault support aircraft — and Congress answered.

KC-130J Hercules

The KC-130J Hercules is the workhorse of Marine aviation, providing state-of-the-art, multi-mission capabilities; tactical aerial refueling; and fixed-wing assault support. KC-130Js have been deployed in support of Operations IRAQI FREEDOM and ENDURING FREEDOM and are in heavy use around the world.

The success of the aerial-refuelable MV-22 in combat is tied to the KC-130J, its primary refueler. The forced retirement of the legacy KC-130F/R aircraft due to corrosion, fatigue life, and parts obsolescence requires an accelerated procurement of the KC-130J. In addition, the Marine Corps will replace its 28 reserve component KC-130T aircraft with KC-130Js, simplifying the force to one Type/Model/Series. The Marine Corps is continuing to plan for a total of 79 aircraft, of which 34 have been delivered.

In response to urgent requests from Marines currently engaged in combat in Afghanistan, additional capabilities are being rapidly fielded utilizing existing platforms and proven systems to enhance intelligence, surveillance, and reconnaissance (ISR) as well as fire support capability. The ISR / Weapon Mission Kit being developed for use onboard the KC-130J will enable the MAGTF commander to take advantage of the Hercules' extended endurance to provide persistent over-watch of ground units in a low-threat environment. A targeting sensor coupled with a 30mm cannon, Hellfire missiles, and/or standoff precision guided munitions will provide ISR coverage with a sting. Additionally, this added capability will not restrict or limit the refueling capability of the KC-130J. The USMC is rapidly pursuing fielding of the first two kits to support operations in Afghanistan in 2009.

H-1 Upgrade

The H-1 Upgrade Program (UH-1Y/AH-1Z) resolves existing operational UH-1N power margin and AH-1W aircrew workload issues while significantly enhancing the tactical capability, operational effectiveness, and sustainability of our attack and utility helicopter fleet. Our Vietnam-era UH-1N Hueys are reaching the end of their useful life. Due to airframe and engine fatigue, Hueys routinely take off at their maximum gross weight with no margin for error. Rapidly fielding the UH-1Y remains a Marine Corps aviation priority and was the driving force behind the decision to focus on UH-1Y fielding ahead of the AH-1Z. Three UH-1Ys deployed aboard ship with a Marine Expeditionary Unit in January of 2009.

Twenty production H-1 aircraft (14 Yankee and six Zulu) have been delivered. Operation and Evaluation Phase II commenced in February 2008, and as expected, showcased the strengths of the upgraded aircraft. Full rate production of the UH-1Y was approved during the fourth quarter Fiscal Year 2008 at the Defense Acquisition Board (DAB) with additional Low Rate Initial Production (LRIP) aircraft approved to support the scheduled fleet introduction of the AH-1Z in the first quarter of Fiscal Year 2011.

CH-53K

The CH-53K is a critical ship-to-objective maneuver and seabasing enabler; it will replace our CH-53E, which has been fulfilling our heavy lift requirements for over 20 years. The CH-53K will be able to transport 27,000 pounds externally to a range of 110 nautical miles, more than doubling the CH-53E lift capability under similar environmental conditions while maintaining the same shipboard footprint. Maintainability and reliability enhancements of the CH-53K will significantly decrease recurring operating costs and will radically improve aircraft efficiency and operational effectiveness over the current CH-53E. Additionally, survivability and force protection enhancements will dramatically increase protection for aircrew and passengers; thereby broadening the depth and breadth of heavy lift operational support to the joint task force commander. Initial Operational Capability for the CH-53K is scheduled for Fiscal Year 2015. Until then, we will upgrade and maintain our inventory of CH-53Es to provide heavy lift capability in support of our warfighters.

Unmanned Aerial Systems (UAS)

When fully fielded, the Corps' Unmanned Aerial Systems will be networked through a robust and interoperable command and control system that provides commanders an enhanced capability applicable across the spectrum of military operations. Revolutionary systems, such as those built into the Joint Strike Fighter, will mesh with these UAS to give a complete, integrated picture of the battlefield to ground commanders.

Our Marine Expeditionary Forces have transitioned our Unmanned Aerial Vehicle Squadrons (VMU) to the RQ-7B Shadow; reorganized the squadrons' force structure to support detachment-based flexibility (operating three systems versus one for each squadron); and are preparing to stand up our fourth active component VMU squadron. The addition of a fourth VMU squadron is critical to sustaining operations by decreasing our deployment-to-dwell ratio — currently at 1:1 — to a sustainable 1:2 ratio. This rapid transition and reorganization, begun in January 2007, will be complete by the middle of Fiscal Year 2010.

In Iraq and Afghanistan, the Marine Corps is currently using an ISR Services contract to provide Scan Eagle systems to our forces, but we anticipate fielding Small Tactical UAS (STUAS), a combined Marine Corps and Navy program, in Fiscal Year 2011 to fill that void at the regiment and Marine Expeditionary Unit (MEU) level. In support of battalion-and-below operations, the Marine Corps is transitioning from the Dragon Eye to the joint Raven-B program.

Airborne Electronic Attack (AEA)

The EA-6B remains the premier electronic warfare platform within the Department of Defense. The Marine Corps is fully committed to the Prowler. While the Prowler continues to maintain a high deployment tempo, supporting operations against new and diverse irregular warfare threats, ongoing structural improvements and the planned Improved Capabilities III upgrades will enable us to extend the aircraft's service life through 2018.

Beyond the Prowler, the future of electronic warfare for the Marine Corps will be comprised of a networked system-of-systems. The constituent components of this network include the F-35B Joint Strike Fighter, Unmanned Aerial Systems, Intelligence, Surveillance, and Reconnaissance pods and payloads, the Next Generation Jammer (NGJ), and ground systems already fielded or

under development. Our future vision is to use the entire array of electronic warfare capabilities accessible as part of the distributed electronic warfare network. This critical and important distinction promises to make Marine Corps electronic warfare capabilities accessible, available, and applicable to all MAGTF and joint force commanders.

Ground Tactical Mobility Strategy

The Army and Marine Corps are leading the Services in developing the right tactical wheeled vehicle fleets for the joint force. Through a combination of resetting and replacing current systems and developing several new vehicles, our work will provide the joint force with vehicles of appropriate expeditionary mobility, protection level, payload, transportability, and sustainability. As we develop new vehicles, it is imperative that our ground tactical vehicles provide adequate protection while still being sized appropriately for an expeditionary force.

Expeditionary Fighting Vehicle (EFV)

The EFV is the cornerstone of the Nation's forcible entry capability and the Marine Corps is in a period of critical risk until the EFV is fielded. Based on current and future threats, amphibious operations must be conducted from over the horizon and at least 25 nautical miles at sea. The EFV is the sole sea-based, surface oriented vehicle that can project combat power from the assault echelon over the horizon to the objective. EFVs are specifically suited to maneuver operations from the sea and sustained operations ashore. It will replace the aging Assault Amphibious Vehicle, which has been in service since 1972. Complementary to our modernized fleet of tactical vehicles, the EFV's amphibious mobility, day and night lethality, enhanced force protection capabilities, and robust communications will substantially improve joint force capabilities.

During the program's Nunn-McCurdy restructure in June 2007, the EFV was certified to Congress as ***essential to National security***. EFV System Development and Demonstration was extended four and a half years to allow for design reliability. The EFV program successfully released a Critical Design Review in the first quarter of Fiscal Year 2009 during a capstone event that assessed the EFV design as mature with a predicted reliability estimate of 61 hours mean time between operational mission failures greatly exceeding the exit criteria of 43.5 hours. These improvements will be demonstrated during the Developmental Test and Operational Test phases starting second quarter Fiscal Year 2010 on the seven new EFV prototypes currently being manufactured at the Joint Services Manufacturing Center in Lima, Ohio. The Low Rate Initial Production decision is programmed for Fiscal Year 2012. The current acquisition objective is to produce 573 EFVs. Initial Operational Capability is scheduled for 2015 and Full Operational Capability is scheduled for 2025.

Mine Resistant Ambush Protected (MRAP) Vehicles

The Marine Corps is executing this joint urgent requirement to provide as many highly survivable vehicles to theater as quickly as possible. In November 2008, the Joint Requirements Oversight Council established a new 16,238-vehicle requirement for all Services and SOCOM. The current Marine Corps requirement of 2,627 vehicles supports our in-theater operations and home station training and was satisfied in June 2008. We are currently developing modifications that will provide for greater off-road mobility and utility in an Afghan environment in those vehicles that have been procured.

Vehicle Armoring

The evolving threat environment requires proactive management of tactical wheeled vehicle programs in order to provide Marine warfighters with the most well protected, safest vehicles possible given technological limitations. Force protection has always been a priority for the Marine Corps. We have fielded a Medium Tactical Vehicle Replacement (MTVR) Armor System for the MTVR; Fragmentation Armor Kits for the High Mobility Multipurpose Wheeled Vehicles (HMMWV); Marine Armor Kits (MAK) armor for the Logistics Vehicle System (LVS); and the Mine Resistant Ambush Protected (MRAP) vehicles. We have developed increased force protection upgrades to the MTVR Armor System, safety upgrades for the HMMWVs, and are developing improved armor for the Logistics Vehicle System. We will continue to work with the Science & Technology community and with our sister Services to develop and apply technology as required to address force protection. Congressional support for our force protection efforts has been overwhelming, and we ask that Congress continue their life-saving support in the coming years.

Marine Air Ground Task Force (MAGTF) Fires

In 2007, we initiated "The MAGTF Fires Study." This study examined the current organic fire support of the MAGTF to determine the adequacy, integration, and modernization requirements for ground, aviation, and naval surface fires. The study concluded that the MAGTF/Amphibious Task Force did not possess an adequate capability to engage moving armored targets and to achieve a volume of fires in all weather conditions around the clock. This deficiency is especially acute during Joint Forcible Entry Operations. We are currently conducting a study with the Navy to analyze alternatives for meeting our need for naval surface fires during this phase. Additionally, we performed a supplemental historical study using Operation IRAQI FREEDOM data to examine MAGTF Fires across the range of military operations. These studies reconfirmed the requirement for a mix of air, naval surface, and ground-based fires as well as the development of the Triad of Ground Indirect Fires.

Triad of Ground Indirect Fires

The Triad of Ground Indirect Fires provides for complementary, discriminating, and non-discriminating fires that facilitate maneuver during combat operations. The Triad requires three distinct systems to address varying range and volume requirements. Offering improved capabilities and mobility, the M777 is a medium-caliber artillery piece that is currently replacing the heavy and aged M198 Howitzer. The High Mobility Artillery Rocket System is an extended range, ground-based rocket capability that provides precision and volume fires. The Expeditionary Fire Support System (EFSS) is a towed 120mm mortar. It will be the principal indirect fire support system for heli-borne and tilt rotor-borne forces executing Ship-to-Objective Maneuver. When paired with an Internally Transportable Vehicle, the EFSS can be transported aboard MV-22 Osprey and CH-53E aircraft. EFSS-equipped units will have immediately responsive, organic indirect fires at ranges beyond those of current infantry battalion mortars. Initial operational capability is planned in 2009 with full operational capability expected for Fiscal Year 2012.

Naval Surface Fire Support

In the last year, the Naval Services have focused on reinvigorating our strategy for building naval surface fire support capable of engaging targets at ranges consistent with our Ship-to-Objective Maneuver concept. In March 2008, the Extended Range Guided Munition development effort, which was designed to provide naval gunfire at ranges up to 53 nautical miles, was cancelled due to numerous technical and design flaws. The DDG-1000 program, which provides for an Advanced Gun System firing the Long Range Land Attack Projectile 70 nautical miles as well as for the Dual Band RADAR counter-fire detection capability, was truncated as priorities shifted to countering an emerging ballistic missile threat. As a result, the Marine Corps and Navy are committed to re-evaluating methods for providing required naval fires.

Aviation Fires

Marine aviation is a critical part of the MAGTF fires capability. The Joint Strike Fighter will upgrade missile and bomb delivery, combining a fifth-generation pilot-aircraft interface, a 360-degree view of the battlefield, and a new generation of more lethal air-delivered ordnance coming online through 2025. Systems, such as Strikelink, will mesh forward air controllers with pilots and infantry officers at all levels. Laser and global positioning systems will provide terminal phase precision to less-accurate legacy bombs, missiles and rockets, providing more-lethal, all-weather aviation fires.

Infantry Weapons

We are also developing infantry weapons systems based on our combat experience and supporting studies. These systems not only support the current fight, but also posture Marines to respond across the full spectrum of war. Our goals include increased lethality and combat effectiveness, reduced weight, improved modularity, and integration with other combat equipment. The Marine Corps and Army are co-leading a joint Service capabilities analysis in support of future developments.

The M16A4 and the M4 carbine are collectively referred to as the Modular Service Weapon. While both weapons have proven effective and reliable in combat operations, we must continually seek ways of improving the weapons with which we equip our warriors. With that in mind, we are re-evaluating current capabilities and determining priorities for a possible future service rifle and pistol.

We are in the process of acquiring the Infantry Automatic Rifle, which is shorter and lighter than the M249 Squad Automatic Weapon and will enable the automatic rifleman to keep pace with the fire team while retaining the capability to deliver accurate and sustained automatic fire in all tactical environments. The Infantry Automatic Rifle will increase the lethality of our rifle squads while reducing logistical burden.

The Marine Corps is also upgrading its aging Shoulder-launched Multipurpose Assault Weapon (SMAW) with a lighter launcher and enhanced targeting and fire control. In concert with this, we are developing a "fire from enclosure" rocket that will enable Marines to fire the SMAW from within a confined space.

Non-lethal Weapons

Our joint forces will continue to operate in complex security environments where unintended casualties and infrastructure damage will work against our strategic goals. Therefore, our warfighters must have the capability to respond using both lethal and non-lethal force. As the Executive Agent for the Department of Defense Non-Lethal Weapons Program, the Marine Corps oversees and supports joint Service operational requirements for non-lethal weapons and their development to meet identified capability gaps. Our efforts extend across the globe, as reflected by the Department of Defense's engagement with the North Atlantic Treaty Organization in identifying emerging non-lethal capabilities. Directed-energy technology is proving to hold much promise for the development of longer-range, more effective non-lethal weapons. Non-lethal weapon applications will provide new options for engaging personnel, combating small boat threats, and stopping vehicles, and are critical to our success against today's hybrid threats.

Command and Control

The Marine Corps' Command and Control Harmonization Strategy articulates our goal of delivering seamless support to Marines. We are taking the best of emerging technologies to build an integrated set of capabilities that includes the Common Aviation Command and Control System (CAC2S), Joint Tactical Radio System, Very Small Aperture Terminal, the Combat Operations Center (COC), Joint Tactical COP Workstation, and Blue Force tracking system.

Combat Operations Center (COC)

By 2010, the MAGTF Combat Operations Center capability will integrate air and ground tactical situations into one common picture. The COC program has a current Authorized Acquisition Objective of 260 systems, of which 242 are COCs supporting regimental/group-size and battalion/squadron-size operating forces. As of 1 May 2009, 22 COCs have been deployed overseas in support of units participating in Operation IRAQI FREEDOM; 16 COCs are deployed in support of Operation ENDURING FREEDOM. COC systems will eventually support the warfighter from the Marine Expeditionary Force-level to the company-level and below.

Marine Corps Enterprise Network (MCEN)

The Marine Corps Enterprise Network (MCEN) enables the Marine Corps' warfighters and business domains to interface with joint forces, combatant commands, and the other Services on our classified and unclassified networks.

To meet the growing demands for a modern, networked force, the Marine Corps, as part of a Department of Navy-led effort, is transitioning its Non-Secure Internet Protocol Routing Network (NIPRNET) from the contract owned and contract operated Navy-Marine Corps Intranet (NMCI) to a government owned and government operated Next Generation Enterprise Network (NGEN). This transition will provide the Marine Corps unclassified networks increased security, control, and flexibility.

The Marine Corps continues to invest in the expansion and enhancement of our Secret Internet Protocol Routing Network (SIPRNET) to ensure a highly secure and trusted classified network that meets our operational and intelligence requirements.

The Marine Corps has enhanced its security posture with a defense-in-depth strategy to respond to cyber threats while maintaining network accessibility and responsiveness. This layered approach, aligned with Department of Defense standards, provides the Marine Corps networks that support our warfighting and business operations while protecting the personal information of our Marines, Sailors, and their families.

Intelligence, Surveillance, and Reconnaissance (ISR)

We continue to improve the quality, timeliness, and availability of actionable intelligence through implementation of the Marine Corps Intelligence, Surveillance, and Reconnaissance Enterprise (MCISR-E). This approach incorporates Marine Corps ISR capabilities into a flexible framework that enables us to collect, analyze, and rapidly exchange information necessary to facilitate increased operational tempo and effectiveness. Through development of the Distributed Common Ground System – Marine Corps (DCGS-MC), the enterprise will employ fully integrated systems architecture compliant with joint standards. This will allow our units to take advantage of joint, national, interagency, and coalition resources and capabilities, while making our intelligence and combat information available to the same. MCISR-E will integrate data from our ground and aerial sensors as well as from non-traditional intelligence assets, such as from battlefield video surveillance systems, Joint Strike Fighter sensors, and unit combat reports. This will enhance multi-discipline collection and all-source analytic collaboration. Additionally, MCISR-E will improve interoperability with our command and control systems and facilitate operational reach-back to the Marine Corps Intelligence Activity and other organizations.

Recent growth in intelligence personnel permitted us to establish company-level intelligence cells, equipped with the tools and training to enable every Marine to be an intelligence collector and consumer. This capability has improved small unit combat reporting and enhanced operational effectiveness at all levels. Collectively, these efforts provide an adaptive enterprise that supports Marine Air-Ground Task Force intelligence requirements across the full range of military operations.

Improved Total Life Cycle Management

To assure effective warfighting capabilities, we are improving the Total Life Cycle Management of ground equipment and weapons systems. Overall mission readiness will be enhanced through the integration of the Total Life Cycle Management value stream with clear aligned roles, responsibilities, and relationships that maximize the visibility, supportability, availability, and accountability of ground equipment and weapons systems.

This will be accomplished through the integration of activities across the life cycle of procuring, fielding, sustaining, and disposing of weapon systems and equipment. Some of the expected benefits include:

- "Cradle to grave" material life cycle management capability
- Clearly defined roles and responsibilities for life cycle management across the enterprise

- Availability of reliable fact-based information for decision making
- Full cost visibility
- Full asset visibility
- Standardized processes and performance metrics across the enterprise
- Improved internal management controls

Water and Energy Conservation

The Marine Corps believes in good stewardship of water and energy resources aboard our installations. In April 2009, we published our *Facilities Energy & Water Management Campaign Plan*, which includes the steps we are taking to reduce greenhouse gas emissions and our dependence on foreign oil. In our day-to-day operations and long-term programs, we intend to reduce the rate of energy use in existing facilities, increase energy efficiency in new construction and renovations, expand the use of renewable resources, reduce usage rates of water on our installations, and improve the security and reliability of energy and water systems.

A Naval Force, for Employment as a MAGTF

Your Corps provides the Nation a multi-capable naval force that operates across the full range of military operations. The Navy, Marine Corps, and Coast Guard will soon publish the *Naval Operations Concept 2009 (NOC 09)*. This publication describes how, when, and possibly where U.S. naval forces will prevent conflict — and/or prevail in war — as part of a maritime strategy. In this era of strategic uncertainty, forward deployed naval forces are routinely positioned to support our national interests. The ability to overcome diplomatic, geographic, and anti-access impediments anywhere on the globe is a capability unique to naval forces. Our strategies and concepts address the following requirements: The ability to maintain open and secure sea lines of communication for this maritime nation; the ability to maneuver over and project power from the sea; the ability to work with partner nations and allies to conduct humanitarian relief or non-combatant evacuation operations; and the ability to conduct sustained littoral operations along any coastline in the world. These strategies and concepts highlight the value of naval forces to the Nation and emphasize the value of our Marine Corps-Navy team.

Seabasing

The ability to operate independently from the sea is a core capability of the Navy and Marine Corps. Seabasing is our vision of future joint operations from the sea. Seabasing is the establishment of a port, an airfield, and a replenishment capability at sea through the physical coupling and interconnecting of ships beyond the missile range of the enemy. We believe sea-based logistics, sea-based fire support, and the use of the ocean as a medium for tactical and operational movement will permit our expeditionary forces to move directly from their ships to the objectives — on the shoreline or far inland. From that base at sea — with no footprint ashore — we will be able to conduct the full range of operations, from forcible entry to disaster relief or humanitarian assistance.

Forcible Entry

Naval forces afford the Nation's only sustainable forcible entry capability. Two Marine Expeditionary Brigades (MEBs) constitute the assault echelon of a sea-based Marine Expeditionary Force. Each MEB assault echelon requires 17 amphibious warfare ships —

resulting in an overall ship requirement of 34 operationally available amphibious warfare ships. In order to meet a 34-ship availability rate based on a Chief of Naval Operations approved maintenance factor of 10 percent (not available for deployment), this calls for an inventory of 38 amphibious ships. This amphibious fleet must be composed of not less than 11 amphibious assault ships (LHA/LHD), 11 amphibious transport dock ships (LPD-17 class), and 12 dock landing ships (LSD), with 4 additional amphibious ships, which could be either LPDs or LSDs. This arrangement accepts a degree of risk but is feasible if the assault echelons can be rapidly reinforced by the Maritime Prepositioning Force (future). The Navy and Marine Corps agreed to this requirement for 38 amphibious warfare ships.

LPD-17

The recent deployment of the first of the San Antonio-class amphibious warfare ship demonstrates the Navy's commitment to a modern expeditionary power projection fleet that will enable our naval force to operate across the spectrum of conflict. It is imperative that, at a minimum, 11 of these ships be built to support the 2.0 MEB assault echelon amphibious lift requirement. Procurement of the 10th and 11th LPD remains one of our highest priorities. The Marine Corps recognizes and appreciates the support Congress has provided in meeting the requirement for 11 LPD-17 ships.

To assist the Navy in transitioning to an optimum number and types of common hull forms, the LPD-17 remains the leading candidate for replacing the dock landing ships (LSD). Constructing new amphibious ships based on the incremental refinement of common hull forms will greatly enhance our ability to meet evolving MAGTF lift requirements. Critical to this strategy is the development of a shipbuilding schedule that will provide a smooth transition from legacy ship decommissioning to new ship delivery, minimizing operational risk while driving costs down.

Today and in the future, LPD-17 class ships will play a key role by forward deploying Marines and their equipment to execute global commitments throughout all phases of engagement. The ship's flexible, open-architecture design will facilitate expanded force coverage and decrease reaction times of forward deployed Marine Expeditionary Units. It will also offer the capacity to maintain a robust surface assault and rapid off-load capability in support of combatant commander forward presence and warfighting requirements.

LHA(R)/LH(X)

A holistic amphibious shipbuilding strategy must ensure that our future warfighting capabilities from the sea are fully optimized for both vertical and surface maneuver capabilities. The MV-22 and Joint Strike Fighter, combined with CH-53 K and the UH-1 Y/Z, will provide an unparalled warfighting capacity for the combatant commanders. Two Amphibious Assault (Replacement) (LHA(R)) ships with enhanced aviation capabilities will replace two of the retiring Amphibious Assault (LHA) class ships and join the eight LHD class amphibious assault ships. The LHA(R) design traded surface warfare capabilities to provide enhanced aviation hangar and maintenance spaces to support aviation maintenance, increase jet fuel storage and aviation ordnance magazines, and increase aviation sortie generation rates.

Operational lessons learned and changes in future operational concepts have caused changes in MAGTF equipment size and weight and have reinforced the requirement for amphibious ships with flexible surface interface capabilities. The Marine Corps remains committed to meeting the

long-standing requirement for simultaneous vertical and surface maneuver capabilities from the seabase. Toward that end, follow-on big deck amphibious ship construction to replace LHAs will incorporate surface interface capabilities while retaining significant aviation enhancements of the LHA Replacement ship.

Maritime Prepositioning Force (Future)

The Maritime Prepositioning Force (Future) (MPF(F)) is a key Seabasing enabler and will build on the success of the legacy Maritime Prepositioning Force program. MPF(F) will provide support to a wide range of military operations, from humanitarian assistance to major combat operations, with improved capabilities such as at-sea arrival and assembly; selective offload of mission sets; persistent, long-term, sea-based sustainment; and at-sea reconstitution. The squadron is designed to provide combatant commanders a highly flexible operational and logistics support capability to meet widely varied expeditionary missions ranging from reinforcing and supporting the assault echelon during Joint Forcible Entry Operations to conducting independent operations throughout the remaining range of military operations. The squadron will preposition a single MEB's critical equipment and sustainment capability for delivery from the sea base without the need for established infrastructure ashore.

The Acting Secretary of the Navy, the Chief of Naval Operations, and the Commandant of the Marine Corps approved MPF(F) squadron capabilities and ship composition in May 2005, as documented in the MPF(F) Report to Congress on 6 June 2005. Those required capabilities and ship composition remain fully valid today in meeting the full range of combatant commander mission requirements. The MPF(F) squadron is designed to be comprised of three aviation-capable ships, three modified Large Medium-Speed Roll-on/roll-off ships (LMSR), three Dry Cargo/Ammunition (T-AKE) supply ships, three Mobile Landing Platforms, and two legacy dense-packed (T-AK) ships.

MPF(F) Aviation Capable Ships: "An Airfield Afloat"

MPF(F) aviation-capable ships are the key Seabasing enablers that set it apart from legacy prepositioning programs. These ships are multifaceted enablers that are vital to the projection of forces from the seabase, offering a new level of operational flexibility and reach. MPF(F) aviation capable ships contain the MEB's command and control nodes as well as medical capabilities, vehicle stowage, and berthing for the MEB. They serve as a base for rotary wing/tilt-rotor aircraft, thus supporting the vertical employment of forces to objectives up to 110 nautical miles from the sea base as well as surface reinforcement via the LHD well deck. These ships allow for the stowage, operation, arming, control, and maintenance of aircraft in the seabase, which directly allows for the vertical and surface employment, projection, and sustainment of forces ashore.

Without these ships, the MPF(F) squadron would have to compensate for the necessary operational capabilities and lift capacities, increasing the number of ships, modifying the remaining platforms in the squadron, and/or accepting significant additional operational risk in areas such as vertical maneuver, command and control, and medical.

Mobile Landing Platform (MLP): "A Pier in the Ocean"

The Mobile Landing Platform (MLP) is perhaps the most flexible platform in the MPF(F) squadron. MLP will provide at-sea vehicle, equipment, and personnel transfer capabilities from the Large Medium Speed Roll-on/Roll-off ship (LMSR) to air-cushioned landing craft via the MLP's vehicle transfer system currently under development. The MLP also provides organizational and intermediate maintenance that enables the surface employment of combat ready forces from over the horizon. In short, the MLP is a highly flexible, multi-purpose intermodal capability that will be a key interface between wide varieties of seabased platforms. Instead of ships and lighters going to a terminal on shore, they will conduct at-sea transfers of combat-ready personnel, vehicles, and equipment to and from the MPF(F).

Beyond its critical role within the MPF(F) squadron, the MLP also serves as the crucial joint interface platform with other Services and coalition partners. The MLP will possess an enhanced container-handling capability, allowing it to transfer containerized sustainment from military and commercial ships to forces ashore.

Dry Cargo/Ammunition Ship (T-AKE): "A Warehouse Afloat"

The Dry Cargo/Ammunition Ship (T-AKE) is a selectively off-loadable, afloat warehouse ship that is designed to carry dry, frozen, and chilled cargo, ammunition, and limited cargo fuel. It is a versatile supply platform with robust underway replenishment capabilities for both dry and wet cargo that can re-supply other ships in the squadron and ground forces as required. Key holds are reconfigurable for additional flexibility. It has a day/night capable flight deck. The squadron's three T-AKEs will have sufficient dry cargo and ammunition capacities to provide persistent sustainment to the Marine Expeditionary Brigade operating ashore. The cargo fuel — in excess of a million gallons — will greatly contribute to sustaining the forces ashore. These ships can support the dry cargo and compatible ammunition requirements of joint forces and are the same ship class as the Combat Logistics Force T-AKE ships.

Large Medium-Speed Roll-on/Roll-off (LMSR) Ship: "Assembly at Sea"

A Large Medium Speed Roll on/Roll off ship (LMSR) platform will preposition MEB assets and will enable at-sea arrival and assembly operations and selective offload operations. Expansive vehicle decks and converted cargo holds will provide sufficient capacity to stow the MEB's vehicles, equipment, and supplies in an accessible configuration. This, combined with selective offload via the MLP's vehicle transfer system, will permit at-sea arrival and assembly operations within the ship. The LMSR will have sufficient berthing for assembly and integration of MEB personnel and associated vehicles and equipment. LMSR modifications will include two aviation operating spots, underway replenishment equipment, a controlled assembly area, and ordnance magazines and elevators. Specific modifications, such as the side port hatch design and inclusion of anti-roll tanks, will facilitate employing the MLP's vehicle transfer system with the MPF(F) LMSR during seabased operations. The LMSR will also have dedicated maintenance areas capable of supporting organizational intermediate maintenance activities for all ground combat equipment.

Our Marines and Families

While our deployed Marines never question the need or ability to live in an expeditionary environment and harsh climates, they have reasonable expectations that their living quarters at home station will be clean and comfortable. Those who are married want their families to enjoy quality housing, schools, and family support. It is a moral responsibility for us to support them in these key areas. A quality of life survey we conducted in late 2007 reflected that despite the current high operational tempo, Marines and spouses were satisfied with the support they receive from the Marine Corps. Marines make an enduring commitment to the Corps when they earn the title Marine. In turn, the Corps will continue its commitment to Marines and their families. We extend our sincere appreciation for Congress' commitment to this Nation's wounded warriors and their direction for the establishment of Centers of Excellence within the Department of Defense that address Traumatic Brain Injury, Post-traumatic Stress Disorder, eye injuries, hearing loss, and a joint Department of Defense / Department of Veterans Affairs Center addressing loss of limbs.

Family Readiness Programs

Last year, we initiated a multi-year plan of action to put our family support programs on a wartime footing. We listened to our families and heard their concerns. We saw that our commanders needed additional resources, and we identified underfunded programs operating largely on the strength and perseverance of hard-working staff and volunteers.

To address the above concerns, we have established full-time Family Readiness Officer billets in more than 400 units and have also acted to expand the depth and breadth of our family readiness training programs. The Family Readiness Officer is supported in this mission by the Marine Corps Community Services Program. For the families communication with their deployed Marines is their number one quality of life requirement. With the Family Readiness Officer serving as the focal point, we have used information technology tools to expand the communication between Marines and their families.

These initiatives and others demonstrate the commitment of the Marine Corps to our families and underscore the significance of family readiness to mission readiness. We thank Congress for the supplemental funding during Fiscal Years 2008 and 2009 that enabled initial start-up. Beginning in Fiscal Year 2010, the funding required to maintain these critical programs will be part of our baseline budget.

Casualty Assistance

Our casualty assistance program is committed to ensuring that families of our fallen Marines are treated with the utmost compassion, dignity, and honor. We have taken steps to correct the unacceptable deficiencies in our casualty reporting process that were identified in congressional hearings and subsequent internal reviews.

Marine Corps commands now report the initiation, status, and findings of casualty investigations to the Headquarters Casualty Section in Quantico, which has the responsibility to ensure the next of kin receive timely notification of these investigations from their assigned Casualty Assistance Calls Officer.

The Headquarters Casualty Section is a 24-hour-per-day operation manned by Marines trained in casualty reporting, notification, and casualty assistance procedures. These Marines have also taken on the additional responsibility of notifying the next of kin of wounded, injured, and ill Marines.

In October 2008, we implemented a mandatory training program for Casualty Assistance Calls Officers that includes a Web-based capability to expand the reach of the course. This training covers notification procedures, benefits and entitlements, mortuary affairs, and grief and bereavement issues. We will continue to monitor the effectiveness of these changes and make adjustments where warranted.

Wounded Warrior Regiment

The Marine Corps is very proud of the positive and meaningful impact that the Wounded Warrior Regiment is having on wounded, ill, and injured Marines, Sailors, and their families. Just over 18 months ago, we instituted a comprehensive and integrated approach to Wounded Warrior care and unified it under one command. The establishment of the Wounded Warrior Regiment reflects our deep commitment to the welfare of our wounded, ill, and injured, and their families throughout all phases of recovery. Our single process provides active duty, reserve, and separated Marines with non-medical case management, benefit information and assistance, resources and referrals, and transition support. The nerve center of our Wounded Warrior Regiment is our Wounded Warrior Operations Center — where no Marine is turned away.

The Regiment strives to ensure programs and processes adequately meet the needs of our wounded, ill, and injured and that they remain flexible to preclude a one-size-fits-all approach to that care. For example, we have transferred auditing authority for pay and entitlements from the Defense Finance and Accounting Service in Cleveland directly to the Wounded Warrior Regiment, where there is a comprehensive awareness of each wounded Marine's individual situation. We have also designed and implemented a Marine Corps Wounded, Ill, and Injured Tracking System to maintain accountability and case management for the Marine Corps Comprehensive Recovery Plan. To ensure effective family advocacy, we have added Family Readiness Officers at the Regiment and our two battalions to support the families of our wounded, ill, and injured Marines.

While the Marine Corps is aggressively attacking the stigma and lack of information that sometimes prevents Marines from asking for help, we are also proactively reaching out to those Marines and Marine veterans who may need assistance. Our Sergeant Merlin German Wounded Warrior Call Center not only receives calls from active duty and former Marines, but also conducts important outreach calls. In the past year, the Marine Corps added Battalion contact cells that make periodic outreach to Marines who have returned to duty in order to ensure their recovery needs are being addressed and that they receive information on any new benefits. The Call centers between them have made over 40,000 calls to those Marines injured since September 2001 to assess how they are doing and offer our assistance.

To enhance reintegration, our Job Transition Cell, manned by Marines and representatives of the Departments of Labor and Veterans Affairs, has been proactively reaching out to identify and coordinate with employers and job training programs to help our wounded warriors obtain positions in which they are most likely to succeed and enjoy promising careers. One example is

our collaboration with the U.S. House of Representatives to establish their Wounded Warrior Fellowship Program for hiring disabled veterans to work in congressional offices.

The Marine Corps also recognizes that the needs of our wounded, ill, and injured Marines and their families are constantly evolving. We must ensure our wounded Marines and their families are equipped for success in today's environment and in the future.

As we continue to improve the care and management of our Nation's wounded, the Marine Corps is grateful to have the support of Congress. In addition to the support provided in the Fiscal Year 2009 National Defense Authorization Act, I would like to thank you for your personal visits to our Wounded Warriors in the hospital wards where they are recovering and on the bases where they live. The Marine Corps looks forward to continuing to work with Congress in ensuring that our wounded, ill, and injured Marines receive the best care, resources, and opportunities possible.

Traumatic Brain Injury (TBI)

With 2,700 new cases of Marines with TBI entered into the Department of Defense and Veteran's Brain Injury Center (DVBIC) in calendar year 2008, we continue to see TBI as a significant challenge that we are confronting. Many of these new cases represent older injuries that are just now being diagnosed, and our expectation is that, with the institution of the Automated Neuropsychological Assessment Metrics (ANAM) for all Marines, we will discover mild Traumatic Brain Injuries more promptly post-deployment. While the Marine Corps is providing leadership and resources to deal with this problem, we cannot solve all the issues on our own.

The Marine Corps continues to work closely with Military Medicine, notably DoD's Center of Excellence for Psychological Health and Traumatic Brain Injury, to advance our understanding of TBI and improve care for all Marines. We are grateful for your continued support in this area.

Psychological Health Care

Marine Corps commanders are fully engaged in promoting the psychological health of our Marines, Sailors, and family members. The message to our Marines is to look out for each other and to know that it is okay to get help. While culture change is hard to measure, we feel that the efforts we have made to reduce the stigma of combat stress are working.

The Marine Corps Combat and Operational Stress Control Program encompasses a set of policies, training, and tools to enable leaders, individuals, and families to prepare for and manage the stress of operational deployment cycles. Our training emphasizes ways in which to recognize stress reactions, injuries, and illnesses early and manage them more effectively within operational units. Our assessments of stress responses and outcomes are rated on a continuum: unaffected; temporarily or mildly affected; more severely impaired but likely to recover; or persistently distressed or disabled. Combat stress deserves the same attention and care as any physical wound of war, and our leaders receive extensive training on how to establish an environment where it is okay to ask for help.

To assist leaders with prevention, rapid identification, and early treatment of combat operational stress, we are expanding our program of embedding mental health professionals in operational

units — the Operational Stress Control and Readiness (OSCAR) program — to provide direct support to all active and reserve ground combat elements. This will be achieved over the next three years through realignment of existing Navy structure supporting the operating forces, and increases in Navy mental health provider inventory. Our ultimate intent is to expand OSCAR to all elements of the Marine Air-Ground Task Force. In the interim, OSCAR teams are filled to the extent possible on an ad hoc basis with assets from Navy Medicine.

Exceptional Family Member Program (EFMP)

Last year, I reported on our intent to establish a continuum of care for our EFMP families. We are actively helping more than 6,000 families in the Exceptional Family Member Program gain access to medical, educational, and financial care services that may be limited or restricted at certain duty stations. We have assigned case managers to all of our enrolled EFMP families, obtained the help of the Bureau of Medicine and Surgery and TRICARE to resolve health care concerns at several bases, and directed legal counsel to advise the EFMP and our families on state and Federal entitlements and processes. Additionally, we are developing assignment policies that will further facilitate the continuum of care.

While no family should have to endure interruptions in care, gaining access to services can be most challenging to families who have Autism Spectrum Disorder (ASD). We sincerely appreciate the support of Congress for our ASD families and others who are entitled to the TRICARE Extended Care Health Option (ECHO) program. For Fiscal Year 2009, you have increased the monthly reimbursement rate for Applied Behavioral Analysis (ABA) — a specific therapy that our Marine families value.

However, there is still more to do. While appropriate TRICARE reimbursement rates are important, the highly specialized services these families require are not always available. We are evaluating how we can partner with other organizations to increase the availability of these specialized services in areas where resources are currently lacking.

Water Contamination at Camp Lejeune

Past water contamination at Camp Lejeune has been, and continues to be, a very important issue for the Marine Corps. Using good science, our goal is to determine whether past exposure to the contaminated water at Camp Lejeune resulted in any adverse health effects for our Marines, their families, or our civilian workers.

The Marine Corps continues to support the Agency for Toxic Substances and Disease Registry (ATSDR) in their health study, which is estimated to be completed in late 2009. With the help of Congress, the National Academy of Sciences is assisting us in developing a way ahead on this difficult issue.

The Marine Corps continues to make progress notifying former residents and workers. We have established a call center and registry where the public can provide contact information so that we can notify them when these health studies are complete.

Our outreach efforts include a range of communication venues to include letters to individuals located from Department of Defense databases, paid print and broadcast advertising, publications

in military magazines, press releases, and a fully staffed call center. As of 22 March 2009, we have had 131,000 total registrations and mailed more than 200,000 direct notifications.

Sexual Assault Prevention and Response

Sexual assault is a crime, and we take every reported incident very seriously. The impact on its victims and the corrosive effect on unit and individual readiness are matters of great concern. A recent Government Accountability Office study reported several shortcomings in our program. To address these findings, we are refreshing our training program and assessing the requirement to hire full-time Sexual Assault Prevention and Response Program coordinators at installations with large troop populations. We have trained more than 3,200 victim advocates to provide assistance upon the request. All Marines receive sexual assault prevention and awareness training upon entry and are required to receive refresher training at least annually. We have also incorporated sexual assault prevention into officer and noncommissioned officer professional development courses and key senior leader conferences and working groups. At the request of our field commanders, we have also increased the number of Marine Corps judge advocates who attend specialized training on prosecution of these crimes and have assembled a mobile training team to teach our prosecutors how to better manage these cases.

Suicide Prevention

With 42 Marine suicides in 2008, we experienced our highest suicide rate since the start of Operation Enduring Freedom and Operation Iraqi Freedom. The number of confirmed Marine suicides has increased from 25 in Calendar Year 2006, to 33 in 2007, to 42 in 2008. Through March 2009, we have eight presumed suicides this year, which place us on a trajectory for 32 this calendar year. Our numbers are disturbing; we will not accept them, or stand idle while our Marines and families suffer.

Our studies have found that regardless of duty station, deployment, or duty status, the primary stressors associated with Marine suicides are problems in romantic relationships, physical health, work-related issues such as poor performance and job dissatisfaction, and pending legal or administrative action. This is consistent with other Services and civilian findings. Multiple stressors are usually present in suicide.

In November 2008, we reviewed our suicide awareness and prevention program and directed the development of a leadership training program targeted at noncommissioned officers. As in combat, we will rely upon our corporals and sergeants to chart the course and apply their leadership skills to the challenge at hand. This program includes high-impact, engaging videos, and a web-ready resource library to provide additional tools for identifying their Marines who appear at risk for suicide. Further, during March 2009, we required all of our commanders to conduct suicide prevention training for 100 percent of the Marines under their charge. This training educated Marines on the current situation in our Corps; it taught them how to identify the warning signs; it reinforced their responsibility as leaders; and it informed them of the resources available locally for support.

The Marine Corps will continue to pursue initiatives to prevent suicides, to include reevaluating existing programs designed to reduce the stressors most correlated with suicidal behavior; developing and distributing new prevention programs; and refreshing and expanding training materials.

Child Development Programs

To ensure Children, Youth, and Teen Programs continue to transition to meet the needs of our families, a Functionality Assessment was conducted in June 2008 to identify program improvements, such as the development of staffing models to improve service delivery, as well as recommendations to explore and re-define services to meet the unique and changing needs of Marines and their families living both on and off our installations. In addition, the Marine Corps has expanded partnerships to provide long- and short-term support for geographically dispersed Marines. We can now provide 16 hours of reimbursed respite care per month for families with a deployed Marine. We are expanding our care capacity in many ways, including extended hours as well as through partnerships with Resource and Referral agencies, off-base family childcare, and Child Development Home spaces.

We are currently providing 11,757 childcare spaces and meeting 63.6 percent of the calculated total need. It is important to note that the Marine Corps has initiated rigorous data collection and analysis improvements. As a result, it will be necessary to correct the 2007 annual summary due to identified reporting errors. Our reported rate of 71 percent of potential need last year is more accurately stated as 59.1 percent. We are not satisfied with our progress to date, and have planned for 10 Child Development Center Military Construction projects in Program Years 2008 through 2013. Two of those projects were executed in Fiscal Year 2008, and one is approved for Fiscal Year 2009. These approved projects will provide an additional 915 spaces.

We also are considering additional modular Child Development Centers, subject to more detailed planning and availability of funds. Planned MILCON and modular centers would add approximately 2,600 spaces, and although our need is expanding, based on our current calculations, this expansion would bring us much closer to the Department of Defense goal. Continued Congressional support will help us provide these needed facilities. As the needs of our families change, our program is committed to grow and adapt to meet these developments.

School Liaison Program

The education of more than 51,000 school-age children of Marine parents has been identified as a readiness and retention issue of great concern. Our Marine children, who are often as mobile as their military parent, face additional stress and challenges associated with frequent moves between schools with differing educational systems and standards. Exacerbating this is the varying degree of satisfaction Marines and their spouses have with the quality and sufficiency of local education systems. The Marine Corps is addressing this issue by establishing national, regional, and installation level School Liaison capability. The School Liaison will help parents and commanders interact with local schools, districts, and state governments to help resolve educational issues. The increased family readiness funding has allowed us to establish a School Liaison position at each Marine Corps installation. Complementing our local effort, the Marine Corps is working with the Department of Defense to establish an "Education Compact" with states to enable reciprocal acceptance of entrance, subject, testing, and graduation requirements. The Education Compact has been enacted in North Carolina and Arizona, and is under varying stages of consideration in the other states with Marine Corps installations.

Posture the Marine Corps for the Future

As we prepare for an unpredictable future, we must continue to assess the potential future security environments and the challenges of tomorrow's battlefields. Our solid belief is that a forward deployed expeditionary force, consistently engaged and postured for rapid response, is as critical for national security in the future as it is today. The Marine Corps, with its inherent advantages as an expeditionary force, can be rapidly employed in key areas of the globe despite challenges to U.S. access. Our sea-based posture will allow us to continue conducting security cooperation activities with a variety of allies and partners around the world to mitigate sources of discontent and deter conflict. We must increase our capacity to conduct security cooperation operations without compromising our ability to engage in a major regional conflict.

Realignment in the Pacific: Defense Policy Review Initiative (DPRI)

The Defense Policy Review Initiative was established in 2002 by the United States and Japan as a means to review each nation's security and defense issues. One of the key outcomes of this process was an agreement to move approximately 8,000 Marines from Okinawa to Guam. The movement of these forces will address encroachment issues facing Marines on Okinawa. Moreover, the relocation will afford new opportunities to engage with our partners in Asia, conduct multilateral training on American soil, and be better positioned to support a broad range of contingencies that may confront the region. Furthermore, the political agreements brokered by the Office of the Secretary of Defense provide for a long term presence of Marines on Okinawa as well as substantial financial support by the Government of Japan.

As can be expected with an effort of this scale and complexity, there are a number of challenges. Developing training areas and ranges on Guam and the Commonwealth of Northern Mariana Islands is a key pre-requisite for moving Marine forces to Guam. We also seek a contiguous base design on Guam where housing, operations, and quality of life facilities can be collocated. This will reduce the road traffic on Guam and provide for a better security posture. We have also found that collocated facilities — where Marines live and work — tend to be used more often, and serve to unify the military community.

We continue to work within the Department of Defense to align our training and installation requirements with ongoing environmental assessments and political agreements. Planned and executed properly, this relocation to Guam will result in Marine forces that are combat ready, forward postured, and value-added to U.S. interests in the Pacific for the next fifty years.

Security Cooperation MAGTF

The Security Cooperation Marine Air Ground Task Force (SC MAGTF) provides geographic combatant commanders with a security cooperation capability for employment in remote, austere locations across the globe. SC MAGTFs will be organized based upon the specific requirements of each training event or operation they are requested to support and will enhance the combatant commander's ability to alleviate the conditions that cause instability to proliferate.

Training and Education

Our training and education systems, from recruit training to top-level Professional Military Education schools, rigorously instill in our Marines the physical and mental toughness and intellectual agility required to successfully operate in today's and tomorrow's complex environments. Marine Corps forces are organized, trained, equipped, and deployed with the expectation of operating under inhospitable conditions against committed and competent foes. Our forces are heavy enough to sustain major combat operations against conventional and hybrid threats but light enough to facilitate rapid deployment. Capability enhancements across the board are supported by a vigorous application of lessons learned from current operations.

Operation ENDURING FREEDOM Pre-deployment Training Program

The Afghanistan Pre-deployment Training Plan provides well-trained individuals and units that are prepared to operate in the austere and challenging environment of Afghanistan. While similar to the current Iraq Pre-Deployment Training Program, the Afghanistan Pre-deployment Training Program emphasizes the inherent capability of the MAGTF to conduct combined arms operations within a joint, multinational, and interagency framework. The capstone event of the Afghanistan Pre-Deployment Training Program incorporates all elements of the MAGTF.

Combined Arms Training, Large Scale Exercises, and Amphibious Operations

Our training programs must prepare Marines to support current commitments and maintain MAGTF proficiency in core warfighting capabilities. We are developing a program of nested training exercises that focus on interagency and coalition operations to support the current fight and prepare the Marine Corps for the Long War.

The Combined Arms Exercise - Next is a service-level, live-fire training exercise that develops the core capability of combined arms maneuver from the individual Marine to the regimental-sized unit level. This exercise focuses on the integration of functions within and between the MAGTF elements. The MAGTF Large Scale Exercise is a service-level training exercise that develops the MAGTF's capability to conduct amphibious power projection and sustained operations ashore in a joint and inter-agency environment.

Amphibious operations are a hallmark of the Marine Corps. Through a combination of amphibious-focused professional military education, classroom training, and naval exercises, we will ensure MAGTFs are capable of fulfilling Maritime Strategy amphibious requirements, combatant commanders' operational plans, and future national security requirements.

Training and Simulation Systems

Cost-effective training requires a combination of live, virtual, and constructive training to attain the requisite level of combat readiness. We have leveraged technologies and simulations to augment, support, and create training environments for Marines to train at the individual, squad, and platoon levels. Virtual and constructive simulations support the pre-deployment training continuum, while live training systems create a training environment that replicates battlefield effects and conditions. Our long-range effort for infantry skills simulation training is the Squad Immersive Training Environment. This provides realistic training for our infantry squads. Over the past year, we have increased our efficiency and provided greater training opportunities for

the individual Marine up to the MAGTF and joint level to satisfy Title 10 and joint training readiness standards.

Training Range Modernization — Twentynine Palms Land Expansion

Our facilities at Twentynine Palms are critical to the pre-deployment training of our deploying Marine units. These facilities support the integration of fires and maneuver of new and emerging weapons systems, which cannot be accomplished within current boundaries of other Marine Corps bases. The Corps believes that to meet obligations to the Nation's defense, we must conduct live-fire and maneuver exercises at the Marine Expeditionary Brigade level.

The Marine Corps' Mission Capable Ranges Initiative guides Marine Corps range planning and investment. A key to this initiative is the proposed expansion of the Marine Air-Ground Task Force Training Command's range complex at Marine Corps Base Twentynine Palms, California. This 507,000-acre installation, established in the 1950s, requires expansion to meet today's training requirements. We have begun the National Environmental Policy Act-required environmental studies to guide decisions during the acquisition process, and we expect acquisition to commence in 2012.

Core Values and Ethics

In an effort to improve values-based training and address the difficult ethical dilemmas faced by Marines, the John A. Lejeune Leadership Institute implemented several initiatives and publications to strengthen core values training. Publications include the Leadership, Ethics, and Law of War Discussion Guide. These guides offer 15 contemporary case studies with suggested topics for discussion group leaders. We have also published a primer on the Law of War and Escalation of Force, a discussion aid on moral development, and *Issues of Battlefield Ethics and Leadership* — a series of brief, fictionalized case studies to develop Small Unit Leaders. These are used in our schools, beginning with recruit training at boot camp and continuing into MOS training and PME schools.

Two video versions of case studies were created to sharpen the focus of our semiannual Commandant's Commanders' Program on the commander's role in setting a climate of positive battlefield ethics, accountability, and responsibility. In addition, the John A. Lejeune Leadership Institute held the first Russell Leadership Conference since 2002 with 230 first-line leaders from across the Corps. The conference broadened and reinforced our leaders' understanding of the role they fill as ethical decision-makers, mentors, and critical thinkers.

Marine Corps University

The Marine Corps University established a Middle East Institute in 2007 to research, publish, and promote regional awareness. A highly successful Iran Conference clearly demonstrated the utility of the institute. The new Marine Corps University Press was a successful step in our outreach program that includes publishing a professional journal. These initiatives were all part of Marine Corps University's health assessment and are an integral part of the University Strategic Plan.

Conclusion

Marines take extreme pride in the comment attributed to journalist Richard Harding Davis, "The Marines have landed, and the situation is well in hand." Our history has repeatedly validated that statement. Our training and organization ensures our fellow Americans that they should never doubt the outcome when her Marines are sent to do the Nation's work. Our confidence comes from the selfless sacrifices we witness every day by courageous young Marines. They responded magnificently after 9/11 — took the fight to the Taliban and Al Qaeda, conducted a lightening-fast offensive campaign in Iraq, and turned the tide in the volatile Al Anbar province. Now, we are ready to get back to the fight in Afghanistan — or wherever else our Nation calls.

Your Marine Corps is grateful for your support and the support of the American people. Our great young patriots have performed magnificently and written their own page in history. They have proven their courage in combat. Their resiliency, dedication, and sense of self-sacrifice are a tribute to this great Nation. They go into harm's way knowing their country is behind them. On their behalf, I thank you for your enduring support. We pledge to be good stewards of the resources you most generously provide and remain committed to the defense of this great land. Thank you again for the opportunity to report to you today.

REMARKS OF MR. MURTHA

Mr. MURTHA. Well, one of the things, Mr. Secretary, that I have harped on over and over again is the fact that we constantly send out RFPs and those RFPs are unrealistically low, either having too great a number that the Navy or Air Force or one of the services asked for or they have an underestimated price. I know I saw in your biography that you ran a company out of bankruptcy in a short period of time. I think it would be a little more difficult just because of the size of the forces but we want to work with you in order to try to get more realistic appraisals because we have done so much research, the Secretary had to cancel a couple of programs before the research was made, which is lost. We may disagree with him about those and see if we can't salvage part of it, but you are going to have a tough time making sure that the services are realistic and then the companies don't underbid this. So you are going to have a very tough job.

And for the Commandant, there is a list of questions in here about your vehicle. We know we got the first report, but if nobody asks the questions, I would hope you would look at those questions and send me a personal answer to the questions about the new vehicle.

Mr. Young.

LITTORAL COMBAT SHIP

Mr. YOUNG. Mr. Chairman, first, I wanted to say to the Secretary congratulations on your assignment. I think you have a very unique opportunity to deal with some just outstanding men and women in the United States Navy and the United States Marine Corps. And I have known a lot of secretaries of the Navy, and I can tell you they are all very, very proud of the services that they represent. So I thank you for being willing to accept that responsibility and I look forward to working with you as we provide whatever it is that our Navy and Marine Corps need.

On the issue of ships, and of course, that is a big issue for the Navy and for the Marines, of course, because Marines use ships to get there, the Sailors and the Marines have some banter back and forth on who does what as far as the mission that they are assigned to, and it is good natured and it is probably morale producing in a positive way. But on ships, LCS, littoral combat ships, have been a very big item for the Navy now for some time. The program has run into some difficulty. My understanding is that in order to keep on schedule, you need 55 LCS ships. We only had one delivered. One was delivered late last year. When do you expect the other to be delivered, the number two?

Mr. MABUS. Sir, the first one has just finished sea trials, and it has gotten back in, and those sea trials while preliminary results are back, indicate that they went very well. The second one is still in the shipyard but has lit off both engines, is doing the testing that it needs inside the shipyard. The follow-on ships, numbers 3 and 4, are being produced now and in the fiscal year 2010 budget, we are asking for funds for three more of these LCSs. LCS, as Admiral Roughead has said on many occasions, is very important to the future of our Navy. He pointed out before the hearing that it

is a program that has brought from idea to implementation in about half the time that Navy ships normally require.

As we move from the first ship of the line further into the follow-on ships, we are seeing costs go down. We are looking at common components. We are looking at ways to continue to drive the costs down, but I think you will see the next ship, which is the first of its class—as you know, there are two LCSs right now—I think you will see it delivered in relatively short order and the follow-on ships on schedule and with the costs continuing to decline.

Mr. YOUNG. Mr. Secretary, what difference do you expect to see in LCS number 4 compared to what you have in the LCS 1?

Mr. MABUS. One of the ways that we are trying to lower the cost is to stop the requirements creep, to make the requirements standard, uniform, and not to continually change requirements during construction. The main change from number 1 to number 4 is a reduction in cost and a speedup in schedule of getting those ships. Number 1, as you know and number 4 are two different hull types, and so I think you will see the unique capabilities of both of those LCS ships.

Mr. YOUNG. And what about the capability? Do you see increased capability with each ship, or will you pretty much have a common ship as when it comes to the capability of each individual vessel?

Mr. MABUS. The two different LCSs, each offer unique capabilities, both of which right now the Navy thinks is important for the future of the fleet. One of the unique things about LCS that gives it much greater flexibility in the future in terms of capabilities is the modules that you can put on there, the weapons systems and different modules that can be placed on the ships so you have got the hull ready to go, you have got the propulsion system, you have got the platform, and you can put different weapons systems, and as you get new technologies, you can incorporate it without building a whole new platform.

Mr. YOUNG. Mr. Secretary, thank you.

Mr. Chairman, because of good attendance here today, I am going to put off my next series of questions, but I want to talk about the F–18 and the Navy's approach to the F–18 as it differs from the Marine Corps approach to the F–18, but I will do that on a second round. So I will yield back at this time.

Mr. MURTHA. Mr. Dicks.

DEPOT MAINTENANCE

Mr. DICKS. I want to welcome Admiral Roughead, Secretary Mabus, and the Commandant. I appreciate all your good work and service.

The Navy has budgeted nearly $5.3 billion for ship depot maintenance in fiscal year 2010. Additionally, the Navy's unfunded requirement list contains only two items, ship and aircraft depot maintenance, requesting an additional $200 million for ships and I think $195 million for aviation depot maintenance. This would be on the unfunded list. Is there a risk here if we don't fund those two items?

Admiral ROUGHEAD. Yes, sir. That is the unfunded list that I submitted. And we normally——

Mr. DICKS. Secretary Gates, I take it, approved your unfunded list?

Admiral ROUGHEAD. We had a good discussion about our unfunded requirements. And I would say that what we have done over the years, Mr. Dicks, is we do not normally fund maintenance up to 100 percent. As we work to balance and make sure that we are covering all of our requirements it is not uncommon for us to lay in the maintenance money about where we did this year. When I was asked by the Congress to provide unfunded requirements, it was in the area of maintenance that I said if I had another dollar to spend, I would put it into maintenance. So those numbers would bring us up to——

Mr. MURTHA. What is the figure?

Mr. DICKS. $5.3 billion.

Mr. MURTHA. Shortfall?

Admiral ROUGHEAD. No.

Mr. DICKS. $200 million.

Admiral ROUGHEAD. It is $200 million in maintenance. It is funded to about 96 percent of what we considered the amount to be.

Mr. DICKS. And aviation depot maintenance is at $195 million shortfall.

Admiral ROUGHEAD. Right. And that is at about 87 percent. And that is consistent with where we have been over the years. So when I had the opportunity to address the unfunded issues, I put that in there because that would remove the maintenance risk. But maintenance risk is important to us, Mr. Dicks, and one of the things I think is important, as I mentioned in my opening statement, is that several years ago, we walked away from engineering approach to maintenance requirements in our conventional surface ships and that was a mistake, and this year we put that back in. I think it will be good for the Fleet because they will be able to better assess what the maintenance requirements are. I believe that it will be better for our maintenance activities, both public and private yards, because they will then be able to see what the requirements are going to be out into the future, and it will all be based on an engineering approach.

Mr. DICKS. Does the fiscal year 2010-based budget have sufficient funding to cover the maintenance requirement for repair of the USS NEW ORLEANS and the USS HARTFORD as well as provide for your planned maintenance requirements in the absence of additional funding? I mean, has this changed this at all, these——

Admiral ROUGHEAD. The HARTFORD and the NEW ORLEANS and the PORT ROYAL were accidents that occurred this year, and those are adjustments that we are going to have to make as we work our way through our maintenance accounts. But those were unfortunate accidents that will cost us.

Mr. VISCLOSKY. If the gentleman would yield for one second.

Mr. DICKS. Of course.

Mr. VISCLOSKY. Talking about working through that, if you have a shortfall of about $200 million for '10, my understanding is given a supplemental request, you would still be short $452 million in '09. So your shortfall on maintenance is about 652. Where will you find that money?

Admiral ROUGHEAD. That is where we will go in and see how we can balance our maintenance accounts. We have not cancelled any maintenance availabilities this year. In some instances we can adjust the scope of the maintenance, but that is the way that we will work our way through the maintenance account, sir.

MISSION FUNDING

Mr. DICKS. If I can go back, even with mission funding, because mission funding, we took a leap of faith, and I went along with the Navy on this, when you change the way you do your accounting and sometimes if you don't have a clear picture of what it is, you are going to be short if you have mission funding. That means that something isn't going to get done unless Congress comes up with a supplemental appropriations bill. So I just hope that if we have got a problem that before the committee marks up for the fiscal year 2010 budget that we would know about that so we could take some action. It is on your unfunded list. I realize that.

Admiral ROUGHEAD. Yes, sir.

SUBMARINES

Mr. DICKS. Let me ask one further question. The President has been very clear in his intention to reduce the number of nuclear weapons in the U.S. inventory in the next four years. The ongoing Nuclear Posture Review will help inform the risk calculus in moving this Presidential initiative forward and serve as a regulator on the pace of change in this area.

Now, if we were going to reduce the number of Trident submarines, for example, would there be any consideration given to converting them to SSGN since I believe the SSGN program has been extraordinarily successful, or are these submarines now too old to be converted and have a 20- or 30-year lifetime to justify the conversion?

Admiral ROUGHEAD. Where we are right now is the Ballistic Missile Submarine Force that we have is—even though we have yet to go through the Nuclear Posture Review (NPR), it remains the significant leg of our nuclear capabilities. So with regard to the OHIO class, I believe we are going to see the OHIO class submarines through their entire life. The four SSGNs that we have we are now beginning to get some usage and some lessons out of those ships. But also in this budget, which is very critical, is the replacement—beginning with the replacement costs for the follow on to the OHIO. Now is the time to start that. We are about in the window where we were when we began the design of the OHIO class. I believe the NPR will inform the number of ships that will be in that class. I think that is an important element of the NPR that will take place. But now is the time and the money in this 2010 budget is key to the replacement for the OHIO submarine, sir.

Mr. DICKS. So you think we will keep the remaining 14 Tridents, maybe we will do some other way of reducing the number of warheads or——

Admiral ROUGHEAD. Sir, I think the number of launch platforms and warheads are related, but they do not become so interdependent until you drop to a certain number, and the flexibility

that the Nation gets from the current fleet of OHIO submarines I believe will remain.

Mr. DICKS. Thank you.

Thank you, Mr. Chairman.

Mr. MURTHA. Mr. Frelinghuysen.

SHORTFALLS

Mr. FRELINGHUYSEN. Thank you, Mr. Chairman. Thank you gentlemen for your service. I held my academy night on Monday night. This is not where we interview young men and women, but not surprisingly, perhaps due to the economy, but certainly there is an element of patriotism there. We had some of the highest numbers we have ever had of freshmen, sophomores, and juniors, and many obviously want to go to the Naval Academy and they want the Marine Corps option. They want to be Navy SEALs. So I thought I would put a good plug in there. There are a lot of young people that you represent and potentially represent that are ready to stand up and serve.

I would sort of like to get to the question of some of the Navy's shortfalls. I know there are shortfalls and there are shortfalls, but there are some shortfalls on the domestic front here that affected your ability, Admiral, for cruises to keep our Sailors up to speed. Those who are trying to improve their flying ability, they need more flying hours. Can you talk a little bit about what is out there, why that has occurred, and what you are doing to remedy it?

Admiral ROUGHEAD. Yes, sir. As we have moved into the latter part of this fiscal year, we are, as I said, operating the Navy at a pretty significant pace. The Navy is globally deployed. It is not just in the Middle East, but in the Western Pacific we are very busy. The pace of operations in the Central Command is high. And on top of that we have experienced extraordinary retention figures and lack of attrition in the force, and so I have been driven for example in the manpower account to where making payroll has become critical, and without the overseas contingency operation funding, the most prudent thing to do was to throttle back on some of the activity that we had going on. I did not short any of the operations that are taking place forward in the Middle East, but I have cut back on the nondeployed operations while I wait the overseas contingency operations.

Mr. FRELINGHUYSEN. But the throttling back means obviously the time that people will be flying, the time that people will be cruising, honing their skills. It sort of begs the question we often used to hear is that when those guys and gals are ready to go, will they be ready in every way to go?

Admiral ROUGHEAD. Right. And what we——

Mr. FRELINGHUYSEN. I gather you have discontinued retention bonuses, I assume, because of this situation.

Admiral ROUGHEAD. I cut back on retention bonuses in those areas where our retention did not demand that we needed to incentivize that retention behavior. So we have cut back on those. We have retained those in the areas where we believe we still need the bonuses. But this was all a function of really overexecuting on payroll because of the economic situation and the desire that our Sailors have to serve, and I am managing to my budget, as anyone

who is a good steward of the public money is expected to do. So by throttling back on that, we have had to make some adjustments as we await the supplemental.

Mr. FRELINGHUYSEN. Often when I have asked that questions to others, people say, well, there are ways to simulate these types of experiences. But obviously flying is flying, sea duty is sea duty. And I would assume that these are all issues that you are taking into consideration.

Admiral ROUGHEAD. Absolutely, sir. The readiness of the force, maintaining that force in a ready status is key. We do make good use of simulation, but there is nothing that compares to going out and doing it on the ocean, in the air, and under the ocean. And as we have monitored our readiness we have made these adjustments. I am comfortable with where we are, but the importance of getting the supplemental is key so that we can get back into what I would call a less constrained mode of operation.

Mr. FRELINGHUYSEN. Okay.

Thank you, Mr. Chairman.

Mr. MURTHA. Mr. Visclosky.

SHIPBUILDING

Mr. VISCLOSKY. Thank you, Mr. Chairman.

Mr. Secretary, let me ask you about shipbuilding and the outyears because it is my understanding we are still talking about a 313-ship Navy.

Mr. MABUS. Yes, sir.

Mr. VISCLOSKY. And I would acknowledge that given the contracts signed that you will be constructing two submarines a year and would also acknowledge your request for 2010 includes eight ships. That is clearly an improvement. We are moving in the right direction. But if you also look at the projections as to when we are going to get to where we need to be, it is now 2019, and those outyears keep slipping. When do you anticipate we are going to start meeting the need as far as that 313 mark for ship construction? This is my annual question for the last decade under several administrations for both parties, but I ask it in all earnestness. It is a very serious issue.

Mr. MABUS. I think it is a good first step, the fiscal year 2010—or a good step, not the first step, a good step in the fiscal year 2010 budget that we are requesting eight ships of various kinds, as you pointed out. I also think that the ongoing Quadrennial Defense Review that is happening right now is going to inform us in terms of types of ships, in terms of quantities that are needed for the future Navy. The CNO has often said that he sees the 313-ship Navy as a floor and not a ceiling, and I think that we have to work diligently toward that. And in my opening statement and my answer to an earlier question, I think one of the ways we get there is to work very earnestly and hard in terms of bringing down costs of these ships because as schedules keep pushing out, as costs keep going up, as a very necessary result of that, numbers tend to go down. And if we are going to reach that goal that we all have, we are going to have to make sure that costs stay within reason and that our schedules are not allowed to slip to the extent that they have in the past.

LEASING OF FOREIGN-BUILT SHIPS

Mr. VISCLOSKY. I appreciate hearing that because the committee has had hearings simply on the costs of ship building, change orders, and other problems that have been faced. And to the extent you can reduce a unit cost, if you would, obviously that would help us along and I think everyone on the committee would to be helpful in that regard too.

If I could ask on the leasing of foreign-built ships, it is my belief that the Navy is not within the spirit, if you would, and the intent of the 1990 Budget Enforcement Act as far as leasing, and I am just wondering what is the plan that's Navy plans to reduce the number of foreign built ships that they lease.

Mr. MABUS. I can ask on one specific thing and that is the Joint High Speed Vessel that we are leasing ships now in that class of ship. And we have one Joint High Speed Vessel in the fiscal year 2010 budget and it is our plan on that class of ship to ramp up production in the U.S. to build those ships and to move the leased ships out and to move U.S. Government ships in to replace those.

Admiral Roughead has a better idea in terms of other leased ships than I do.

Admiral ROUGHEAD. Sir, if I recall, I believe right now we have 14 foreign built ships under lease, and all of those ships are compliant with the appropriate regulations. And it is my understanding that in the solicitation, there were no U.S. built ships that were offered up. So, I mean we do open the competition and it is just a question of those that respond to that solicitation, but we are very mindful of that and——

Mr. VISCLOSKY. Why do you think that is?

Admiral ROUGHEAD. I would offer my personal opinion, and that is that we simply do not have the U.S. built fleet that is able to respond to these solicitations.

Mr. VISCLOSKY. And that is my concern, and I am not personally or professionally blaming you for it, but it is that classic chicken and egg, that as the Navy has leased foreign vessels and we look overseas and then shipyards close, suddenly it is a self-fulfilling prophecy and now we have people not bidding because they don't have the ability to build. And I think we have some real responsibility to look at that industrial base and our citizens having those jobs for our national defense. I just think it is a very important principle.

Admiral ROUGHEAD. I agree, sir. And I think that the notion that we are a maritime nation is something that goes beyond the Navy. I believe that we should not lose sight of the fact that we are tied to the oceans and that we, as a maritime nation, have to look at it holistically and do all we can to encourage that level of interest that you described.

Mr. VISCLOSKY. And I would encourage you. And, gentlemen, thank you very much.

Thank you, Mr. Chairman.

THE "JONES ACT"

Mr. MURTHA. Chief, we put in $60 million last year for the Jones Act, which helps commercial building. Does that help the Navy

also? Does that help shipbuilding in the United States? It translates into big money, as I understand it.

Admiral ROUGHEAD. Yes, sir. I would like to take that question for the record to make sure—if there is any financial effect. But clearly it would seem to me that should there be growth in application of that money in our shipyards, in our Nation's shipyards, then that would mean that's overhead would be coming down and——

Mr. MURTHA. For example, San Diego gets those commercial ships as well as Navy ships; right? So it's not a help in situations like that.

Admiral ROUGHEAD. Right. But it also brings overhead down.

[The information follows:]

The Maritime Loan Guarantee Program was established pursuant to Title XI of the Merchant Marine Act of 1936 (the "Jones Act") and provides commercial shipbuilders a full faith and credit guarantee by the U.S. Government of debt obligations on commercial bank loans. Commercial shipbuilders may use this funding to help finance new ships built in U.S. yards, or to finance capital improvements that modernize and upgrade shipyard infrastructure.

There is no mandate that Jones Act funding be awarded for the construction of ships with military utility. The U.S. Department of Transportation's Maritime Administration (MARAD), which administers Jones Act funding for the Department of Navy, allocates loan guarantees solely on financial viability. It is possible that Navy could benefit from Jones Act funding if commercial shipyards that also build Navy ships reduce overhead costs and improve their infrastructure as a result of receiving Jones Act funding.

Mr. MURTHA. Mr. Kingston.

RIVERINE MISSION

Mr. KINGSTON. Thank you, Mr. Chairman.

Admiral Roughead, I wanted to ask you about the riverine mission and what your vision is for expanded capacity, and maybe just talk to the committee a little bit about how important they are to irregular warfare that is——

Admiral ROUGHEAD. Yes, sir. And thank you for that question. As you know, we established or reestablished a riverine force a couple of years ago. We had a significant one in Vietnam. We did away with it. And then we brought a riverine capability back, and our Sailors who are in that riverine force are doing extraordinary work in Iraq guarding some critical infrastructure and should that infrastructure be attacked, it would have devastating consequences. And I can't say enough about the great work they are doing.

The other thing I have done with regard to riverine and what we call our Navy Expeditionary Combat Command, which has our SEABEES, our EOD, riverine, and other expeditionary types of capabilities, is this years budget for the first time brings that capability—a bigger part of it into the base budget. We had been running that capability on supplemental money, which was to me a huge mistake. So we brought that into the base.

I have also, in order to expand the knowledge base of the riverine force, have reached out to some of my foreign counterparts and we are working with getting the riverine force into environments that are different than Iraq or different than in the United States. When I went out and for the first time we did a force structure analysis of that capability. We went to every Combatant Commander so we could get their input to give us a better idea of what

we have to go grow in the future. So I think we have made some very positive, significant, substantive steps to better size, better resource, and better shape that force for the future. But in the input that we have received back from the Combatant Commanders, the size of the riverine force that is being demanded right now is what we have. That said, we are going to continue to look at it. We are going to continue to explore other areas of operations, and that will inform where we go in the future.

Mr. KINGSTON. What is the size right now?

Admiral ROUGHEAD. The size of the riverine force is we have three squadrons. They are on a very tight deployment schedule to Iraq but we are not getting the demands out of the other Combatant Commanders yet. So the force is doing quite well and I am very proud of the work that they do.

Mr. KINGSTON. Thank you.

Thank you, Mr. Chairman.

Mr. MURTHA. Ms. Kaptur.

REMARKS OF MS. KAPTUR

Ms. KAPTUR. Thank you, Mr. Chairman and thank you gentlemen for your service to our country. Welcome, Secretary Mabus. Good to have you here. General Conway, Admiral Roughead.

There is just so much to ask. I began my week this week with a phone call with several other members, Governors and Senators, from the head of General Motors informing us of the number of plant closures that would be occurring in our country and the tens of thousands of Americans that will become unemployed. One of the—and I note the increasing number of those you are able to recruit because of the fallout in the commercial economy of this country. One of the issues we got into in that phone call was the lack of certain technologies that have caused our country to fall behind, certainly in the area of energy production, and we got into the issue of batteries. And General Conway, I am looking at you because of the Expeditionary Fighting Vehicle and thinking about the various investments that people of the United States make in the Department of Defense in the national interest and wondering about the lack of our ability to successfully transfer to the commercial sector when it is obviously so vitally needed.

Secretary Mabus, I was glad to see you mention briefly in your testimony something about energy efficiency. I like the term "energy independence" again for America. And I would like to ask each of you gentlemen, the President campaigned on this issue when Congress passed the recovery bill. Energy independence was one of the three top priorities in addition to broadband and health information systems that were laid out for the Nation. As you look at your responsibilities, how do you think about helping our Nation domestically become energy independent again and transferring some of the knowledge that is being developed under your watch to help our country when it is so vitally needed? And you can talk about projects that may be underway for power-train development for your various systems, new types of energy production whether they be cryogenic hydrogen, cellulosic ethanol, biofuels of different kinds, advanced solar. I would be very interested to hear how you think about this because I can tell you that this country would be

a much weaker Nation defense-wise if we do not have a strong transportation infrastructure in this country.

General CONWAY. I will start now, ma'am, and say that we have been doing experimentation for some time now with what we call our supporting establishments, our bases and stations. And in fact, we have an experiment underway at this point with two bases that are attempting to be zero energy in terms of their requirements outside the wire. Both in Southern California. One with wind turbine, the other pretty much with solar power. And thus far, the results have been fairly optimistic. We are encouraged by what we see. How much that will, I will say, transport to other bases and stations outside Southern California (SOCAL), of course, remains to be seen.

But we ask ourselves as an expeditionary force, why can't we transfer some of that to our operational forces? And being green is a part of it, of course, but being lighter and more expeditionary is the true objective here. We are holding a conference here at Quantico in the next few weeks on this very issue. Can we have some sort of alternative power to lighten our load with batteries? Batteries are very heavy. Batteries wear out and you need more batteries. The same with fuels, the same with lighter weight ammunition components, those types of things to be able to lighten our load and at the same time conserve our resources.

Ms. KAPTUR. Is there anyone that—obviously, we have the Secretary of the Navy here. Is there someone within the Department charged with thinking about this and linking across this massive agency and the massive number of units and massive number of research projects as you look at your own department? Is there a reporting structure on energy independence within DOD?

Mr. MABUS. I know that energy independence inside DOD is one of the top priorities. And in my confirmation hearing I did talk about energy independence for the Navy and the Marine Corps in particular. To give you a very concise answer to your particular question, I don't know.

Ms. KAPTUR. That's honest.

Mr. MABUS. But I will find out and will be happy to let you know what I do find out. In terms of the Navy and the Marine Corps, some of the things that I have been thinking about in talking with the CNO and the Commandant about, the Commandant mentioned onshore continental U.S. bases. Right now the Navy and Marine Corps are producing about 17 percent of the energy that we need from alternative sources, which is good but can be a lot better. The second thing is in noncombat operations, we buy a lot of vehicles and we can certainly work to buy vehicles that are alternate fuel vehicles, that are American vehicles, that can hopefully help some of the jobs that you were talking about. And, third, as the Commandant also said, in our deployed forces, ships, airplanes, ground vehicles, we have got to look at alternative energy sources both from an operational standpoint, as the Commandant pointed out and as the CNO has spoken of, but also to cut our dependence on sources of energy that are doubtful or can be interrupted. And operationally, I know that our ships that we are building and are building for the future are taking more and more energy all the time to run. And so just operationally being tied so closely to an

oiler, for example, gives you less flexibility. So that is one of the areas that I hope during my tenure here that I can work on very hard with the Congress very closely.

Ms. KAPTUR. Mr. Secretary, I, along with many members of this committee and Congress, support you in those efforts. And I have seen some of the Marine vehicles coming off one of the lines at General Dynamics that builds the Abrams tank near my district. And I have looked at some of the new vehicles coming off the line and I am thinking to myself you mean we can't take this and make it better and more fuel efficient and more energy independent and move the knowledge up into the commercial sector 50 miles up the road? What is wrong with us? If we can do the Abrams tank, which is an unbelievable vehicle, if we can do all this and yet we can't beat the Japanese or the Chinese in terms of fuel efficiency and fuel systems? And I would just urge you, Mr. Secretary, to devote time to this. If you need funds to place people at DOD or to transfer people who think about this on a regular basis, my sense is for a very long time it has been happenstance and it is not a real commitment, although we spend enormous amounts on research. And it just doesn't seem to—I think your statement is honest. The vehicles that come out use more fuel. We become more vulnerable rather than less vulnerable. Someone over there has got to be charged with thinking about this a lot and filtering it down through the Department, which is so huge. Thank you.

Thank you, Mr. Chairman.

[The information follows:]

Question. Is there anyone that—obviously, we have the Secretary of the Navy here. Is there someone within the Department charged with thinking about this and linking across this massive agency and the massive number of units and massive number of research projects as you look at your own department? Is there a reporting structure on energy independence within DOD?

Answer. Representative Kaptur, I intend to make seeking smart energy solutions, achieving greater energy dependence, and being good stewards of the environment top priorities during my time as the Secretary of the Navy. I have directed a review of all related activities inside the Department and am now in the process of formulating plans and objectives to guide our efforts to pursue both expanded and new renewable energy solutions and to decrease dramatically energy usage across the Department. As these plans have not yet been fully developed, let me now tell you the current state of the reporting structure inside the Department of the Navy (DON).

The Department of the Navy currently provides energy oversight through the Navy Energy Policy Office under the Deputy Assistant Secretary of the Navy (Installations and Facilities). The Office of Naval Research (ONR) provides Science and Technology support for both Navy and Marine Corps research and development. In December 2008, the Chief of Naval Operations established Task Force Energy (TFE) and the Navy Energy Coordination Office (NECO) to provide operational energy plans and programs for Navy. As part of its responsibility, NECO works with ONR and the major Navy systems commands (e.g. Naval Sea Systems Command, Naval Air Systems Command, Naval Expeditionary Combatant Command, and Naval Facilities Engineering Command) to oversee all energy related research and development.

In concert with the Office of the Secretary of Defense and in accordance with the National Defense Authorization Act (NDAA) of 2009, the Navy Energy Policy Office will transition into the Naval Energy Office (NEO) within the Office of the Secretary of the Navy to align and consolidate these functions within DON and its components to provide oversight of operational energy plans and programs (to include research and development) for DON.

The Naval Energy Office will provide a consolidated and comprehensive voice for the Navy Secretariat and its operational components. The office will also speak to Navy and Marine Corps facilities on energy infrastructure plans and programs and roadmaps toward energy "security". Moreover, NEO will bring a broad, strategic ap-

proach to establishing policy and for overseeing programs within Navy and Marine Corps, as well as coordinating within Department of Defense (DOD) and with other federal agencies on their respective energy initiatives and investments. The Naval Energy strategic plan and roadmap includes sections for energy R&D addressing mobility fuels and electrical grid security.

There is also a reporting structure on energy within DOD. The Principal Deputy, Director Defense Research and Engineering is currently lead for the DOD Energy Security Task Force. DOD reporting requirements for energy initiatives, such as those resourced through the American Reinvestment and Recovery Act of 2009, are coordinated through this office. In accordance with Section 902 of the National Defense Authorization Act (NDAA) for Fiscal Year 2009, the Office of the Secretary of Defense will establish a Director of Operational Energy Plans and Programs (DOEP&P) as the principal advisor to the Secretary of Defense regarding operational energy plans and programs and the principal policy official within the senior management of DOD regarding operational energy plans and programs.

Representative Kaptur, based on my ongoing review, I may make further changes to the current energy oversight and reporting structure. Under any circumstances, however, I look forward to working with you and the Committee toward the goal of a "green" and energy efficient Department of the Navy.

Mr. MURTHA. Ms. Granger.

MV–22 OSPREY

Ms. GRANGER. Thank you.

Mr. Secretary, thank you for being with us and thank you for the job you are doing. And to Admiral Roughead and General Conway, thank you for your service and being here to answer some questions.

To the Commandant I have a question. The MV–22 will be going into Afghanistan in October. Tell me and tell this committee what capabilities we brought with the Osprey and what difference it will make in Afghanistan.

General CONWAY. Yes, ma'am. Well, we think it will make a huge difference over and above our current medium lift helicopter. We have had three now successful deployments to Iraq where in every instance, the aircraft I think it is fair to say exceeded our expectations. There is currently a squadron aboard ship, aboard the Marine Expeditionary Unit, that will be shortly headed into the theater, into CENTCOM, and the aircraft will be available for use there when that (ARG/MEU) Amphibious Readiness Group/Marine Expeditionary Unit arrives. The aircraft basically, ma'am, gives you at least twice the capability of our current medium-lift helicopter, the CH–46.

In fact, you will find very few CH–46s in Afghanistan today because although the aircraft was created to carry as many as 18 combat-loaded Marines, elevations and temperatures in the summer in particular put the lift at about five or six combat-loaded Marines. So we have been forced to cycle CH–53s in to serve, in many cases, what our medium helicopter ought to be able to do. Three times the range, five times the payload, twice the speed, cruises at 13,000 feet, comes out of a zone like a rocket ship and can stop abruptly over a zone to come back into place. Our challenge at this point is to stop thinking about it as a helicopter and think about it as something else in terms of its operational capacity, and that is a pleasant problem to have.

JOINT STRIKE FIGHTER

Ms. GRANGER. It is. It took a long time coming, but it has enormous capabilities and possibilities.

My other question is to the Commandant and to the Admiral. Both of you have expressed strong concerns about the shortfall in the Joint Strike Fighter. So what I would like to know is how important that is that we keep on track with that to the operations of the Navy and Marines and even accelerate that? What difference is it going to make and what can we do to help that?

Admiral ROUGHEAD. Well, in our budget, ma'am, we have the four essentially test articles for the Navy variant. We, as a service, are the last ones to get Joint Strike Fighter, and Joint Strike Fighter is extraordinarily important to t our future and naval aviation. The importance of getting on with the program is key, and I am pleased that we have those airplanes in this budget so that that we can move on toward that. We need that airplane because as our Hornets are aging, we have to make sure that we can provide the number of airplanes on our carrier decks that we need and keeping Joint Strike Fighter on track is absolutely key.

General CONWAY. Ma'am, we are the first to field the Joint Strike Fighter of all the services in 2012. We bought our last fixed wing attack aircraft in 1998. That is 14 years of waiting for a fifth generation kind of capability that we think we will desperately need in the future. Now we have ridden hard our F–18s A through D. We are in the process of trying to get 10,000 hours now out of those aircraft to bridge that gap and mitigate the risks that we see. Our venerable Harriers are doing great work for us as well both in Iraq and in Afghanistan. But there is some risk and we are emphatic with the vendor that we cannot afford a delay past 2012. We want those aircraft on time and on delivery.

Ms. GRANGER. Good. We will try to help you make that happen. Thank you very much.

Thank you, Mr. Chairman.

Mr. MURTHA. Mr. Moran.

IRREGULAR WARFARE

Mr. MORAN. Thank you, Mr. Chairman.

It is nice to see you, Mr. Secretary. It is good to see your colleagues in uniform, but I haven't seen Mr. Mabus for a long time.

I want to ask about irregular warfare because this past December the Deputy Secretary of Defense issued guidance that was DOD Directive 3000.07 and it elevated the importance of irregular warfare to be as strategically important as traditional warfare. The policy requires that the department integrate irregular warfare concepts and capabilities into doctrine, organization, training, material, leadership, personnel, and facilities. The Army and the Marine Corps have de facto changed doctrine and training due to their prolonged intense involvement in Iraq and Afghanistan, but the Navy's planning and curricula have not changed.

So I want to ask how has their irregular warfare concept been—because there was a directive—how is it reflected in the 2010 budget request? Is the Navy doing anything to revise doctrine, organization, training, material, leadership, personnel, and facilities to re-

flect a sharpened focus on irregular warfare as the Secretary instructed and as the Army and Marine Corps complied? So I was going to ask that of Secretary Mabus, but if that is not fair, I will ask that of the Admiral and the General.

Mr. MABUS. With your permission, sir, I will give that to the——

Mr. MORAN. I had a suspicion.

Admiral, do you want to go ahead with that? The Marine Corps is fine; so there is no sense in putting General Conway on the spot.

Admiral ROUGHEAD. I would be very pleased to do that. In fact, I would say that this budget captures our contribution, our commitment to irregular warfare quite well with three littoral combat ships, and one Joint High Speed Vessel. Those are new types of ships that will allow us to get into the type of environments that I think are going to be very important. For the first time, this budget represents taking our expeditionary combat command, which is the Navy's core of irregular warfare capability apart from our SEALs, and for the first time we have pulled that into our base budget. I believe that is a significant statement with regard to our contribution to irregular warfare.

I would also say that our curricula at the Naval War College has also been changed to reflect irregular warfare and the type of environments in which we are going to operate. The use that we have made of our amphibious ships as we go forward and do theater security cooperation, much like we have just finished in the Africa Partnership Station where for six months we took one of our amphibious ships in a very different application and worked with the nations on the west coast of Africa on littoral maritime security issues and humanitarian assistance.

The use of our hospital ships that has been ongoing now for three years is also a dimension that gets into a different form of the application of naval power. The fact that we have taken our P–3 aircraft and used them over Iraq, as opposed to the maritime patrol mission to which they are normally suited, is key.

The fact that in the rescue of Captain Phillips from the Maersk Alabama that there was an unmanned aerial vehicle deployed from a guided missile destroyer that provided the information, surveillance, and reconnaissance, I would say that also is a significant statement.

The fact that for the first time in the history of the United States Navy an unmanned autonomous vehicle took off and landed at night from a ship is another statement. So I think we have plenty of examples in the budget——

MRAPS

Mr. MORAN. Well, you certainly do, Admiral, and you seem to be well prepared for that. But I am informed that the training has not been altered in the way it has with the Marine Corps and the Army. You are fully prepared for that so we can pursue.

I do have one other question I wanted to ask, and that is with regard to the MRAPs. The committee is proud that it provided the funding for that because there have been far fewer IED deaths. But it is too big for Iraqi city streets and many bridges and adverse terrain. And now that we are moving forces into Afghanistan, with

the terrain even more problematic, a lighter and smaller and more agile form of MRAP is needed, the all-terrain vehicle.

I would like to get some response, probably from General Conway, in terms of what you are doing with regard to that, because the big MRAPs in Iraq are even less practical in Afghanistan. So how are we applying the lessons of Iraq to Afghanistan, and are the Soldiers and Marines, do they feel equally secure in the ATV as they did in the bigger version of the MRAP?

General CONWAY. Sir, we don't have the ATV variant yet. It is under development and looks to be available in about an 18,000-pound variant by our best information at this point. Your analysis is right on the MRAPs for the most part that we bought in Iraq. They were not as off-road worthy, in some cases were too big, and we actually found our commanders going back to Humvees in order to make their convoys effective and accomplish their mission.

What we are doing, sir, in the Marine Corps is taking a look at how we enhance the off-road capability of our smallest MRAP, the Cat 1's that weigh about 38,000 pounds, and we have successfully moved the independent suspension of our 7-ton trucks onto those MRAPs. It gives them a tremendous off-road capability. The terrain we are operating in in the south is not as nasty as it is in the north and the east where some Army components are. We are not operating off the spine of a mountain with those vehicles. It is high desert. And in fact it is pretty well-suited.

In fact, my visit there, about six weeks ago now, showed me that the most popular vehicle currently in Afghanistan is the 7-ton truck, is the MTVR. So we can rapidly transition those vehicles. It gives us a promise for the rest of the fleet in future use of MRAPs in the Marine Corps. We can do it sooner so we can protect our Marines more rapidly. And we can do it much cheaper than what we can with the MATV arriving. I think we will still buy some MATVs. We see a need to replace some of our Humvees, but not nearly at the scope and scale, I think, that we originally envisioned.

Mr. MORAN. My fuel conscious colleague has requested that I ask what miles per gallon do you get on those.

General CONWAY. On the Cat 1 MRAPs?

Mr. MORAN. Yes.

General CONWAY. It is not real good, sir. I can take it for the record.

Mr. MORAN. About a mile a gallon.

Ms. KAPTUR. If my dear friend could yield, if you would, just for a second. General, could you provide for the record for the vehicles under your command what their fuel efficiency is?

General CONWAY. Yes ma'am. I can get you a listing of each.

[The information follows:]

Answer. The fuel efficiency for vehicles in the Marine Corps inventory is provided in the following attachment:

Marine Corps Vehicles MPG (Miles Per Gallon)		
Nomenclature	**Vehicle**	**mpg**
TRUCK UTILITY, SHELTER CARRIER, 1 1/4 T 4X4	HMMWV D1180 M1037	13.5
TRUCK UTILITY, SHELTER CARRIER, 1 1/4 T 4X4	HMMWV D1180 M1042	13.5
HEAVY HIGH MOBILITY MULTIPURPOSE WHEEL	HMMWV D0187 M1097/A1	13.5
	HMMWV most A-TAMCNs M1097/A1	13.5
COMPRESSED AIR-FOAM SYSTEM, MOBILE/FIR	HMMWV B0625/B0626 M1097/A1	13.5
SHOP EQUIPMENT, CONTACT MAINT	HMMWV C7033 M1097/A1	13.5
SYSTEM GROUP, METEOROLOGICAL(MSG) AN/	HMMWV E1035 M1097/A1	13.5
RECEIVER, INFRARED, STINGER	HMMWV E1837 M1097/A1	13.5
GUIDED MISSILE BATTERY (ADVANCED MAN P(	HMMWV E1839 M1097/A1	13.5
COMPLEMENTARY LOW ALTITUDE WEAPONS S	HMMWV E3250 M1097/A1	13.5
TRUCK UTILITY, SHELTER CARRIER, 1 1/4 T 4X4	HMMWV D1180 M1097A2	11
HEAVY HIGH MOBILITY MULTIPURPOSE WHEEL	HMMWV D0187 M1097A2	11
	HMMWV most A-TAMCNs M1097A2	11
COMPRESSED AIR-FOAM SYSTEM, MOBILE/FIR	HMMWV B0625/B0626 M1097A2	11
SHOP EQUIPMENT, CONTACT MAINT	HMMWV C7033 M1097A2	11
SYSTEM GROUP, METEOROLOGICAL(MSG) AN/	HMMWV E1035 M1097A2	11
RECEIVER, INFRARED, STINGER	HMMWV E1837 M1097A2	11
GUIDED MISSILE BATTERY (ADVANCED MAN P(	HMMWV E1839 M1097A2	11
COMPLEMENTARY LOW ALTITUDE WEAPONS S	HMMWV E3250 M1097A2	11
TRUCK UTILITY, SHELTER CARRIER, 1 1/4 T 4X4	HMMWV D1180 M1097A2 MAK	11
HEAVY HIGH MOBILITY MULTIPURPOSE WHEEL	HMMWV D0187 M1097A2 MAK	11
	HMMWV most A-TAMCNs M1097A2 MAK	11
COMPRESSED AIR-FOAM SYSTEM, MOBILE/FIR	HMMWV B0625/B0626 M1097A2 MAK	11
SHOP EQUIPMENT, CONTACT MAINT	HMMWV C7033 M1097A2 MAK	11
SYSTEM GROUP, METEOROLOGICAL(MSG) AN/	HMMWV E1035 M1097A2 MAK	11
RECEIVER, INFRARED, STINGER	HMMWV E1837 M1097A2 MAK	11
GUIDED MISSILE BATTERY (ADVANCED MAN P(	HMMWV E1839 M1097A2 MAK	11
COMPLEMENTARY LOW ALTITUDE WEAPONS S	HMMWV E3250 M1097A2 MAK	11
TRUCK UTILITY, SHELTER CARRIER, 1 1/4 T 4X4	HMMWV D0022 (D1180) M1152	10.26
TRK, UTILITY, CARGO TRP CARR 1 1/4 TON W/E	HMMWV D0022 (D1158) M1152	10.26
HEAVY HIGH MOBILITY MULTIPURPOSE WHEEL	HMMWV D0022 (D0187) M1152	10.26

Marine Corps Vehicles MPG (Miles Per Gallon)		
	HMMWV most A-TAMCNs M1152	10.26
B0045-ESFS	HMMWV B0045 M1152	10.26
	HMMWV B0625/B0626 M1152	10.26
SHOP EQUIPMENT, CONTACT MAINT COMMON	HMMWV C7007 M1152	10.26
SHOP EQUIPMENT, CONTACT MAINT	HMMWV C7033 M1152	10.26
SYSTEM GROUP, METEOROLOGICAL(MSG) AN/	HMMWV E1035 M1152	10.26
RECEIVER, INFRARED, STINGER	HMMWV E1837 M1152	10.26
GUIDED MISSILE BATTERY (ADVANCED MAN P(	HMMWV E1839 M1152	10.26
COMPLEMENTARY LOW ALTITUDE WEAPONS S	HMMWV E3250 M1152	10.26
TRUCK UTILITY, SHELTER CARRIER, 1 1/4 T 4X4	HMMWV D0033 (D1180) M1152A1 w/IAP	10.26
TRK, UTILITY, CARGO TRP CARR 1 1/4 TON W/E	HMMWV D0033 (D1158) M1152A1 w/IAP	10.26
HEAVY HIGH MOBILITY MULTIPURPOSE WHEEL	HMMWV D0033 (D0187) M1152A1 w/IAP	10.26
	HMMWV most A-TAMCNs M1152A1 w/IAP	10.26
B0045-ESFS	HMMWV B0045 M1152A1 w/IAP	10.26
	HMMWV B0625/B0626 M1152A1 w/IAP	10.26
SHOP EQUIPMENT, CONTACT MAINT COMMON	HMMWV C7007 M1152A1 w/IAP	10.26
SHOP EQUIPMENT, CONTACT MAINT	HMMWV C7033 M1152A1 w/IAP	10.26
SYSTEM GROUP, METEOROLOGICAL(MSG) AN/	HMMWV E1035 M1152A1 w/IAP	10.26
RECEIVER, INFRARED, STINGER	HMMWV E1837 M1152A1 w/IAP	10.26
GUIDED MISSILE BATTERY (ADVANCED MAN P(	HMMWV E1839 M1152A1 w/IAP	10.26
COMPLEMENTARY LOW ALTITUDE WEAPONS S	HMMWV E3250 M1152A1 w/IAP	10.26
TRUCK UTILITY, SHELTER CARRIER, 1 1/4 T 4X4	HMMWV D0033 (D1180) M1152A1 w/IAP & B Kit	10.26
TRK, UTILITY, CARGO TRP CARR 1 1/4 TON W/E	HMMWV D0033 (D1158) M1152A1 w/IAP & B Kit	10.26
HEAVY HIGH MOBILITY MULTIPURPOSE WHEEL	HMMWV D0033 (D0187) M1152A1 w/IAP & B Kit	10.26
	HMMWV most A-TAMCNs M1152A1 w/IAP & B Kit	10.26
B0045-ESFS	HMMWV B0045 M1152A1 w/IAP & B Kit	10.26
	HMMWV B0625/B0626 M1152A1 w/IAP & B Kit	10.26
SHOP EQUIPMENT, CONTACT MAINT COMMON	HMMWV C7007 M1152A1 w/IAP & B Kit	10.26
SHOP EQUIPMENT, CONTACT MAINT	HMMWV C7033 M1152A1 w/IAP & B Kit	10.26
SYSTEM GROUP, METEOROLOGICAL(MSG) AN/	HMMWV E1035 M1152A1 w/IAP & B Kit	10.26
RECEIVER, INFRARED, STINGER	HMMWV E1837 M1152A1 w/IAP & B Kit	10.26
GUIDED MISSILE BATTERY (ADVANCED MAN P(	HMMWV E1839 M1152A1 w/IAP & B Kit	10.26
COMPLEMENTARY LOW ALTITUDE WEAPONS S	HMMWV E3250 M1152A1 w/IAP & B Kit	10.26

Marine Corps Vehicles MPG (Miles Per Gallon)		
TRK, UTILITY, CARGO TRP CARR 1 1/4 TON W/E	HMMWV D1158 M998/A1	13.5
TRK, UTILITY, CARGO TRP CARR 1 1/4 TON W/E	HMMWV D1158 M1038/A1	13.5
RADIO SET	HMMWV A1935 M998/A1	13.5
RADIO SET	HMMWV A1935 M1038/A1	13.5
TERMINAL SET, RADIO	HMMWV A1955 M998/A1	13.5
TERMINAL SET, RADIO	HMMWV A1955 M1038/A1	13.5
RADIO SET	HMMWV A1957 M998/A1	13.5
RADIO SET	HMMWV A1957 M1038/A1	13.5
POSITION AZIMUTH DETERMINATION SYS(PAD	HMMWV E1210 M998/A1	13.5
POSITION AZIMUTH DETERMINATION SYS(PAD	HMMWV E1210 M1038/A1	13.5
TRK, UTILITY, CARGO TRP CARR 1 1/4 TON W/E	HMMWV D1158 M1123 MAK	11
RADIO SET	HMMWV A1935 M1123 MAK	11
TERMINAL SET, RADIO	HMMWV A1955 M1123 MAK	11
RADIO SET	HMMWV A1957 M1123 MAK	11
POSITION AZIMUTH DETERMINATION SYS(PAD	HMMWV E1210 M1123 MAK	11
TRK, UTILITY, CARGO TRP CARR 1 1/4 TON W/E	HMMWV D0031 (D1158) M1165	10.26
RADIO SET	HMMWV A1935 M1165	10.26
TERMINAL SET, RADIO	HMMWV A1955 M1165	10.26
RADIO SET	HMMWV A1957 M1165	10.26
TRK, UTILITY, CARGO TRP CARR 1 1/4 TON W/E	HMMWV D0034 (D1158) M1165A1 w/IAP	10.26
RADIO SET	HMMWV A1935 M1165A1 w/IAP	10.26
TERMINAL SET, RADIO	HMMWV A1955 M1165A1 w/IAP	10.26
RADIO SET	HMMWV A1957 M1165A1 w/IAP	10.26
TRK, UTILITY, CARGO TRP CARR 1 1/4 TON W/E	HMMWV D0034 (D1158) M1165A1 w/B3 armor kit	10.26
RADIO SET	HMMWV A1935 M1165A1 w/B3 armor kit	10.26
TERMINAL SET, RADIO	HMMWV A1955 M1165A1 w/B3 armor kit	10.26
RADIO SET	HMMWV A1957 M1165A1 w/B3 armor kit	10.26
TRK, UTILITY, ARMT CARR W/SA 1 1/4 TON W/E	HMMWV D1159 M1043	13.5
TRK, UTILITY, ARMT CARR W/SA 1 1/4 TON W/E	HMMWV D1159 M1044	13.5
TRK, UTILITY, ARMT CARR W/SA 1 1/4 TON W/E	HMMWV D1159 M1043A2	11
TRK, UTILITY, ARMT CARR W/SA 1 1/4 TON W/E	HMMWV D1159 M1043A2 MAK	11
TRK, UTILITY, ARMT CARR W/SA 1 1/4 TON W/E	HMMWV D1159/D0001 M1114	10
TRK, UTILITY, ARMT CARR W/SA 1 1/4 TON W/E	HMMWV D1159/D0030 M1151A1 IAP	10.26

Marine Corps Vehicles MPG (Miles Per Gallon)		
TRK, UTILITY, ARMT CARR W/SA 1 1/4 TON W/E	HMMWV D1159/D0030 M1151A1 IAP and B Kit	10.26
TRUCK,UTILITY, TOW CARRIER	HMMWV D1125 M1045	13.5
TRUCK,UTILITY, TOW CARRIER	HMMWV D1125 M1046	13.5
TRUCK,UTILITY, TOW CARRIER	HMMWV D1125 M1045A2	11
TRUCK,UTILITY, TOW CARRIER	HMMWV D1125 M1045A2 MAK	11
TRUCK,UTILITY, TOW CARRIER	HMMWV D1125/D0032 M1167A1	10.26
TRK AMB, 4 LITTER ARMD, 1 1/4 TON HMMWV	HMMWV D1001 M997/A1	13.5
SHOP SET, FM, CONTACT VAN, ORDNANCE	HMMWV E1716 M997/A1	13.5
TRK AMB, 4 LITTER ARMD, 1 1/4 TON HMMWV	HMMWV D1001 M997A2	11
SHOP SET, FM, CONTACT VAN, ORDNANCE	HMMWV E1716 M997A2	11
TRK AMB, 4 LITTER ARMD, 1 1/4 TON HMMWV	HMMWV D1001 M997A2 MAK	11
SHOP SET, FM, CONTACT VAN, ORDNANCE	HMMWV E1716 M997A2 MAK	11
TRK AMB, 2 LITTER, SOFT TOP, 1 1/4 TON HMM	HMMWV D1002 M1035	13.5
TRK AMB, 2 LITTER, SOFT TOP, 1 1/4 TON HMM	HMMWV D1002 M1035A2	11
TRK AMB, 2 LITTER, SOFT TOP, 1 1/4 TON HMM	HMMWV D1002 M1035A2 MAK	11
TRK AMB, 2 LITTER, SOFT TOP, 1 1/4 TON HMM	HMMWV D1002/D00?? M11??	10.26
TRUCK, FIREFIGHTING, 1 1/4T, 4X4	HMMWV D1082	13.5
D1161	ITV	17
D1162, D1163, E1070, D0840	EFSS vehicles	17
D1160	IFAV	24
	MRAP I	6
	MRAP II	5
	MRAP III	3.5
D0198 14 ft bed cargo w/ and w/out winch Mk 23/25	MTVR Cargo	3.4
D0198 15 ft bed personnel w/ and w/out winch Mk 2	MTVR Personnel	3.4
D1062 20 ft bed cargo w/ and w/out winch Mk 27/28	MTVR Long-bed cargo	3.4
D1073 Mk 29/30	MTVR Dump truck	3.4
D1213 Mk 36	MTVR Wrecker	3.4
D0009 Mk 31	MTVR Tractor	3.4
D0003/4 14 ft bed cargo w/ and w/out winch Mk 23/	Armored MTVR Cargo	3.4
D0003/4 15 ft bed personnel w/ and w/out winch Mk	Armored MTVR Personnel	3.4
D0005/6 20 ft bed cargo w/ and w/out winch Mk 27/	Armored MTVR Long-bed cargo	3.4
D0007/8 Mk 29/30	Armored MTVR Dump truck	3.4

Marine Corps Vehicles MPG (Miles Per Gallon)		
D0015 Mk 36	Armored MTVR Wrecker	3.4
D0013 Mk 31	Armored MTVR Tractor	3.4
D0876 MK14, D0209 MK48 (FPU)	LVS Flatbed	2.1
D0877 MK15, D0209 (FPU)	LVS Recovery Wrecker	2.1
D0878 MK16, D0209 (FPU)	LVS 5th Wheel	2.1
D0879 MK17, D0209 (FPU)	LVS MHC	2.1
D0881 MK18, D0209 (FPU)	LVS SelfLoader Ribbon Bridge	2.1
D0886	LVSR Cargo	2
D0887	LVSR 5th wheel	2
D1214	LVSR Wrecker	2
D0886	Armored LVSR Cargo	2
D0887	Armored LVSR 5th wheel	2
D1214	Armored LVSR Wrecker	2
E0846	AAV Personnel	1.25
E0796	AAV Command	1.25
E0856	AAV Recovery	1.25
E1500	HIMARS	5.4
E0947	LAV-25	6.5
	LAV-AD	6.5
E0942	LAV-AT	6.5
E0946	LAV-C2	6.5
E0949	LAV-M	6.5
E0950	LAV-R	6.5
E0946A	LAV-MEWSS	5.5
E0948	LAV-L	6.5
E1888	M1A1	0.6
D0210	Aviation Refueler	2
B0160	ABV	1.694631
M1030B1	Motorcycle (Gasoline)	55
D0201 M1030M1	Motorcycle (JP8/Diesel)	96

IRREGULAR WARFARE

Mr. DICKS. Will the Chairman yield to me just for a second. I would like to give Admiral Roughead a chance to answer the question about training on irregular warfare. I think it was unfair of my good friend and my Vice Chairman of Interior to cut you off and not give you a chance to answer the question.

Mr. MORAN. If the gentleman would yield momentarily. I don't think Admiral Roughead gets his feelings hurt very easily. But we would like to know, even if it is just for the record, how the flying curricula has been altered to reflect that irregular warfare directive.

Admiral ROUGHEAD. What I would say, sir, is that our aviators have been involved in irregular campaigns for quite some time. And it is the aircraft carrier that is in the Indian Ocean that is providing about 46 percent; one aircraft carrier, 46 percent of the close air support supporting our troops on the ground in Afghanistan. That same skill and competence was demonstrated in Iraq and in so many other places. So our naval air aviation capability coming off of our carriers, our helicopter pilots who are flying medevac missions, who are in support of our SEALs, are in the fight and they are doing extraordinary work.

Mr. DICKS. But they are training to do this. They just didn't think it up, right?

Admiral ROUGHEAD. That is part of what our curriculum is.

Mr. MURTHA. So how far are these aircraft carriers from the action.

Admiral ROUGHEAD. It is a long flight into the area of operation.

Mr. MURTHA. Refueling is a major issue not only for the Air Force but for the Navy.

Admiral ROUGHEAD. Yes, sir. Gas, when you are flying an airplane off an aircraft carrier, gas is the most important thing that you think about. But I would also say with our E and F we are able to tank the strike packages going in off of E and F, which gives us great capability as we go into that environment. But fixed-wing tanking is key to us.

Mr. MURTHA. Mr. Boyd.

Mr. BOYD. Mr. Chairman, I will pass and come later.

Mr. MURTHA. Mr. Bishop.

RESET OF EQUIPMENT

Mr. BISHOP. Thank you very much. Gentlemen, welcome. And a special welcome to you, Governor Mabus. We have some family ties there that go back to my roots in Mississippi, so I especially want to give you a warm welcome to the committee.

Let me just ask a question here. I understand that the war effort in both Iraq and Afghanistan have placed an unprecedented demand on the core ground and aviation equipment. And thus far the committee has provided over $12 billion toward resetting your equipment. Could you tell us what more is needed to address the Marine Corps capacity to receive and to perform the critical maintenance on returning equipment to Blount Island and the Marine Corps depots, albeit Barstow?

General CONWAY. Sir, first of all let me thank this committee and your Senate counterparts for the reset moneys that have been provided to date. We have a running tally, of course, with Afghanistan and Iraq continuing, and that bill is about $20 billion. We received about $12 billion of that already and we continue to receive more. Blount Island is in fact on our unfunded priority list of things we see that we need, because Blount Island is the focal point for arrival back in the States on that equipment where triage essentially takes place. And either the piece of equipment is deemed not suitable for replacement or repair and it is junked, or we repair it at our depots at Albany and Barstow; or, in some cases, we buy the next-generation equipment, depending upon just the nature of the end item.

Blount Island has more capacity at this point for throughput than we have space for. So our unfunded priority is associated with just enhancing the facility down there so that our throughput can stay abreast and even be better than what we see coming back from theater.

Mr. MURTHA. Gentlemen, what is the figure we are talking about at Blount Island?

General CONWAY. Sir, as I recall, our total unfunded was $155 million to make it into what we know it needs to be.

Mr. MURTHA. And how would you use that money?

General CONWAY. Sir, we would use it to just create space, create a hard stand, create vehicle racks, enhance the throughput if you will.

Mr. MURTHA. This is O&M money, this is not military construction?

General CONWAY. No, sir. This is military construction money.

Mr. MURTHA. Mr. Bishop.

Mr. BISHOP. Continue, sir.

General CONWAY. That is the essence of the message, Congressman Bishop. Thank you.

Mr. BISHOP. So all of that would be done at Blount Island. You don't need to do that at Albany or Barstow?

General CONWAY. Sir, Albany would be where we actually do the repair. But Blount Island, again, is that point where the equipment arrives and we do the analysis there. I might add we are in the process right now of rehabilitating our Third MPS Fleet. We have been on cycle now since about 2007. We have rehabbed two of the three, and that third one is currently at Blount Island undergoing that kind of evaluation and reset.

Mr. BISHOP. Thank you, sir. I appreciate that very much. I, as you probably know, represent the Albany depot.

General CONWAY. I was aware of that, sir.

EXPEDITIONARY FIGHTING VEHICLE (EFV) PROGRAM

Mr. BISHOP. Let me talk about another perhaps sore topic, and that is the Expeditionary Fighting Vehicle (EFV) program and the requirements. With the initial operational capability now projected at 2015 and full operational capability projected at 2025, isn't that an excessive development cycle for a program of that magnitude, and are there scenarios that will justify the program? But the fact that we have not had a beach assault landing in 59 years, is it pos-

sible that the EFV is no longer necessary? And it has been suggested that the fleet might need to operate at least 100 miles away from shore which is, again, beyond the range of the EFV.

Have we reached a point in the debate where we should really take a hard look at whether or not the program should continue to go forward with the large sums of money that have already been invested with not very much input?

General CONWAY. Sir, two points I would make to answer your question. One, that precise set of questions is under review in the Quadrennial Defense Review. And the question that has to be asked of that review and I think of the Department of the Navy, and ultimately of the Congress, is does this country need a forceable entry capability. If the answer is no, then we don't need the vehicle. If the answer is yes, then we most assuredly need the vehicle.

With the anti-access systems that exist today really across the globe—I mean, we saw Hezbollah, political party, knocking down ships at 12 miles. With the anti-access systems that exist our Navy should not go closer than about 25 miles to a coastline with Admiral Roughead, Sailors, my Marines and his ships.

So we have to make that determination first of all as to whether or not there is a need for a forcible entry capability. If the answer is yes, then we assuredly need that vehicle.

Now, in terms of the development cycle, I will tell you, sir, we are at risk right now because right now those ships are going closer than 25 miles. If you witness, say, the Korean scenario that we all watch the papers for daily, there would be a need there for Marines and ships and amphibious capability. And we are concerned about our ability to execute those type of things with the vehicles that we currently own. By the way, the Chinese are building 1,500 like-vehicles to give them that hydroplane kind of capability to close on other nations ashore.

Mr. BISHOP. The design on the EFV is flat-bottom aluminum. And of course once it hits the ground you have designed, I think in response to some of the concerns that were raised by the committee, an armor capacity. At what point is somebody going to have to get out of the vehicle and strap on—bolt on that armor while they are potentially under fire? Is that realistic or is that going to subject our folks to more risk?

General CONWAY. That is a point that needs clarification. We would not go onto a beach that has that kind of defensive capability associated with it. We would bypass those things with our speed and mobility presented by the EFV and the Osprey that would be working in conjunction with such an effort. It would be dependent upon the threats that start to appear. My guess is it would be days or weeks, maybe hundreds of miles inland, before we would be stationery enough for an enemy to plot our movement and be able to use those kinds of weapon systems against us. When that time comes, it would be about a four to six hour evolution to strap this armor onto those vehicles. That puts the protection on these vehicles somewhere below an M2 Abrams tank and just above a Bradley. So we are comfortable that we have the necessary protection.

Mr. BISHOP. In the case of a Korea or any other beachhead landing, particularly if it would be anticipated by the enemy that there would be such, wouldn't they plant those IEDs there well ahead of time?

General CONWAY. Sir, we have engineers that—we call it a mine threat—and we have engineers that deal with that. We have means available on a routine basis to breach minefields and move on, again incorporating the mobility that the vehicle gives us.

Mr. MURTHA. I don't know how extensive the questions on the record are, but we still need you to look at those because the committee really has some questions about this particular vehicle. Mr. Boyd.

TACTICAL AIRCRAFT

Mr. BOYD. Thank you, Mr. Chairman. I have a couple of questions for you, Mr. Secretary. In the F–18, the 2010 budget reduced—I have problems with this technology, Mr. Chairman. I did earlier today.

Mr. MURTHA. High-tech.

Mr. BOYD. The 2010 budget reduced the number of F–18 aircraft requested by half of what was presumed in the 2009 budget, from 18 to 9; is that correct?

Mr. MABUS. Yes, sir.

Mr. BOYD. With the looming tactical aircraft shortfall the Navy is facing, how do you rationalize this reduced procurement?

Mr. MABUS. Well first, as Admiral Roughead said, the Joint Strike Fighter is crucial to the future tactical aircraft in the Navy and Marine Corps. In terms of the Fa–18E/F, it has been reduced. But the 31 aircraft that are requested in this budget, which nine are the E and F and the remainder are the Growler electronic version of the aircraft, are more than enough to keep that line, that F–18 line going at a stable rate. And so as the Quadrennial Defense Review looks at the need for tactical air across the services they can make decisions based on a capacity both for the Joint Strike Fighter, but also a line for the F–18 that is hot, so to speak, that has more than enough airplanes going through it to maintain that line.

Mr. MURTHA. If I can interrupt, I think what we have to look at, Mr. Boyd, is a multiyear for the F–18. I thought we could get there with speeding up the JSF. But they told me prior to our hearing that the research is still going on with the JSF and we are just not going to get there. So we are going to have a shortfall unless we put X number, I don't know what the figure is, but you have got to work with us, giving us a figure so we don't have the shortfall down the road, and look back and say, I wish we had put more in there.

Mr. BOYD. Well, Mr. Chairman I think that was the point. You know, a year later, when the only additional information we have is that the JSF is not coming along like we expected it to, so we can't expect those replacements as quickly. So is it all cost-related, budget-related, deficit-related issues? Are those really—I mean you didn't mention that, but I assume that that is part of the equation here.

Mr. MABUS. It is part of the equation, but it is more related to a total look at what tactical air requirements there are in the QDR that is going on right now. And the other part of this is the Navy/Marine Corps Air is looking at extending the life of our current F–18 fleet to carry some of those to 10,000 hours. And it appears that about half of the F–18s that we have now can be extended and the cost of that extension is being looked at right now.

Mr. BOYD. To the Chairman's point, do you consider it to be a viable option to extend the scheduled completion of the F–18 beyond 2012?

Mr. MABUS. Sir, I think that I need to defer my answer on that to whatever the Quadrennial Defense Review comes out with in terms of overall TACAIR.

Mr. BOYD. Thank you, Mr. Chairman.

Mr. MURTHA. Mr. Hinchey.

VH–71 HELICOPTER

Mr. HINCHEY. Thank you, Mr. Chairman. Gentlemen, thank you very much. It is a pleasure to be with you and I very much appreciate the work that you do; and it was very interesting to listen to your statements and the answers that you give to these questions.

I wanted to ask a question myself with regard to one of the most controversial and, interestingly enough, increasingly criticized aspects of this budget recommendation, and that is the VH–71 helicopter. This helicopter is getting a lot of attention for a number of reasons.

First of all, the number of jobs that are lost, about 2,000 across the country—maybe more than that—and the amount of money that is apparently being just swept aside or wasted if this vehicle is actually abolished. And that would be more than $4 billion which would have been wasted. And the need for a helicopter is very, very apparent because the one that is being used for all of the purposes that this one would be used for was designed back in the 1950s and not put together until the 1970s. So the ones that are being used are, most of them, much more than 30 years old. So that situation is causing a great deal of concern.

We need to have a vehicle like this. We need to have one that is going to work effectively. And if we don't move forward with this one, which is solid and secure, there doesn't seem to be any serious question about its ability to function and function very well, then we are going to need something else at some point in the near future, and that will mean the expenditure of huge amounts of additional money. So none of this seems to make any sense. And, as I mentioned, it is increasingly criticized.

There were a number of issues that came out within the last several days in some of the prominent newspapers and some of the news articles that functioned specifically on the military. So I am wondering what we really need to do. I can't understand the motivation for moving this way with regard to this vehicle. It doesn't seem to make any rational sense. So I wonder what you think we might do and why this program is being dealt with in the way it apparently has, for very little real reasons. And just, you know, like that.

Mr. MABUS. Well, I can tell you what we are asking for in the fiscal year 2010 budget on this. Based on Secretary Gates' decision, the Navy has, as you know, cancelled the contract on this a couple of days ago.

Mr. HINCHEY. A couple of days ago.

Mr. MABUS. Yes, sir. And we are asking for money for two things in the budget for fiscal year 2010. One is to extend the life of the current fleet of helicopters that are now flying. And my information is that extension can be done within very good safety and operational requirements. And, secondly, is money to restart the competition for the next generation of helicopter. I am sure you know both of these things. And I am, as I said, I am not giving you any news here, but simply what we are requesting in the 2010 budget.

Mr. HINCHEY. I appreciate that, and I appreciate the sense of humor that you have with regard to this issue and the way it is being handled.

Mr. DICKS. Will the gentleman yield?

Mr. HINCHEY. Yes.

Mr. DICKS. Can you tell us what the numbers are, what amount of money? You said for extension—how much is in there for that and how much is in there to restart the competition?

Admiral ROUGHEAD. The numbers that I have, Mr. Dicks, are that we have $85 million in the budget for termination, and then also for the beginning process of the way ahead. And with regard to the maintenance of the existing fleet, I don't have that number.

Mr. DICKS. Could we get it for the record? Thank you. Thank you for yielding.

[The information follows:]

Navy's FY10 budget requests $42.5M in aircraft procurement modification funds to sustain the existing VH–3D and VH–60N Fleet of helicopters. The $85M requested in FY10 provides $55M to contribute to the balance of the estimated VH–71 termination costs and $30M to start work on a VH–71 replacement program.

Mr. HINCHEY. I just want to mention something about that.

Mr. MURTHA. Mr. Hinchey, let me make a couple points here. The staff tells me it would cost $4.4 billion to extend the present helicopter.

Mr. MABUS. Sir, my information for the next year is that we are requesting substantially less than that.

Mr. MURTHA. The staff is usually pretty right on this stuff. They have been around a long time and they dig into this. And so they say $4.4 billion to extend the life of the present helicopters that fly the President around.

Now, we have already spent $3.2 billion in research on this airplane. I had 14 people in here the other day, and I don't blame the service in this case, this is the White House. And I had the guy that is in charge of the White House, I had all these different people and I asked them—and this is before the new administration came in—what do you do with this airplane, why do we need an airplane with such extensive capabilities? Well, they told me they wanted to get the President out of town in a hurry and so forth and so on, they had to have all these communications because of this, that and the other.

I said, what about the rest of us? Dead silence. I mean, the President is going to be out there by himself if this plan would come to

fruition. So I said, well, let's relook at this. They said, well, we will put it off until the next administration, and that is what they have done.

But we are still looking at this. I mean we are still trying to figure out if there is not a way that we can use some of this money that we have already spent on research and get some benefit out of this research. I mean, this is unacceptable that we would spend so much money and get nothing out of it. I know this decision was made by the Defense Department.

Mr. DICKS. Mr. Chairman, on this point, weren't a number of these helicopters already built that are Phase I that are going to be upgraded? Wasn't there like nine of them, or some number—five, nine?

General CONWAY. Five, sir.

Mr. DICKS. Five that are already there.

Mr. MURTHA. You are flying those now? Are they flying? We have five flying now?

General CONWAY. Yes, sir, five that have been produced. I assume they are flying.

Mr. MURTHA. Is the Marine Corps flying them?

General CONWAY. They are flown by Marine Corps pilots.

Mr. MURTHA. And this idea you only get 5 years out of them, I can't believe. I mean, that is some of the figures that I have heard.

General CONWAY. I can't speak to that, sir. What I can say—and I will put a mark on the wall and get back to you if it is different—but my staff briefed me that it was about $47 million to enhance the aircraft that we are flying right now to give them a service life extension.

[The information follows:]

Of the five VH–71 aircraft procured, the current service life of each aircraft is 1500 hours.

Mr. MURTHA. Believe me, if the staff tells me it will be $4.4 billion over the lifetime of the system, it will be $4.4 billion or more. They know that I will remember what they told me. Mr. Hinchey.

Mr. HINCHEY. Thank you very much, Mr. Chairman. I just wanted to mention that the flight test areas are pretty high for this vehicle. I think it is something like 800 flight test hours, something like that, which just indicates how effective this vehicle really is. And all of the association it has with others indicate that it will be very, very capable—I am talking about the VH–71—very, very capable for at least 30 years, in spite of the fact that there has been some discussion which is contrary to that.

And with regard to the $55 million for termination fees, my information is that the Navy has estimated that the termination fees would be about $555 million, 555, while industry estimates that could be significantly higher or would be significantly higher.

So I think that this is something I know you understand and I know you understand it thoroughly and I know that you have focused attention on it and you are deeply concerned about it. And I just hope we can work this out in some way that is going to provide the President with a helicopter that is going to be strong, effective, efficient and do the job that is needed to be done—which is a great improvement over what is being done now—and do it

without wasting money, without wasting tens of billions of dollars over what has already been spent.

Mr. MURTHA. The time of the gentleman has expired. We have four votes so we are going to try to complete this hearing. Ms. Kilpatrick.

MRAP LIGHTS

Ms. KILPATRICK. Thank you, Mr. Chairman, and thank you gentlemen, Admiral, Secretary, as well as the General for all that you do, and expert testimony this afternoon. My father is a World War II Navy veteran so he would be delighted to hear you today.

I want to go back to General Conway in terms of the M-Light up-armored—Humvees is what we call them now. I want you to go back to what you said. I think you said you are finding that you won't need as many MRAP Lights and you are finding that the Humvees will be suitable for you in Afghanistan. Did I hear that correctly?

General CONWAY. Not entirely ma'am. We are undergoing a series of tests this month now, about the middle of the month, to make sure our initial survey of what we call this ISS vehicle, the vehicle that is our Cat 1 MRAP, with the new suspension, is as functional as we think it is going to be. The transition time for these vehicles is pretty quick. So pending successful tests this month, we think we can have as many as 40 into theater beginning late July.

Ms. KILPATRICK. Of which one?

General CONWAY. Of the MRAP with a 7-ton suspension on it.

Ms. KILPATRICK. And that is the weapon of choice? Is that the vehicle of choice?

General CONWAY. Yes ma'am, for a number of reasons. We don't normally like weight in the Marine Corps. But in dealing with a blast, weight has a quality all its own. This is a 38,000-pound vehicle. And where we can run it off road we think there is value in doing so for the protection it is going to give our Marines and Sailors.

Now, we still have up-armored Humvees and they are still running in both Iraq and Afghanistan. Our interest in the MRAP MATV, the new variant when it is produced some months from now, will be to replace those up-armored Humvees as required, based upon requests from the field.

Ms. KILPATRICK. And that is what I wasn't clear on. You still have a use for the Light, MRAP Light, but you want to make sure that you have what you need now—and they are in production, you don't have them in theater yet—so the up-armored Humvees will suffice for what you need.

General CONWAY. Yes ma'am.

Ms. KILPATRICK. Then I notice in 2008 the appropriation was $352 million for those Humvees, 981, and now back in 2010 to $205 million. So are you asking for more production of the up-armored Humvees as well?

General CONWAY. No ma'am. I think what you are referencing is the total buy for Army and Marine Corps.

Ms. KILPATRICK. Right.

General CONWAY. We have a sustained buy for up-armored Humvees, but it is much less than that. I will get back to you with our exact figure.

[The information follows:]

The Expanded Capacity Vehicle (ECV) Program is currently significantly short of its Approved Acquisition Objective of 29,942. The current shortfall is 13,078 vehicles. The recent Overseas Contingency Operations (FY09) funding will procure approximately 644 ECVs toward the current shortfall. We cannot provide details of funding and quantity beyond the FY10 request for $10 million, but the funding and quantities are anticipated to increase above that level in subsequent budget submissions.

JOINT LIGHT TACTICAL VEHICLE

Ms. KILPATRICK. I guess I am getting at do you want more up-armored Humvees for Afghanistan?

General CONWAY. Ma'am it gets complicated. To the degree there is another vehicle out there called a Joint Light Tactical Vehicle——

Ms. KILPATRICK. Right.

General CONWAY [continuing]. It is a replacement, ostensibly the replacement for the up-armored Humvee. Right now the Joint Light Tactical Vehicle is weighing about 18,000 pounds too, which is way too heavy for Marine Corps use. If we don't take some weight off that vehicle, we are going to be forced to look at our existing fleet of Humvees and say how do we modify these things for the future until we get a lighter vehicle that gives us the same level of protection.

Ms. KILPATRICK. So it is almost like a project in process, as we are in theater in Afghanistan; and, unfortunately, upping our numbers there as we go forward, we are kind of testing and seeing which one fits best. Are my Marines safe? There is no water for the Navy that is right up there, and drop off the Marines.

General CONWAY. Ma'am, you hit it on a key. It is a science project, and there are a lot of variables in this whole evolution. But number one with us is giving the Marines a vehicle that makes them safe and allows them to accomplish their mission. That is the value we see in this creation that we have now, bringing two vehicles together.

Ms. KILPATRICK. And then the unmanned vehicle, will you use it and will you lighten the load of the field?

General CONWAY. We are experimenting right now with an unmanned logistics vehicle that will lift, through man control on the ground, as much as several kilometers. We are guardedly optimistic that it may work. And if that happens it will relieve the pressure on our helicopters and some of our route convoys. So we are avidly following the development of that capacity.

Ms. KILPATRICK. And you will let this committee know what you need actually.

General CONWAY. Absolutely.

Ms. KILPATRICK. Thank you very much. Thanks, Mr. Chairman.

Mr. MURTHA. Mr. Young.

DDG–51

Mr. YOUNG. Mr. Chairman, I have just one quick question. The F–18 issue was already discussed by General Conway. But, Admiral Roughead, in your opening comments you mentioned about DDG–1000 and moving the emphasis to DDG–51. But DDG–1000 was supposedly a step toward DDX.

Am I reading this correct when I think that DDX——

Admiral ROUGHEAD. CGX.

Mr. YOUNG [continuing]. May be out of the system and that we are going to move eventually into CGX, bypassing DDX?

Admiral ROUGHEAD. Yes, sir. The DDG–1000 has a long history that starts in 1992. But the DDG–1000 would eventually bridge us to a CGX cruiser of the future. And when I became CNO, I looked at our shipbuilding programs and specifically at the DDG–1000. And looking at the trends that were taking place in the world, the proliferation of ballistic missiles, the proliferation of sophisticated anti-ship missiles that were already mentioned by the Commandant—and that is the capability that Combatant Commanders are asking for, the ability to conduct integrated air and missile defense. We have in the DDG–51 the best combatant in the world today. It has those attributes, the DDG–1000 does not. But in truncating the DDG–1000, where we build a couple of those, we can take the technologies from that, we are advancing the integrated air and missile defense capability of the DDG–51. And those two things will give us a better sense of where we have to go with the new cruiser.

Mr. YOUNG. Do you have any kind of an estimated time line for moving into the CGX?

Admiral ROUGHEAD. No, sir. We continue to look at that. And the reason why there needs to be some more work done is that the CGX will be an advanced air and missile defense capability. But I believe we have to define the rest of the components of the architecture that the Nation will use and that the military will use. Until that is defined, I am not sure we know what the design is for our piece of that.

And so by doing what we have done with the DDG–51 and the DDG–1000 I believe we best position ourselves to let these things sort out and then we can move on.

Mr. YOUNG. Okay, sir, thank you very much for that. Mr. Chairman, thank you.

Mr. MURTHA. You mean what you recommend that we do.

Admiral ROUGHEAD. I am sorry, sir?

Mr. MURTHA. You mean what you recommend that we do. We pay for it.

Admiral ROUGHEAD. Yes, sir.

Mr. MURTHA. Thank you very much. The committee is now adjourned.

[CLERK'S NOTE.—Questions submitted by Mr. Frelinghuysen and the answers thereto follow:]

W76 LIFE EXTENSION PROGRAM

Question. Admiral Roughead, you receive your nuclear warheads from the Department of Energy's National Nuclear Security Administration (NNSA). A story last weekend in the Los Angeles Times seemed to question the NNSA's ability to fulfill

its mission to support your needs in the Navy. At issue is the W76 warhead, and the NNSA's claims that its life extension program was a success.

Now I'm well aware of the unexpected problems that the department has faced in maintaining this weapon. But as far as I'm concerned, until the government decides we no longer need this weapon, it's the responsibility of NNSA to make sure your needs are met.

The NNSA requested $209 million for fiscal year 2010. Could you tell us if this is enough to keep you on schedule? How much more will they need?

Answer. The Fiscal Year 2010 NNSA request for $209 million will delay the Navy's planned production rate for Fiscal Year's 2010–2011; however, the delay can be accommodated provided the shortfall is recovered by Fiscal Year 2014.

Question. My information is that the NNSA's budget request is $24 million short to meet your needs. Did they consult with you before they submitted this inadequate request to Congress?

Answer: Yes, and NNSA and Navy have maintained a dialogue to coordinate a sufficient Fiscal Year 2010 production rate needed to support Navy requirements.

OHIO Class Reactor Funding

Question. Admiral Roughead, your Naval Reactor program is split between the Navy and the Department of Energy. The Energy Department is requesting $59M to begin design work on the new reactor for a new generation of ballistic missile submarines to replace the OHIO class.

How much money is the Navy requesting for the potential new reactor?

Answer. The Navy's FY10 President's Budget includes a request for $107.9M.

Future of the Ballistic Submarine Program

Question. We don't know what the Nuclear Posture Review or the Quadrennial Defense Review will say or what decisions your Administration will make. Please explain why we should embark on this new reactor program when we don't know for sure the future of the ballistic submarine program?

Answer. The President has reaffirmed the need to maintain a strong strategic deterrent for the foreseeable future. We are able to start design of the replacement submarine before the Quadrennial Defense Review and Nuclear Posture Review (NPR) conclude because the focus of the NPR will be on the number of weapons and warheads required, rather than on the design of our nuclear submarines which we know must be recapitalized.

To ensure there is no gap in strategic coverage when the OHIO Class SSBNs begin to retire in 2027, we should start concept and system definition for the OHIO Class Replacement in Fiscal Year 2010. Starting this work now is consistent with the 20-year timeline used to develop, build, and test the existing OHIO Class submarines.

Key technical and schedule drivers require the Fiscal Year 2010 start so design and technology can mature to support a Fiscal Year 2019 ship construction schedule. For example, reactor plant components are typically procured at least two years in advance of the submarine construction, and the OHIO Class Replacement submarine's propulsion plant will require new materials and advanced technologies beyond our previous designs to support the energy requirements for a ballistic missile submarine.

EFFECT ON SUBMARINE STRATEGY

Question. Would there be any effect on your submarine strategy and outfitting if we do not approve the funding request for the new reactor design this year?

Answer. The Fiscal Year 2010 funding is critical to ensure the proper level of design maturity for timely fabrication and construction of the replacement SSBN.

The Navy has seven years (Fiscal Years 2010–2017) to complete the reactor design for the OHIO Class Replacement submarine to a level of maturity sufficient to support advance procurement in 2017 and ship construction in 2019. This seven-year design timeframe is consistent with the amount of time it took to design other Navy submarines. For comparison, the VIRGINIA Class submarine, while representing only a nominal change from previous development work, required approximately six years to reach the level of design maturity to initiate advance procurement. The OHIO Class Replacement represents a major step change in technology and capability (e.g., power rating, reactor life, acoustics, etc.); therefore, we will need to accomplish more design work in a similar amount of time.

[CLERK'S NOTE.—End of questions submitted by Mr. Frelinghuysen.]

TUESDAY, JUNE 9, 2009.

ARMY POSTURE

WITNESSES

HON. PETE GEREN, SECRETARY OF THE ARMY

GENERAL GEORGE W. CASEY, JR., CHIEF OF STAFF, UNITED STATES ARMY

INTRODUCTION

Mr. MURTHA. We want to try to finish this by 10:30 because we have a Full Committee meeting. We want to finish by 10:30 because we have a Full Committee meeting. I want to welcome the Secretary, who is leaving, and wish him well. He has done an outstanding job. And I know that Secretary Gates speaks very highly of your work, as we do. We appreciate the difficulties the Army has gone through, and you have just done a marvelous job with that. And we appreciate that.

Welcome, General Casey, who has started to work things out here. So this team has been a good team, and we are going to miss you, Mr. Secretary.

Mr. GEREN. Thank you.

Mr. MURTHA. Mr. Young.

REMARKS OF MR. YOUNG

Mr. YOUNG. Mr. Chairman, I just want to welcome the leaders of the world's best Army, and look forward to their testimony. I have a written statement that I would submit for the record.

Mr. MURTHA. If you would give us a summary of your statements, we will put your statements in the record and then get right to questions.

SUMMARY STATEMENT OF SECRETARY GEREN

Mr. GEREN. All right. Thank you, Mr. Chairman and Congressman Young and members of the committee, thank you for the opportunity to appear before you. Mr. Chairman, thank you very much for your kind words; Mr. Young as well. Thank you as always. It has really been a privilege to work with you.

I do have a statement I would like to put in the record, but before I do that we have got a few soldiers I would like to introduce to you. Mr. Chairman, 2009 is the year of the noncommissioned officer, and we are recognizing the noncommissioned officers and the extraordinary work that they do, the glue that holds our Army together.

We have also recognized the Members of Congress who served as noncommissioned officers that served in our military. And two of

them are on your committee: Mr. Young and Mr. Rogers. I want to thank them for their service.

INTRODUCTION OF SOLDIERS

But I would like to also introduce some soldiers I have with us today, two noncommissioned officers and a specialist. We have Sergeant Shane Payne of Sunset, Louisiana. He is a heavy equipment operator who served in Afghanistan in 2006 and 2007. He received a Purple Heart for wounds received in action. And I appreciate his being here and thank him for his service. Thank you, Sergeant.

And Sergeant Joel Dulashanti. Sergeant Dulashanti is a Wounded Warrior from Cincinnati, Ohio. He was in the 82nd Airborne Division. He was assigned to their sniper platoon. He graduated the top of his class from AIT and from sniper school. He was deployed to Afghanistan with the 82nd on the Pakistani border, where he was seriously injured. He was caught in an ambush, shot in his knee and his stomach. He is a distinguished soldier, received a Purple Heart, Army Commendation Medal with a V Device and Combat Infantry Badge. He has gone to all of the posture hearings this year and has found it so interesting that he volunteered to be part of legislative liaison. So he is now working in legislative liaison with us.

Mr. MURTHA. He thinks Afghanistan was a challenge?

Mr. GEREN. Yes, sir. He figured he has been shot at in Afghanistan, he is ready to tackle the Hill.

We are also joined today by a future NCO, Specialist James Fay of Spring Harbor, Michigan. Specialist Fay is a combat engineer deployed to Afghanistan with the 173rd Airborne Brigade. Conducted route clearance for the brigade. And I want to thank these three outstanding soldiers as representatives of the soldiers that stand with them, and appreciate you giving me the opportunity to introduce them.

ARMY BUDGET OVERVIEW

Let me say very briefly about our budget request, it is $142 billion, and it is mostly about people and operations and maintenance to support them. Our personnel and O&M accounts make up fully two-thirds of our budget, demonstrating the axiom that we heard from General Abrams over and over: People are not in the Army, people are the Army. And this budget makes an investment in those people.

I want to thank this Committee for your tremendous support over these 7-plus years of war. You all have stood with the soldiers and with the families, and in many ways have led the government and made investments that we had not been able to ask you for on behalf of the Army. In so many of the mental health areas, soldier support areas, child development centers, this Committee really has led the way for our government. And I just want to thank you very much for your extraordinary support to soldiers and families during this time. And I will submit the rest of my statement for the record.

[CLERK'S NOTE.—The Fiscal Year 2010 Army Posture Statement is printed at the end of this hearing.]

Mr. MURTHA. General Casey.

SUMMARY STATEMENT OF GENERAL CASEY

General CASEY. Thank you, Chairman, members of the committee. I would like to just give you a quick progress report here on what we have done over the last year, because I think it is important that you have a sense of where we are on our efforts to put ourselves back in balance. And you will recall in 2007 I said that the Army was out of balance, that we were so weighed down by our current commitments that we could not do the things we knew we needed to do to preserve the volunteer force and to prepare ourselves to do other things.

I would tell you my broad assessment is we have made progress toward getting ourselves back in balance, but we are not out of the woods yet. The next 12 to 18 months, until we start feeling the impacts of the Iraq drawdown, will be tough for us. We get past that, I think we will be in fairly good shape.

FOUR IMPERATIVES FOR ACHIEVING BALANCE

To put ourselves back in balance, we said we needed to make progress on four imperatives: sustain the soldiers and families; continue to prepare ourselves for success in the current conflict; reset our forces effectively when they return; and then continue to transform for an uncertain future.

GROWTH IN END STRENGTH

Now, let me just give you a couple of nuggets here on where we are on our objectives to get back in balance. Our first objective was to finish our growth. You will recall in 2007 the President said increase the size of the Army by 74,000, most of that is in the Active force, but some in the Guard and Reserve. As of last month, all components, Active, Guard and Reserve, have met their end strength targets. And that is a good thing for us. Originally, we were not supposed to be finished with that until 2012. With the Secretary of Defense's help, we had advanced that to 2010, and we basically got done a year ahead of that.

FINISH GROWTH AND END STOP LOSS

Now, we still have to build the units, match those people up with the equipment and the training to build the units. That will take us a couple more years. It is important for a number of reasons. One, it allows us to begin coming off of stop loss. I know you have been very concerned about stop loss. And we will begin this August with the Army Reserve deploying units without stop loss, September for the Guard, and then the first of January 2010 for the Active force. And as those units that deployed before that finish up their deployments, by the end of 2011 we should be off of stop loss. That has been our objective all along. As we modernize the Army, it has been our objective to deploy our forces without stop loss.

TIME AT HOME STATION

The second reason it is important is the increased strength allows us to increase the time our soldiers spend at home. And I

have come to believe that the single most important element of putting ourselves back in balance is increasing the time the soldiers spend at home. Now, several reasons: one, it allows them to recover effectively; two, it allows them to have a more stable preparation period for the next mission; and third, it allows them to begin preparing to do other things.

CHANGING COLD WAR FORMATIONS TO MODULAR STRUCTURE

The third element of getting ourselves back in balance is getting away from our Cold War formations. And we have been working on this and building modular organizations that are far more relevant to the current conflict than we were in the past. We are 85 percent done converting all the brigades in the Army to these new organizations. We are also about two-thirds of the way through rebalancing the Army, moving soldiers away from Cold War skills into skills more relevant in the 21st century. We are two-thirds of the way through that.

I will tell you, just by way of example, what that means is we have taken about 200 tank companies, artillery batteries, and air defense batteries, and converted those soldiers into military police, civil affairs, engineers, Special Forces. That is the scope of what is going on there. Together, those two things—modular conversions and rebalancing—is the largest organizational transformation of the Army since World War II. And we have done it while we are deploying 150,000 over and back every year.

ESTABLISHING ARMY ROTATIONAL MODEL

The fourth element, we are putting the whole Army on a rotational model much like the Navy and the Marine Corps has been on for years. And that is the only way that we can sustain commitments and preserve the volunteer force. We have to be able to give our soldiers and families a sustainable deployment tempo.

REBASING

Fifth, we are halfway through our rebasing effort. And you know the scope of the BRAC effort. And when you add to that the increased growth and the return of forces from Europe, we are affecting 380,000 soldiers and families, moving around the Army here in the next several years. We are on track to complete BRAC.

And lastly, Mr. Chairman, as we complete all these, balance entails having the strategic flexibility to do other things quickly. And as we increase the dwell and the soldiers get to 18 months or more time at home, which I expect to see start happening early part of next year, they will have more time to train, to do some of the things they have not had time to train for.

Now, so that is where we are. I would tell you to sum it up: progress. Next 12 to 18 months tough, not quite out of the woods yet.

STRYKER SERGEANT STORY

Let me just close, if I could, Mr. Chairman, with a story about a great noncommissioned officer to give you some sense of the quality of the men and women that we have in our Army and that you

see sitting behind me here. But in April 2007, Staff Sergeant Christopher Waiters was on a patrol in Baghdad. He was in a Stryker. He was following a Bradley. The Bradley hit an IED in an ambush. It burst into flames. He rushed across 100 yards, got into the Bradley, drug two soldiers out of the burning vehicle, dragged them back to his vehicle, was giving them first aid when they told him there was still another soldier in the Bradley. He went back across the hundred yards of open ground, got into the vehicle, realized that the soldier in there was already dead, and the ammunition there was starting to cook off. He went back to the Bradley, got a body bag, returned, pulled the soldier out. For that he was awarded the Distinguished Service Cross, our second highest award for valor. And that is the type of men and women you have not only in the Army, but in all our Armed Forces. So I look forward to answering your questions here.

CONTRACTING

Mr. MURTHA. One thing you did not mention is contracting. Where are we with contracting?

Mr. GEREN. The issue of contracting has been one that we have really wrestled with, worked with over the course of this war. As you know, over the nineties when we shrunk the Army, we also shrunk and outsourced many of the responsibilities that had previously been done by soldiers: the personnel support, feed, housing, fuel, transportation, recreation. And when the war started, we had this model that would rely heavily on outsourcing. And it has grown to a level we have not seen previously.

When soldiers deploy now, it is roughly one to one, one soldier deployed for one contractor. We are working on building up both the civilian and military side to reverse that trend. We have added thousands of people, both civilian and military, in the contracting billets. With the Congress' support, we have created five new contracting general officer positions. We are now instructing our promotion boards to promote contractors. And we are working hard to provide the oversight and also shrink the number of contractors.

The Gansler Commission a couple years ago, gave us a blueprint to move forward. We acted on it immediately, and we are making headway in that regard. And this administration also has instructed us to continue this effort. And we plan over the course of this year to add additional—in-source jobs. We are moving in the direction away from contracting. But where we have contracting, we are also beefing up the oversight over what we have had in the past.

COST OF CONTRACTOR V. SOLDIER

Mr. MURTHA. Well, I know I asked Mr. Holt, who was in Iraq over the weekend, to talk to General Abizaid. He said you are down 16 percent, down to 132,000, and maybe somewhere in between that. But the point is everybody understands the importance because it costs $44,000, on average, more. And it looks like you are going the right direction. We applaud that. Last year we put in a billion dollars for direct hire and $5 billion out of the contracting. But you know, in conference we changed that. We recognize that is the direction to go. So we applaud that effort.

Mr. GEREN. We are moving in that direction.

Mr. MURTHA. Mr. Young.

Mr. YOUNG. Mr. Chairman, on the issue of contracting, Mr. Secretary, if you have for every soldier one contractor and you do away with the contractors, who does the job that the contractor did for the soldier?

RELIANCE ON CONTRACTORS

Mr. GEREN. We are adding more billets, both military and civilian, to take some of those responsibilities. We are moving more people from other areas within the Army into these contracting billets. But we definitely are not ever going to find ourselves in a position where we do not have a significant reliance on contractors.

There are limits, when you consider the stresses on the rest of the force, how much of that we are going to be in-sourcing. But we are in-sourcing more. We are providing greater oversight. So where we continue to have a high percentage of contractors, we are going to be providing better oversight.

But when it comes to food service, so much of just the maintenance and support of deployed soldiers, that will continue to be heavily reliant on contractors. The food services, many of those are nationals from both Afghanistan and Iraq. That will not go away. We are going to provide better oversight, but we are shrinking them at the same time. We are moving more civilians, Army civilians and uniformed military into those positions.

Mr. YOUNG. So the tasks that are performed by the contractors now would not just go away, somebody would still do them?

Mr. GEREN. Yes. Yes, sir.

General CASEY. But I think as the troop levels in Iraq and Afghanistan—or Iraq particularly—come down, you will need less contractors.

OFFICER SHORTAGES

Mr. YOUNG. That is a legitimate response. But now talk about the military personnel. And our Army should be commended and you all should be commended for having achieved your end strength goals even ahead of schedule. But I understand that you are still short in the officer corps. You are short about 2,000 captains, short about 3,000 majors. And I know the NCOs do a tremendous and dynamic job, but they still need some officers in the chain of command.

What are you doing to make up for—well, number one, are those figures accurate? And number two, what are you doing to close the gap?

General CASEY. The numbers are generally accurate. And the officer shortages come from the fact that as we built these modular organizations, the ones I talked about that are much more relevant to this environment, they needed more captains and majors to do the tasks that they need to do. And so we significantly increased the numbers of captains and majors that we required. And for several years we have been increasing the numbers of officers that we bring into the Army to meet that goal.

Unfortunately, a lot of those—not unfortunately, but just the fact is a lot of those folks come in through ROTC, 4 years of college,

you do not get them quite as quickly as you need. So it is going to take us some time to do that. We are at our highest levels in a while in ROTC graduates. That is a good thing. So we will overcome that. I think in about the next 2 or 3 years we will get back to a position where we are meeting our own demands.

INCENTIVES FOR OFFICER RETENTION

Mr. GEREN. We also have some incentive programs in place to encourage retention in those areas. We have our officers, our second lieutenants coming out of West Point. We are giving them an opportunity there to agree to extend their commitment in return for a commitment to be able to go to graduate school, branch of choice, station of choice, giving them an opportunity to make a commitment now in return for a commitment to them—instead of 5 years go to 8 years.

We also did last year and the year before this captains' retention bonus, and also provided them similar types of opportunities in return for continuing in their service. And that was well received. So in the short term we are working to encourage, incentivize the captains to stay on and continue their career. And that has had a positive contribution.

General CASEY. If I could just piggyback on this for a second, because there is a misperception that the reason we have officer shortages is because officers are leaving at higher-than-normal rates. And the fact of the matter is we are actually retaining officers, and captains in particular, at a slightly better rate than has been the historic average over the last decade. So as I said, it is a shortage that has come from changing and adapting our organizations to be better in the environment that we will be operating in.

COMMENDING SECRETARY GEREN

Mr. YOUNG. Mr. Chairman, Secretary Geren was a very respected Member of Congress. Went to the Pentagon and became Secretary of the Army at a rather awkward time and a rather awkward situation. And he has performed admirably. I believe that this will be his last hearing before the Congress as Secretary of the Army. And I just want to take just a minute to say, Secretary, thank you very much for the service that you have given to the country. You have a right to be proud of what you have contributed to our national security.

Mr. GEREN. Thank you very much. I appreciate your kind words.

Mr. MURTHA. Mr. Dicks.

FUTURE COMBAT SYSTEMS

Mr. DICKS. Mr. Secretary, General Casey, in restructuring the Future Combat System program, please describe the strategy behind the decisions on which FCS systems were retained and which systems were deleted. I understand the Secretary of Defense played a major role in this. But this was somewhat surprising. I thought, you know, especially you, General Casey, had worked so hard on educating the members on this whole program. What happened?

General CASEY. We had a very significant discussion about the future and about the future in the 2010 budget. I worked, the Secretary and I both worked very closely with the Secretary of Defense on the Future Combat System program. We went back to him three times on its importance and its necessity. And it all came down to the fact that I could not convince the Secretary that we had incorporated enough of the lessons learned from the current conflict into the design of the manned ground vehicle. And it is the manned ground vehicle program that will be halted. And the rest of the program, the network and the other devices that are part of it, will be continued.

And I think you have heard the Secretary of Defense himself say that he very much supports the network and very much supports the spin-outs as they are called.

And so what we have done—and we are working with the Department to publish an acquisition decision memorandum. The Department publishes that. I would expect that to be on the street in the next week or so. I have seen what is purported to be the final version of that. And it looks like it is ready to go. We will then move to restructure the program into different elements—the network, the spin-outs, the other systems, and then a ground combat vehicle. And we are——

IMPROVEMENTS NEEDED IN FUTURE COMBAT SYSTEMS

Mr. DICKS. What is it that the Secretary wants in the ground vehicle that was not part of the FCS?

General CASEY. I think, Senator, the program suffered from a perception that it was a Cold War program. I mean I wrestled with that, talking within the building and with Members of Congress. And the fact of the matter is when we started this program it was designed to fight conventional war as we thought conventional war would look like in the 21st century. We have to be up front with that.

So there was a perception this was a Cold War system that was not relevant in the environments we are operating in today. And I believe what the Secretary wants and what I want is a vehicle that is capable across the spectrum of conflict, because that is what we think we need. And I believe we can build that. We know where vehicular technology is. We know where protection technology is, because we pushed it there with this program. And people should not think that we have got nothing out of our investment here. We know the state of technology to build ground vehicles. And we hope to bring that and combine that with the lessons that we have learned here and produce a vehicle in 5 to 7 years. And I think we can do that, and we have the full support of the Secretary of Defense to do that.

GROUND SOLDIER ENSEMBLE

Mr. DICKS. I had one other question, Mr. Chairman. The Land Warrior program was terminated, but it was resurrected as the Ground Soldier Ensemble. Budget justification materials describe Ground Soldier Ensemble as a system which connects the ground soldier to the network and provides protection, mobility, sustainability, and embedded training. Now, as I understand it, Land

Warrior was used by several brigades, some of which came out of Fort Lewis, and was very successful. And the soldiers and the leadership of these brigades thought this was a very important system. Can you tell us more about it and kind of what you think the future has for this?

General CASEY. Again, Congressman, in fact listening to you say those words, "Ground Soldier Ensemble," I said to myself we have got to find another name.

Mr. DICKS. Sounds like some violinists.

General CASEY. Does not sound very military. Anyway, I am quite familiar with the Land Warrior.

Mr. DICKS. I like that a lot better, frankly. It could be Land Warrior II.

General CASEY. I visited the unit in Iraq. This system basically brings the network down to the sergeant, the team leader. And it has an eye piece and it has really a BlackBerry, almost, that is portable. And he can look in his eye piece and he can see where soldiers are. We are connecting it to unmanned aerial vehicles, where he can see what is on top of the roof in front of him. It is a wonderful system.

The soldiers told me, and I am sure they were exaggerating, but they said they would rather go off base without their weapons than they would without this system. And as we studied the output of this, it significantly increased their performance. There were like double the number of targets they were able to engage compared to other like units.

Mr. DICKS. So why did we terminate it, then?

General CASEY. It was terminated, frankly, before I got here. The Ground Soldier Ensemble was always part of the Future Combat Systems program. And so we are just basically moving that into the Ground Soldier Ensemble. But we have to connect the soldier to the network. The soldier needs to benefit from the knowledge and the awareness that he gets from the network. And so that is a part of the whole Future Combat System program. It is one of the elements that will be continued as we go forward.

Mr. GEREN. If I could?

Mr. DICKS. Mr. Secretary.

Mr. GEREN. Congressman, I would just like to add on your question about the Future Combat Systems, the Secretary did terminate the manned ground vehicle, but he strongly endorsed the spin-outs, the unmanned ground vehicles, unmanned aerial vehicles, the unattended sensors, and the non-line-of-sight missiles. And we have expanded—instead of just 15 brigades getting all those spin-outs, all 73 brigades would be getting those spin-outs. And this budget continues to push that forward.

FUNDING FOR FUTURE COMBAT SYSTEMS

There are some that have raised some questions about the money we have in the 2010 budget. In fact, there is an effort by some, in some of the other committees in the House, to try to take a good bit of money out of the research in that area. And we asked that the Committee fully support that funding, because it is critically important to keep those spin-outs on track and deliver those technologies to the soldiers.

We are greatly enhancing the situational awareness of soldiers with these, expanding them, giving them capabilities to leverage their capabilities on the ground. And we ask the committee's strong support for the budget as written. We have taken a hit on Future Combat Systems, but this has considerable investments to allow us to keep on track. And we ask your support for that budget, the number that is in the 2010 budget.

Mr. DICKS. Thank you for that clarification. Thank you, Mr. Chairman.

Mr. MURTHA. When we got into FCS, you were only putting $2 billion into the budget, and you had $160 billion total. So it did not add up at all. So I am glad to see this thing has been rewired to be more realistic. And I assume you asked for more money for this year. What was the request for this year for FCS?

General CASEY. About $2.9 billion.

Mr. MURTHA. It is down from last year. Last year it was 4.

Mr. GEREN. Manned ground vehicle is out of this. We are working on an alternative to the manned ground vehicle. And we will have money in the 2011 budget request. We are going to be delivering a proposal to the Secretary right after Labor Day that will be a restart for the manned ground vehicle. But this is for the research, this is for more spin-outs. This is to advance the spin-outs and the technology support for the individual soldiers.

Mr. MURTHA. Mr. Frelinghuysen.

Mr. FRELINGHUYSEN. Thank you, Mr. Chairman. Let me piggyback on that. I think it is pretty devastating that we are going to sort of start over on the ground vehicles. I mean, that worries me a lot. We just have to sort of start from scratch here. Maybe the MRAP model is the one you are going to be going with. But a hell of a lot of research, a lot of money has gone into this Future Combat Systems, and a lot of the vehicles we are talking about here—Abrams and Bradleys, I mean, hell, they have been around for a hell of a long time. We have got to get something to replace them.

PROCUREMENT FUNDING

On procurement, those of us who were here a few years ago were treated to General Schoomaker's famous holes in the yard presentation. You may remember that, General Casey. His contention was that the Army arrived in the post–11 era with a $56 billion procurement shortfall, which had obviously an effect as to what we were doing in Afghanistan and Iraq. As I look at your budget request, your request for fiscal year 2010 totals just $30 billion. Back in 2008, not including the Joint IED Task Force, the procurement budget was $61 billion. The procurement budget for fiscal year 2009 was $37 billion. We are headed in the wrong direction here.

Can you comment about what that effect is going to have on the ability of the Army to do whatever we need to do? I mean, hell, we are moving big time into Afghanistan. We are not out of Iraq.

General CASEY. No, I understand. And I think what you are seeing——

Mr. FRELINGHUYSEN. We are headed in the wrong direction.

General CASEY. We are; but what we are benefiting from in the years that you mentioned was a significant spike to make up for the $56 billion worth of holes in the yard. And so now I think we

are coming down to a more sustainable level. The other element is that—and I think you are including the OCO procurement numbers in your $30 billion number. That is a sustainable level of investment for us at this time. And we will continue to work our modernization efforts. And if it looks like we need to ask for more, well, then we will ask for more.

SUPPLEMENTAL FUNDING

Mr. FRELINGHUYSEN. How are you going to ask for more if we are, quote, doing away with traditional supplementals, which has actually been your way of sort of funding a lot of what you are doing here? We call them overseas contingent funds, but that is not an option you are going to be able to have available. And as the Chairman has repeatedly said in sort of forewarning, the day has come here. You cannot rely on the supplemental process.

How are you going to meet the demands of today's Army? The Army has always been on the short end of the stick anyway when it comes to sort of service allocations. Now you have a procurement situation which is substantially less than you did a year ago.

PROCUREMENT FUNDING

General CASEY. Again, it is; but we have benefited significantly from a spike in procurement to fill those holes in the yard. And I think we are stabilizing at a level that will be sustainable for us. But again, we are looking, as a result of this Future Combat Systems restructuring, we are going back and relooking at our whole modernization effort. And if we need more procurement as a result of that effort——

Mr. FRELINGHUYSEN. That is all fine and good. A lot of what you have in the way of equipment is so beat up to begin with.

General CASEY. We have——

Mr. FRELINGHUYSEN. You have replaced a lot.

General CASEY. We have benefited an awful lot. And the money that you put in for reset is going an awful long way in keeping that equipment moving and operational. So it is a combination both of procurement and of the reset money. And there is $11 billion in this budget for reset. And we still need that.

Mr. FRELINGHUYSEN. I am disturbed about your trends.

General CASEY. Thank you.

Mr. FRELINGHUYSEN. The procurement account is pretty important.

General CASEY. Right.

Mr. FRELINGHUYSEN. If we increase the size of the Army, you know, the procurement account ought to reflect, obviously, what is going to be I think apparently greater obligations, continued obligations in Iraq that are not inexpensive. And now we are going to have greater obligations in Afghanistan. North Korea is rattling their saber. And Iran is out there. God only knows if we had to do another contingency operation, which we would not certainly encourage, but——

General CASEY. I appreciate your concerns, Congressman. Thank you.

Mr. FRELINGHUYSEN. Thank you, Mr. Chairman.

Mr. MURTHA. Mr. Visclosky.

JOINT TACTICAL RADIO SYSTEM

Mr. VISCLOSKY. Thank you, Mr. Chairman.

Secretary, General, I am very interested in the radio program and the Joint Tactical Radio System you are developing as well as SINCGARS. And the first question I would have is, it would appear that you have about $650 million appropriated for SINCGARS that have not yet been obligated. What is the plan to obligate those funds?

SINGLE CHANNEL GROUND AND AIRBORNE RADIO SYSTEM

Mr. GEREN. We are finishing out the SINCGARS buy. We have 56,000 additional radios to buy, and it is a little over $600 million, the $600 million you referred to. We have recently had a competition, and we have decided on the winner of that competition. It is a partnership between ITT and—I have always mispronounced the other partner's name—T-h-a-l-e-s, Thales or Thales. I am not sure of the proper pronunciation. The award was made several days ago, and it is still in the post-contract review period. It will be final over sometime in the next couple of weeks.

Mr. VISCLOSKY. Would that be for the Joint Tactical Radio System?

Mr. GEREN. That is for the SINCGARS. The contract I was just talking about was the SINCGARS purchase of 56,000 SINCGARS radios, which is the ITT-Thales contract. The JTRS radio, the Joint Tactical Radio——

Mr. VISCLOSKY. Can I get back to the $650 million? Is that what you are——

Mr. GEREN. Yes, that is for the SINCGARS.

Mr. VISCLOSKY. So that is now going to be expended?

Mr. GEREN. It is, yes.

Mr. MURTHA. Let me clarify for the gentleman. Since we took out a hundred million for SINCGARS, they decided they would spend some of that $650 million. And a day or so later they put in—they spent $400 million. So there is now only $200 million in that. So in the supplemental we have agreed that $50 million rather than a hundred million cut, because of the gentleman's interest in this program.

Mr. VISCLOSKY. I appreciate the Chairman's clarification. If I could then ask, funding of $128 million was requested for overseas contingency operation; $71 million went to purchase replacement radios; $57 million was paid for management, other hardware, and total package fielding.

Why in that portion of the package—and I assume that is separate from the $650 million—are the administrative and fielding costs so high?

Mr. GEREN. I will have to get back to you for the record on that. The $600 million-plus is for that 56,000 radios finishing up the SINCGARS buy. The JTRS plan that will transition in will phase out the old first-generation SINCGARS radios. And that will begin in 2015, assuming the JTRS is in position at that point. But as far as the application of those individual tranches of funds that you asked about, I will need to get back to you for the record.

[The information follows:]

The administrative costs are not included in the $128M Overseas Contingency Operations (OCO) request. The OCO request includes $71M to procure the Radio/Transmitters (SINCGARS radios) and the other $57 million covers Other Hardware Costs and Total Package Fielding Costs to procure hardware items and to support fielding the radios. These costs break down as follows: Other Hardware Costs of $9.539 million to procure hardware updates to the test set to support the new SINCGARS RT–1523G model and address obsolescence sustainment issues, Embedded Global Positioning System (GPS) Receiver (EGR) enhancements, and installation kits for the 6,409 radios to support increased vehicle density per Department of the Army direction. The other $48.05 million in OCO is required for Total Package Fielding (TPF) costs that are used primarily to cover the costs of 220 Field Installers through FY12.

The Administrative costs of $4.9M are covered in the Base Budget and not the OCO budget request. The $4.9M is for engineering and programmatic support, coordination of Engineering Change Proposals (ECPs), technical manual updates, safety assessments, software and hardware enhancements and program support.

JOINT TACTICAL RADIO SYSTEM

Mr. VISCLOSKY. And the Joint Tactical Radio System would be fielded in 2015, did you say?

Mr. GEREN. 2015. That is the current plan.

Mr. VISCLOSKY. And there is still a competition ongoing for that as you work through?

Mr. GEREN. That is still in the development phases.

Mr. VISCLOSKY. Thank you very much. Thank you, Mr. Chairman.

Mr. MURTHA. Mr. Kingston.

FORT STEWART, GEORGIA

Mr. KINGSTON. Thank you, Mr. Chairman. General, Mr. Secretary.

Mr. Secretary, I wanted to talk to you about something a little more provincial, but you and I have had several conversations about Fort Stewart. And I wanted to go through that, because I do think that we have done a terrible injustice to the community in Hinesville, Georgia, where Fort Stewart is located. And I want to walk you through some of these things. But basically, as you know, the announcement was made from BRAC that there would be two new brigades coming to Fort Stewart, Fort Carson, and Fort Bliss, and that the community needed to get ready for it.

And just to underscore that that was not a whim—and I know you know that—but for the record, December 19th, 2007, the Vice Chief of Staff of the Army, General Dick Cody, said two infantry brigade combat teams will go to Fort Stewart. On December 19th, 2007, my office, along with Senators Isakson and Chambliss and Congressman Barrow made the announcement as well. January 2nd, 2008, the AUSA News said that Fort Stewart would be getting two new brigades. April 3rd, 2008, in Army.com, 23,000 soldiers would be coming there in 2011; 27,000 by the end of that year. November 14th, 2008, General Cucolo said a brigade will be on its way to Fort Stewart. January 25th, 2009, General Cucolo to the Hinesville, Liberty County Chamber of Commerce: Get ready, be prepared, because they are coming. January 26th, 2009, General Cucolo said the brigade will bring service jobs and—well, excuse me, bring service, and jobs are on the way. Where we need help, "we" being the Army, we need help in family housing. We need

family housing for all ranks. February 15th, 2009, Colonel Todd Buchs: We are getting ready. We have $400 million in projects coming.

These announcements were not casual announcements. They were not infrequent. They were very frequent. And they were done by people in authority, not by somebody, you know, not by politicians just trying to sound good to the people back home.

COMMUNITY INVESTMENT FOR FORT STEWART

As a result, this committee put in $154 million in MILCON for Fort Stewart in 2008 and $372 million in 2009. And in fact, without the new brigade we will have an excess capacity of 800 rooms down there, 800 rooms and barracks. The local city, the municipality, has put in about—and I am counting about $38 to $39 million in public works for schools and roads, and similarly, the private contractors have put in about $74 million in excess houses.

Now, actually, the real numbers are a lot bigger than this. But what I asked them to do is tell me where you are really out there. If you were expecting 10 people for dinner and only 8 showed up, I only want to figure out where are the two extra plates. So do not tell me about the whole thing, because some of this is going to be absorbed because of normal growth. And Fort Stewart has grown.

I have really tried to focus on what did you do that you would not have done. But to give you an example, I think this statistic really says a lot: 2008, when housing was flat in Georgia as around the country, this city, this small community of 60,000 people, issued 634 housing permits. Nobody was doing that. Banks made loans and developers invested in property, and they all did it because we instructed them to do it.

ADDITIONAL UNITS AND MISSIONS FOR FORT STEWART

So I have a number of questions here. You know, I guess the first thing is, is there anything that we can do to compensate these folks? Another question is, are there other missions that we can bring there? And how seriously is the Army considering putting in some other missions? And keep in mind, the Army will have excess capacity here. It is not just, oh, we feel bad for the community, but we have overbuilt. And should the community be expecting it?

And perhaps the central question is to our constituents back there: Are they dangling on a limb right now, hoping that something is going to happen, or are they actually in a free fall and we need to go ahead and tell them they are in this free fall and they need to go ahead and decide that they need to declare bankruptcy if they are a developer, or that these loans are going to go bad if they are a banker? Are we giving them additional disservice and false hopes thinking that something can happen that we are scrambling around?

So you and I have had many conversations. You have been very sensitive to this. You have visited it yourself. The Chairman has been down there. He knows how patriotic the community is. But it is not just Hinesville, because I know Fort Drum actually had this situation several years ago, and I was told they did not get prepared because they did not believe the Army, and then they did get additional troops. I am not that familiar with Fort Drum, but

that is one of the things I have heard. But all communities are going to be watching this, not just Carson and Bliss and Stewart. You know, if a town overbuilds and the Army does not deliver, why would you take the Army for its word next time?

Mr. GEREN. Well, you and I have had many conversations about this, and I appreciate the opportunity to discuss it again. Nobody could have been a more forceful advocate for the community of Hinesville than you have been. And I respect that, and I appreciate that. The community has gone out on a limb. The people of Hinesville, they love the military. We did encourage them to step up, because we wanted every installation that was going to grow to be ready to accommodate the families and have schools for the children. And what you read is an accurate depiction of what happened. We strongly encouraged, and Hinesville stepped up. And it is not a big community; as you noted, 60,000 people. That is a huge investment for a community the size of 60,000 people. And we want to look at ways to mitigate that impact.

I cannot tell you right now how we will do that. You know, over the time ahead there are decisions that are made that move resources around, move people around. The end strength of the Army is not going to shrink. The end strength of the Active Duty is going to stay at the same levels that we had before the decision regarding those brigades.

REDUCTION IN NUMBER OF ARMY BRIGADES

We were all surprised by that decision to cut the number of brigades from 48 to 45 in the Active component. And we want to work with you and figure out ways to mitigate it. I cannot lay out a game plan for you right now. But I look forward to continuing to work with you. And again, you have forcefully advocated for your community in this regard. The community did lean very far forward to accommodate soldiers and families, and we appreciate that. And we want to do what we can to mitigate the negative impact. In fact, I had a conversation with the Chairman about this matter as well.

Mr. MURTHA. Mr. Bishop has a question.

Mr. BISHOP. Would the gentleman yield?

Mr. KINGSTON. Yes. And I wanted to also say, Mr. Secretary, Mr. Bishop and I have worked closely on this, as has Congressman Marshall and Barrow and our Senators. So this has been a Georgia delegation issue. But I know in the other States they are doing the same thing. And so this has got a high level of emotion right now and involvement.

Mr. BISHOP. A very high level, particularly since BRAC and the Army's plans are going to impact Fort Benning, which also is connected with the 3rd I.D. But I wanted to ask whether or not this decision, if you know, was budget-driven.

DECISION TO REDUCE THE NUMBER OF ARMY BRIGADES

Mr. GEREN. No, it was not. Secretary Gates made the decision to go from 48 to 45. In fact, the immediate budget impact is not significant. The Secretary made his decision in order to increase the number of personnel that would be available to fill the 45 brigades that are remaining. It was his decision. The term he used was

"thicken." He wanted to thicken the supply of personnel that would be available for those.

Mr. BISHOP. This is the dwell time and training in existing brigades as opposed to establishing some new ones.

Mr. GEREN. That is right.

Mr. BISHOP. It was not budget-driven?

Mr. GEREN. It was a policy decision on the part of the Secretary. He talked with us, with the chief and me, at length about the issue.

Mr. BISHOP. What is the fiscal impact going to be? How much money will be saved?

ASSISTANCE FOR FORT STEWART COMMUNITY

Mr. MURTHA. The time of the gentleman has expired. Let me say this to both you gentlemen, and Mr. Barrow and Mr. Marshall. We are going to work this out. What you laid out happens occasionally throughout the country. Working with the Army, we are going to find out exactly what was spent, we are going to find out exactly if they can put more troops in there and mitigate it that way. If they do not, then we are going to find a way to reimburse the community for what they did at the urging of the military. I mean, this is unacceptable to us. And we do it all the time.

So I would like to have done it in the supplemental, but we just do not have enough information this soon. The trouble is our bill is not going to be passed probably until October 1st, and your folks will have to hang on. Now, the Army will make a decision here shortly about some of these other things. But we are going to work with you and with them. And we are going to work this out, no question about it. You can assure the folks down there that legitimate expenses are going to be taken care of, because it was not their fault; it is because the Army urged them to make these expenditures, and we are going to take care of it.

Mr. KINGSTON. Thank you, Mr. Chairman. Mr. Secretary.

Mr. MURTHA. Mr. Moran.

BASE REALIGNMENT AND CLOSURE

Mr. MORAN. Thanks, Mr. Chairman. And I think both witnesses know the high regard we have for them. And it is great to see you, General Casey, and Pete. We are sorry to see you leave, really.

I do have a problem, though, with an issue that I just cannot justify in my mind, or fiscally, or anything else. And that has to do with the BRAC decision. And what I would like is a candid response. You know, nothing diplomatic, just straightforward. And I know you are both capable of doing that. But the problem is that the costs to implement BRAC have increased to $32 billion. It is a 50 percent increase over what we were told would be the cost. The savings are less than half of the savings we were told would be achieved. And in fact, there are 230 locations around the country that are scheduled to be completed only within the last 2 weeks of the statutory deadline. So 230 relocations and they are going right up to 2011. I think we know it is impossible for them to truly meet those deadlines.

Now, we have a particular problem in the back yard of the Pentagon. We had 20,000 workers, some of them within walking dis-

tance of the Pentagon, but all of them at Metro stations, public transit stations. Many of them lived in those high-rises near the Pentagon. They worked in offices that they could go across the street to. They were right at a public transit station; 20,000 of them are being moved to a place where there is no public transit, primarily to Fort Belvoir. And your Army Corps of Engineers has said that this move is going to cause a 3- to 4–hour back-up each morning and each evening.

Now, that does not make sense to me, and I would like to get a candid response from you as to why we continue to go down this path. And it is right in the back yard of the Pentagon.

Mr. GEREN. The reason we continue to go down this path is the BRAC law. And we are committed to getting these projects completed by the fall of 2011. And it is going to be a challenge. We feel like we are on track, but it is going to be just barely making it under the wire. And the funding that we have this year, it absolutely has to be received on time. We do not have any margin for error now.

Mr. MURTHA. Mr. Secretary, where did they get the cost estimates? For instance, when they said they were going to move Walter Reed, they said $200 million, $300 million. It is now well over $2 billion. Where did the cost estimates come for BRAC? Didn't they come from you folks?

Mr. GEREN. The cost estimates were generated by all the services. They were generated back in, I guess, 2003, 2004, as they prepared for the BRAC. They were internally generated.

Mr. MORAN. Pete, do you think it makes sense to take 20,000 people away from public transit and stick them down someplace where it is going to cause a 3- to 4–hour congestion, where on the very roads that every Federal—most Federal employees have to travel every single morning? It is going to delay everybody 3- to 4 hours every single day of every workday.

TRANSPORTATION PROBLEMS AT FORT STEWART

Mr. GEREN. I was not around when the decision was made. I never understood the decision to move so many people from this urban center down to Fort Belvoir. And as you have been personally very involved in trying to address the transportation concerns, we have worked to try to mitigate it somewhat by moving some of them in other locations by expanding the definition of Belvoir. But there is no doubt the transportation network is not sufficient to support the size of this relocation down there. It is going to be a very significant traffic problem for a long period of time.

Mr. MORAN. But yet we continue down this path. And what the Army did do to relocate on Interstate Highway 395 without any exit ramp is going to further complicate the problem. And the Army will not build the roads because it says, rightfully, that it is not just the Army being served by these roads, it is other agencies, intelligence agencies, and so on. So the Army will not take responsibility for fixing the transportation problem.

Mr. GEREN. No. We have been in extended discussions with the county and with the State, as you know. And you have been involved in that. And at the present time the infrastructure will not support this additional growth without significant impact on the

travel times for people in that entire region. It is going to be a very significant transportation challenge for a long time.

Mr. MORAN. The Corps of Engineers is going to tell us, we told you so. We told you it could be 8 hours every day of back-up. And we are going to say you told us that; then why didn't we listen? I mean I know I am getting tedious on this, but you can see it coming, and there is no way to avoid it, and yet we continue down this path. I probably used up my time.

Mr. MURTHA. The time of the gentleman has expired. We want to be done before we have an 11 o'clock Full Committee. Without objection, Mr. Hinchey has one question before he has to leave.

OUTSOURCING

Mr. HINCHEY. Thank you very much, Mr. Chairman. Mr. Casey, Mr. Geren, thank you very much. I appreciate it.

I wanted to ask you a question about the outsourcing situation. This is a very, very questionable situation that was initiated for reasons that were in themselves very questionable. But on March 23rd, this Committee sent a letter saying that the outsourcing was not working, that it was costing more than it was saving, and that it should be stopped. I also sent you a letter asking for the same kind of review.

OUTSOURCING AT WEST POINT

We have a situation now, a number of places, but including in West Point, resulted in a decision to let 400 public employees lose their jobs, while bringing in a private corporation from someplace else out of State.

Mr. GEREN. Georgia, I believe.

Mr. HINCHEY. So you have two Government Accountability reports issued last year. It is not a matter of where the State is. The question is: Is it right to do it? That is the point. Not what State the private company is coming from. The question is: Is this wrong? And all the indications, all the evidence shows clearly that it is wrong. It does not make any sense. And this committee has asked that you stop it because it does not make any sense.

So I am asking you now, are you going to continue to engage in this and eliminate 400 jobs out of West Point? I am not saying that because that is in my district. It is not. But I am just concerned about the situation and the way it has been carried out. You have been asked to stop it, OMB has shown that it does not make any sense, it costs more money than it saves, it has been dragged out year after year, and you have been asked over and over again to stop it. Are you going to stop it with regard to West Point?

Mr. GEREN. Yeah, I am not in regard to West Point.

Mr. HINCHEY. Pardon me?

Mr. GEREN. No, I am not in regard to West Point.

Mr. HINCHEY. You are not going to stop it with regard to West Point?

Mr. GEREN. No, sir, I am not.

Mr. HINCHEY. You are going to eliminate 400 jobs at West Point?

Mr. GEREN. We began the A–76—let me put it in context. We are not starting any new A–76 programs anywhere. We have four underway right now, West Point being one of the four. I have looked

very carefully at the West Point A–76 effort. Based on our examination of it, it was conducted in accordance with the FAR and with the OMB guidelines. Right now, both of the contract awards are under protest. There were two contracts that were under consideration: the public works, which the award was to a private contractor. The custodial services, the government won the award. Both of them are under protest right now, so neither of those decisions have been made. But I have looked at it very carefully. And I have found no justification for terminating it. It has been conducted in accordance with the FAR. I can assure you——

Mr. HINCHEY. Allow me to interrupt you. You found no justification for stopping something which has been shown over and over again to make no sense? It makes no sense for the people employed, it makes no sense for the operation where they are employed, because the effectiveness and the inefficiency drops. And it makes no sense in terms of anything that is supposed to be achieved here. The whole thing is seen as a failure. And the budget that was passed by this Committee eliminates the A–76 program.

But you are telling me in spite of that, you are going to continue to do this because it was set up in a way that—for reasons that I do not want to go into detail about, those reasons why it was set up, but it makes absolutely no sense. But you are telling me that you are going to continue it anyway, in spite of the fact that it makes no sense in all of those ways?

Mr. MURTHA. Let us stop on that at this point and let the Committee take a look at this. This is the first I have heard of this, and let's see exactly what we are talking about. One of our staffers has been involved in this. I don't personally know about it, but we will take a look at it.

Mr. GEREN. One thing, the Committee did instruct us to not start any new A–76 programs, and we have abided by the directive of the Committee. So we are fully in conformity with the requirements of the Committee.

This A–76 started well before that direction came from the Committee. And across all of the services——

Mr. MURTHA. Mr. Secretary, I appreciate what you are saying. Sometimes our Members living in a community have much better advice. And you, as a Member of Congress at one time, know what I am talking about. Let us look into it and see if we can work something out here.

Ms. Granger.

Ms. GRANGER. Thank you, General Casey, Mr. Secretary, for your service and for being here.

And, Mr. Secretary, I want to add my words to what Bill Young said for the wonderful service you have given.

I am going to tell you that our folks back home, yours and mine, send their best regards. They send their respect and appreciation, and that happens every time I am home.

Mr. GEREN. Thank you very much.

SUICIDE AND MENTAL HEALTH

Ms. GRANGER. We all appreciate what you did as a Member of Congress, some of which I take credit for now, and what you have done as Secretary of the Army.

One of the issues you came in to deal with was the health care of our service members. And you and I have talked about that. I know that you have undertaken a large and broad study of suicide and mental health about what is happening. I want to ask you, particularly now, do we have the resources? Do we have the authority to deal with the problem of suicide and to help with prevention? And then, also, what did you find out about causes, deployment versus dwell time? What are some of the results of the study?

Mr. GEREN. Well, just to begin with your last question first, we found that, when you look at those soldiers who have committed suicide, roughly a third take place while they are deployed; a third of the soldiers have deployed; and a third of the soldiers who have committed suicide have never deployed.

When we examine the individual cases, the typical suicide victim is young, 19 to 25. They are male. Often there is some sort of drug or alcohol involved, and the majority of them use their weapon to commit suicide.

The factors that are the precipitating events are the same inside the service as outside the service. It is relationship issues, financial problems, some sort of workplace humiliation. But we have to assume that the stress that they are all under, the ones who have deployed and haven't deployed, the separation from family, the extraordinary stress of an institution like the Army after 7-plus years of war, those exacerbate every one of those issues.

If you have a relationship problem, it makes it harder. If you have some mental health issues, it makes it harder to get help, and it makes a tough situation worse.

We are working hard to encourage our soldiers to seek help. Stigma is a big issue. Stigma is an issue on the outside, and it is certainly an issue in the Army. There is a high premium on self-reliance. We are working hard to try to break down that stigma and get people past that barrier and seek care.

We are directing much of our suicide-prevention efforts all of the way down to the grassroots level, trying to enlist all 1.1 million soldiers in suicide prevention. We have the advantage of being able to force people to take training. We are making literally every single soldier in the Army participate in suicide-prevention training, not only so he or she can see the issues in himself, but to see it in their buddies with an imperative to intervene on behalf of your fellow soldiers.

We know there is much that we don't know. There are many mysteries still locked inside this issue. With the support of this committee, we have a partnership with the National Institute of Mental Health. It is a 5-year program. We hope this is a groundbreaking research effort. It is a huge one. It is the biggest suicide investigation research project undertaken by anybody anywhere. It is a $50 million program over 5 years. They are going to spin out the information as they go and help us better understand it.

General Chiarelli, vice chief of staff of the Army, is in charge of the program across the entire Army, and we are working to not just focus on that narrow aspect of mental health issues, but build overall resiliency of our soldiers. Resiliency training. It is a multifaceted effort. I can assure you every senior leader in this depart-

ment considers it a very high priority and thinks about it and works on it every single day.

SHORTAGE OF MENTAL HEALTH PROFESSIONALS

Right now, it is not a question of resources so much as just sustaining this effort. It is hard to hire mental health professionals; they are short, particularly in rural areas where many of our installations exist. We are using special pays and different types of incentives to bring mental health professionals into the Army and looking at innovative ways to do that.

MENTAL FITNESS

General CASEY. If I can just add, the other thing that we are looking at is trying to build resilience into soldiers. We have been working for about the last year on a program we call the comprehensive soldier fitness program. It is designed to bring mental fitness up to the same level that we give to physical fitness because you can build mental resilience; people can build mental resilience much like you can build muscle mass.

About 3 weeks ago I was up at the University of Pennsylvania where they are running a program to train our sergeants to be resilience trainers, master resilience trainers. And it was a remarkable program. There were about 50 people there, and I said, send me an e-mail; will this work in the Army, or is it too touchy feely?

Almost to a person they came back and said, you have to tweak it a bit because this is pretty much designed for civilians, but this is exactly what my soldiers need.

People think that anyone who goes to combat gets post-traumatic stress. But the fact of the matter is that the majority of people who go to combat have a growth experience because they are exposed to something very, very difficult, and they succeed. Our objective is to give more and more soldiers the skills to have a growth experience.

We will be starting this in July, and I think it will be something that will benefit us over the long haul.

Ms. GRANGER. Thank you both for that response.

Mr. MURTHA. Ms. Kaptur.

Ms. KAPTUR. I wanted to follow-on on what Ms. Granger was questioning about, and thank you, Secretary Geren and General Casey, for your work, particularly in this area of neurological and psychiatric care, and to urge you on.

I would like very much, Secretary Geren, for any member of this Committee who is interested to have a briefing from the Department of Defense on how you have organized this department-wide. In other words, I know Ohio fits somewhere in this because we have major consortium studies going on with Case Western Reserve and with our Ohio Army Guard and Air Guard, and the University of Michigan is involved. That is just one little part of the country.

I am interested in how this is organized on a departmental level. Can you help provide a briefing? There are so many interested Members. Senator Boxer in the Senate had a proposal for California. One of their doctors came in here a couple of years ago and gave some testimony. But I can't honestly say that I understand

how you as a department or DOD is looking at this whole neuropsychiatric area. Could you provide that kind of briefing?

Mr. GEREN. We would be glad to do that.

Ms. KAPTUR. So we have a comfort level how you have designed this within the department.

Mr. GEREN. All of the services are working it, as well as OSD. This is a priority across the entire Department of Defense.

ARMY COMMITMENTS FOR SECURITY AND ASSISTANCE

Ms. KAPTUR. I thank you very much. I don't know if Ms. Granger would want to join me for that, but thank you.

This is excellent. Whoever did this, congratulations to you. It is sobering.

I worry about many things. One of them is this: "Indigenous governments and forces frequently lack the capability to resolve or prevent conflicts. Therefore, our Army must be able to work with these governments," these governments that are incapable, and many times undemocratic, "to create favorable conditions for security and assist them in building their own military and civil capacity."

I have some serious doubts about where we are headed, but let me ask you this. In the Afghan and Pakistani situations, now you have got the number of Army commitments globally, and you have over 100,000 listed for Iraq, today, can you provide now or for the record, in both Afghanistan, Iraq and whatever we are going to be doing in Pakistan, what other countries are involved with us directly, and how many personnel they are providing, and how much money they are providing? Is that possible?

General CASEY. Sure. Not right now. You are talking about the allied countries that are operating with us, what are they providing in terms of troop and financial support?

INTERNATIONAL PARTICIPATION IN IRAQ AND AFGHANISTAN

Ms. KAPTUR. Absolutely. Troops, any kind of logistically support, whatever it is, and money; what are we getting from them?

I have a sense, am I wrong, that we are pretty much out there alone for the tough duty, for the training of security forces, for most of the money?

General CASEY. In Afghanistan, not so much.

In Iraq, more so.

Ms. KAPTUR. But as we ratchet up in Afghanistan, are others joining us?

General CASEY. Certainly not at the level that—I mean, the people that are there will stay. They are not ratcheting up at the level that we are ratcheting up.

Ms. KAPTUR. I am very interested in those statistics.

I want to ask you two different questions.

General Casey, Secretary Gates talks about, we are changing from a counterterrorism to counterinsurgency mode. What does that mean for Army as you view it?

And, number two, Secretary Geren, who within Army is responsible for energy independence within the department? Who thinks about new energy systems, the types of fuels and propulsion systems used by the vehicle fleets under your control? Who reports?

Who is the person within Army? What is the structure within Army on the research side? So my questions are dealing with counterinsurgency versus counterterrorism, and on energy independence, who thinks about that on a daily basis?

COUNTERTERRORISM AND COUNTERINSURGENCY

General CASEY. I will give you a short answer, but it is not a question that lends itself to a short answer.

We adopted, in February 2008, a doctrine called Full Spectrum Operations, that wherever the Army forces operate across the spectrum, we will apply offense, defense, and stability operations to seize and retain the initiative and achieve our results. And so that is how we are dealing with that effort to be relevant to the conflicts that we will be dealing with in the 21st century.

Ms. KAPTUR. Say that again for me.

General CASEY. We will apply offense, defense, and stability operations. So we have raised stability operations, which include training indigenous forces, reconstruction, those kinds of things, to the level of offense and defense because that is the type of hybrid warfare that we are going to be confronting here in the 21st century.

SENIOR ENERGY COUNCIL

Mr. GEREN. Quickly on the energy front, I have set up a senior energy council in the Army and appointed a senior energy executive. Our goal is to lead the department when it comes to advances on the proper use of energy.

We have made some starts over the last couple of years. We are buying 4,000 electric vehicles to use on our installations. We have four up the hill at Fort Myer. Those 4,000 vehicles will save around 12 million gallons of gas over the 6 years of their life.

We are working on developing energy alternatives on our installations. We now have about 19,000 kilowatts of energy that are generated on our installations out of nonfossil-fuel sources; solar, geothermal, heat pumps.

We have got a plan underway to build, at least compared to what is in existence today, the biggest solar panel farm any place in the country at Fort Irwin. So we are exploring options across the country.

Up at Hawthorne, we are doing a geothermal partnership with the Navy.

We are building all of our new buildings according to the LEEDs standards, silver LEEDs standards.

Mr. MURTHA. Why don't you send the rest of your answer for the record? We are very short on time.

Mr. GEREN. We have got a lot of work in that area. And I would like to brief you on it.

The Army is improving its energy security posture and assuring access to critical power to a full spectrum of Army missions. Army Directive 2008–04 established the term Army Energy Enterprise and the Senior Energy Council (SEC) charter was signed by the Secretary of the Army and the Chief of Staff of the Army giving responsibility for a strategic plan for the Army Energy Enterprise. This plan is the Army Energy Security Implementation Strategy (AESIS), which was approved on January 13, 2009.

The Army Senior Energy Executive is responsible for monitoring the Army's progress in meeting the goals and objectives of the AESIS and reporting such progress to the Army Senior Energy Council (SEC). The AESIS encompasses all aspects of Army energy consumption and utilization, to include weapon systems. The ASA (ALT) is a member of the SEC, along with the G–8 and G–3. The SEC, through the 2-star general officer-level advisory board and colonel-level working group, links up directly with the offices of primary responsibility throughout the Army for the implementation of the AESIS, which includes research and development.

The SEC oversees the Army's energy enterprise that encompasses all aspects of energy consumption and utilization to include installations and facilities, weapon systems, and contingency operations base camps.

The Army is making significant investments in energy security and through the American Recovery and Reinvestment Act is applying $469M toward energy security initiatives.

Many of our installations have significant renewable energy opportunities to include renewable and alternative energy programs, smart grid technology, Energy Savings Performance Contract, Waste-to-Energy, and Waste-to-Fuel demonstrations.

Addressing energy concerns is also a key to increasing our tactical advantage in contingency operations, in particular by reducing our fuel requirements. Our investment in the insulation of temporary structures and the deployment of smart microgrid technology will help reduce fuel requirements even further, potentially saving Soldier lives.

Ms. KAPTUR. Thank you for your service, Secretary Geren. We will miss you.

UNMANNED AERIAL SYSTEMS

Mr. ROGERS. Thank you, Mr. Chairman.

Welcome, gentlemen.

Let me ask you, General Casey, about your vision of where we are and where we are going with unmanned aerial systems, both in counterinsurgency and in force-to-force situations.

General CASEY. As I mentioned earlier, we are talking about being able to operate across the spectrum of conflict, from peacetime engagement to major conventional operations, and any place in between.

One of the elements in any place on the spectrum is being able to see your enemy with sufficient clarity to target them. And unmanned systems, particularly aerial systems, give us that capability to a far greater degree than most other systems. So they will be a part of our inventory and I think will probably increase in sophistication for the foreseeable future.

COMMAND AND CONTROL OF UNMANNED AERIAL VEHICLES

Mr. ROGERS. Have you resolved the command and control aspects with the Air Force?

General CASEY. We are close to doing that. I met with the chief of staff of the Air Force probably now a year ago, and we agreed that the strategic level belonged to the Air Force and that the tactical level belonged to the Army. And it was really at the theater level where we had friction. And we asked two of our majors at subordinate commands to get together and work out an operational concept. They have completed that, and they are bringing that to the chief of staff of the Air Force and I. I am hopeful here. I know that we have made good progress. I am hopeful that we have resolved it.

Mr. ROGERS. It is an on-the-ground situation today, is it not, both in Iraq and Afghanistan?

General CASEY. It is. And the deconfliction issues in theater now are well-established. My whole time there, I cannot recall an issue where we had a problem that caused us to miss a target, for example. So the actual practical application in theater is taking place effectively. The doctrinal level is what needs to be resolved.

FIRE SCOUT

Mr. ROGERS. I see. What about the vertical UAVs like the Fire Scout, what is your vision for those?

General CASEY. The UAVs that can stand and hover give you a slightly different capability than ones that constantly orbit.

And so there is relevance and need to have a mix of both. You'll recall we have a small one that is designed for the platoon and company level that looks like a beer keg, but it is a vertical hover. I think we will wind up with a mix of hover-capable systems and orbit systems.

Mr. ROGERS. So you are happy with the Fire Scout?

General CASEY. So far.

Mr. GEREN. And we are developing prototypes for the Fire Scout right now. It is in the critical design review this year, and the first flight is planned for 2011. But it is certainly an area of active work.

Mr. ROGERS. Do you have adequate numbers of UAVs in theater?

General CASEY. I believe we do, and the number is increasing over time.

Mr. ROGERS. All right. Thank you.

Mr. MURTHA. Mr. Boyd.

Mr. BOYD. Mr. Chairman, I will be very brief. I don't have a question, but I just wanted to say to both of these gentlemen, as an old—as a former Army infantry officer, I am delighted, and I just wanted to commend both of you for your service to this country, General Casey.

And to my long time acquaintance and friend, Pete Geren, thank you for your service to this country.

Mr. MURTHA. Mr. Bishop.

SUICIDE

Mr. BISHOP. Let me join Mr. Boyd in thanking you for your service, both of you.

I am particularly concerned with the suicides and what is happening with our force. As I understand it, 46 percent of the Army's enlisted ranks are between the ages of 17 and 25, which places them in the adolescent category medically. Ms. Granger asked whether or not you have what you need in terms of medical providers to treat mental health with regard to this age group. Could you provide the Committee with specific information of how many of your providers are trained in adolescent psychology, which is this particular age group? Provide that for the record, please.

POST TRAUMATIC STRESS DISORDER

The other thing has to do with, General Schoomaker testified several weeks ago before this subcommittee, and it was emphasized I think to some extent in what you said, Secretary Geren, that frac-

tured relationships and not PTSD account for the majority of the numerous suicides in the Army.

I find that very hard to believe. To me, that is almost like saying, when an individual is killed by a gun shot or a stab wound, that the cause of death is heart failure, which is obvious. It seems to me that there ought to have been, and I think that there must be some ongoing studies that relate PTSD, the impact that PTSD has on relationships, to families. I think we asked General Schoomaker to provide us with that information, and I don't think the Committee has received it yet, of the relationship between PTSD and the fractured relationships in families.

The other thing that I am concerned about is the Army, according to General Schoomaker, does not teach or give soldiers an opportunity to measure post-traumatic growth or lack of growth, so how is it that you have a basis for saying that the relationship between PTSD is not directly or indirectly related to suicides, and that is essentially what General Schoomaker said?

That is very disturbing to me, and I would like to get some more specific information on that because our troops, 46 percent of them being in the adolescent category, have got to be impacted. The medical professionals who have testified before our committees from all of the branches, General Casey, have indicated, and the researchers, that any soldier who is in combat or in that theater for 2 to 3 weeks has been impacted and is very likely to have some form of PTSD. That is what the medical professionals have said in this Committee.

General CASEY. There is no question that everybody that goes to combat gets stressed.

Mr. BISHOP. I am asking about PTSD, not just stressed.

I get stressed when I drive down the interstate that Mr. Moran is talking about.

I am talking about PTSD specifically.

General CASEY. What I would tell you is that, as part of this comprehensive soldier fitness program, one of the key elements is an assessment tool that every individual will take online, and it will give them direct feedback to themselves about how they are doing in different areas.

And then it will connect them to self-help modules that will allow them to work on building resilience in the other areas. So we do not currently have a tool to assess, but we have built one, and it is being tested right now. And by the end of this summer, it will be in use across the Army. I think that is a very positive step.

SELF-ADMINISTERED MENTAL HEALTH TOOL

Mr. BISHOP. Let me interrupt you because I have some serious problems about that because this subcommittee has put in several appropriations bills requirements for the pre- and post-deployment tests that we require by statute, and that was fulfilled by the department by a self-administered assessment also, and that was for medical problems. Now do you really realistically expect that a self-administered tool online for mental illness would be as effective or even more effective than one for physical, which we found that to be inadequate?

POST DEPLOYMENT MENTAL HEALTH ASSESSMENT

Mr. GEREN. When a soldier comes home from a deployment, they have a face-to-face interview with a primary care provider as well as a post-deployment mental health assessment.

Mr. BISHOP. We know that statutorily they are supposed to, but we have been getting information that that does not take place unless they fill out this form and then some clinician reviews their files and determines that they answered affirmatively to certain specific questions; only then will they get that face to face contact. That is what we have been told.

Mr. GEREN. They don't necessarily have a face-to-face with a mental health professional. They have a face-to-face with a primary care provider, and they would only have the mental health professional if circumstances warranted. And then we have another reassessment at 90 to 180 days, and we provide them continuing care.

We are not where we need to be in that regard. I don't want to tell you that the solution has been found and the problem is solved. We have soldiers that come back with unmet psychological needs, and we continue to work to develop appropriate responses.

And your point at the beginning of your comments that PTSD unquestionably contributes to strained personal relationships; there is no doubt about that.

[The information follows:]

Psychiatrists, child psychiatrists, psychologists, social workers, and psychiatric nurses provide behavioral health care to our Soldiers. All of these providers receive training in child and adolescent psychology during their formal education. The Army also provides specialized training in the form of child and adolescent fellowships for psychiatrists, psychologists, and social workers. Although these providers are very highly specialized, most are treating the active duty population, rather than military dependents. The Army has approximately 47 uniformed child psychiatrists with specialized fellowship training in child and adolescent psychiatry, with another 10 child psychiatrists in training, at any given time. The vast majority of the child and adolescent trained psychiatrists are trained in one of our two child and adolescent psychiatry training fellowships, either at Walter Reed Army Medical Center or Tripler Army Medical Center. The Army graduates, on average, five newly trained child and adolescent psychiatrists each year. It is important to understand that all adult psychiatrists are specifically and formally trained to treat the unique 18–25 year old age group. The Army has 61 uniformed adult psychiatrists and 70 civil service or contractor providers in this specialty area.

Furthermore, the Army currently has eight uniformed psychologists who have completed a two year post-doctoral fellowship in child psychology. These fellowships in child psychology are located at Tripler and Madigan Army Medical Centers. In addition, the Army manages a child psychology fellowship at Brooke Army Medical Center that trains civil service psychologists.

Walter Reed Army Medical Center has a child and family social work fellowship, which graduates one or two providers per year. The Army currently has 13 military and two civil service child-trained social workers.

Even with a focus on active duty Soldiers, there are insufficient uniformed and civilian adult psychiatrists to support the 18–25 year old age population. The Army is attempting to attract and retain civilian psychiatrists and psychologists to help meet the increasing demand for psychological health services. Unfortunately, OPM's hiring policies limit the ability for Army hospitals to compete for these specialists. The salary caps and salary restrictions for hiring graduating medical professionals limit the Army's ability to effectively recruit and retain qualified professionals. These rules should be reviewed and updated to allow the DoD to compete in the medical professional labor market.

Mr. MURTHA. The gentleman's time has expired.

Ms. Kilpatrick.

Ms. KILPATRICK. Thank you, Mr. Chairman.

Mr. Secretary and General, thank you for your service and your understanding.

Please don't underestimate the stress, and I know you don't, and I know you come to this Committee and say, you will take care of the soldiers, and thank you for doing that. It is going to be a problem.

My father is a World War II veteran who survived it with his mind.

And I had an uncle who lost his mind. Didn't know until—he came home looking well, and 60 days later, he spent the next 30 years in military hospitals because of stress.

So we are here to help you on that. I don't want to sweep it; I want to be there for them in the theater and when they leave with this committee and chairman and ranking member. We support that effort. Just know that.

STRYKER

I want to talk about the Stryker just a bit. This committee and the Congress has given you well, and it has performed well. There were additional Strykers in the supplemental as well as in the 2010 budget some upgrades for safety and security.

What is the way forward for the Stryker program? How will it fit as we go to Afghanistan? The MRAP light is going to be part of some of that. The terrain is different. I know we are rushed for time. I would like to see how it fits and how we are going to prepare ourselves for Afghanistan?

General CASEY. With respect to Afghanistan, the first Strykers have actually arrived in Afghanistan, and so they are moving there right now.

As we look to the future, one of the things that strikes us, and I think we all intuitively know it, the thing about the future is we never get it quite right. No matter how hard we try, we never get it exactly right. So we need to build a versatile mix of forces. And we think we need a mix of heavy forces, Strykers and infantry forces, infantry forces probably mounted on things like MRAP ATVs. So between those three kinds of systems, we think that we can give the Nation a very versatile Army that can respond any place on the continuum.

Now, as we are looking through the Quadrennial Defense Review, we are looking hard at whether we need to increase the number of Stryker brigade combat teams that we have in the Army. My inclination is that we do. It is a very capable system. And again, it fills a middle weight place on the spectrum of forces that we have. So we are looking at it hard, and we haven't made any decisions, but that is the direction we are leaning.

Ms. KILPATRICK. Is the Stryker a candidate for the man-down vehicle?

General CASEY. Probably not because it is not a fighting vehicle. It is a troop carrier. It is a networked troop carrier, and that is a good thing, but it is not a vehicle that you can fight your way down the main part of Baghdad.

MEDICAL EVACUATION IN AFGHANISTAN

Ms. KILPATRICK. When the Secretary came, he talked about evacuation. From Iraq, it is an hour with the capability of lifting out and getting to a hospital before bringing them to some of the more secure facilities. Afghanistan, it is a couple of hours. Why the difference, and can we improve it and save more lives?

Mr. GEREN. We are working to improve it. The Army has been working with the Secretary over the last few months. Dr. Gates has given a very clear directive to the theaters that there should be parity between the two theaters. We are moving helicopter assets into Afghanistan to get the numbers comparable. It is trained personnel. It is helicopters, and it is also battlefield geometry. You have certain challenges that come with the terrain and the altitude in Afghanistan. But our commitment is to have the same standard both places, and that is 60 minutes. That is our commitment, and we are working to achieve that. We feel very strongly about it, and we are doing everything possible to get there.

Ms. KILPATRICK. Do you have the resources to get that done?

Mr. GEREN. We do. The resources are moving into theater right now. We have some bridge resources. We have worked with all of the services; Navy as well as the Air Force, have provided some bridge resources to support it. 82nd CAB is there now. We have everything underway to achieve that.

Our commitment is that it doesn't matter which theater you are in, you are going to receive the same type of support when it comes to medical evacuation.

Mr. MURTHA. Mr. Dicks.

ONLINE MENTAL HEALTH ASSISTANCE

Mr. DICKS. I just wanted to say that I very much strongly support what General Chiarelli is doing with this online operation. I think this is something worth examining. I think especially for people in rural areas, the Guard and Reserve, when they come back, I can even see a situation where people could use it in the country and go online if they are having problems. Maybe this will help overcome the stigma issue. I think this is worth examining. We have been strongly supporting it.

Mr. GEREN. Thank you.

Mr. MURTHA. The Committee is now adjourned.

[CLERK'S NOTE.—Questions submitted by Mr. Rothman and the answers thereto follow:]

WARFIGHTER INFORMATION NETWORK–TACTICAL (WIN–T)

Question. Secretary Geren and General Casey, in the FY 2010 Defense Budget, the Office of the Secretary of Defense directed a $193 million funding reduction, and a two and a half year delay, to the Warfighter Information Network–Tactical (WIN–T) Research and Development program, yet on April 16, 2009, in a speech at the Army War College, Secretary Gates stated, "the connectivity of the WIN–T will dramatically increase the agility and situational awareness of the Army's combat formations. And we will accelerate its development and field it, along with proven FCS spin-off capabilities, across the Army." Can you explain the apparent discrepancy in Secretary Gates' statement and the budget request?

Answer. The Army cannot provide any insight into the apparent discrepancy. WIN–T capability is important to the Army, and we routinely engage OSD and Congress to provide information regarding the progress of the program and funding requirements.

SINGLE CHANNEL GROUND AND AIRBORNE RADIO SYSTEM (SINCGARS)

Question. Secretary Geren, I suspect we'll hear more about the Joint Tactical Radio System (JTRS) in the coming months as programs begin to deliver capabilities for test and evaluation. In the meantime, what's the status of the last major Single Channel Ground and Airborne Radio System (SINCGARS) acquisition?

Answer. The government awarded the SINCGARS contract to ITT Communications Systems (teaming with Thales Corporation Inc.) on June 4, 2009. The procurement includes the purchase of 56,525 receiver-transmitters required to satisfy the Army Acquisition Objective of 581,000. The procurement includes 44,496 "F" model SINCGARS (fixed COMSEC devices) and 12,029 "G" model SINCGARS (offering programmable COMSEC and Software Communications Architecture (SCA) compliance). Deliveries of the "F" model will begin in December 2009 and deliver at a rate of 3,625 receiver-transmitters per month through January 2011. The "G" model deliveries will begin in January 2011 and continue through April 2011. This schedule allows necessary lead-time to fully qualify the "G" model radio to Army specified requirements, satisfy the Army Campaign Plan, and prevent production breaks.

[CLERK'S NOTE.—End of questions submitted by Mr. Rothman. Questions submitted by Mr. Tiahrt and the answers thereto follow:]

AERIAL COMMON SENSOR (ACS)

Question. The Army is now briefing a new acquisition strategy for the Aerial Common Sensor (ACS) program, which focused on bringing near-term, affordable solutions quickly to the battlefield. Can you describe for the committee your plans to acquire and field the ACS system? Why is a turbo-prop the right solution for the Army? When do you expect to have a Request for Proposal and contract award?

Answer. The decision to restructure the ACS program to a turboprop solution is based on Secretary of Defense guidance, lessons learned from current overseas operations, and Army budgetary guidance. The primary ACS mission is now supporting Irregular Warfare (IW) and direct support to Brigade Combat Teams.

The Program Manager, ACS will award two Technology Development (TD) contracts to competing industry partners. Engineering activities throughout this phase will culminate in the execution of a Preliminary Design Review and the development of flying system prototypes. The Army will own the system prototypes by fiscal year (FY) 2012 and may conduct a field operational assessment. The program released a draft Request for Proposal (RFP) for the TD phase activities on July 1, 2009 and is preparing for a Materiel Development Decision and final RFP release in early FY10. Contract awards are planned for the Second Quarter FY10. After completion of the TD phase, a single contract will be awarded for the execution of the Engineering and Manufacturing Development (EMD) phase. Three EMD systems will be developed and operationally tested by FY15, followed by a Milestone C, Low Rate initial Production decision in FY16. Fully production compliant and tested ACS systems will begin fielding in FY17.

The aircraft performance required to support IW missions differs from the performance needed in the original ACS effort. As a result, the aircraft's range, altitude and endurance are reduced. This new flight profile allows for a turboprop solution; a less expensive platform. Additionally, the turboprop flight characteristics will better enable on board sensors to support IW. The primary sensors optimized to support IW missions include: communications intelligence collection and location of modern signals; ground moving target indicator sensor detection and location of vehicles and dismounted targets; and electro-optical/infrared imagery.

WARFIGHTER INFORMATION NETWORK—TACTICAL (WIN–T)

Question. There appears to be a lack of funding in the Army budget for the Warfighter Information Network—Tactical (WIN–T). As you know, WIN–T is the Army's broadband wide area mobile network serving tactical command posts from Theater down through Company level. I am told that the lack of this funding will result in a three-year delay in the program. In a speech at the Army War College in April, however, Secretary Gates called for the acceleration of WIN–T. Can you reconcile the budget request and Secretary Gates' statements?

Answer. The Army cannot provide any insight into the apparent discrepancy. WIN–T capability is important to the Army, and we routinely engage OSD and Congress to provide information regarding the progress of the program and funding requirements.

[CLERK'S NOTE.—End of questions submitted by Mr Tiahrt. Questions submitted by Mr. Kingston and the answers thereto follows:]

BCT STATIONING DECISION

Question. The Hinesville community did not ask for an additional brigade; however, community leaders responded to the Army's insistence to aggressively build in time to accommodate the additional troops. This decision will undoubtedly lead to overinvestment in Liberty County. This rural community of 60,000 has overextended itself and overbuilt. To that end, we would like to ask the following questions:

As part of the Army's transformation and growth, additional combat support units are being stood up. Did the Army consider stationing additional support units at Fort Stewart when it decided not to establish the 46th brigade at Fort Stewart? What types of units were considered?

Answer. The Army did not consider stationing additional support units at Forts Stewart, Carson, or Bliss when the decision was made to stop at 45 brigades. The Army was already at its authorized end strength, currently 547,400, and had stationed those units as part of the Grow the Army Stationing Plan in December 2007.

Question. On June 2nd the Army announced White Sands Missile Range, New Mexico was also identified to no longer receive a Brigade Combat Team (BCT). The brigade planned for White Sands was coming from Germany in 2013. What is the current stationing plan for that brigade?

Answer. The restationing of two Heavy BCTs scheduled to return from Europe in FY12 and FY13 is being examined as part of the ongoing Quadrennial Defense Review, which will reassess the global force structure end state for all the Services.

Question. If the brigade growth is stopped at 45, will those brigades be better manned? What permanent increase in soldier strength should the brigades currently stationed at Fort Stewart expect to see?

Answer. The decision to stop the growth of the Army at 45 brigade combat teams (BCTs) was to ensure that the Army has fully-manned, ready to deploy units. The Army has more documented and undocumented requirements (jobs) for Soldiers than the Active Component 547,400-Soldier Army can currently fill. By removing three Brigade Combat Teams from the program in fiscal year (FY) 2011, the Army is estimating the removal of approximately 10,300 requirements, allowing those associated Soldiers to be used to offset requirements existing elsewhere in the Force. In FY11, this will allow the Army to improve manning levels of next-to-deploy units regardless of their location, much sooner than we are currently able.

The population growth at Fort Stewart published in the June 2, 2009 Army press release reflected the combined growth of both Fort Stewart and Hunter Army Air Field (HAAF). The published fiscal year (FY) 2013 population of 24,970 was based on the Fort Stewart/HAAF growth reported in the December 17, 2007 Grow the Army report (28,470) minus a typical Infantry Brigade Combat Team (BCT) of 3,500 military. This growth only included Army military, Army students, and Army civilians—not all population increases (i.e., other military, transient military, other civilians, contractors). The April 30, 2009, Army Stationing and Installation Plan shows the FY13 growth at Fort Stewart at 22,592 and HAAF at 5,923, for a total of 28,515 for Army military, Army students, and Army civilians. Adjusting this number to reflect the de-activation of the BCT in question (3,443) reduces the population to 19,149 at Fort Stewart, and no change at HAAF, for a total growth of 25,072. Installation population projections will continue to fluctuate based on operational needs and force management decisions.

Question. The lack of dwell time at home between deployments for Soldiers has been a continuing serious concern. Since the Army employs the force by rotating organizations, primarily combat brigades, what impact will having only 45 brigades have on the Army's efforts to increase soldiers' dwell time at home?

Answer: Secretary Gates announced in April 2009 that the active Army will grow to 45 BCTs instead of the 48 BCTs as reported in the December 2007 Grow the Army plan to Congress. The decision to stop the Army's growth at 45 BCTs versus 48 was made to raise the readiness and percentage fill of deploying units. This ensures that we retain our ability to support future requirements to include rotations to Iraq, Afghanistan, and other contingencies. This decision also contributes to helping to put an end to the routine use of stop-loss to increase deploying units' manning. The Secretary of Defense, in July 2009, temporarily increased the Army end strength from its current 547,400 to 562,400 in 2010 and the authority to increase to 569,000 in 2012. With this additional increase we will be better postured to rebalance our enabling forces which perform key functions on the battlefield in support of our BCTs.

The decision to stop at 45 BCTs will not have an immediate impact on improving BOG-to-Dwell ratios. The end strength growth these three BCTs represent will increase individual dwell for those Soldiers who would have had to fill the ranks of those units identified for deployment.

Question. It is well understood that one of the great stressors on soldiers and families is the short time the soldiers are home between deployments or short dwell time. How will the Army increase dwell time in the near term? It seems the only two ways to do that is to reduce the number of deployments or increase the size of the Army in terms of soldiers and brigades that can deploy. This seems to be a problem that has not been resolved since 2003. As we expand our commitment to Afghanistan shouldn't we reasonably increase the size of the Army and be ready for the demand with well-rested and well-trained soldiers?

Answer. The Army's size and force structure given current and project demands, which includes the transitions in OIF and OEF and other global commitments, are being examined as part of the Department of Defense's Quadrennial Defense Review. In July 2009, the SECDEF temporarily increased the Army end strength from its current 547,400 to 562,400 in 2010 and the authority to increase to 569,000 in 2012. These additional forces will be used to ensure deploying units can increase dwell time and are properly manned and trained. They will not be used to create new combat formations.

Question. Additionally, we question the Army's press release which stated that Fort Stewart would grow from 20,512 soldiers to 24,970 by 2013. Does this number include personnel assigned to Hunter Army Airfield as well? We understand that a significant percentage or that growth is projected for Hunter Army Airfield (HAAF) located in Savannah, Georgia and not Hinesville. Can you please explain?

Answer. The population growth at Fort Stewart published in the June 2, 2009 Army press release reflected the combined growth of both Fort Stewart and Hunter Army Air Field (HAAF). The published fiscal year (FY) 2013 population of 24,970 was based on the Fort Stewart/HAAF growth reported in the December 17, 2007 Grow the Army report (28,470) minus a typical Infantry Brigade Combat Team (BCT) of 3,500 military. This growth only included Army military, Army students, and Army civilians—not all population increases (i.e., other military, transient military, other civilians, contractors). The April 30, 2009, Army Stationing and Installation Plan shows the FY13 growth at Fort Stewart at 22,592 and HAAF at 5,923, for a total of 28,515 for Army military, Army students, and Army civilians. Adjusting this number to reflect the de-activation of the BCT in question (3,443) reduces the population to 19,149 at Fort Stewart, and no change at HAAF, for a total growth of 25,072. Installation population projections will continue to fluctuate based on operational needs and force management decisions.

Question. Secretary Gates reasoned that by continuing to increase the Army's strength to 547,000 soldiers while stopping the growth of combat brigades at 45 that this would allow the existing brigades to be better manned. This would also minimize or eliminate the use of initiatives like stop-loss. With an end-strength of 547,000 would a 48 brigade Army be undermanned and cause the continued use of stop loss?

Answer. Regardless of the number of brigade combat teams, the Army is committed to phasing out stop loss beginning in January 2010, and completely eliminating stop loss by March 2011.

Question. Fort Stewart has the largest training area east of the Mississippi River and no other Army post has the transportation infrastructure like Fort Stewart which has nearby a major port and a major airfield with railways connecting all critical points. Would you characterize Fort Stewart as the Army's most capable and well-equipped power projection platform in the continental US? How would you rate Fort Stewart in terms of being ready for more missions and ready for more forces to be assigned?

Answer. Fort Stewart has 251,000 acres of maneuver training land and over 18,000 acres of impact area with 51 live-fire ranges. Relative to the missions that are being placed on Army commanders and the distances that our new systems are able to cover, Fort Stewart is somewhat limited in the training that can be realistically provided because of the size and characteristics of its training land. Although the training land is limited, the level of live-fire training capability at Fort Stewart still establishes it as one of the Army's most important training complexes. The Army remains committed to the development and sustainment of Fort Stewart as a major training asset and the recent changes in the Army growth posture does not significantly reduce the overall training support capability that is planned at Fort Stewart. In 2007, we analyzed installations that would be capable of activating one of the six Grow the Army Infantry Brigade Combat Teams (IBCTs) and Fort Stewart ranked high due to its growth capacity, power projection, training, and Well-

being for Soldier and Families capabilities. It was the combination of all these criteria that enabled it to be considered and selected as an installation to receive an IBCT. The Army has several power projection platforms within the United States that are fully capable and all have different qualities.

Question. Over the past two years, when the Army was pressed to mobilize, train and deploy National Guard Brigade Combat Teams from Indiana, Texas and Oregon, few posts inside the United States were better equipped to prepare these citizen soldiers for the rigors of combat. Although the Army may desire to avoid mobilizing National Guard units from Army installations, Fort Stewart's great training and billeting facilities make it an ideal site (perhaps even preferred site) for power projection. The community and the post consistently step up to support these efforts. Recently the staff from the Oregon delegation visited Fort Stewart and gave rave reviews for the post. What could the community do to accommodate these visiting units and continue to provide strong support for the Army?

Answer. Communities may continue to support the Army's mobilization mission. Strong partnerships between local communities and neighboring Army installations provide a solid foundation to support Soldier and Family quality of life and mission preparedness. Additionally, community investments increase military value to better posture the installation for consideration for future Army stationing actions.

Question. The 3rd Infantry Division has a modular brigade located across the state of Georgia at Fort Benning in Columbus. Where is the ideal location for the Heavy Infantry Brigade Combat Team to train? Will the joining of the Armor Center with the Infantry Center have any effect on this BCT? Would the BCT have to compete for access to land and ranges? Could the effects of any current environmental impact issues be relieved by relocating the BCT to Fort Stewart until these get resolved? Wouldn't it make more sense to re-locate that Heavy BCT to Fort Stewart where it can train on the largest training area in the eastern U.S. and be next door to an exceptionally capable airfield and seaport? Once the environmental impact issues are fully addressed, could a BCT from Germany be relocated to Fort Benning?

Answer. The ideal location for a Brigade Combat Team (BCT) to train is at an installation that has growth capacity, power projection capabilities, training opportunities, and provides for the well being of Soldiers and their Families; the Army has several installations with these qualities. Merging the Armor Center and Infantry Center into the Maneuver Center of Excellence is mandated by the Base Realignment and Closure Commission 2005, and the recommendation was based on their in-depth analysis of installations within the United States. The training land and range capability at Fort Benning will be able to support the 3rd Infantry Division brigade as well as the Armor Center and the Infantry Center once all of the BRAC-related range construction is complete. The Army is working with the United States Fish and Wildlife Service to mitigate environmental issues at Fort Benning, and analysis has concluded that relocating a Heavy BCT out of Fort Benning would have minimal impact for mitigating the current environmental issues. Whether it would make more sense to relocate the Heavy BCT to Fort Stewart would require further analysis. The Quadrennial Defense Review has agreed to review the status of the two heavy brigades in Germany. One heavy brigade is returning to Fort Bliss in 2012, while the other heavy brigade will return in 2013—that is, if the QDR agrees with that recommendation. Until a decision from the QDR is made and until the environmental impact issues are fully addressed, we do not have a projection on whether a BCT could be relocated to Fort Benning.

Question. What does this say for the next community? What precedent are we setting by making these policy decisions?

Answer. We supported Secretary of Defense Gates' decision to stop the growth of Army BCTs at 45. We analyzed criteria that would maximize FY09 and FY10 investments, minimize disruption to the current plan, minimize community impact if at all possible, and maintain flexibility for future force mix decisions. Our final stationing decisions reflect the results of analysis and best military judgment. We understand that communities have made significant investments which impact the community. As partners with the community, we are committed to providing critical information as quickly as possible—especially when the community may perceive it as bad news. This allows maximum time for communities and investors to reassess their investments and make necessary adjustments in order to minimize negative impacts.

[CLERK'S NOTE.—End of questions submitted by Mr. Kingston. Questions submitted by Ms. Granger and the answers thereto follow:]

RESIDENTIAL COMMUNITIES INITIATIVE (RCI) PROGRAM

Question. Given the complexities inherent in the Residential Communities Initiative (RCI) program and uncertainties in the financial markets, shouldn't the Army be focused on getting the best value in its service contracts so these technically demanding financial and real estate transactions can be completed in a timely and efficient manner?

Answer. The Army is always interested in obtaining the best value for its service contracts; however, best value is a difficult metric in the service environment. The Military Housing Privatization Initiative (MHPI) program was enacted in 1996, and the associated business protocols have matured significantly over the life of the program making a deliverables-based, Low-Price, Technically Acceptable (LPTA) contract a cost effective vehicle to acquire technical financial consulting services. This is based upon several factors to include the fact that several consultants have gained significant experience in advising the Office of the Secretary of Defense and the Military Departments in executing successful privatization programs resulting in a pool of well-qualified firms that can perform this mission. To ensure that only qualified firms are eligible for award, the Army will require all offerors to meet minimum experience qualifications before submitting a price proposal. Competition between such top-notch experienced companies will be healthy and produce an advisor who is qualified to perform the required tasks at the lowest price, thus allowing the Army to use any potential savings for other high-priority missions. The Army will work to develop a scope of work that will provide both a low price and best value in its service contracts.

Additionally, due to the maturity of the MHPI program and the knowledge base of the government workforce, the Army is now able to prudently re-balance the tasks performed by its employees and private consultants. This "re-balancing" of the workforce between the contractor community and government personnel has been an emphasis of the Congress for some time now.

** Since the 9 June HAC–D hearing, and based on further coordination with Army Corps of Engineers Contracting Officer, Army leadership now recognizes that a "best value solicitation process" to obtain service contracts in support of RCI is the Army's preferred approach. The solicitation process is ongoing, with plans to issue a "best value" solicitation no later than January, 2010.

Question. Experience within the Department of Defense has shown an increased risk inherent with selecting financial advisors based on lowest bid. Given this, why is the Army considering deviating from a "best value" model?

Answer. The Army will not be selecting its financial advisor solely on lowest bid. The Army intends to use a Low Price, Technically Acceptable procurement strategy as part of the implementation of new business processes regarding the use of consultant support. The Military Housing Privatization Initiative program has matured significantly since its implementation over 10 years ago, and the government workforce has become more experienced and better qualified to execute these private sector projects. Government program managers are more technically capable and accountable for the level of contractual support required to execute their duties.

The Army is now able to prudently re-balance the tasks performed by its employees and private consultants and will focus consultant use on provision of the real estate financial expertise which is not inherent in the Army workforce. By requiring both the public and private sector alike to be more diligent about eliminating redundancy, evaluating value added, and improving the efficiency of the transactions that we manage, the Army will continue to make significant strides in our ongoing requirement to be good stewards of the taxpayers' money.

[CLERK'S NOTE.—End of questions submitted by Ms. Granger. Questions submitted by Mr. Murtha and the answers thereto follow:]

ARMY SUICIDES

Question. Yearly increases in suicides have been recorded since 2004 and on January 29, 2009, the Army released its 2008 data showing suicides among Army troops have increased from 2007 to an all time high. At least 128 soldiers killed themselves in 2008; the final count likely could be higher because more than a dozen suspicious deaths are still being investigated and could turn out to be self-inflicted. The new figure of more than 128 compares to 115 in 2007 and 102 in 2006—and is the highest since recordkeeping began in 1980. The Army's report calculates at a rate of 20.2 per 100,000 soldiers—which is higher than the adjusted civilian rate for the first time since the Vietnam War. In response to the rise in suicides the Army mandated

that between February 15 and March 15, 2009 all Army personnel received training for peer-level recognition of behaviors that may lead to suicidal behavior, and intervention at the buddy level.

However, so far this year the Army has experienced 64 suicides and Army officials are also investigating other deaths as possible suicides. Specifically, at Fort Campbell, Kentucky there have been at least 11 confirmed suicides this year. In response to this the Base was closed for three days beginning May 27th to allow commanders to identify at-risk soldiers and help them with their mental health issues.

General Casey, Fort Campbell currently leads Army installations in the number of suicides this year, with 11 confirmed incidents since January, please discuss the situation at Fort Campbell. How many times have units at Fort Campbell been deployed to Iraq or Afghanistan and do you think that repeated lengthy combat tours combined with limited dwell time at home station are major factors contributing to the increase in the rate of suicides?

Answer. Over the past year, the Army has engaged in a sustained effort to reduce the rate of suicide within its ranks. This effort has included an Army-wide suicide prevention stand-down and chain teach for every Soldier; the implementation of the Army Campaign Plan for Health Promotion, Risk Reduction and Suicide Prevention; the establishment of both a Suicide Prevention Task Force and Suicide Prevention Council; a long-term partnership with the National Institute of Mental Health (NIMH) to carry out the largest ever study of suicide and behavioral health among military personnel; and more than 160 specific improvements to Army suicide prevention policies, doctrine, training and resources.

The 101st Airborne Division, Headquarters has deployed three times; 1st Brigade, three times; 2nd Brigade, three times; 3rd Brigade, four times; and 4th Brigade, two times. The 101st and 159th Combat Aviation Brigades have each deployed three times. The 101st Sustainment Brigade has deployed three times. The 5th Special Forces Group has deployed (in six-month rotations) seven times.

Although I believe that repeated combat tours combined with limited dwell time are stressful, and that they may be factors contributing to the increase in suicides, that is not entirely clear. Nonetheless, I am working to improve unit dwell time to 1 year deployed and 2 years at home station for active duty units and 1:4 dwell time for Reserve Component units. In October 2008, the Army and the NIMH entered into a memorandum of agreement for NIMH to conduct a longitudinal study to ascertain, if possible, the causes and risk factors for suicides within the Army's ranks.

Question. General Casey, what resources are included in the FY 2010 budget request to deal with this dilemma and how will they be used? Does the Army need any additional funding to help prevent suicides?

Answer. The Army Suicide Prevention Program expands access to care (behavioral, primary, and substance abuse) through various means: the 3R's (recruit, relocate, retain) incentives to retain substance abuse personnel, increased staff in the Office of The Surgeon General (primary care doctors, behavioral health doctors and support staff), and expanded operating hours for hospitals and clinics with additional clinical substance abuse doctors. The Army is funding new initiatives such as Comprehensive Soldier Fitness (CSF) Action Plan to support Soldiers, Families, and Army Civilians in an era of high operational tempo and persistent conflict. The Army is increasing dwell time to 1:2 Active and 1:4 Reserve to allow Soldiers more time at home and to train. In addition, the Army is funding the Strong Bonds Program, investing in research and training (National Institute of Mental Health (NIMH), Tele-behavioral Health, Point of Injury Registry, training products), suicide prevention program managers to integrate health promotion and provide installation suicide prevention, and an Integrated Net-Centric comprehensive database.

The Army base requirements for FY10 Suicide Prevention Programs total $29.8 million and the Defense Health Program requirements are $45.8 million. The Army continues to review requirements for suicide prevention programs but is not requesting additional funding at this time.

Question. Secretary Geren, is this an active duty Army problem or are you seeing this in the Army National Guard and Army Reserve as well?

Answer. Suicides occur in all three components of the Army, but the Active duty is overrepresented by suicides. That is, to date for calendar year 2009, the Active component has comprised 49 percent of the Total Army, but represents 60 percent of the Army's suicides. The Army Reserve is under-represented for the same period; it has comprised 18 percent of the Total Army but represents only 11 percent of the Army's suicides. The National Guard is within expected parameters; it has comprised 33 percent of the Total Army, and represents 29 percent of the Army's suicides for calendar year 2009.

Question. Gentlemen, of the 64 suicides this year, how many of these occurred while in theater and how many occurred at home installations?

Answer. We are now at 90 suicides Army-wide for calendar year 2009, including the Army National Guard, U.S. Army Reserve, and one cadet. Of those, 67 occurred in the United States; 12 occurred in Iraq or Afghanistan; and 11 occurred in other areas (including five in Germany and three in South Korea).

Question. The Army's BATTLEMIND training helps prepare Soldiers and their Families for the stresses of war, and also assists with the detection of possible mental health issues before and after deployment. Please explain what services are available to Soldiers in Theater?

Answer. Combat and Operational Stress Control (COSC) is the Army program that provides behavioral healthcare to service members in a deployed/operational environment. There has been a robust COSC presence in theater since the beginning of combat operations, with over 200 deployed behavioral health providers in Iraq, and an additional 30 providers in Afghanistan. Behavioral healthcare assets are deployed in support of overseas contingency operations with the following organizations: COSC Medical Detachments, Combat Support Hospitals, Medical Companies Area Support, and Behavioral Health Sections of Brigade Combat Teams.

COSC units provides full spectrum behavioral healthcare in theater. This includes prevention and consultation services, traumatic event management, behavioral healthcare and treatment, and stabilization and restoration of both Soldiers and units. The restoration units operate much like an intensive outpatient program. Mental Health Advisory Team reports have demonstrated the necessity of these front line behavioral health efforts.

In addition, Battlemind provides a range of resiliency training modules throughout the deployment cycle. Specific tactical tools include the Battlemind event driven and time driven psychological debriefings. Finally, all deploying behavioral health providers are required to attend a one week COSC Course. This course helps to ensure that all deploying behavioral health providers receive specialized training in battlefield behavioral healthcare.

Question. The Army and National Institute of Mental Health signed an agreement in October 2008 to conduct long-term research to identify factors impacting the mental and behavioral health of Soldiers and to share intervention and mitigation strategies that will help decrease suicides. During this study, which is expected to last five years, what aspects of soldier life will be examined?

Answer. The Army-National Institute of Mental Health Suicide Study is a multiyear study that will assess a broad range of aspects of Soldier life. Personal factors such as history of suicidal behavior and mental disorders, adverse childhood experiences, psychological traits, cognitive function, stressful life events, social supports and mental health treatment will be assessed via Soldier self-reports. This information will be augmented with information gathered from Army administrative data sources, and from Soldiers' buddies, supervisors, and family members about the Soldier and his/her perceived work environment, including unit-level information such as cohesion, morale, and leadership, as well as operational tempo measures related to deployment and combat. The study will also collect biological specimens to examine the relationship between certain biomarkers and the risk for, or development of, adverse outcomes such as suicidal behavior or mental illness. All data collection will be subject to appropriate consent and confidentiality protections.

A key objective of the study is to identify modifiable risk and protective factors associated with suicide, mental disorders, and psychological resilience, so that evidence-based recommendations for intervention targets can be provided to the Army.

GROW-THE-ARMY BRIGADES

Question. For the past several years, the Army has been adding end-strength and equipment in order to form six new infantry brigades, bringing the total number of combat brigades to 48. However Secretary Gates recently announced a decision to stop increasing the number of Army combat brigades at 45.

What is the impact on the Army, including Army force generation, of Secretary Gates' decision to hold active Army brigades at 45, rather than growing to 48?

Answer: Due to wartime operational demands, the Army has more requirements for Soldiers than it can fill in the Active Component (AC) end strength of 547.4K. By removing three Brigade Combat Teams (BCTs) from the program in fiscal year (FY) 2011, the Army is estimating the removal of approximately 10,300 requirements allowing those associated Soldiers to be used to offset requirements existing elsewhere in the force. This reduction should improve individual operational tempo and stabilization. The reduction of three BCTs will generally reduce the Army's capacity to source BCTs by one BCT per Army force generation cycle. In FY11, this will allow the Army to improve manning levels of next-to-deploy units much sooner than it is currently able.

Question. To what extent has DoD and the Army encouraged local investment to support a greater military population at the bases that were to have received the 46th, 47th, and 48th brigades but now will not see additional brigades? To what extent does DoD and the Army intend to compensate these communities for these investments?

Answer. The Army has and will continue to provide the communities with the most current information available regarding stationing decisions. There is no plan to compensate communities, per se; however, their investments increase military value to better posture local installations for consideration for future Army stationing actions. The Army will still grow to 547,400 as planned and is currently analyzing where these Soldiers will be stationed to fill existing unit shortfalls.

Question. What is the status of manning, equipping, and training the Grow-the-Army brigades? When will the Grow-the-Army brigades be available for combat deployment?

Answer. Grow the Army brigade (GTA) #1, the 4/4 Infantry Division (ID) Infantry Brigade Combat Team (IBCT) became available in FY08; GTA#2, the 4/3 ID IBCT began its one year conversion process in March 2009; and GTA#3, the 3/1 Armor Division (AD) IBCT will begin its one year activation process in September 2009.

The 4/4 ID IBCT (GTA#1) is currently manned at approximately 92%; 4/3 ID IBCT (GTA#2) is manned at approximately 91%; and 3/1 AD IBCT (GTA#3), having not yet activated, is not yet manned.

The 4/4ID IBCT (GTA#1) has 92% of its equipment on hand; the 4/3 ID IBCT (GTA#2) has 95% of its equipment on hand; and the 3/1 AD IBCT (GTA#3) is not yet equipped.

The 4/4 ID (GTA#1) just deployed having completed all necessary individual/crew/squad, company, battalion, and brigade level training prior to their culminating training event. The 4/3 ID (GTA#2) recently redeployed and continues to focus on individual/crew/squad level training under the IBCT design, individual professional development, and new equipment training. The unit will begin conducting collective training in September 2009 with their culminating training event at the Joint Readiness Training Center in the summer of 2010; they will deploy in 1st Quarter FY10.

The 4/4 ID IBCT (GTA#1) is currently employed in OEF; the 4/3 ID IBCT (GTA#2) is in a reset status, currently focused on individual training, and the unit will begin collective training to reenter the available pool in the 1st Quarter, FY10; and 3/1 AD IBCT (GTA#3), once manned, equipped, and trained, should enter the available pool in 4th Quarter, FY10.

Question. For the past several years, the Army has been adding end-strength and equipment in order to form six new infantry brigades, bringing the total number of combat brigades to 48. However Secretary Gates recently announced a decision to stop increasing the number of Army combat brigades at 45. Is the necessary equipment for the Grow-the-Army brigades fully funded?

Answer. The reduction of Grow the Army by three Infantry Brigade Combat Teams was accompanied by funding adjustments to account for the reduced equipment requirements. Given continued support of Base and Supplemental funding (i.e., continued support of reset for two years beyond Operation Iraqi Freedom and Operation Enduring Freedom deployments) the Army is on track to provide equipment to the remaining Grow the Army force structure.

STOP LOSS

Question. There are currently over 12,000 soldiers in the Army, Army Reserve and Army National Guard who remain on active duty beyond their scheduled separation date as a result of stop loss. To help ease the burden of those affected by stop loss, the FY2009 Defense Appropriations Act established and funded a new special pay of $500 per month for all servicemembers extended by stop loss during FY2009. Secretary Geren, Secretary Gates has been quoted several times stating that he would like to end stop loss completely. What policy steps are being taken to meet this goal?

Answer. Each Army component has a comprehensive plan to achieve the goal of ending the use of Stop Loss, taking into consideration the circumstances unique to each component. The intent is to cut the number of Stop Lossed Soldiers in half by June 2010, and to discontinue the use of Stop Loss by March 2011. The Active Component will begin deploying units without Stop Loss in January 2010. Deployment policies will be adjusted to permit certain Soldiers to deploy for portions of the unit deployment. The U.S. Army Human Resources Command (HRC) will provide replacements prior to deployment for Soldiers who will not deploy due to insufficient time remaining in service and in-theater replacements for losses, dependent on unit strengths, available inventory, and projected redeployment dates. Additionally, each component has developed and implemented an incentive program to encourage Sol-

diers to extend to complete the deployment. The Active Component is using the Deployment Extension Incentive Program, the Army National Guard is using the Deployment Extension Stabilization Program, and the Army Reserve is using the Designated Unit Stabilization Program. The Army Reserve will begin mobilizing deploying units without Stop Loss in August 2009. The Army Reserve will implement special pay for mobilizing units to assist in stabilizing units for deployment. Soldiers in units identified for mobilization who have insufficient time to complete the deployment will be encouraged to extend. Soldiers who do not commit to complete the mobilization will be transferred to another unit until separation, and the Army Reserve will seek volunteers in other units to replace these Soldiers. The Army National Guard will begin mobilizing deploying units without Stop Loss in September 2009. The Army National Guard will adjust mobilization and deployment policies, utilize voluntary cross-leveling, and implement an incentive program to encourage Soldiers to extend to complete the deployment. For those Soldiers who are not extending and their projected demobilization date is after their Expiration of Term of Service (ETS), they will not be mobilized. Soldiers with an ETS after demobilization but prior to the post-mobilization stabilization period (90 days post-mobilization) will be mobilized and deployed, but will be returned to home station 90 days prior to separation for transition.

Question. While keeping these Soldiers maintains unit integrity, aren't you concerned that this undermines morale?

Answer. Clearly Stop Loss is an issue with Soldiers and Families who are affected. But it appears that the great majority of Soldiers understand the need to maintain cohesion and ensure that a fighting force that has trained together remains together in combat. Our deployed forces reenlist at a higher rate than our non-deployed forces, and we have not seen indications that Stop Loss has been a significant detriment to morale. However, we recognize that Stop Loss causes a hardship for those Soldiers affected, and in March 2009 the Army announced the implementation of Stop Loss Special Pay. Stop Loss Special Pay provides $500.00 for each month or portion of a month a Soldier is held in the Army under Stop Loss authority. The Army's intent has always been to end the program as soon as operationally feasible to maintain unit cohesion and stabilization without the use of Stop Loss. The Army Reserve began deploying units without Stop-Lossed Soldiers in August 2009, the Army National Guard in September 2009, and the Active Army will begin in January 2010.

QUALITY OF TODAY'S SOLDIER

Question. The Army admitted recruits in 2005 through 2007 that were below standard. Interviews with Non-Commissioned Officers (NCOs) revealed that they believe sub-standard Soldiers end up in units and cannot be utilized, making it harder on that unit to accomplish its mission. In addition, the NCOs indicated that some new recruits are unable to pass a physical readiness test. The NCOs feel that the basic training course needs to be updated to provide the recruits with the skills they will need upon deployment to theater. Essentially, the NCOs believe the Army needs to get "harder" as new recruits lack discipline. In addition, the NCOs feel that their influence to train and shape recruits has eroded. Data supports the NCOs assessment of overall quality. In June 2003 initial entry training (IET) attrition rates were 14.78%. In December 2007 the attrition rate for IET was 8.49%. General Casey, given the state of the economy and people more willing to enlist, will the Army be able to raise its standards back to the original levels? Gentlemen, please explain the effect of the poor economy on recruit quality.

Answer. The Army has not lowered its recruiting standards and remains committed to ensuring we recruit the best from the available pool of qualified volunteers who desire to serve our Nation as Soldiers. Every Soldier enlisting and volunteering in the Army is fully qualified for the military occupational specialty selected. The affects of a poor economy may have a positive impact on quality mark improvement.

Question. General Casey, even though the Marine Corps is growing its forces like the Army, the Marine Corps seems to always meet DoD quality benchmarks. Why does the Army continue to struggle with this issue?

Answer. The Army's annual recruiting mission is almost three times the size of the Marine Corps' mission. The Army's substantial manpower demands and recruiting environment—which in previous years yielded recruiting cohorts that significantly exceeded the Army's and the DoD's recruiting quality standards—have impacted our ability to meet DoD quality mark goals for the past five years. However despite these shortfalls, we are now experiencing a return to favorable conditions and the result is a marked increase in fiscal year 2008 and 2009 recruit quality. The Army's percentage of new enlisted Soldiers considered "high quality" with a

Tier 1 education (high school diploma) increased by 2.1% in 2008. Additionally, recruits who scored highly (50–99%) on the Armed Forces Qualification Test (AFQT) increased 1.6%; and recruits who scored poorly (30% and below) on the AFQT decreased 1.2%. The Army is expected to exceed every DoD quality mark goal in all components for FY09.

Question. What is the current percentage of Army recruits with high school diplomas?

a. How many waivers were granted to recruits and what is the most common waiver granted?

b. What is the attrition rate for recruits without high school diplomas?

c. Has the Army performed any analysis on the conduct of these recruits? Are discipline issues more frequent in this group?

Answer. In FY08 the percentage of Regular Army Non-Prior Service recruits with Tier I (High School Diploma Graduate) credentials was 82.8%. As of end of month May 09 Non-Prior Service recruits with Tier I (High School Diploma Graduate) credentials was 94.5%.

In FY08, the Army granted 19,202 regular Army non-prior service waivers; the most common granted was for conduct (9,229). Most waivers stem from when applicants were young and immature. In considering waivers, we look at the applicant's recent history and behavior, such as employment, schooling, and references from teachers, coaches, clergy, or others who know the person well. We also look for signs of remorse and changed behavior. The Army has always had waivers to enable otherwise qualified applicants to serve their country. Young people who made mistakes earlier in life can change. A one-time incident may not accurately reflect an enlistee's character or potential.

A recent Tier II Attrition Screen (TTAS) report completed by the United States Army Accessions Command indicated the Tier II (Non-High School Diploma Graduate/Alternate Credential Holder) 36–month attrition rate was 33.5% and the Tier I 36-month attrition rate was 20.1% for the FY05 cohort.

The Army is conducting a longitudinal study on recruits who were granted waivers for conduct. In general, recruits granted waivers are high quality and perform well. Their education and aptitude are higher on average. Soldiers who enlisted with a conduct waiver in recent years train and perform better than those without waivers initially. Indiscipline rates and first term attrition are slightly higher for recruits with conduct waivers.

Recruiting and Retention

Question. A key principle of the U.S. Armed Forces is to attract and retain competent personal to assure readiness and operational effectiveness. The Army has generally met its aggregate recruiting and retention goals. In some cases, the Army has lowered recruiting standards and increased the amount of enlistment and reenlistment bonuses. However, with the deteriorating economy many troops are electing to stay in the Army and more civilians are considering enlisting in the Army. Recruiting always remains a challenge, but a tighter job market provides more opportunities for the Army to appeal to young men and women. Many factors other than bonuses are appealing to Soldiers and recruits such as: a 32 percent increase in military pay since 2001, compared to 24 percent for the general population; the new GI bill; and job security. This appears to be a good time to reduce enlistment and reenlistment bonuses as well as return standards back to higher levels. Gentleman, how have the current economic conditions affected recruiting and retention?

Answer. Recruiting. The economic downturn has had a positive impact on Army recruiting in FY09; as a result of the current demand for military enlistment, we are now experiencing a return to favorable conditions and a marked increase in fiscal years 2008 and 2009 recruit quality marks. Additionally, the current environment has allowed us to reduce our incentive amounts and the number of occupations that receive bonuses. However, we need to retain the flexibility to offer bonuses as necessary to attract and retain talent in shortage military occupational specialties (MOSs) or to channel applicants into less desirable MOSs. We will continue to monitor the trends and make adjustments as required.

Retention. The affects of a tightening U.S. job market have had a positive impact on Soldier's retention decisions; the Army easily achieved the FY09 mission and has reduced bonuses this year. Challenges will remain as the Army continues to attain its end-strength goals.

Question. General Casey, the Committee remains concerned regarding the recruitment and retention for mission-critical occupational specialties. Has the Grow-the Army recruitment helped fill the critical specialties? If not, what steps are being taken to fill the specialty occupations?

Answer. The Grow-the-Army initiative has had a minimal impact on filling critical specialties. The Army is using targeted incentives to fill critical specialties. Incentives help the Army channel quality recruits to required critical MOSs by offering seasonal and targeted bonuses to fill training seats at the right time. The Army also recently launched a Military Accessions Vital to the National Interest (MAVNI) recruitment pilot which could prove crucial in filling critical health care professional shortages.

Question. General Casey, has the Army analyzed why these occupational specialties have consistently been under-filled? What is the operational impact of these shortages? Does the FY 2010 budget provide the resources that are needed to fill these positions?

Answer. Yes, the protracted conflict has been a major factor impacting our ability to fill critical occupational specialties. These shortages have impacted our ability to offer increased dwell time to our troops. We believe the FY10 budget provides the necessary resources to properly incentivize Recruiting and Retention to increase the fill of critical occupational specialties for the Army.

ENLISTMENT AND RETENTION BONUSES

Question. The military services offer a variety of enlistment and re-enlistment bonuses to attract new recruits into military specialties that are considered "hard to fill," as well as to encourage experienced military members in "shortage jobs" to stay in past their first enlistment period. The Army has more enlistment incentives than any of the other military services. Programs include Enlistment, Overseas Extension, and Reenlistment bonuses. Bonus levels are in constant flux. Secretary Geren, what was the total funding for Army recruiting and retention bonuses for FY 2009 and what is the total for FY 2010?

Answer. The total cash bonus funding for the Army recruiting and retention bonuses for FY09 are below. Also listed below you will find the FY10 bonus funding request.

FY09 Recruiting funding—$544.2M
FY10 Recruiting funding requested—$450.3M
FY09 Retention funding—$486.1M
FY10 Retention funding requested—$444.4M

*FY09 retention bonus total includes a $140M conference mark reduction for recruiting and retention. The total retention bonus request was $626.1M prior to the mark.

Question. Secretary Geren, what is the range of individual bonuses for recruiting? For retention? Please indicate why there are differences.

Answer. Recruiting. Recruiting bonuses range from as low as $2,000 up to the statutory limit of $40,000. Bonuses for skills vary greatly depending on shortages in the particular skill and mission requirements. As of March 1, 2009, 45 of 149 skills receive a cash incentive.

Retention. The Army uses monetary incentives to retain quality Soldiers in critical and hard-to-fill skills as a means to manage and shape the force. Bonus amounts are adjusted based on the criticality of a specialty. The Army currently uses the following bonuses as part of the Army's Retention Program:

Selective Reenlistment Bonus (SRB). Currently the SRB is used for skills identified as critical Army-wide. The program offers from $1K to $12K for Soldiers in select skills, while Soldiers in special critical skills can receive up to $27K.

SRB-Deployed. The SRB-Deployed program offers Soldiers deployed to Afghanistan, Iraq, and Kuwait up to a maximum of $9.5K.

Critical Skills Retention Bonus (CSRB). The CSRB currently targets seasoned, combat veterans to stay in the ranks beyond retirement eligibility offering a lump sum bonus based on the Soldier's length of commitment to serve. The program is currently paying Soldiers in Special Operations Forces skills a maximum payment of $150K for a six-year commitment. Six additional skills can receive a maximum payment of $50K to $100K for a six-year commitment (the total number of CSRBs averages less than 700 per year).

Question. Gentlemen, have you found any imbalances or inequities in your recruiting and retention bonus structure that have been improved for FY 2010?

Answer. The Army has not identified any inequities or imbalances in our recruiting and retention bonus structure. The recruiting and retention incentives structure is reviewed quarterly to determine if imbalances or inequities exist and to correct any problems found. The Army makes a concerted effort to target high quality recruits and to insure marketing efforts are targeted to diverse populations of potential applicants in urban, suburban and rural areas.

The Army continually measures the effectiveness of retention incentives offered and makes adjustments as necessary.

Question. Gentlemen, since the Army has reached the Grow-the-Army end strength goal and more people seem to be willing to join the Army because of the state of the economy, does the FY 2010 Army budget reflect the current environment?

Answer. Yes. Recruiting. Through refinement of the Active Army enlistment bonus payment schedule, bonuses for specialties that had received bonuses during fiscal years 2005–2007 were reduced approximately 20% for fiscal year 2009 and 2010. The savings resulting from bonus management will be approximately $65M per year through fiscal year 2011. Reliance on seasonal bonuses which were required to fill short term training seats has been curtailed in favor of building a long term Delayed Entry pool. Seasonal bonuses, which previously ranged up to $20,000 per new recruit have been cut nearly in half and will be used less frequently. These changes will result in nearly $35M per year in expected bonus savings in fiscal year 2010 and beyond.

Retention: The Army continues to measure the effectiveness of retention incentives offered. While the economy plays a part in a Soldiers decision to reenlist it is not the only reason. The reenlistment bonus not only incentivizes Soldiers in shortage critical skills MOSs to reenlist; it also encourages them to reenlist earlier and for longer periods of service. Accordingly, the Army has steadily decreased the SRB amounts paid per Soldier for the past year as reenlistments increased. The Army has reduced maximum SRB payments from a high of $40,000 to $27,000. The average SRB payment has been reduced from $12,900 to $10,387. The Army's newest SRB message reduces bonus amounts by 23% across all bonus zones and removes an additional 15 skills form the bonus list.

Question. Secretary Geren, at a time when the Army is having unprecedented success at retaining its soldiers, especially in view of the new, flexible GI Bill and the job security that military service holds, has the Army reviewed its recruiting and retention bonus program?

Answer. Yes. Recruiting. The Army, with the assistance of researchers from the Research and Development Corporation and the Army Research Institute, is working to refine and integrate bonus prediction models that will enhance current bonus payment procedures. The goal is precision recruiting in key critical skills and demographic areas needed to effectively man the force. Existing internal models are also undergoing revision to provide more precise and cost savings methodology in filling critical training seats and to attract prospects in higher mental and educational categories. The Army expects to implement the new and refined methodology in late fiscal year 2009 for fielding during fiscal year 2010 and beyond. Additionally, the Army reviews and adjusts enlistment incentives on a quarterly basis to ensure that the appropriate critical military occupational specialties are targeted with an appropriate incentive.

Retention. Reenlistment options and bonuses are used as incentives to shape the force. Current incentives are achieving mission success in every category. Additionally, the Army reviews and adjusts reenlistment incentives on a quarterly basis to ensure that the appropriate critical MOSs are targeted with an appropriate incentive. The Army will continue to make monetary adjustments to various specialties based on evolving requirements.

Question. Secretary Geren, is the Army going to promote non-monetary bonuses such as tuition assistance and the new GI Bill?

Answer. Yes, the Army will promote the new GI Bill, tuition assistance, and other non-monetary incentives to the maximum extent feasible.

FUTURE COMBAT SYSTEMS

Question. The Army's Future Combat Systems began in 2003 and the first FCS equipped brigade was scheduled to be fielded between 2015 and 2017. The FCS program originally included 18 subsystems. Over time, four subsystems were deferred. During the appropriations process for fiscal year 2009 the Army decided to shift the focus of technology spin outs from heavy brigades to light brigades. Total program cost according to the Army estimate is $160 billion. The GAO estimates the program cost could be $203 to $234 billion. In the fiscal year 2010 budget request the FCS program has been restructured, deleting the eight variants of manned ground vehicles, and accelerating the fielding to all 73 brigade combat teams, of the remaining FCS systems, such as UAVs, unattended sensors, unmanned ground vehicles, and the network. The Committee understands that despite stripping the manned ground vehicles from the FCS program that the Army still intends to field a fleet of new combat vehicles within seven years. Please describe the process the Army is going

through to review the requirement and restart the manned ground vehicle effort. What improvements over the current FCS manned ground vehicles are needed?

Answer. The Army seized upon opportunities in re-examining the operational requirements, technology readiness, and acquisition approach for a new manned vehicle. We formed a special task that conducted in-depth analysis of capability gaps and the operational environment. The ground combat vehicle (GCV) requirements development process considered the full spectrum of operations. We also conducted a comprehensive review of lessons learned from seven plus years of war including insights from the Marine Corps and key allies. These assessments underpinned our revision of the Army capstone operational concept as well as requirements definition for a modern GCV. The shift from the FCS manned vehicle program included retaining elements that were operationally and technologically sound while addressing needed improvements. GCV operational design principles include improvements in versatility, force protection, and mobility to address the limitations of current platforms as well as shortfalls from the FCS manned ground vehicle program. The GVC modular design, particularly for armor and armaments, provides commanders with configuration and employment options, and complements the Army's versatile mix of forces. The GCV provides improved force protection to our Soldiers. The first GCV increment provides all occupants explosive blast protection equivalent to MRAP as well as the ability to observe 360 degrees from inside the vehicle. House

The GCV provides full tactical mobility, able to negotiate the confined spaces presented in complex urban terrain, with cross country mobility to preclude being restricted to existing road networks. Additionally, we included growth potential as an operational requirement to facilitate upgrades and adapt the vehicles as new technologies become available. This growth potential was lacking for some parts of the FCS manned ground vehicle. The Army's GCV plan includes the assessment of all combat vehicles (e.g. MRAP, M1 Abrams, etc). We will upgrade, reset, divest, and build new combat vehicles as part of a holistic vehicle modernization effort that leverages investments to date.

Question. Does the Army's recent experience in Iraq and Afghanistan suggest that wheeled vehicles, such as Stryker and MRAP All Terrain Vehicles, could be the best solution for an expeditionary force Army?

Answer. We see Stryker and MRAP vehicles as part of the Army's wheeled vehicle fleet for a long time to come. These wheeled vehicles provide protected mobility for Soldiers and we have added selected technologies where feasible to improve them. However, the size, weight, and power limitations for these vehicles makes them only a part of the solution, but not the "best solution." Given the volatility, uncertainty, complexity and ambiguity of current and future strategic demands, versatility is the defining quality that must inform every dimension of our Army. This versatility applies at the platform level where protection, survivability, mobility, lethality, and sustainment all come into play. We are currently working on the operational requirements for the new ground combat vehicles to determine the "best solution" for Army forces. The limitations of current wheeled and tracked vehicles are all part of our ongoing assessment. While trades will be made as the designs for future vehicle finalize, our goal is to modernize the force with vehicles capable of full spectrum operations across the entire continuum of conflict.

Question. The Secretary of Defense has criticized the fee structure for the FCS contract for front loading the payment of fee to the contractor and for failing to adequately tie contractors' pay to performance. How does this budget with the associated restructure of the FCS program address those concerns?

Answer. The Army views the impact of the FCS FY10 budget and the direction to restructure the FCS program as an opportunity to enter into negotiations to align a fee structure that is in the best interest of the taxpayer and eliminates the Secretary of Defense's concerns. We will use this new incentive arrangement to drive behavior, to drive performance, and reduce risk. We have had high level discussions with Boeing, who understands that as the program is restructured, the fee arrangement will undergo significant changes.

Question. With the significantly revised and downsized Future Combat Systems program, will the Army continue to use a contractor as the Lead Systems Integrator (LSI), or will Army Acquisition Professionals assume that role?

Answer. There is no longer a role for a LSI. The Program Manager (PM) has taken contractual actions transitioning Boeing from the role of LSI to that of a Prime Contractor. The PM has modified the existing contract to implement Acquisition Decision Memorandum direction and align with the Army modernization strategy in which the Boeing Company will have a diminished role. Boeing will retain network development reduced to support only Increment 1 (formally known as Spin Out Early-Infantry Brigade Combat Team) and the follow-on increment. The govern-

ment will increase technical and program management staff to assume a greater responsibly for work under the revised prime contract arrangement.

WAR DEMAND FOR AVIATION ASSETS

Question. Discussions of combat units needed for the wars in Afghanistan and Iraq usually focus on the brigades that conduct combat patrols mounted in HMMWVs, MRAPs, or on foot. However, the Committee is aware that the demand for combat aviation brigades has remained high and has tested the ability of the Army to meet the demands of the combatant commanders. How many aviation brigades does the Army have, and how many are required in Afghanistan and Iraq?

Answer. The Army has 11 Combat Aviation Brigades (CABs) in the Active Component (AC) and 8 in the Reserve Component (RC). Two CABs are required in Afghanistan and four CABs are required in Iraq.

Question. What is the combat tour duration for Army aviation brigades, end how much home station dwell time is provided between combat tours?

Answer. The combat tour duration, Boots on Ground, for Army aviation brigades is 12 months for Active Component Aviation Brigades and approximately 9 months for Reserve Component Aviation Brigades. Active Component Aviation Brigades average approximately 16 months of dwell while Reserve Component Aviation Brigades average 36 months of dwell.

Question. What types and numbers of aviation assets are provided by our allies?

Answer. In Iraq there are no coalition rotary wing aircraft besides the Iraqi organic assets. In Afghanistan, our allies provide 79 rotary wing aviation assets. These assets are divided into the following numbers by types:

20 × CH–47s,
6 × A–129s,
3 × AB–212s,
13 × AH–64s,
5 × SH–3s,
5 × AS–532s,
2 × AS–332s,
2 × EC–725s,
8 × CH–146s,
7 × CH–53s,
3 × Bell 412s, and
5 × Lynxes.

Question. How does the fiscal year 2010 budget request address the need for more Army aviation assets?

Answer. In its 2010 Aircraft Procurement budget submission, the Army is requesting almost $7 billion to address its critical aviation requirements. Approximately $5.3 billion is contained with the base request with an additional $1.6 billion contained in the Overseas Contingency Operations portion of the budget. This combined budget request would provide the Army with 83 UH–60M Black Hawk, 39 CH–47F Chinook, 54 UH–72A Lakota, and eight AH–64D Apache helicopters. The budget submission also includes 36 MQ–1 Sky Warrior and 1,392 Raven Unmanned Aerial Aircraft, and six C–12 fixed wing aircraft. Finally, the budget requests funds to modify a number of aviation systems to include CH–47 Chinook, OH–58D Kiowa Warrior, and AH–64 Apache helicopters, the RQ–7 Shadow UAS, the Guardrail Common Sensor fixed wing platform, and procurement of aircraft survivability equipment.

REQUESTING AND EQUIPPING U.S. FORCES

Question. A U.S. Combatant Commander is responsible for a particular geographic region, but the combatant commander does not raise, equip, and train forces, rather he receives trained and ready units from the Army, Navy, Marine Corps, and Air Force after requesting them, by type, through the Joint Staff. General Casey please describe for the Committee how the potential war fighting requirements of the combatant commanders help shape the budget request that you submit to support your efforts in recruiting, equipping, and training Army units.

Answer. The Combatant Commanders (COCOMs) conduct extensive annual reviews with the supporting component commanders (Capability review/integrated priority list. For example—U.S. Air Forces in Europe, U.S. Army Europe, Naval Forces Europe, etc., for European Command). Based on the outcome of this review, the COCOMs submit their shortfalls during the Program Budget Review to OSD and the Joint Staff, which then works with the Services to meet requirements. The Army considers the COCOM requirements within the scope of the Army priorities,

alongside lessons learned from continuous operations. The FY10 budget reflects Army decisions that incorporate this input and fields adaptive, trained forces to meet the Nation's missions.

Question. Please elaborate on the process you go through to ensure that the right type forces, in the right numbers, are available, properly equipped, and well trained. Is the process responsive?

Answer. The Army continuously strives to design and field the most effective force possible across all three components within our authorized end strength. We continuously analyze current and anticipated requirements for the Army capabilities combatant commanders deem necessary to support ongoing operations and successfully accomplish the National Security Strategy. Based on this analysis we seek to build a sufficient number of organizations of each required capability to not only meet but also to sustain employment of those capabilities over time in a way that enables the Army to sustain it's all volunteer soldiers and professional leaders.

Total Army Analysis (TAA) is a robust, systematic, cyclical process by which we routinely relook at force structure to validate Army emerging requirements prioritization and resourcing strategy across all three components. While the Army has been progressively adapting since the end of the Cold War, it is through TAA that we are able to take advantage of what we continue to learn in our current operations, leverage emerging technology and continuously adapt to build a balanced Army to meet the demands of 21st Century conflict.

The requirement to generate rotational forces for combatant commanders, defend the homeland, and provide Defense Support of Civil Authorities (DSCA) led to the 2005 Army decision to shift from a tiered-readiness system to a cyclic readiness process, called Army Force Generation (ARFORGEN). The Army continues to implement the ARFORGEN process to meet the strategic requirements for a campaign-quality, expeditionary Army, and to preserve the All-Volunteer Force in an era of persistent conflict.

The overarching purpose of ARFORGEN is to provide combatant commanders and civil authorities with a steady supply of trained and ready units that are task organized in modular expeditionary packages and tailored to joint requirements for each specific mission. ARFORGEN is inherently more responsive than the tiered readiness because operational requirements drive the prioritization and synchronization of institutional functions to recruit, organize, man, equip, train, sustain, mobilize and deploy units on a cyclic basis. ARFORGEN is scalable and can be accelerated based on demand to provide additional forces for short periods of time.

The Army continues to improve the ARFORGEN process to ensure Soldiers and units remain prepared to meet the strategic land-power requirements of the Nation.

Question. The Committee understands that in some cases, military personnel are assigned to work in mission areas that are not ordinarily associated with the usual unit mission. For example you might have an artillery unit performing an infantry mission or provincial reconstruction mission. Please explain how such manning decisions are made and how that information is transmitted to units as they prepare for deployment.

Answer. In-lieu-of manning decisions are made in coordination with Combatant Commands, the Joint Staff, Joint Forces Command and U.S. Forces Command (Army's force provider) when specific type units are not readily available and the in-lieu-of sourcing solution is capable of performing the mission. Units selected are manned, equipped and trained to execute the missions and tasks outside their core competencies. Units selected for in-lieu-of sourcing solutions are notified by the Army's force provider via deployment orders. All in-lieu-of units are provided the time to be fielded the necessary equipment and to become proficient with new equipment training and mission-specific training in accordance with the Secretary of Defense approved Latest Arrival Date for the specified mission.

Question. Army units have little time to prepare for operations other than counter insurgency. What are your concerns regarding overall readiness to respond to potential threats across the full spectrum of warfare?

Answer. As a key component of a very capable joint force, the Army remains focused on Counterinsurgency (COIN) operations, but trains for full spectrum operations (FSO). Our current operational commitments have produced a combat experienced force and our units are also beginning to benefit from marginal increases in dwell time at home station, thus providing greater training opportunities and we see this trend continuing. The Army remains committed to achieving a balanced force capable of executing across the full spectrum of conflict and in environments including peace operations, peacetime military engagements, limited intervention, and irregular warfare all the way up to major combat operations.

Due to the demand from combatant commanders for combat, combat support, and combat service support (all Army functions), the Army finds itself strategically fixed

on operations in OIF or OEF—that is—our forces are manned, trained, and equipped for those two unique operational environments. This limits the Army's strategic flexibility and contributes significantly to the overall risk to the National Security Strategy. The Army consumes its readiness as quickly as it is built and challenges the Army to achieve a 1:2 (Active) and 1:4 (Reserve) dwell rate by the end of 2011.

ARMED RECONNAISSANCE HELICOPTER (ARH)

Question. One of the Army's key acquisition programs had been the Armed Reconnaissance Helicopter. The program was designed to produce a replacement and capability upgrade for the Vietnam era OH–58 series helicopter. The ARH program had advanced to the production phase in 2008 and 2009. The Army had planned to procure 512 aircraft with a total program cost of $5.9 billion. Funding appropriated for Aircraft Procurement, Army for fiscal year 2009 included $242 million for aircraft production. However, in October 2008 following a Nunn-McCurdy review of cost and schedule breaches, the program was terminated. The ARH was to be a simple, inexpensive, modified off-the-shelf aircraft. What caused the schedule slip and cost growth?

Answer. The scheduled slip was initially caused by a slow start within the program management at Bell Helicopter. Beyond managerial issues, integration of key elements of the mission equipment and availability of parts for manufacturing the prototype aircraft contributed to schedule slips in the program.

The decision to cancel the production contract with Bell was based on growth in both the development and unit procurement costs of the ARH. Significant increases in manufacturing labor rates, manufacturing labor hours and materiel costs in the production phase of the program were the primary contributing factors to the cost growth.

Question. The Army Audit Agency conducted a review of the Armed Reconnaissance Helicopter program termination and concluded that the decision to limit the initial production cost to $5.2 million stifled competition and was based on faulty assumptions. General Casey, please explain how this cost cutting strategy was supposed to work and how it failed in the end?

Answer. The $5.2M initial production cost, for the first 36 Low Rate Initial Production aircraft, was established to steer industry to provide existing platforms, to minimize development/modifications, and to use technologically mature mission equipment already in the Army/DoD inventory. Theoretically, this strategy would aggressively and rapidly field the ARH—replacing the aging OH–58 series helicopter. The strategy failed when selected mission equipment which was required to meet the strict cost and schedule criteria was less technically mature than anticipated. This resulted in development cost and schedule growth.

Question. Does the Army still have a valid requirement for a new, modern armed reconnaissance helicopter?

Answer. Yes, the Army has an enduring Joint Requirements Oversight Council (JROC) approved requirement for a light, armed reconnaissance capability. The termination of the ARH program as a result of the Nunn-McCurdy process did not decrease the Army's continuing need for an armed scout capability. The Army is initiating an analysis of alternatives to determine the best way to meet the armed scout requirement including a detailed analysis of manned-unmanned teaming.

Question. What is the current status and way ahead for the ARH program?

Answer. On April 14, 2009, the Secretary of the Army approved a revised Armed Scout Helicopter Strategy. The new strategy will reinvest in the OH–58D to provide sustainment until a viable replacement is procured, modernize the four remaining National Guard AH–64A battalions to AH–64D battalions, review and revise requirements, and conduct a comprehensive Analysis of Alternatives (AoA) to determine the best way to meet the Army's enduring Armed Scout Helicopter requirement. Currently, the Army is seeking a Material Development Decision from the Defense Acquisition Executive to initiate the AoA. The AoA will take a holistic look at the still valid requirements for the armed scout capability to include manned systems, unmanned systems, and the possibility of a manned-unmanned team. The AoA is expected to take 12 months to complete with a final report in September 2010.

Question. The Committee understands that the Army has lost 45 OH–58D Kiowa Warriors in combat operations. What is the status of the current fleet of OH–58D Kiowa Warrior armed reconnaissance aircraft?

Answer. The current Kiowa Warrior fleet is down to 338 aircraft. Of those, 249 are assigned to MTOE units (51 short of required) while the others are for training

(36 aircraft) or in test/maintenance status to include the Safety Enhancement Program.

Due to these shortages, it is increasingly difficult to provide 24 aircraft for units in garrison while ensuring that deployed units remain at required quantities (30 each).

Cabins from divested OH–58A models will be retained and converted into D model cabins to provide OH–58D Wartime Replacement Aircraft (WRA). This WRA effort is dependent on congressional support for OCO Supplemental funding. Even with OCO funding, the Army will continue to experience shortages until FY13.

Life Support 2020 is the program that will sustain the OH–58D for the near future by addressing performance enhancement through weight reduction, improved sensor, and survivability. Initial production for this effort will begin in FY13 and full rate production will likely start eight months later. This program is funded almost entirely in the POM FY10–15 with a projected completion date of FY17.

Question. How well suited is the OH–58D for operations in Afghanistan?

Answer. There are currently two squadrons of OH–58D Kiowas deployed to OEF (60 aircraft). Although the Kiowa Warrior is limited in power and incapable of performing in some of the high/hot areas of Afghanistan, the scout helicopter crews flying the OH–58D are significantly contributing to the warfight through the expert performance of reconnaissance, security and close combat attack missions in support of our Soldiers on the ground.

JOINT CARGO AIRCRAFT (JCA)

Question. The Joint Cargo Aircraft (or C–27J) is a medium sized, multi-purpose cargo aircraft that supports a full range of sustainment missions. The JCA program was initiated by the Army to relieve pressure on rotor craft for near-front-line logistics. The program eventually was made a joint Army and Air Force effort. However, the fiscal year 2010 budget request proposes to make the program entirely an Air Force program, and to cut the number of aircraft to be fielded from 78 to 38. The Army had planned on replacing a number of older, small fixed wing utility aircraft with the JCA. Given the decision to transfer the entire program to the Air Force, what is the Army's plan for replacing its fleet of small utility fixed wing aircraft?

Answer. The Army is conducting an assessment of the remaining useful life of its current small fixed wing utility fleet of C–12, C–26, and UC–35 aircraft to determine a required replacement timeframe. Given the transfer of the C–27J program, the Army will conduct an analysis to re-assess the required composition and quantity of its small fixed wing utility aircraft fleet.

Question. Please explain the command and control of JCA aircraft that are operated by the Air Force but have the mission of performing front line resupply for Army Units.

Answer. Air Force C–27J aircraft that are providing direct support to the Army will be co-located and under the tactical control (TACON) of the senior Army Aviation unit commander. Direct support missions will be assigned by the senior Army aviation unit commander in accordance with priorities set by the ground component commander.

Question. How many JCA have been delivered to the Army, and where are they based? Have JCA been deployed to Iraq or Afghanistan?

Answer. Two JCA have been delivered to the Army and they are based at Robins AFB, Georgia. These aircraft are currently supporting required test and training activities. The initial US forces deployment of the C–27J is planned for the fall of 2010 to Afghanistan.

Question. Where are the JCA assembled and where does integration of military hardware take place? When is the final assembly operation scheduled to move from Italy to the United States? Will production move to the United States if only a small number are ordered or will they all be made in Italy?

Answer. JCA are assembled in Caselle, Italy, and the integration of U.S. military hardware is done in Waco, Texas. The final assembly operation move from Italy to the United States is on hold. This was a business decision made by Alenia after the U.S. reduced the JCA procurement quantity from 78 to 38.

Question. Many of the JCA that had been planned for the Army were to be assigned to Army National Guard units. Without JCA, will these units be without aircraft and without a mission?

Answer. The Army, in close coordination with the National Guard Bureau, will make a determination whether to stand down the C–23 equipped aviation units or transform them into other type aviation units.

M113 Armored Personnel Carrier

Question. The M113 Armored Personnel Carrier, or APC, is a lightly armored, flat bottomed vehicle that is prolific in mechanized unit formations. In various configurations, it has been used as a troop carrier, ambulance, mortar carrier, engineer squad vehicle, command post vehicle and for other purposes. The Committee understands that in the current conflicts in Iraq and Afghanistan the M113 vehicles are not used for patrols, or other missions, off of the operating bases. General Casey, if the M113 is not suitable to participate in missions in Iraq and Afghanistan, what substitute vehicles are used?

Answer. Currently, Mine Resistant Ambush Protected (MRAP) ambulances replace M113 ambulances for units deployed in Theater. M1064A3 120mm Mortar Carrier Vehicles and M1068A3 Command Post Vehicles continue to be utilized in Iraq on bases. M113 Family of Vehicles (FOV) is not fielded to Stryker Brigade Combat Teams and Infantry Brigade Combat Teams. M113s are authorized by Modified Table of Equipment to equip Heavy Brigade Combat Teams (HBCT) only. There are no deployed HBCTs in Afghanistan.

Question. Does the Army have a requirement to replace all M113s throughout the Army?

Answer. The Quadrennial Defense Review (QDR) will assess force structure and force mix which may result in future adjustments for Army combat vehicle requirements.

Question. Will M113 replacement vehicles be wheeled vehicles or tracked vehicles? Will they be based on a variant of an existing vehicle such as a Bradley Fighting Vehicle or Stryker?

Answer. The design configuration of the replacement vehicle(s) for the M113 FOV has not yet been determined. M113 replacement will be informed by the results of the QDR.

M109 Paladin

Question. The Army's current self-propelled howitzer, the M109 Paladin, dates back to the 1960s. The M109 lacks the mobility, speed and agility of the Abrams tanks and Bradley Fighting vehicles which it accompanies in heavy brigade combat teams. The Paladin was to be replaced by the Crusader 155mm self-propelled Howitzer; however, the Department of Defense canceled the Crusader program in May 2002. Technologies developed for the Crusader were to be used to produce a lighter and more deployable cannon, the Non-Line-of-Sight Cannon, a system within the Army's Future Combat Systems (FCS). The Non-Line-of-Sight Cannon is the most advanced of the FCS manned ground vehicles, and the program had produced several operational pre-production prototypes. However on April 6, 2009, Secretary of Defense Gates announced termination of the FCS manned ground vehicles, including the Non-Line-of-Sight Cannon. General Casey, what is the status of the Army's modernization effort for the M109 series 155mm self-propelled howitzer?

Answer. The Army will modernize the M109 series 155mm self-propelled Howitzer through the Paladin Integrated Management (PIM) program. The PIM program will insert new technologies to address obsolescence and sustainment issues to ensure the long-term sustainment of the platform and provide a viable life cycle solution through 2050. The Paladin PIM program delivers a ready, relevant, and sustainable platform. The Army is investing over $169 million in the development of the PIM program between fiscal years (FY) 2008 through FY10. Starting in FY10, the first 13 Paladin PIM and Field Artillery Ammunition Support Vehicle (FAASV) sets will be produced. The current program continues through FY21 totaling 600 Paladin PIM and FAASV sets.

Question. General Casey, the fiscal year 2010 budget request includes $96 million for M109 modernization. What sort of modernization does the funding buy? What is the Paladin Integrated Management Program?

Answer. The $96 million requested in the budget will procure and field 13 Paladin Integrated Management (PIM) vehicle sets (Paladin and Field Artillery Ammunition Support Vehicle (FAASV)) as part of Low Rate Initial Production. Technology insertion and system improvements to PIM consist of:

—Improved commonality and reliability through integration of Bradley common components (engine, transmission and suspension),

—Leveraging FCS NLOS—Cannon (NLOS–C) Azimuth and Elevation Electric Drives and Rammer Design,

—Common Modular Power Supply (CMPS),

—Vehicle Health Management System (VHMS),

—Improved Survivability (new chassis structure, Growth to accommodate Add on Armor (side and belly)).

The PIM program is a sustainment program to address obsolescence, increase sustainability, and reduce operation and support costs of the Paladin and FASSV fleet. The PIM program utilizes the existing M109A6 main armament and cab while integrating more sustainable and reliable Bradley common components (engine, transmission and suspension) into a new more survivable chassis. PIM also integrates selected technologies from the NLOS–C (modified electric projectile rammer and electric-gun azimuth and elevation drives) to replace the current hydraulically operated elevation and azimuth controls. The program also leverages the PEO Ground Combat Systems 600 volt Common Modular Power System and Vehicle Health Management System (VHMS) to improve vehicle power management and provide onboard vehicle diagnostics/prognostics. Execution of the PIM program will ensure that the Paladin/FAASV systems continue to meet the needs of the Army's Heavy BCT maneuver commander.

Question. What is the impact on the overall Army artillery program of the termination of the Future Combat Systems (FCS) Non-Line-of-Sight Cannon (NLOS–C)?

Answer. The Army's original plan was to replace the M109 Paladin with the FCS NLOS–C in 15 Heavy Brigade Combat Teams. With the termination of the NLOS–C program, we will upgrade the 15 Paladin battalions through the Paladin Integrated Management (PIM) program. The PIM program will insert new technologies to address obsolescence and sustainment issues to ensure the long-term viability of the platform and provide an efficient life cycle solution through 2050.

STRYKER

Question. The Army received $951 million in fiscal year 2009 appropriations for procurement of 119 Stryker vehicles, including 40 Nuclear, Biological and Chemical Reconnaissance vehicles, and 79 Mobile Gun Systems. The request for fiscal year 2009 Supplemental Appropriations for Overseas Contingency Operations proposed $112.7 million for six Stryker Mobile Gun Systems plus survivability enhancements on existing Strykers. The House bill added $338.4 million to procure additional Stryker vehicles. The final amount will be settled in conference with the Senate. The additional funding also would keep the Stryker industrial base warm while the Army establishes the way ahead for Stryker. The fiscal year 2010 budget request of $388.6 million provides for safety and survivability upgrades but no additional production of vehicles. General Casey, what is the way ahead for the Stryker program?

Answer. The Quadrennial Defense Review will assess force structure and force mix. This may result in future adjustments to Army Stryker requirements. Until then, the fiscal year (FY) 2009 and anticipated FY10 funding is sufficient to keep the Stryker industrial base viable while the Army establishes the way ahead for Stryker.

Question. Will the Army replace certain M113 variants, such as the ambulance, with Strykers?

Answer. The Quadrennial Defense Review will assess force structure and force mix which may result in future adjustments for Army Stryker requirements. Currently, Mine Resistant Ambush Protected (MRAP) ambulances replace M113 ambulances for units deployed in Theater.

Question. Will the Army create additional Stryker brigades?

Answer. The Army continuously evaluates and adapts to a versatile mix of tailorable and networked organizations, operating on a rotational cycle, to provide a sustained flow of trained and ready forces for Full Spectrum Operations and to hedge against unexpected contingencies at a tempo that is predictable and sustainable for our all-volunteer force. The Army's strategic estimate, based on the premise of the unforeseeable future, is we will need a robust multi-weight force, composed of Infantry Brigade Combat Teams augmented with the protection and versatility of the Stryker Brigade Combat Teams and Heavy Brigade Combat Teams.

Question. Is a Stryker type of vehicle a likely candidate for the manned ground vehicle replacement program as part of the Brigade Combat Team Modernization?

Answer. All current vehicle systems are potential candidates for the manned ground vehicle replacement program. The Army will use the requirements identified from current operations and other assessed requirements to determine the capabilities the ground combat vehicle must meet. The analysis of alternatives will assess the current platforms' ability to meet these capability requirements.

MINE RESISTANT AMBUSH PROTECTED VEHICLES (MRAPS)

Question. The Army has had a goal of procuring approximately 12,000 MRAPs and DoD acquisition reports indicate that just over 11,000 have been received by the Army with 8,344 in Iraq and 1,020 in Afghanistan. In addition, the MRAP Joint

Program Office is in the process of procuring 1,080 new MRAP-All Terrain Vehicles (or M-ATV), which are lighter and more maneuverable off-road, but still offer MRAP level of protection. General Casey, the Army now owns and operates a fleet of over 11,000 Mine Resistant Ambush Protected (MRAP) vehicles and will soon receive approximately 1,000 MRAP All Terrain Vehicles which are lighter and more maneuverable. Please describe the Army's strategy for incorporating MRAPs in various units throughout the Army, beyond Afghanistan and Iraq.

Answer. The Army has been working on this for a while. We know they will be needed for training for the foreseeable future and started flowing vehicles to training sets several months ago. Additionally, we have identified a requirement for over 1,400 Medium Mine Protected vehicles in our Explosive Ordnance and Route Clearance formations. We will harvest approximately 1,000 of our MRAPs to fill this requirement when they are no longer needed for ongoing operations. In an effort to determine the best uses for the remaining MRAPs, we have engaged multiple agencies to study different aspects of the vehicles ranging from operational capabilities, mobility, and survivability to maintainability to determine how many of each variant to place in the force and where to place them. We anticipate seeing the recommendations from these efforts at the end of the year and then we will begin finalizing plans to place MRAPs in the force structure.

Question. What functions that were to be performed by Future Combat Systems maimed ground vehicles can be performed by MRAPs?

Answer. The plan for Future Combat Systems manned ground vehicles included eight separate vehicles with different mission roles. These included: Infantry Fighting Vehicle; Mounted Combat System; Reconnaissance; Cannon; Mortar; Command and Control; Maintenance and Recovery; and Medical Treatment and Evacuation. Today's MRAP vehicles perform several roles for combat with the primary one being the transport of Soldiers to protect against IED blasts. However, MRAPs are not fighting vehicles designed for assaulting objectives against multiple threats and rapid transitions from mounted to dismounted operations in close combat, tasks essential to dealing with today's and tomorrow's hybrid threats. Additionally, MRAP vehicles are not generally well suited for use as recovery vehicles for other platforms due to center of gravity and chassis designs. However, we are assessing the current use of MRAP vehicles for medical evacuation for future applications. MRAP vehicles are part of the Army's vehicle fleet for a long time to come. The key for Army formations is a variety of vehicle options from which the commander can choose to meet specific mission requirements against adaptive enemies.

Question. In order to more rapidly field MRAPs, the Joint Program Office contracted with several producers for each of them to produce their version of the MRAP as quickly as possible. What have been the maintenance challenges in maintaining and repairing a fleet of vehicles consisting of several different models built by several different companies?

Answer. The DoD's strategy was to procure and field MRAP vehicles as rapidly as possible, and in order to do that it was necessary to procure MRAPs from multiple manufacturers. This is of course not optimal from a supportability standpoint; however, it was the right thing to do—and by getting MRAPs into the field quickly, we have saved lives and reduced casualties. There is no question that the fielding of several different MRAP variants has created maintenance and sustainment challenges, particularly in our most forward maintenance activities, not the least of which is a lack of commonality of repair parts across these multiple variants, which has caused our tactical supply support activities to have to stock around 40% more parts than would have been required if there was commonality. The problem with repair parts is further compounded by the necessity for frequent modifications to each of the variants, many of which would not have been required if there had been time to do more deliberate testing, where many of these needs for modification would have been identified and addressed before fielding. Despite the maintenance challenges, the operational readiness rate for the Army's MRAP fleet remained at 90 percent or higher for the last several months. The Army is responding to repair parts challenges by making the most frequently demanded vehicle components for all variants, such as engines, transmissions, starters, alternators, and generators available through the standard Army supply system, and positioning them well forward in Iraq and Afghanistan; additionally, the Joint Program Office has an extensive contractor logistics support network in both Iraq and Afghanistan, to assist with maintenance, especially the more difficult to repair battle-damaged MRAPs.

Question. The Army has had a goal of procuring approximately 12,000 MRAPs and DoD acquisition reports indicate that just over 11,000 have been received by the Army with 8,344 in Iraq and 1,020 in Afghanistan. In addition, the MRAP Joint Program Office is in the process of procuring 1,080 new MRAP–All Terrain Vehicles (or M–ATV) which are lighter and more maneuverable off-road, but still offer MRAP

level of protection. When will MRAP–ATVs be fielded in Afghanistan? Will the MRAP–ATV satisfy the requirements for the Joint Light Tactical Vehicle?

Answer. On June 30, 2009, the government awarded an initial production delivery contract to Oshkosh Corporation for the M–ATV. Initial fielding to Army units in Afghanistan is scheduled to begin in December 2009.

The M–ATV will not satisfy all of the requirements of the Joint Light Tactical Vehicle (JLTV). Two key areas in which the M–ATV will not meet required capabilities are transportability and payload. The M–ATV is too heavy to be transported by rotary-wing aircraft. This is a critical requirement for the JLTV. In addition, the M–ATV is too heavy to carry the projected payload of the JLTV. The Army intends to apply lessons learned in development and testing of the M–ATV to the JLTV program.

OUTSOURCING

Question. A March 23, 2009 Defense Subcommittee letter to Secretary Gates called attention to the need to revise the Department's policy on outsourcing. Over the past eight years OMB Budget Circular A–76, the policy which governs public private competitions, has been misused and has become a mandate for pushing more and more work into the private sector. The letter advised that, in light of the Omnibus Appropriations Act, the Secretary should cease to initiate or announce new A–76 studies. The letter also suggested the Secretary halt A–76 studies pending OMB review of the A–76 program. On April 15, then Undersecretary for Acquisition, Technology and Logistics responded ". . . the Department is reviewing the current program and will look at the status of ongoing competitions." However, the Department continues to proceed with A–76. Plans are now in process to outsource functions at West Point in June. Secretary Geren, why have you not halted A–76 outsourcing, particularly given:

- Your insourcing efforts in fiscal year 2009 (which are commendable),
- The further insourcing reflected in year 2010 budget request, and
- The GAO's findings that an error in the A–76 calculation of "overhead" wrongly and unfairly has resulted in work performed by federal employees being contracted out?

Answer. Although the Fiscal Year 2009 Omnibus Appropriation Bill prohibits the start of any "new" public-private competitions pursuant to the OMB Circular A–76 for the remainder of the fiscal year, it did not stop on-going A–76 competitions. Significant time, money, and resources have been invested on these competitions, and the Army anticipates a savings of 20–25% over the next five years as a result of implementation. The A–76 competitive process includes provisions for resolving any protests submitted by interested parties. Stopping the competitive process after a decision has been rendered would not be prudent in that such action will have significant financial impact and may lead to legal action. Continuing on-going competitions meets the requirements placed on the service pursuant to the OMB circular and is in the best interests of providing efficient service at the lowest cost and minimizes further adverse impact on the workforce.

Question. Will you proceed with the plan to outsource jobs at West Point?

Answer. The Fiscal Year 2009 Omnibus Appropriation Bill prohibits the start of any "new" public-private competitions pursuant to the OMB Circular A–76 for the remainder of the fiscal year, it did not stop on-going A–76 competitions such as those conducted at West Point. Significant time, money, and resources have been invested on these competitions, and the Army anticipates a savings of 20–25% over the next five years as a result of implementation. The A–76 competitive process includes provisions for resolving any protests submitted by interested parties. Stopping the competitive process after a decision has been rendered would not be prudent in that such action will have significant financial impact and may lead to legal action. Implementing the decisions at West Point is the best course of action for the Department of Defense. The Army will make every effort to minimize adverse impact on the workforce.

Question. On December 1, 2008, the Deputy Secretary of Defense issued guidance elevating the importance of "irregular warfare",[1] to be as strategically important as "traditional warfare", and[2] the policy requires that the Department integrate irreg-

[1] DoD defines "Irregular Warfare" as a violent struggle among state and non-state actors for legitimacy and influence over the relevant population. Irregular warfare favors indirect and asymmetric approaches, though it may employ the full range of military and other capacities, in order 10 erode an adversary's power, influence and will.

[2] DoD defines "traditional warfare" as combat operations between regulated states in which the objective to defeat the adversary's armed forces, destroy an adversary's war-making capacity, or control territory to change an adversary's government.

ular warfare concepts and capabilities into doctrine, organization, training, material, leadership, personnel and facilities. The Army and the Marine Corps have de facto changed doctrine and training due to their prolonged intense involvement in Iraq and Afghanistan, but the planning and curricula has not changed. The irregular warfare policy is intended to substantially change the way the DoD plans and prepares for future conflict. Secretary Geren, has irregular warfare doctrine (DoD Directive 3000.07) been reflected in your 2010 budget request?

Answer. Yes, the Army is meeting and exceeding DoDD 3000.07 guidance with revised doctrine and the operational concept of "Full Spectrum Operations" as outlined in the recently published Army Field Manual, 3–05 Unconventional Warfare. The Army has redefined itself along each of the capability functions to institutionalize a shift in focus from Major Conventional Operations toward Irregular Warfare (IW).

The Army has taken measureable steps to include IW in the FY10 budget request. This includes the issuance of the Army Training and Leader Development Guidance/Strategy and a change in Professional Military Education shifting emphasis toward IW. There has been investment in new equipment and technology to enhance survivability, lethality, mobility, and situational awareness for units and individual Soldiers operating in IW environments. The Army has created modular units to increase options available to Combatant Commanders shifting from division/corps-centric forces required for major conventional operations to brigade-centric forces required for distributed operations in an IW environment. The Army has also instituted an Army Force Generation model to provide sustainable, predictable, adaptable, and appropriately trained supply of forces for operations, as required, anywhere on the spectrum of conflict or in any phase of the campaign.

IRREGULAR WARFARE

Question. Is the Army doing anything to revise doctrine, organization, training, material, leadership, personnel and facilities to reflect a sharpened focus on irregular warfare (IW)?

Answer. The Army recognizes that IW is an important aspect of today's conflicts. Of the four roles of land forces in the 21st century, three address IW. First, the Army must prevail in protracted counterinsurgency (COIN) campaigns, both in current and future operations. Second, the Army must engage to help other nations build capacity and to assure friends and allies and prevent future conflicts by increasing the capacity of other nations' security forces—both military and police. Third, the Army must deter and defeat hybrid threats and hostile state actors. With these complex and dynamic demands of 21st century warfare in mind, the Army has institutionalized significant IW-related changes since 2001. Doctrinally, the Army has revised several Field Manuals, including the Army capstone doctrine, FM 3–0, Operations to account for IW-related operations and published over 500 IW-related handbooks with lessons learned. Organizationally, the Army has developed and fielded new organizations to provide commanders a more holistic perspective on operations conducted among the population; established new organizations to provide Army-wide solutions for complex asymmetric threats, weapons of strategic influence, and other challenges; and embedded Information Operations, Public Affairs, Civil Affairs, Psychological Operations (PSYOP), Explosive Ordnance Disposal, Electronic Warfare, and Human Terrain Teams into Brigade Combat Teams (BCT). Today in Iraq, in addition to Special Operations Forces, Army General Purpose Force (GPF) Advise and Assist Brigades (AAB), like the 4th Brigade, 82nd Airborne Division, are task organized and augmented with additional senior level mentors to deliver SFA. With regard to training, the Army has adopted the contemporary operating environment at the Combat Training Centers, created COIN academies in Iraq and Afghanistan, supported COIN Centers of Excellence in Iraq and Afghanistan, and established a permanent and enduring training formation—162nd Training Brigade at Fort Polk—as the center for institutional development for the delivery of SFA. Regarding leader development and education, the Army has updated Professional Military Education curricula at all levels to address IW. In terms of materiel, the Army has created the Rapid Equipping Force and the Army Requirements and Resourcing Board to accelerate fielding of material solutions to meet emerging war fighter needs, adjusted FCS and complementary programs fielding to provide needed IW-relevant capabilities to infantry units first because they are at the highest risk, and equipped Soldiers with advanced situational awareness systems required to defeat irregular threats. In terms of personnel, the All Volunteer Force remains the center of gravity for the United States Army. People are what matter most and operations in complex environments against irregular and hybrid threats require motivated, highly trained, and experienced professionals. The Army continuously evaluates recruitment, retention, promotion, and separation programs and policies to ensure the

quality of the All Volunteer Force remains capable of conducting full spectrum operations. To this end, the Army has improved balance across all components to provide more capacity of high demand/low density capabilities essential for conducting IW. Increases include Infantry and Stryker BCTs, Engineer Construction Companies, Military Police, Contracting Support Teams, Civil Affairs Companies and Tactical PSYOP detachments. Additionally, Army SOF will increase by one third through 2013. With regard to facilities, the Army constructed new, enhanced, and more realistic Urban Operations Training facilities at Fort Knox, Fort Benning, and the Combat Training Centers. Since 2001, the Army has made dramatic changes in its capability to perform IW and will continue to do so in the future in order to best posture the Army to win in the current conflicts and prepare for future Full Spectrum Operations.

Question. How has the Army's training curriculum for tank miles and flying hours been substantially updated since the Berlin wall came down? When did it occur? When will the training curricula be updated to reflect the new and different skills needed to sharpen the focus on irregular warfare while remaining capable to dominate and prevail in major combat operations?

Answer. The Army continuously updates the training strategies and training scenarios used to prepare units for deployment/employment, based on lessons learned during operations, changes in Army doctrine, transformation of Army force structure and organizational design, advances in training technology, and changes in other factors over time. For example, the Army recently adjusted training strategies to reflect adoption of the doctrinal imperative to always conduct some level of stability operations along with offense and defense operations—full spectrum operations—regardless of where the unit operates along continuum of operations. As a consequence, Army current training strategies/requirements provide flexibility that adequately enables units to prepare for irregular warfare, for major combat operations, or for any assigned mission.

Over the preceding two decades, the Army has adjusted doctrinal training strategies principally for the contribution of virtual training (primarily in FY01, FY02, and FY04), for unit stabilization achieved with life cycle management of units (primarily in FY04–05), for transition to a modular force and the adoption of Army Force Generation construct (during FY06–07), and for adoption of stability operations doctrine (primarily in FY08).

The Army is currently conducting a review of the way we determine training requirements to ensure we best represent training required to prepare forces to conduct operations including irregular warfare or major combat operations.

Question. With no outyear data available, how can the Congress be assured that "rebalancing" has been reflected in the budget?

Answer. A journey rather than a destination, the rebalancing of Army structure is a continuous effort requiring frequent review and adjustment to meet projected operational demand within authorized resources. Moreover, execution of force structure change is not immediate, it requires time and resources. These changes are, and will continue to be, reflected in Army budgets. Some examples of programmed growth from FY06 to FY15 include 47 military police combat support companies, 9 air ambulance companies, 12 explosive ordnance disposal companies, 117 civil affairs companies, and 107 psychological operations detachments.

The President's Budget Request for FY10 adds additional Army force structure for Echelons above Brigade, with over 100 new Army units of various sizes (detachments to full size battalions). These new units are part of the phased implementation of Grow the Army and other force structure initiatives. They provide the Army with operational depth needed to sustain enduring levels of force deployment to meet global commitments. Included are many high demand engineer, military police, signal, intelligence, air defense, and transportation units. This growth will help reduce the stress for these high demand units. In addition, this budget provides increased home station training funding to support the modular force design which will bring the Army closer to a balanced training program for the entire force.

Question. With no outyear data and no movement to change doctrine and training curricula significantly, how can the Congress be assured that "irregular warfare" isn't just a convenient excuse to cut programs that have a big impact on local economies?

Answer. The Army has been and continues to be committed to updating, developing, and refining Irregular Warfare (IW) related training and doctrine in light of the current operating environment. At the center of this effort is the Army's Training and Doctrine Command, which is focused on preparing versatile leaders and units through integrating IW-related capabilities, concepts, and doctrine. Current Army doctrine emphasizes full-spectrum operations, which includes IW. New and updated principle field manuals include FM 3–0, Operations; FM 3–07, Stability Op-

erations; FM 7–0, Training; FM 3–24, Counterinsurgency and FM 3–07.1, Security Force Assistance. Additional manuals with IW focus include FM 2–91.6, Soldier Surveillance and Reconnaissance: Fundamentals of Tactical Information Sharing, FM 2–91.4, Intelligence Support to Urban Operations, FM 3–36, Electronic Warfare in Operations, and FM 3–90.119, Combined Arms Improvised Explosive Device Defeat Operations. The Army has created Counterinsurgency (COIN) Academies and Centers of Excellence in Iraq and Afghanistan and a permanent and enduring training institution at 162nd Training Brigade to train the Joint Force with skills crucial for advisors and mentors. Advisor Core Competencies trained at 162nd Training Brigade—the central training location for Brigade Combat Teams (BCTs) assigned the SFA mission—include Counterinsurgency (COIN) fundamentals, application, and Political, Military, Economic, Social, Infrastructure, and Information (PMESII). Typical training for BCTs training for Iraq deployment when they cycle through 162nd Training Brigade includes Iraqi Culture, History, and Islam; Security Overview and Host Nation Security Forces Overview; Implications of Rapport, Influence, and Negotiations; Interpreter Management; Border/Point Of Entry Overview; Operational Framework and COIN/Stability Operations (SO) Overview; and Role of Advisors and Team Dynamics. Mission Essential Task Lists used in training at 162nd Training Brigade and home station training focus upon training the key skills required when operating in an IW environment, including language training, cultural awareness, and advising. The tasks associated with IW, including SO and SFA tasks, include Establish Civil Security, Establish Civil Control, Support to Economic and Infrastructure Development, Develop and enable the ISF, Restore Essential Services, and Support Governance. All of these tasks are trained as part of a BCT train-up for full spectrum operations deployment, to include IW-related deployments. With 1,000 train-the-trainers at 162nd Training Brigade and the capacity to train IW-related tasks at Fort Polk, the BCT home station, or in theater, each BCT, and the 3,500 Soldiers assigned to the BCT as well as augmentees, receive IW-related training prior to deployment. Additionally, the Army has institutionalized an IED-Defeat Strategy, funding initiatives and developing them into a core capability. Current Mission Readiness Exercises at the Army's Combat Training Centers at Fort Polk, Fort Irwin, and in Germany replicate the operational environment with IW-focused scenarios and include language- and culture-proficient civilians, host nation security forces, other government agencies, and non-governmental organizations to create realistic and complex situational training. The Army has updated training curriculum at all levels to address IW and has incorporated training capabilities and cultural aspects into individual and unit training through various ranges, training lanes, simulators, computer exercises, seminars, workshops, computer software, and tactics, techniques and procedures. The Army's IW enhancements are likely to impact local economies in a positive manner with the additional employment of civilian role-players and associated net growth to local community jobs.

CONTRACT SERVICES

Question. The cost of the contracted workforce compared to the military and federal civilian workforce has grown extraordinarily, fueled in part by OMB's "competitive sourcing" direction. In 1997, DoD spending on contract services and supplies was less than half, and now it is greater than half, of the DoD budget. Further, spending on government payroll fell from a third to just over a quarter of the DoD total spending. President Obama's 2010 defense budget request may begin to reverse this trend. On March 4th, President Obama stated ". . . we will stop outsourcing services that should be performed by the Government. . . ." Then on April 6th, Secretary Gates stated that the 2010 budget request will reduce. . . . the number of support service contractors from the current 39 percent of the workforce to the pre-2001 level of 26 percent and replace them with full-time government employees. Our goal is to hire as many as 13,000 new civil servants in FY10 to replace contractors with up to 30,000 new civil servants in place of contractors over the next five years." Are you aware of GAO's and DODIG findings that an error in the A–76 calculation of "overhead" wrongly and unfairly has resulted in work performed by federal employees being contracted out?

Answer. Yes, we are aware that there are some GAO and DODIG findings that have challenged the overhead calculation methodology in some DOD competitions. In response, the Director, Housing and Competitive Sourcing, Office of the Deputy Under Secretary of Defense (Installations and Environment) modified cost estimating software to flag the proper use of economic price adjustments in estimating the government cost estimate to prevent erroneous data entry in the future. DoD continues to use the standard cost factor for overheard required by OMB Circular A–76, which continues to be an acceptable method for capturing federal agency over-

head costs. After competing over 32,000 positions over the last several years, the Army has reduced DoD's cost of operating the services they perform by 40% compared to the costs before competition. Annual recurring savings are over $660 million.

Question. Why are you converting federal jobs to contractors at West Point in June 2009, rather than just holding pat until OMB finishes its review of A–76?

Answer. The two West Point public-private competitions were conducted in accordance with OMB Circular A–76, the Federal Acquisition Regulation, and related statutes. Both competition decisions were protested, and the Army is not implementing the competition decision in order to comply with the GAO decisions made in response to the GAO protests.

[CLERK'S NOTE. End of questions submitted by Mr. Murtha. The Fiscal Year 2009 Army Posture Statement follows:]

A STATEMENT ON THE POSTURE OF THE UNITED STATES ARMY 2009

submitted by

THE HONORABLE PETE GEREN and
GENERAL GEORGE W. CASEY JR.

to the Committees and Subcommittees of the

UNITED STATES SENATE

and the

HOUSE OF REPRESENTATIVES

1st SESSION, 111th CONGRESS

MAY 2009

May 7, 2009

Our Nation is in its eighth year of war, a war in which our Army—Active, Guard, and Reserve—is fully engaged. The Army has grown to more than one million Soldiers, with 710,000 currently serving on active duty and more than 255,000 deployed to nearly 80 countries worldwide. Our Soldiers and Army Civilians have performed magnificently, not only in Afghanistan and Iraq, but also in defense of the homeland and in support to civil authorities in responding to domestic emergencies.

Much of this success is due to our Noncommissioned Officers. This year, we specifically recognize their professionalism and commitment. To honor their sacrifices, celebrate their contributions, and enhance their professional development, we have designated 2009 as the "Year of the Army NCO." Our NCO Corps is the glue holding our Army together in these challenging times.

Today, we are fighting a global war against violent extremist movements that threaten our freedom. Violent extremist groups such as Al Qaeda, as well as Iran-backed factions, consider themselves at war with western democracies and even certain Muslim states. Looking ahead, we see an era of persistent conflict—protracted confrontation among state, non-state, and individual actors that are increasingly willing to use violence to achieve their political and ideological ends. In this era, the Army will continue to have a central role in providing full spectrum forces necessary to ensure our security.

The Army remains the best led, best trained, and best equipped Army in the world, but it also remains out of balance. The demand for our forces over the last several years has exceeded the sustainable supply. It has stretched our Soldiers and their Families and has limited our flexibility in meeting other contingencies. In 2007, our Army initiated a plan based on four imperatives: Sustain our Soldiers and Families; Prepare our forces for success in the current conflicts; Reset returning units to rebuild readiness; and Transform to meet the demands of the 21st Century. We have made progress in all of these and are on track to meet the two critical challenges we face: restoring balance and setting conditions for the future.

Our Army is the Strength of this Nation, and this strength comes from our values, our ethos, and our people—our Soldiers and the Families and Army Civilians who support them. We remain dedicated to improving their quality of life. We are committed to providing the best care and support to our wounded, ill, and injured Soldiers—along with their Families. And our commitment extends to the Families who have lost a Soldier in service to our Nation. We will never forget our moral obligation to them.

We would not be able to take these steps were it not for the support and resources we have received from the President, Secretary of Defense, Congress, and the American people. We are grateful. With challenging years ahead, the Soldiers, Families, and Civilians of the United States Army require the full level of support requested in this year's base budget and Overseas Contingency Operations funding request. Together, we will fight and win the wars in Afghanistan and Iraq, restore balance, and transform to meet the evolving challenges of the 21st Century. Thank you for your support.

orge W. Casey, Jr.
General, United States Army
Chief of Staff

Pete Geren
Secretary of the Army

2009 ARMY POSTURE STATEMENT

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[1] Required by National Defense Authorization Act of 1994 (hard copy separate)
* Online

UNITED STATES ARMY

"As we consider the road that unfolds before us, we remember with humble gratitude those brave Americans who, at this very hour, patrol far-off deserts and distant mountains. They have something to tell us, just as the fallen heroes who lie in Arlington whisper through the ages. We honor them not only because they are guardians of our liberty, but because they embody the spirit of service; a willingness to find meaning in something greater than themselves."

President Barack Obama
Inaugural Address, January 2009

Introduction

Our combat-seasoned Army, although stressed by seven years of war, is a resilient and professional force—the best in the world. The Army—Active, National Guard, and Army Reserve—continues to protect our Nation, defend our national interests and allies, and provide support to civil authorities in response to domestic emergencies.

The Army is in the midst of a long war, the third longest in our Nation's history and the longest ever fought by our All-Volunteer Force. More than one million of our country's men and women have deployed to combat; more than 4,500 have sacrificed their lives, and more than 31,000 have been wounded. Our Army continues to be the leader in this war, protecting our national interests while helping others to secure their freedom. After seven years of continuous combat, our Army remains out of balance, straining our ability to sustain the All-Volunteer Force and maintain strategic depth. The stress on our force will not ease in 2009 as the demand on our forces will remain high. In 2008, the Army made significant progress to restore balance, but we still have several challenging years ahead to achieve this vital goal.

As we remain committed to our Nation's security and the challenge of restoring balance, we remember that the Army's most precious resources are our dedicated Soldiers, their Families, and the Army Civilians who support them. They are the strength of the Army—an Army that is The Strength of the Nation.

Strategic Context

An Era of Persistent Conflict

The global security environment is more ambigu and unpredictable than in the past. Many national security and intelligence experts share the Army's assess-

ment that the next several decades will be characterized persistent conflict—protracted confrontation among ate, non-state, and individual actors that are increasingly willing to use violence to achieve their political and ideological ends. We live in a world where global terrorism and extremist ideologies, including extremist movements such as Al Qaeda, threaten our personal freedom and our national interests. We face adept and ruthless adversaries who exploit technological, informational, and cultural differences to call the disaffected to their cause. Future operations in this dynamic environment will likely span the spectrum of conflict from peacekeeping operations to counterinsurgency to major combat.

Global Trends

Several global trends are evident in this evolving security environment. Globalization has increased interdependence and prosperity in many parts of the world. It also has led to greater disparities in wealth which set conditions that can foster conflict. The current global recession will further increase the likelihood of social, itical, and economic tensions.

Technology, which has enabled globalization and benefited people all over the world, also is exploited by extremists to manipulate perceptions, export terror, and recruit people who feel disenfranchised or threatened.

Population growth increases the likelihood of instability with the vast majority of growth occurring in urban as of the poorest regions in the world. The limited resources in these areas make young, unemployed males especially vulnerable to anti-government and radical ideologies. The inability of governments to meet the challenges of rapid population growth fuels local and regional conflicts with potential global ramifications.

Increasing demand for resources, such as energy, water, and food, especially in developing economies, will increase competition and the likelihood of conflict. Climate change and natural disasters further strain already limited resources, increasing the potential for humanitarian crises and population migrations.

The proliferation of weapons of mass destruction (WMD) remains a vital concern. Growing access to technology increases the potential for highly disruptive or even catastrophic events involving nuclear, radiological, chemical, and biological weapons or materials. Many terrorist groups are actively seeking WMD. Failed or failing states, lacking the capacity or will to maintain territorial control, can provide safe havens for terrorist groups to plan and export operations, which could include the use of WMD.

These global trends, fueled by local, regional, and religious tensions, create a volatile security environment with increased potential for conflict. As these global trends contribute to an era of persistent conflict, the character of conflict in the 21st Century is changing.

The Evolving Character of Conflict

Although the fundamental nature of conflict is timeless, its ever-evolving character reflects the unique conditions of each era. Current global trends include a diverse range of complex operational challenges that alter the manner and timing of conflict emergence, change the attributes and processes of conflict, require new techniques of conflict resolution, and demand much greater integration of all elements of national power. The following specific characteristics of conflict in the 21st Century are especially important.

Diverse actors, especially non-state actors, frequently operate covertly or as proxies for states. They are not bound by internationally recognized norms of behavior, and they are resistant to traditional means of deterrence.

Hybrid threats are dynamic combinations of conventional, irregular, terrorist, and criminal capabilities. They make pursuit of singular approaches ineffective, necessitating innovative solutions that integrate new combinations of all elements of national power.

Conflicts are increasingly waged among the people instead of around the people. Foes seeking to mitigate our conventional advantages operate among the people to avoid detection, deter counterstrikes, and secure popular support or acquiescence. To secure lasting stability, the allegiance of indigenous populations becomes the very object of the conflict.

Conflicts are becoming more unpredictable. They arise suddenly, expand rapidly, and continue for uncertain durations in unanticipated, austere locations. They are expanding to areas historically outside the realm of conflict such as cyberspace and space. Our nation must be able to rapidly adapt its capabilities in order to respond to the increasingly unpredictable nature of conflict.

Indigenous governments and forces frequently lack the capability to resolve or prevent conflicts. Therefore, our Army must be able to work with these governments, to create favorable conditions for security and assist them in building their own military and civil capacity.

Interagency partnerships are essential to avoid and resolve conflicts that result from deeply rooted social, economic, and cultural conditions. Military forces alone cannot establish the conditions for lasting stability.

Images of conflicts spread rapidly across communication, social, and cyber networks by way of 24-hour global media and increased access to information through satellite and fiber-optic communications add to the complexity of conflict. Worldwide media coverage highlights the social, economic, and political consequences of local conflicts and increases potential for spillover, creating regional and global destabilizing effects.

Despite its evolving character, conflict continues to be primarily conducted on land; therefore, landpower—the ability to achieve decisive results on land—remains central to any national security strategy. Landpower secures the outcome of conflict through an integrated application of civil and military capabilities, even when landpower is not the decisive instrument. The Army, capable of full spectrum operations as part of the Joint Force, continues to transform itself to provide the prompt, sustainable, and dominant effects necessary to ensure our Nation's security in the 21st Century.

Global Commitments

In this era of persistent conflict, the Army remains essential to our Nation's security as a campaign capable, expeditionary force able to operate effectively with Joint, interagency, and multinational partners across the full spectrum of conflict. Today, the Army has 255,000 Soldiers deployed in nearly 80 countries around the world, with more than 145,000 Soldiers in active combat theaters. To fulfill the requirements of today's missions, including defending the homeland and supporting civil authorities, the Army has over 710,000 Soldiers on active duty from all components. Additionally, 258,000 Army Civilians are performing critical missions in support of the Army. More than 4,100 of our Civilians and more than 33,000 U.S. contractors are forward-deployed, performing vital missions abroad.

The Army's primary focus continues to be combined counter-insurgency operations in Iraq and Afghanistan, while training each nation's indigenous forces and building their ability to establish peace and maintain stability. Our Army is also preparing ready and capable forces for

ARMY GLOBAL COMMITMENTS

AS OF 5 MAY 2009

ARMY PERSONNEL STRENGTH

COMPONENT		RC AUTHORIZED FOR MOBILIZATION/ON CURRENT ORDERS
ACTIVE (AC)	548,900	
RESERVE (RC)		
USAR	200,300	29,800
ARNG	362,000	65,100
	1,111,200	

- 255,000 SOLDIERS FORWARD DEPLOYED IN NEARLY 80 COUNTRIES OVERSEAS
- MORE THAN 4,100 ARMY CIVILIANS AND MORE THAN 33,000 U.S. CONTRACTORS ARE FORWARD DEPLOYED

other national security requirements, though at a reduced rate. These forces support combatant commanders in a wide variety of military missions across the entire spectrum of conflict. Examples of Army capabilities and recent or ongoing missions other than combat include:

- Responding to domestic incidents by organizing, training, and exercising brigade-sized Chemical, Biological, Radiological, Nuclear, and high yield Explosive Consequence Management Reaction Forces—the first in 2008, the second in 2009, and the third in 2010
- Supporting the defense of South Korea, Japan, and many other friends, allies, and partners
- Conducting peacekeeping operations in the Sinai Peninsula and the Balkans
- Supporting the establishment of Africa Command and its Army component headquartered in Germany and Italy respectively
- Providing military observers and staff officers to UN peacekeeping missions in Haiti, Iraq, Liberia, the Republic of Georgia, Israel, Egypt, Afghanistan, and Chad
- Conducting multinational exercises that reflect our longstanding commitments to our allies and alliances
- Supporting interagency and multinational partnerships with technical expertise, providing critical support after natural disasters
- Continuing engagements with foreign militaries to build partnerships and preserve coalitions by training and advising their military forces
- Supporting civil authorities in responding to domestic emergencies

- Participating, most notably by the Army National Guard, in securing our borders and conducting operations to counter the flow of illegal drugs
- Supporting operations to protect against WMD and prevent their proliferation
- Protecting and eliminating chemical munitions

Current combat operations, combined with other significant demands placed on our forces, have stressed our Army, our Soldiers, and their Families. While we remain committed to providing properly manned, trained, and equipped forces to meet the diverse needs of our combatant commanders, we face two critical challenges.

Two Critical Challenges

While fully supporting the demands of our Nation at war, our Army faces two major challenges—**restoring balance** to a force experiencing the cumulative effects of seven years of war and **setting conditions for the future** to fulfill our strategic role as an integral part of the Joint Force.

The Army is out of balance. The current demand for our forces in Iraq and Afghanistan exceeds the sustainable supply and limits our ability to provide ready forces for other contingencies. Even as the demand for c forces in Iraq decreases, the mission in Afghanistan a other requirements will continue to place a high demand on our Army for years to come. Current operational requirements for forces and insufficient time between deployments require a focus on counterinsurgency training and equipping to the detriment of preparedness for the full range of military missions. Soldiers, Families, support systems, and equipment are stressed due to lengthy and repeated deployments. Overall, we are consuming readiness as fast as we can build it. These conditions must change. Institutional and operational risks are accumulating over time and must be reduced in the coming years.

While restoring balance, we must simultaneously set conditions for the future. Our Army's future readiness will require that we continue to modernize, adapt our institutions, and transform Soldier and leader development in order to sustain an expeditionary and campaign capable force for the rest of this Century.

Modernization efforts are essential to ensure technological superiority over a diverse array of potential adversaries. Our Army must adapt its institutions to more effectively and efficiently provide trained and ready forces for combatant commanders. We will continue to transform how we train Soldiers and how we develop agile and adaptive leaders who can overcome the challenges of full spectrum operations in complex and dynamic operating environments. We also must continue the transformation of our Reserve Components to an operational force to achieve the strategic depth necessary to successfully sustain operations in an era of persistent conflict.

Through the dedicated efforts of our Soldiers, their Families, and Army Civilians, combined with continued support from Congressional and national leadership, we are making substantial progress toward these goals. Our continued emphasis on the Army's four imperative Sustain, Prepare, Reset, and Transform—has focused our efforts. We recognize, however, that more remains

to be done in order to restore balance and set conditions for the future.

Restoring Balance: The Army's Four Imperatives

Sustain

We must sustain the quality of our All-Volunteer Force. Through meaningful programs, the Army is committed to providing the quality of life deserved by those who serve our Nation. To sustain the force, we are focused on recruitment and retention; care of Soldiers, Families, and Civilians; care for our wounded Warriors; and support for the Families of our fallen Soldiers.

Recruit and Retain

- Goal – Recruit quality men and women through dynamic incentives. Retain quality Soldiers and Civilians in the force by providing improved quality of life and incentives.
- Progress – In 2008, nearly 300,000 men and women enlisted or reenlisted in our All-Volunteer Army. In addition, the Army created the Army Preparatory School to offer incoming recruits the opportunity to earn a GED in order to begin initial entry training. All Army components are exceeding the 90% Tier 1 Education Credential (high school diploma or above) standard for new recruits. In addition, our captain retention incentive program contributed to a nearly 90 percent retention rate for keeping experienced young officers in the Army.

Care of Soldiers, Families, and Civilians

- Goal – Improve the quality of life for Soldiers, Families, and Civilians through the implementation of the Soldier and Family Action Plan and the Army Family Covenant. Garner support of community groups and volunteers through execution of Army Community Covenants.
- Progress – The Army hired more than 1,000 new Family Readiness Support Assistants to provide additional support to Families with deployed Soldiers. We doubled the funding to Family programs and services in 2008. We began construction on 72 Child Development Centers and 11 new Youth Centers and fostered community partnerships by signing 80 Army Community Covenants. Our Army initiated the "Shoulder to Shoulder, No Soldier Stands Alone" program to increase suicide awareness and prevention. The Army also committed to a 5-year, $50 Million study by the National Institute for Mental Health for practical interventions for mitigating suicides and enhancing Soldier resiliency. In addition, the Army implemented the Intervene, Act, Motivate (I.A.M. Strong) Campaign with a goal of eliminating sexual harassment and sexual assault in the Army. To enhance the investigation and prosecution of criminal behavior, the Army's Criminal Investigation Command and Office of The Judge Advocate General have taken new measures to support victims, investigate crimes and hold offenders accountable. The Army also has provided better access to quality health care, enhanced dental readiness programs focused on Reserve Component Soldiers, improved Soldier and Family housing, increased access to child care, and increased educational opportunities for Soldiers, children, and spouses.

Warrior Care and Transition

- Goal – Provide world-class care for our wounded, ill, and injured Warriors through properly resourced Warrior Transition Units (WTUs), enabling these

Soldiers to remain in our Army or transition to meaningful civilian employment consistent with their desires and abilities.

- Progress – The Army established 36 fully operational WTUs and 9 community-based health care organizations to help our wounded, ill, and injured Soldiers focus on their treatment, rehabilitation, and transition through in-patient and out-patient treatment. We initiated programs to better diagnose and treat Post-Traumatic Stress Disorder, Traumatic Brain Injury and other injuries through advanced medical research. We also have made investments in upgrading our clinics and hospitals including a $1.4 Billion investment in new hospitals at Forts Riley, Benning, and Hood.

Support Families of Fallen Comrades

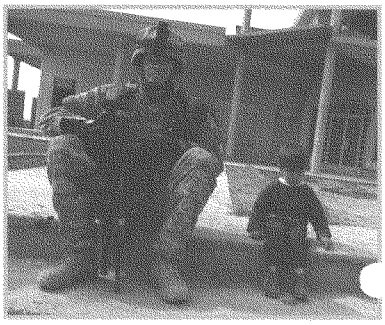
- Goal – Assist the Families of our fallen comrades and honor the service of their Soldiers.
- Progress – The Army is developing and fielding Survivor Outreach Services, a multi-agency effort to care for the Families of our Soldiers who made the ultimate sacrifice. This program includes benefit specialists who serve as subject matter experts on benefits and entitlements, support coordinators who provide long-term advocacy, and financial counselors who assist in budget planning.

Prepare

We must prepare our force by readying Soldic units, and equipment to succeed in the current conflicts, especially in Iraq and Afghanistan. We continue to adapt institutional, collective, and individual training to enable Soldiers to succeed in combat and prevail against adaptive and intelligent adversaries. We are equally committed to ensuring Soldiers have the best available equipment to both protect themselves and maintain a technological advantage over our adversaries. To prepare our force, we continue to focus on growing the Army, training, equipping, and better supporting the Army Force Generation (ARFORGEN) process.

Grow the Army

- Goal – Accelerate the end strength growth of the Army so that by 2010 the Active Components has 547,400 Soldiers and the National Guard has 358,200 Soldiers. Grow the Army Reserve to 206,000 Soldiers by 2012 even as the Army Reserve works an initiative to accelerate th·· growth to 2010. Grow the Army's forces to . Brigade Combat Teams (BCTs) and approximately 227 Support Brigades with enabling combat support and combat service support structure by 2011. Simultaneously develop the additional facilities and infrastructure to station these forces.



- Progress – With national leadership support, our Army has achieved our manpower growth in all components during 2009. The Army grew 32 Modular Brigades in 2008 (7 Active Component Brigades and 25 Brigades in the Reserve Components). This growth in the force, combined with reduced operational deployments from 15 months to 12 months, eased some of the strain on Soldiers and Families.

Training

- Goal – Improve the Army's individual, operational, and institutional training for full spectrum operations. Develop the tools and technologies that enable more effective and efficient training through live, immersive, and adaptable venues that prepare Soldiers and leaders to excel in the complex and challenging operational environment.
- Progress – The Army improved training facilities at home stations and combat training centers, increasing realism in challenging irregular warfare scenarios. Army Mobile Training Teams offered career training to Soldiers at their home station, preventing them from having to move away for schooling and providing more time for them with their Families. Our Army continues to improve cultural and foreign language skills.

Equipment

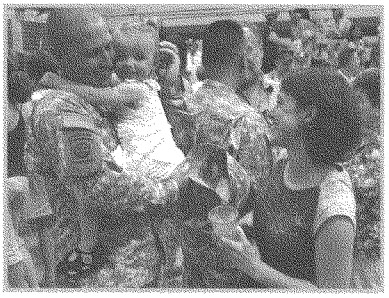
- Goal – Provide Soldiers effective, sustainable, and timely equipment through fully integrated research and development, acquisition, and logistical sustainment. Continue modernization efforts such as the Rapid Fielding Initiative and the Rapid Equipping Force, using a robust test and evaluation process to ensure the effectiveness of fielded equipment.
- Progress – In 2008, the Army fielded more than one million items of equipment including over 7,000 Mine-Resistant, Ambush-Protected (MRAP) vehicles, providing Soldiers fighting in Iraq and Afghanistan the best equipment available.

Army Force Generation (ARFORGEN) Process

- Goal – Improve the ARFORGEN process to generate trained, ready, and cohesive units for combatant commanders on a rotational basis to meet current and future strategic demands. Achieve a degree of balance by reaching a ratio of one year deployed to two years at home station for Active Component units, and one year deployed to four years at home for Reserve Component units by 2011.
- Progress – Recent refinements in the ARFORGEN process have increased predictability for Soldiers and their Families. When combined with the announced drawdown in Iraq, this will substantially increase the time our Soldiers have at home.

Reset

In order to prepare Soldiers, their Families, and units for future deployments and contingencies, we must reset the force to rebuild the readiness that has been consumed in operations. Reset restores deployed units to a level of personnel and equipment readiness necessary for future missions. The Army is using a standard reset model and is continuing a reset pilot program to further improve the effectiveness and efficiency of the ARFORGEN process. To reset our force, we are revitalizing Soldiers and Families; repairing, replacing, and recapitalizing equipment; and retraining Soldiers.



Revitalize Soldiers and Families

- Goal – Increase the time our Soldiers and Families have together to reestablish and strengthen relationships following deployments.
- Progress – In the reset pilot program, units have no readiness requirements or Army-directed training during the reset period (6 months for the Active Component and 12 months for the Reserve Components). This period allows units to focus on Soldier professional and personal education, property accountability, and equipment maintenance, and also provides quality time for Soldiers and their Families.

Repair, Replace, and Recapitalize Equipment

- Goal – Fully implement an Army-wide program that replaces equipment that has been destroyed in combat and repairs or recapitalizes equipment that has been rapidly worn out due to harsh conditions and excessive use. As units return, the Army will reset equipment during the same reconstitution period we dedicate to Soldier and Family reintegration.
- Progress – The Army reset more than 125,000 pieces of equipment in 2008. The maintenance activities and capacity at Army depots increased to their highest levels in the past 35 years.

Retrain Soldiers, Leaders, and Units

- Goal – Provide our Soldiers with the criti specialty training and professional military education necessary to accomplish the full spectrum of missions required in today's strategic environment.
- Progress – The Army is executing a Training and Leader Development Strategy to prepare Soldiers and units for full spectrum operations. The Army is 60 percent complete in efforts to rebalance job skills required to meet the challenges of the 21st Century.

Reset Pilot Program

- Goal – Provide lessons learned that identify institutional improvements that standardize the reset process for both the Active and Reserve Component and determine timing, scope, and resource implications.
- Progress – In 2008, the Army initiated a six-mon pilot reset program for 13 units (8 Active Comp nent and 5 Reserve Component). The Army has learned many significant lessons and is applying them to all redeploying units to allow units more time to accomplish reset objectives at their home stations.

Transform

We must transform our force to provide the combatant commanders dominant, strategically responsive forces capable of meeting diverse challenges across the entire spectrum of 21st Century conflict. To transform our force, we are adopting modular organizations, accelerating delivery of advanced technologies, operationalizing the Reserve Components, restationing our forces, and transforming leader development.

Modular Reorganization

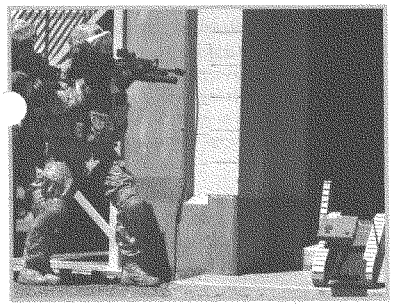
- Goal – Reorganize the Active and Reser Components into standardized modular orga zations, thereby increasing the number of BCTs

and support brigades to meet operational requirements and creating a more deployable, adaptable, and versatile force.

- Progress – In addition to the 32 newly activated modular brigades, the Army converted 14 brigades from a legacy structure to a modular structure in 2008 (5 Active Component and 9 Reserve Component Brigades). The Army has transformed 83 percent of our units to modular formations—the largest organizational change since World War II.

Advanced Technologies

- Goal – Modernize and transform the Army to remain a globally responsive force and ensure our Soldiers retain their technological edge for the current and future fights.



- Progress – The Army will accelerate delivery of advanced technologies to Infantry BCTs fighting in combat today through "Spin-outs" from our Future Combat Systems program. This aggressive fielding schedule, coupled with a tailored test and evaluation strategy, ensures Soldiers receive reliable, proven equipment that will give them a decisive advantage over any enemy.

Operationalize the Reserve Components

- Goal – Complete the transformation of the Reserve Components to an operational force by changing the way we train, equip, resource, and mobilize Reserve Component units by 2012.
- Progress – The Army continued efforts to systematically build and sustain readiness and to increase predictability of deployments for Soldiers, their Families, employers, and communities by integrating the ARFORGEN process.

Restationing Forces

- Goal – Restation forces and families around the globe based on the Department of Defense's (DoD) Global Defense Posture and Realignment initiatives, Base Realignment and Closure (BRAC) statutes, and the expansion of the Army directed by the President in January 2007.
- Progress – To date, in support of BRAC, our Army has obligated 95 percent of the $8.5 Billion received. Of more than 300 major construction projects in the BRAC program, 9 have been completed and another 139 awarded. The Army has also completed 77 National Environmental Policy Act actions, closed 1 active installation and 15 U.S. Army Reserve Centers, terminated 9 leases, and turned over 1,133 excess acres from BRAC 2005 properties. The Army is on track to complete BRAC by 2011.

Soldier and Leader Development

- Goal – Develop agile and adaptive military and Civilian leaders who can operate effectively in Joint, interagency, intergovernmental, and multinational environments.
- Progress – The Army published Field Manual (FM) 3-0, *Operations*, which includes a new operational concept for full spectrum operations where commanders simultaneously apply offensive, defensive, and stability operations to achieve decisive results. Additionally, the Army published FM 3-07, *Stability Operations* and FM 7-0, *Training for Full Spectrum Operations* and is finalizing FM 4-0, *Sustainment*. The doctrine reflected in these new

manuals provides concepts and principles that will develop adaptive leaders to train and sustain our Soldiers in an era of persistent conflict.

Setting Conditions for the Future: Six Essential Qualities of Our Army

In an era of persistent conflict, our Army is the primary enabling and integrating element of landpower. The Army's transformation focuses on distinct qualities that land forces must possess to succeed in the evolving security environment. In order to face the security challenges ahead, the Army will continue to transform into a land force that is versatile, expeditionary, agile, lethal, sustainable, and interoperable.

Versatile forces are multipurpose and can accomplish a broad range of tasks, moving easily across the spectrum of conflict as the situation demands. Our versatility in military operations—made possible by full spectrum training, adaptable equipment, and scalable force packages—will enable us to defeat a wide range of unpredictable threats.

Our Army must remain an expeditionary force—organized, trained, and equipped to go anywhere in the world on short notice, against any adversary, to accomplish the assigned mission, including the ability to conduct forcible entry operations in remote, non-permissive environments. Working in concert with our force projection partners, the United States Transportation Command and sister services, we will enhance our expeditionary force projection and distribution capability to provide rapid, credible, and sustainable global response options for the Joint Force.

Agile forces adapt quickly to exploit opportunities in complex environments. Our Army is developing agile Soldiers and institutions that adapt and work effectively in such environments.

A core competency of land forces is to effectively, efficiently, and appropriately apply lethal force. The lethal nature of our forces enables our ability to deter, dissuade, and, when required, defeat our enemies. Because conflicts will increasingly take place among the people, the Army will continue to pursue technological and intelligence capabilities to provide lethal force with precision to minimize civilian casualties and collateral damage.

Our Army must be organized, trained, and equipped to ensure it is capable of sustainable operations for as long as necessary to achieve national objectives. In addition, we will continue to improve our ability to guarantee the logistical capacity to conduct long-term operations while presenting a minimal footprint to reduce exposure of support forces.

The extensive planning and organizing capabilities and experience of U.S. land forces are national assets. These capabilities are essential to preparing and assisting interagency, multinational, and host nation partners to execute their roles in conflict prevention and resolution. Our force needs to be increasingly interoperable to effectively support and integrate the efforts of Joint, interagency, intergovernmental, multinational, and indigenous elements to achieve national goals.

As we look to the future, our Army is modernizing and transforming to build a force that exhibits these six essential qualities in order to meet the challenges of the security environment of the 21st Century. The Army's adoption of a modular, scalable brigade-based organization provides a broad range of capabilities that are inherently more versatile, adaptable, and able to conduct operations over extended periods.

Another critical transformation initiative to enhance the Army's capabilities is the modernization of our global information network capabilities through integration of the Global Network Enterprise Construct (GNEC). The GNEC will enable network war-fighting capabilities, dramatically improve and protect the LandWarNet, improve both efficiency and effectiveness of the network, and ensure Army interoperability across DoD.

As part of our transformation, the Army is adapting as an institution principally in three areas: streamlining the Army Force Generation (ARFORGEN) process, implementing an enterprise approach, and establishing a more effective requirements process. A streamlined ARFORGEN process more efficiently mans, equips, and trains units to strengthen our expeditionary capability. The enterprise approach—a holistic method to improve the effectiveness and efficiency of the Army's policies and processes—will make our institutions more efficient and more responsive to the needs of the combatant commanders. An improved requirements process will provide more timely and flexible responses to meet the needs of our Soldiers. In transforming our training and leader development model, we produce more agile Soldiers and Civilians who are capable of operating in complex and volatile environments.

The Army's modernization efforts are specifically designed to enhance the six essential land force qualities by empowering Soldiers with the decisive advantage across the continuum of full spectrum operations. Modernization is providing our Soldiers and leaders with leading-edge technology and capabilities to fight the wars we are in today while simultaneously preparing for future complex, dynamic threats. The Army is improving capabilities in intelligence, surveillance, and reconnaissance; information sharing; and Soldier protection to give our Soldiers an unparalleled awareness of their operational environment, increased precision and lethality, and enhanced survivability.

The Army also is addressing the capability gaps in our current force by accelerating delivery of advanced technologies to Soldiers in Infantry BCTs. For example, more than 5,000 robots are currently in Iraq and Afghanistan, including an early version of the Small Unmanned Ground Vehicle (SUGV). Soldiers are using the SUGV prototype to clear caves and bunkers, search buildings, and defuse improvised explosive devices. In addition, an early version of the Class I Unmanned Aerial Vehicle (UAV) is currently supporting Soldiers in Iraq with reconnaissance, surveillance, and target acquisition. The Class I UAV operates in open, rolling, complex, and urban terrain and can take off and land vertically without a runway. It is part of the information network, providing real time information that increases Soldier agility and lethality while enhancing Soldier protection.

Overall, Army modernization efforts provide a technological edge for our Soldiers in today's fight and are essential to the Army's efforts to empower Soldiers with the land force qualities needed in the 21st Century.

Stewardship/Innovations

The Nation's Army remains committed to being the best possible steward of the resources provided by the American people through the Congress. We continue to develop and implement initiatives designed to conserve resources and to reduce waste and inefficiencies wherever possible.

The recent establishment of two organizations highlights the Army's commitment to improving efficiencies. In 2008, the Secretary of the Army established the Senior Energy Council to develop an Army Enterprise Energy Security Strategy. The Senior Energy Council is implementing a plan that reduces energy consumption and utilizes innovative technologies for alternative and renewable energy, including harvesting wind, solar and geothermal energy, while leveraging energy partnerships with private sector expertise. The Army is replacing 4,000 petroleum-fueled vehicles with electric vehicles. We also are underway in our six-year biomass waste-to-fuel technology demonstrations at six of our installations.

As part of the Army's efforts in adapting institutions, we also established the Enterprise Task Force to optimize

the ARFORGEN process for effectively and efficiently delivering trained and ready forces to the combatant commanders.

In addition, in order to increase logistical efficiencies and readiness, the Army is developing 360 Degree Logistics Readiness—an initiative that proactively synchronizes logistics support capability and unit readiness. This new approach will allow the Army to see, assess, and synchronize enterprise assets in support of our operational forces. The 360 Degree Logistics Readiness bridges the information system gaps between selected legacy logistics automation systems and the Single Army Logistics Enterprise. It will improve visibility, accountability, fidelity, and timeliness of information to facilitate better decisions at every managerial level.

Finally, the Army is committed to reforming our acquisition, procurement, and contracting processes to more efficiently and responsively meet the needs of our Soldiers. A streamlined requirements process based reasonable requirements with adequately mature technology will produce a system with greater urgency and agility and guard against "requirements creep." The Army also will continue to grow its acquisition workforce and provide disciplined oversight to its acquisition programs.

Accomplishments

The Army has been fully engaged over the past year. We remain focused on prevailing in Iraq and Afghanistan, while concurrently working to restore balance and transforming to set the conditions for success in the future. Despite the high global operational tempo and our continuing efforts to restore balance and prepare for future contingencies, we have accomplished much in the last year:

ARMY ACCOMPLISHMENTS

- Manned, trained, equipped, and deployed 15 combat brigades, 34 support brigades, and 369 military and police transition teams in support of Iraq and Afghanistan
- Deployed more than 293,000 Soldiers into or out of combat in Iraq and Afghanistan
- Repaired more than 100,000 pieces of Army equipment through the efforts at the Army's depot facilities
- Invested in the psychological health of the Army by investing more than $500 Million in additional psychological health providers, new facilities, and world-class research
- Reduced the on-duty Soldier accident rate by 46 percent in 2008 through Soldier and leader emphasis on Army safety measures
- Reduced the Army's ground accidents by 50 percent and the Army's major aviation accidents by 38 percent in 2008 through leader application of the Army's Composite Risk Management model
- Implemented Family Covenants throughout the Army and committed more than $1.5 Billion to Army Family programs and services
- Improved on-post housing by privatizing more than 80,000 homes, building 17,000 homes, and renovating 13,000 homes since 2000 at 39 different installations through the Residential Communities Initiative
- Reduced energy consumption in Army facilities by 10.4 percent since 2003 through the implementation of the Army's energy strategy
- Won six Shingo Public Sector Awards for implementing best business practices
- Destroyed more than 2,100 tons of chemical agents, disposed of 70,000 tons of obsolete or unserviceable conventional ammunition, and removed 163,000 missiles or missile components from the Army's arsenal
- Fostered partnerships with allies by training more than 10,000 foreign students in stateside Army schools and by executing more than $14.5 Billion in new foreign military sales to include $6.2 Billion in support of Iraq and Afghanistan
- Saved $41 Million by in-sourcing more than 900 core governmental functions to Army Civilians
- Improved Soldier quality of life by constructing or modernizing 29,000 barracks spaces

America's Army—The Strength of the Nation

The Army's All-Volunteer Force is a national treasure. Less than one percent of Americans wear the uniform of our Nation's military; they and their Families carry the lion's share of the burden of a Nation at war. Despite these burdens, our Soldiers continue to perform magnificently across the globe and at home, and their Families remain steadfast in their support. Our Civilians remain equally dedicated to the Army's current and long-term success. They all deserve the best the Nation has to offer.

America's Army has always served the Nation by defending its national interests and providing support to civil authorities for domestic emergencies. Seven years of combat have taken a great toll on the Army, our Soldiers, and their Families. To meet the continuing challenges of an era of persistent conflict, our Army must restore balance and set the conditions for the future while sustaining our All-Volunteer Force. We must ensure our Soldiers have the best training, equipment, and leadership we can provide them. Our Army has made significant progress over the last year, but has several tough years ahead. With the support of Congress, the Army will continue to protect America's national security interests while we transform ourselves to meet the challenges of today and the future. **America's Army—The Strength of the Nation.**

UNITED STATES ARMY

ADDENDUM A - Information Papers

360 Degree Logistics Readiness

Accelerate Army Growth

Active Component Reserve Component (ACRC) Rebalance

Adaptive Logistics

Add-on Armor for Tactical Wheeled Vehicles

Africa Command (AFRICOM)

Armed Forces Recreation Centers

Army Asymmetric Warfare Office (AAWO)

Army Career and Alumni Program (ACAP)

Army Career Tracker (ACT) Program

Army Civilian University (ACU)

Army Community Service (ACS) Family Programs

Army Community Service (ACS) Family Readiness Programs

Army Energy Plan (AEP)

Army Environmental Programs

Army Evaluation Task Force (AETF)

Army Family Action Plan (AFAP)

Army Force Generation (ARFORGEN)

Army Geospatial Enterprise (AGE)

Army Integrated Logistics Architecture (AILA)

Army Leader Development Program (ALDP)

Army Modernization Strategy

Army Onesource

Army Physical Fitness Research Institute

Army Physical Readiness Training (FM 3-22.02)

Army Preparatory School

Army Prepositioned Stocks (APS)

Army Reserve Employer Relations (ARER) Program

Army Reserve Voluntary Education Services

Army Reserve Voluntary Selective Continuation

Army Spouse Employment Partnership (ASEP) Program

Army Strong

Army Suicide Prevention Program (ASPP)

Army Values

Army Volunteer Program

ARNG Active First Program

ARNG Agribusiness Development Team

ARNG Community Based Warrior Transition Units

ARNG Critical Skills Retention Bonus

ARNG Education Support Center

ARNG Environmental Programs

ARNG Every Soldier a Recruiter

ARNG Exportable Combat Training Capability

ARNG Family Assistance Centers

ARNG Freedom Salute Campaign

ARNG GED Plus Program

ARNG Muscatatuck Army Urban Training Center

ARNG Operational Support Airlift Agency

ARNG Periodic Health Assessment (PHA)

ARNG Post Deployment Health Reassessment (PDHRA)

ARNG Recruit Sustainment Program

ARNG Recruiting Assistance Program (G-RAP)

ARNG Strong Bonds

ARNG Western Army Aviation Training Site (WAATS)

Asymmetric Warfare Group

Base Realignment and Closure (BRAC) Program

Basic and Advanced NCO Courses

Basic Officer Leader Course (BOLC)

Behavioral Health

Better Opportunity for Single Soldiers (BOSS)

Biometrics

Broad Career Groups

Building Partnership Capacity Through Security Cooperation

Campaign Capable Force

Capabilities Development for Rapid Transition (CDRT)

UNITED STATES ARMY

ADDENDUM A - Information Papers

Generating Force Support for Operations

Global Force Posture

Global Network Enterprise Construct (GNEC)

Helicopter, Black Hawk Utility Helicopter (UH-60)

Helicopter, Chinook Heavy Lift Helicopter (CH-47)

Helicopter, Lakota (UH-72)

Helicopter, Longbow Apache (AH-64D)

Human Terrain System (HTS)

HUMINT: Growing Army Human Intelligence (HUMINT) Capabilities

Information Doctrine

In-Sourcing

Installation Planning Board

Institutional Adaptation

Institutional Training Under Centers of Excellence (COE)

Intelligence Transformation

Interceptor Body Armor (IBA)

Interpreter/Translator Program

Irregular Warfare Capabilities

Joint Basing

Joint Knowledge Development and Distribution Capstone Program (JKDDC)

Joint Precision Airdrop System (JPADS)

Leader Development Assessment Course - Warrior Forge

Lean Six Sigma: Continuous Process Improvement Initiative

Lean Six Sigma: G-4 Initiative

Life Cycle Management Initiative

Live, Virtual, Constructive Integrated Training Environment

Manpower Personnel Integration Program (MANPRINT)

March 2 Success

Medical and Dental Readiness

Military Construction (MILCON) Program

Military Construction (MILCON) Transformation

Military Family Life Consultants (MFLC) Program

Military Intelligence Capacity

Mine-Resistant, Ambush-Protected Vehicles (MRAP)

Mobile Training Teams (MTT) for Warrior Leader Course (WLC)

Mobilization Tiger Team

Modular Force Conversion

Morale Welfare and Recreation (MWR)

Multinational Exercises

Multi-Source Assessment and Feedback (MSAF) Program

National Guard CBRNE Enhanced Response Force Package (CERFP)

National Guard Counterdrug Program

National Guard Public Affairs Rapid Response Team (PARRT)

National Guard State Partnership Program

National Guard Weapons of Mass Destruction Civil Support Teams (WMD-CSTs)

National Guard Yellow Ribbon Program

National Guard Youth ChalleNGe

National Security Personnel System (NSPS)

Next Generation Wireless Communications (NGWC)

Officer Education System (OES)

Officer Education System - Warrant Officers

Officer Retention

Pandemic Influenza Preparation

Partnership for Youth Success Programs (PaYS)

Persistent Air and Ground Surveillance to Counter IED

Persistent Conflict

Physical Disability Evaluation System (PDES)

Post Deployment Health Reassessment (PDHRA)

Power Projection Platform

Privatization of Army Lodging

Property Accountability

Rapid Equipping Force (REF)

Rapid Fielding Initiative (RFI)

UNITED STATES ARMY

ADDENDUM B - Websites

Headquarters, Department of the Army and other Commands

This site has links for information regarding the Headquarters, Department of the Army (HQDA), Army Command Structure, Army Service Component Commands (ASCC), and Direct Reporting Units (DRU).

http://www.army.mil/institution/organization/

The Army Homepage

This site is the most visited military website in the world, averaging about seven million visitors per month or approximately 250 hits per second. It provides news, features, imagery, and references.

http://www.army.mil/

The Army Modernization Strategy

http://www.g8.army.mil/G8site_redesign/modStrat.html

The Army Posture Statement

This site provides access to archived Army Posture Statements from 1997 to 2008.

http://www.army.mil/aps

The Army Staff

Personnel: G-1

http://www.armyg1.army.mil/

Intelligence: G-2

http://www.dami.army.pentagon.mil/

Operations, Plans, and Policy: G-3/5/7

https://www.g357extranet.army.pentagon.mil

Logistics: G-4

http://www.hqda.army.mil/logweb/

Programs: G-8

This site provides information on material integration and management.

http://www.army.mil/institution/organization/unitsandcommands/dcs/g-8/

Installation Management

This site provides information about policy formulation, strategy development, enterprise integration, program analysis and integration, requirements and resource determination, and best business practices for services, programs, and installation support to Soldiers, their Families, and Army Civilians.

http://www.acsim.army.mil/

Army Commands (ACOMs)

Army Forces Command (FORSCOM)

http://www.forscom.army.mil/

Army Training and Doctrine Command (TRADOC)

http://www.tradoc.army.mil/

Army Materiel Command (AMC)

http://www.army.mil/institution/organization/unitsandcommands/commandstructure/amc/

Reserve Components

Army Reserve

http://www.armyreserve.army.mil

Army National Guard

http:www.arng.army.mil

Other informative websites

Army Wounded Warrior Program

This site provides information on the Army's Wounded Warrior Program which provides support to severely wounded Soldiers and their Families.

https://www.aw2.army.mil

My ArmyLifeToo Web Portal

This site serves as an entry point to the Army Integrated Family Network and Army OneSource.

http://www.myarmylifetoo.com

	Active Component
ACOM	Army Command
ACP	Army Campaign Plan
AETF	Army Evaluation Task Force
ARFORGEN	Army Force Generation
AFRICOM	Africa Command
AMAP	Army Medical Action Plan
AMC	Army Material Command
APA	Army Prepositioned Stocks
AR	Army Regulation
ARCIC	Army Capabilities Integration Center
ARNG	Army National Guard
C	Army Sustainment Command
ASCC	Army Service Component Command
AWG	Asymmetric Warfare Group
AWO	Asymmetric Warfare Office
AW2	Army Wounded Warrior Program
BCT	Brigade Combat Team
BCTP	Battle Command Training Program
BOLC	Basic Officer Leader Course
BRAC	Base Realignment and Closure
RN	Chemical, Biological, Radiological, and Nuclear
CBRNE	Chemical, Biological, Radiological, Nuclear, and (High-Yield) Explosives
CCDR	Combatant Commander
CCMRF	CBRNE Consequence Management Reaction Force
CES	Civilian Education System
C4ISR	Command, Control, Communications, Computer, Intelligence, Surveillance and Reconnaissance
CMETL	Core Mission Essential Task List
CMTC	Combat Maneuver Training Center
COCOM	Combatant Command
COE	Center of Excellence; Common Operating Environment; Contemporary Operating Environment
COIN	Counterinsurgency
COTS	Commercial Off-The-Shelf
CS	Combat Support
CSS	Combat Service Support
CT	Counter Terrorism
CTC	Combat Training Center
DA	Department of the Army
DA PAM	Department of the Army Pamphlet
DCGS-A	Distributed Common Ground System-Army
DMDC	Defense Manpower Data Center
DMETL	Directed Mission Essential Task List
DoD	Department of Defense

UNITED STATES ARMY

ADDENDUM C - Acronyms

DOTMLPF	Doctrine, Organization, Training, Material, Leadership and Education, Personnel, and Facilities
EBCT	Evaluation Brigade Combat Team
EOD	Explosive Ordnance Disposal
ES2	Every Soldier a Sensor
ETF	Enterprise Task Force
FCS	Future Combat Systems
FM	Field Manual
FORSCOM	Forces Command
FY	Fiscal Year
GBIAD	Global Based Integrated Air Defense
GCSS-A	Global Combat Service Support-Army
GDPR	Global Defense Posture Realignment
GNEC	Global Network Enterprise Construct
HBCT	Heavy Brigade Combat Team
HMMWV	High Mobility Multipurpose Wheeled Vehicle
HUMINT	Human Intelligence
IBA	Improved Body Armor
IBCT	Infantry Brigade Combat Team
IED	Improvised Explosive Device
ISR	Intelligence, Surveillance, and Reconnaissance
IT	Information Technology
JIEDDO	Joint Improvised Explosive Device Defeat Organization
JIIM	Joint, Interagency, Intergovernmental, and Multinational
JRTC	Joint Readiness Training Center
JTF	Joint Task Force
LMP	Logistics Modernization Program
LSS	Lean Six Sigma
MI	Military Intelligence
METL	Mission Essential Task List
MOUT	Military Operations in Urban Terrain
MRAP	Mine-Resistant, Ambush-Protected
MRE	Mission Readiness Exercise
MRX	Mission Rehearsal Exercise
MTOE	Modified Table of Organization and Equipment
MTT	Mobile Training Teams
NBC	Nuclear, Biological, Chemical
NEPA	National Environmental Protection Act
NET	New Equipment Training
NCO	Noncommissioned Officer
NDAA	National Defense Authorization Act
NDS	National Defense Strategy

...OS-C	Non Line of Sight-Cannon
NMS	National Military Strategy
NSPS	National Security Personnel System
NSS	National Security Strategy
NTC	National Training Center
OCO	Overseas Contingency Operations
OEF	Operation Enduring Freedom
OIF	Operation Iraqi Freedom
OPTEMPO	Operational Tempo
O&M	Operations and Maintenance
...M	Program Objective Memorandum
PSYOP	Psychological Operations
PTSD	Post-Traumatic Stress Disorder
QDR	Quadrennial Defense Review
QOL	Quality of Life
RC	Reserve Components
RCI	Residential Communities Initiative
REF	Rapid Equipping Force
RFI	Rapid Fielding Initiative
...LE	Single Army Logistics Enterprise
SBCT	Stryker Brigade Combat Team
SFAP	Soldier and Family Action Plan
SHARP	Sexual Harassment / Assault Response and Prevention (SHARP) Program
SIGINT	Signal Intelligence
SOF	Special Operations Forces
SOS	Survivor Outreach Services
TBI	Traumatic Brain Injury
TDA	Table of Distribution and Allowances
TRADOC	Training and Doctrine Command
TTP	Tactics, Techniques, and Procedures
UAH	Up-Armored HMMWV
UAS	Unmanned Aircraft System
UAV	Unmanned Aerial Vehicle
UGV	Unmanned Ground Vehicle
USAR	United States Army Reserve
VBIED	Vehicle Borne Improvised Explosive Device
WMD	Weapons of Mass Destruction
WO	Warrant Officer
WTBD	Warrior Tasks and Battle Drills
WTU	Warrior Transition Units

No public hearings were held, but statements are provided for the record:

NBCC

NATIONAL BREAST CANCER COALITION

grassroots advocacy in action

Testimony of
Fran Visco, J.D.
President
National Breast Cancer Coalition

Submitted to the
House Appropriations Subcommittee on Defense

April 3, 2009

Thank you, Mr. Chairman and members of the Appropriations Subcommittee on Defense, for the opportunity to submit testimony today about a Program that has made a significant difference in the lives of women and their families.

I am Fran Visco, a 21-year breast cancer survivor, a wife and mother, a lawyer, and President of the National Breast Cancer Coalition (NBCC). My testimony represents the hundreds of member organizations and thousands of individual members of the Coalition. NBCC is a grassroots organization dedicated to ending breast cancer through action and advocacy. The Coalition's main goals are to increase federal funding for breast cancer research and collaborate with the scientific community to implement new models of research; improve access to high quality health care and breast cancer clinical trials for all women; and expand the influence of breast cancer advocates wherever breast cancer decisions are made.

You and your Committee have shown great determination and leadership in funding the Department of Defense (DOD) peer-reviewed Breast Cancer Research Program (BCRP) at a level that has brought us closer to eradicating this disease. Chairman Murtha and Ranking Member Young, we appreciate your longstanding personal support for this Program. I am hopeful that you and your Committee will continue that determination and leadership.

I know you recognize the importance of this Program to women and their families across the country, to the scientific and health care communities and to the Department of Defense. Much of the progress in the fight against breast cancer has been made possible by the Appropriations Committee's investment in breast cancer research through the DOD BCRP. This Program has launched new models of biomedical research that have benefited other agencies and both public and private institutions. It has changed for the better the way research is performed and has been replicated by programs focused on other diseases, by other countries and states. To support this unprecedented progress moving forward, we ask that you support a separate $150 million appropriation for Fiscal Year (FY) 2010. In order to continue the success of the Program, you must ensure that it maintain its integrity and separate identity, in addition to the requested level of funding. This is important not just for breast cancer, but for all biomedical research that has benefited from this incredible government Program. In addition, as Institute of Medicine (IOM) reports concluded in 1997 and 2004, there continues to be excellent

1101 17th Street, NW, Suite 1300, Washington, DC 20036 phone: (202) 296-7477 fax: (202) 265-6854 www.stopbreastcancer.org

science that would go unfunded without this Program. It is only through a separate appropriation that this Program is able to continue to focus on breast cancer yet impact all other research. The separate appropriation of $150 million will ensure that this Program can rapidly respond to changes and new discoveries in the field and fill the gaps in traditional funding mechanisms.

Since its inception, this Program has matured into a broad-reaching influential voice forging new and innovative directions for breast cancer research and science. Despite the enormous successes and advancements in breast cancer research made through funding from the DOD BCRP, we still do not know what causes breast cancer, how to prevent it, or how to cure it. It is critical that innovative research through this unique Program continues so that we can move forward toward eradicating this disease.

Overview of the DOD Breast Cancer Research Program

The DOD peer-reviewed Breast Cancer Research Program has established itself as a model medical research program, respected throughout the cancer and broader medical community for its innovative, transparent and accountable approach. The pioneering research performed through the Program has the potential to benefit not just breast cancer, but all cancers, as well as other diseases. Biomedical research is being transformed by the DOD BCRP's success.

This Program is both innovative and incredibly streamlined. It continues to be overseen by an Integration Panel including distinguished scientists and advocates, as recommended by the IOM. Because there is little bureaucracy, the Program is able to respond quickly to what is currently happening in the research community. Because of its specific focus on breast cancer, it is able to rapidly support innovative proposals that reflect the most recent discoveries in the field. It is responsive, not just to the scientific community, but also to the public. The flexibility of the Program has allowed the Army to administer it with unparalleled efficiency and effectiveness.

An integral part of this Program has been the inclusion of consumer advocates at every level. Breast cancer is not just a problem of scientists; it is a problem of people. Advocates bring a necessary perspective to the table, ensuring that the science funded by this Program is not only meritorious, but it is also meaningful and will make a difference in people's lives. The consumer advocates bring accountability and transparency to the process. Many of the scientists who have participated in the Program have said that working with the advocates has changed the way they approach research. Let me quote Dr. Michael Diefenbach of Mount Sinai School of Medicine:

> *I have served as a reviewer for the Department of Defense's Breast and Prostate Cancer Review programs and I am a member of the behavioral study section for the National Cancer Institute... I find survivors or advocate reviewers as they are sometimes called bring a sense of realism to the review process that is very important to the selection and ultimately funding process of important research... Both sides bring important aspects to the review process and the selected projects are ultimately those that can fulfill scientific rigor and translatability from the research arena to clinical practice. I urge that future review panels include advocate reviewers in the review process.*

Since 1992, nearly 600 breast cancer survivors have served on the BCRP peer review panels. As a result of this inclusion of consumers, the Program has created an unprecedented working relationship between the public, scientists, and the military, and ultimately has led to new avenues of research in breast cancer. The vital role of the advocates in the success of the BCRP has led to consumer inclusion in other biomedical research programs at DOD. This Program now serves as an international model.

It is important to note that the Integration Panel that designs this Program has a strategic plan for how best to spend the funds appropriated. This plan is based on the state of the science – both what scientists know now and the gaps in our knowledge – as well as the needs of the public. While this plan is mission driven, and helps ensure that the science keeps that mission – eradicating breast cancer – in mind, it does not restrict scientific freedom, creativity or innovation. The Integration Panel carefully allocates these resources, but it does not predetermine the specific research areas to be addressed.

Unique Funding Opportunities

The DOD BCRP research portfolio includes many different types of projects, including support for innovative ideas, networks to facilitate clinical trials, and training of breast cancer researchers.

Developments in the past few years have begun to offer breast cancer researchers fascinating insights into the biology of breast cancer and have brought into sharp focus the areas of research that hold promise and will build on the knowledge and investment we have made. The Innovative Developmental and Exploratory Awards (IDEA) grants of the DOD Program have been critical in the effort to respond to new discoveries and to encourage and support innovative, risk-taking research. Concept Awards support funding even earlier in the process of discovery. These grants have been instrumental in the development of promising breast cancer research by allowing scientists to explore beyond the realm of traditional research and unleash incredible new ideas. IDEA and Concept grants are uniquely designed to dramatically advance our knowledge in areas that offer the greatest potential. IDEA and Concept grants are precisely the type of grants that rarely receive funding through more traditional programs such as the National Institutes of Health and private research programs. They therefore complement, and do not duplicate, other federal funding programs. This is true of other DOD award mechanisms also.

Innovator awards invest in world renowned, outstanding individuals rather than projects, by providing funding and freedom to pursue highly creative, potentially groundbreaking research that could ultimately accelerate the eradication of breast cancer. The Era of Hope Scholar Award supports the formation of the next generation of leaders in breast cancer research, by identifying the best and brightest scientists early in their careers and giving them the necessary resources to pursue a highly innovative vision of ending breast cancer.

These are just a few examples of innovative funding opportunities at the DOD BCRP that are filling gaps in breast cancer research. Scientists have lauded the Program and the importance of these award mechanisms. In 2005, Zelton Dave Sharp wrote about the importance of the Concept award mechanism:

Our Concept grant has enabled us to obtain necessary data to recently apply for a larger grant to support this project. We could have never gotten to this stage without the Concept award. Our eventual goal is to use the technology we are developing to identify new compounds that will be effective in preventing and/or treating breast cancer...Equally important, however, the DOD BCRP does an outstanding job of supporting graduate student trainees in breast cancer research, through training grants and pre-doctoral fellowships...The young people supported by these awards are the lifeblood of science, and since they are starting their training on projects relevant to breast cancer, there is a high probability they will devote their entire careers to finding a cure. These young scientists are by far the most important "products" that the DOD BCRP produces."

- Zelton Dave Sharp, Associate Professor, Interim Director/Chairman, Institute of Biotechnology/Dept. Molecular Medicine, University of Texas Health Science Center (August 2005)

The DOD BCRP also focuses on moving research from the bench to the bedside. DOD BCRP awards are designed to fill niches that are not addressed by other federal agencies. The BCRP considers translational research to be the application of well-founded laboratory or other pre-clinical insight into a clinical trial. To enhance this critical area of research, several research opportunities have been offered. Clinical Translational Research Awards have been awarded for investigator-initiated projects that involve a clinical trial within the lifetime of the award. The BCRP has expanded its emphasis on translational research by also offering five different types of awards that support work at the critical juncture between laboratory research and bedside applications.

The Centers of Excellence award mechanism brings together the world's most highly qualified individuals and institutions to address a major overarching question in breast cancer research that could make a significant contribution towards the eradication of breast cancer. Many of these Centers are working on questions that will translate into direct clinical applications. These Centers include the expertise of basic, epidemiology and clinical researchers, as well as consumer advocates.

Dr. John Niederhuber, now the Director of the National Cancer Institute (NCI), said the following about the Program when he was Director of the University of Wisconsin Comprehensive Cancer Center in April, 1999:

Research projects at our institution funded by the Department of Defense are searching for new knowledge in many different fields including: identification of risk factors, investigating new therapies and their mechanism of action, developing new imaging techniques and the development of new models to study [breast cancer]...Continued availability of this money is critical for continued progress in the nation's battle against this deadly disease.

Scientists and consumers agree that it is vital that these grants continue to support breast cancer research. To sustain the Program's momentum, $150 million for peer-reviewed research is needed in FY10.

Scientific Achievements

One of the most promising outcomes of research funded by the DOD BCRP was the development of the first monoclonal antibody targeted therapy that prolongs the lives of women with a particularly aggressive type of advanced breast cancer. This drug could not have been developed without first researching and understanding the gene known as HER-2/neu, which is involved in the progression of some breast cancers. Researchers found that over-expression of HER-2/neu in breast cancer cells results in very aggressive biologic behavior. The same researchers demonstrated that an antibody directed against HER-2/neu could slow the growth of the cancer cells that over-expressed the gene. This research, which led to the development of the targeted therapy, was made possible in part by a DOD BCRP-funded infrastructure grant. Other researchers funded by the DOD BCRP are identifying similar kinds of genes that are involved in the initiation and progression of cancer.

Another example of innovation in the Program is in the area of imaging. One DOD BCRP awardee developed a new use for medical hyperspectral imaging (MHSI) technology. This work demonstrated the usefulness of MHSI as a rapid, noninvasive, and cost-effective evaluation of normal and tumor tissue during a real-time operating procedure. Application of MHSI to surgical procedures has the potential to significantly reduce local recurrence of breast tumors and may facilitate early determination of tumor malignancy.

Studies funded by the DOD BCRP are examining the role of estrogen and estrogen signaling in breast cancer. For example, one study examined the effects of the two main pathways that produce estrogen. Estrogen is often processed by one of two pathways; one yields biologically active substances while the other does not. It has been suggested that women who process estrogen via the biologically active pathway may be at higher risk of developing breast cancer. This research will yield insights into the effects of estrogen processing on breast cancer risk in women with and without family histories of breast cancer.

Another example of success from the Program is a study of sentinel lymph nodes (SLNs). This study confirmed that SLNs are indicators of metastatic progression of disease. The resulting knowledge from this study and others has led to a new standard of care for lymph node biopsies. If the first lymph node is negative for cancer cells, then it is unnecessary to remove all the lymph nodes. This helps prevent lymphodema which can be painful and have lasting complications.

Federal Money Well Spent

The DOD BCRP is as efficient as it is innovative. In fact, 90 percent of funds go directly to research grants. The flexibility of the Program allows the Army to administer it in such a way as to maximize its limited resources. The Program is able to quickly respond to current scientific advances and fulfills an important niche by focusing on research that is traditionally under-funded. This was confirmed and reiterated in two separate IOM reports released in 1997 and 2004. The areas of focus of the DOD BCRP span a broad spectrum and include basic, clinical, behavioral, environmental sciences, and alternative therapy studies, to name a few. The BCRP benefits women and their families by maximizing resources and filling in the gaps in breast cancer research.

The Program is responsive to the scientific community and to the public. This is evidenced by the inclusion of consumer advocates at both the peer and programmatic review levels. The consumer perspective helps the scientists understand how the research will affect the community and allows for funding decisions based on the concerns and needs of patients and the medical community.

The outcomes of the BCRP-funded research can be gauged, in part, by the number of publications, abstracts/presentations, and patents/licensures reported by awardees. To date, there have been more than 12,241 publications in scientific journals, more than 12,000 abstracts and nearly 550 patents/licensure applications. The American public can truly be proud of its investment in the DOD BCRP. Scientific achievements that are the direct result of the DOD BCRP grants are undoubtedly moving us closer to eradicating breast cancer.

Independent Assessments of Program Success

The success of the DOD peer-reviewed Breast Cancer Research Program has been illustrated by several unique assessments of the Program. The IOM, which originally recommended the structure for the Program, independently re-examined the Program in a report published in 1997. They published another report on the Program in 2004. Their findings overwhelmingly encouraged the continuation of the Program and offered guidance for program implementation improvements.

The 1997 IOM review of the DOD peer-reviewed Breast Cancer Research Program commended the Program, stating, "the Program fills a unique niche among public and private funding sources for cancer research. It is not duplicative of other programs and is a promising vehicle for forging new ideas and scientific breakthroughs in the nation's fight against breast cancer." The 2004 report spoke to the importance of the program and the need for its continuation.

Transparent and Accountable to the Public

The DOD peer-reviewed Breast Cancer Research Program not only provides a funding mechanism for high-risk, high-return research, but also reports the results of this research to the American people every two to three years at a public meeting called the Era of Hope. The 1997 meeting was the first time a federally-funded program reported back to the public in detail not only on the funds used, but also on the research undertaken, the knowledge gained from that research and future directions to be pursued.

Sixteen hundred and consumers and researchers met for the fifth Era of Hope meeting in June, 2008. As MSNBC.com's Bob Bazell wrote, this meeting "brought together many of the most committed breast cancer activists with some of the nation's top cancer scientists. The conference's directive is to push researchers to think 'out of the box' for potential treatments, methods of detection and prevention in ways." He went on to say "the program…has racked up some impressive accomplishments in high-risk research projects…"

One of the topics reported on at the meeting was the development of more effective breast imaging methods. An example of the important work that is coming out of the DOD BCRP includes a new

screening method called molecular breast imaging, which helps detect breast cancer in women with dense breasts – which can be difficult using a mammogram alone. I invite you to log on to NBCC's new website http://influence.stopbreastcancer.org/ to learn more about the exciting research reported at the 2008 Era of Hope.

The DOD peer-reviewed Breast Cancer Research Program has attracted scientists across a broad spectrum of disciplines, launched new mechanisms for research and facilitated new thinking in breast cancer research and research in general. A report on all research that has been funded through the DOD BCRP is available to the public. Individuals can go to the Department of Defense website and look at the abstracts for each proposal at http://cdmrp.army.mil/bcrp/.

Commitment of the National Breast Cancer Coalition

The National Breast Cancer Coalition is strongly committed to the DOD BCRP in every aspect, as we truly believe it is one of our best chances for finding cures for and ways to prevent breast cancer. The Coalition and its members are dedicated to working with you to ensure the continuation of funding for this Program at a level that allows this research to forge ahead. From 1992, with the launch of our "300 Million More Campaign" that formed the basis of this Program, until now, NBCC advocates have appreciated your support.

Over the years, our members have shown their continuing support for this Program through petition campaigns, collecting more than 2.6 million signatures, and through their advocacy on an almost daily basis around the country asking for support of the DOD BCRP.

There are three million women living with breast cancer in this country today. This year, more than 40,000 will die of the disease and more than 240,000 will be diagnosed. We still do not know how to prevent breast cancer, how to diagnose it truly early or how to cure it. It is an incredibly complex disease. We simply cannot afford to walk away from this program.

Since the very beginning of this Program in 1992, Congress has stood with us in support of this important investment in the fight against breast cancer. In the years since, Chairman Murtha and Ranking Member Young, you and this entire Committee have been leaders in the effort to continue this innovative investment in breast cancer research.

NBCC asks you, the Defense Appropriations Subcommittee, to recognize the importance of what has been initiated by the Appropriations Committee. You have set in motion an innovative and highly efficient approach to fighting the breast cancer epidemic. We ask you now to continue your leadership and fund the Program at $150 million and maintain its integrity. This is research that will help us win this very real and devastating war against a cruel enemy.

Thank you again for the opportunity to submit testimony and for giving hope to all women and their families, and especially to the 3 million women in the United States living with breast cancer.

Testimony Submitted to the House Appropriations Subcommittee on Defense
Karen Peluso, Executive Director, Neurofibromatosis, Inc., Northeast

April 17, 2009

Thank you, Mr. Chairman, for the opportunity to submit testimony to the Subcommittee on the importance of continued funding for Neurofibromatosis (NF), a terrible genetic disorder closely linked to many common diseases widespread among the American population.

On behalf of Neurofibromatosis, Inc., Northeast, a participant in a national coalition of NF advocacy groups, I speak on behalf of the 100,000 Americans who suffer from NF as well as approximately 175 million Americans who suffer from diseases linked to NF such as cancer, brain tumors, heart disease, memory loss and learning disabilities.

Mr. Chairman, I am requesting increased support, in the amount of **$20 million, to continue the Army's highly successful Neurofibromatosis Research Program (NFRP),** which is now conducting clinical trials at nation-wide clinical trials centers created by NFRP funding. These clinical trials involve drugs that have already succeeded in eliminating tumors in humans and rescuing learning deficits in mice. Administrators of the Army program have stated that the number of high-quality scientific applications justify a much larger program.

What is Neurofibromatosis (NF)?
NF is a genetic disorder involving the uncontrolled growth of tumors along the nervous system which can result in terrible disfigurement, deformity, deafness, blindness, brain tumors, cancer, and/or death. NF can also cause other abnormalities such as unsightly benign tumors across the entire body and bone deformities. In addition, approximately one-half of children with NF suffer from learning disabilities. While not all NF patients suffer from the most severe symptoms, all NF patients and their families live with the uncertainty of not knowing whether they will be seriously affected because NF is a highly variable and progressive disease.

NF is not rare. It is three times more common than Multiple Sclerosis (MS) and Cystic Fibrosis combined, but is not widely known because it has been poorly diagnosed for many years. Approximately 100,000 Americans have NF, and it appears in approximately one in every 3,000 births. It strikes worldwide, without regard to gender, race or ethnicity. Approximately 50 percent of new NF cases result from a spontaneous mutation in an individual's genes, and 50 percent are inherited. There are two types of NF: NF1, which is more common, and NF2, which primarily involves tumors causing deafness and balance problems. In addition, advances in NF research stand to benefit over 175 million Americans in this generation alone because NF, the most common neurological disorder caused by a single gene, is directly linked to many of the most common diseases affecting the general population.

NF's Connection to the Military
Research on NF stands to benefit the military because this disorder is closely linked to cancer, brain tumors, learning disabilities, brain tissue degeneration, nervous system degeneration, deafness, memory loss, and balance. Because NF manifests itself in the nervous system, findings generated by the Army-supported research on NF address peripheral nerve regeneration after injury from such things as missile wounds and chemical toxins, and is important to gaining a

better understanding of wound healing and war-related illnesses. In addition, NF research now includes important investigations into genetic mechanisms which involve not just the nervous system but also other cancers.

Link to Other Illnesses

Researchers have determined that NF is closely linked to cancer, heart disease, learning disabilities, memory loss, brain tumors, and other disorders including deafness, blindness and orthopedic disorders, primarily because NF regulates important pathways common to these other disorders such as the RAS, cAMP and PAK pathways. Research on NF therefore stands to benefit millions of Americans:

Cancer – NF is closely linked to many of the most common forms of human cancer, affecting approximately 65 million Americans, because of its tumor suppresser function. Research has demonstrated that NF's tumor suppressor protein, neurofibromin, inhibits RAS, one of the major malignancy causing growth proteins involved in 30 percent of all cancer. Accordingly, advances in NF research may well lead to treatments and cures not only for NF patients but for all those who suffer from cancer and tumor-related disorders. Similar studies have also linked epidermal growth factor receptor (EGF-R) to malignant peripheral nerve sheath tumors (MPNSTs), a form of cancer which disproportionately strikes NF patients.

Heart disease – Researchers have demonstrated that mice completely lacking in NF1 have congenital heart disease that involves the endocardial cushions which form in the valves of the heart. This is because the same *ras* involved in cancer also causes heart valves to close. Neurofibromin, the protein produced by a normal NF1 gene, suppresses *ras*, thus opening up the heart valve. Promising new research has also connected NF1 to cells lining the blood vessels of the heart, with implications for other vascular disorders including hypertension, which affects approximately 50 million Americans. Researchers believe that further understanding of how an NF1 deficiency leads to heart disease may help to unravel molecular pathways involved in genetic and environmental causes of heart disease.

Learning disabilities – Learning disabilities are the most common neurological complication in children with NF1. Research aimed at rescuing learning deficits in children with NF could open the door to treatments affecting 35 million Americans and 5 percent of the world's population who also suffer from learning disabilities. Leading researchers have already rescued learning deficits in both mice and fruit flies with NF1 with a number of drugs, and clinical trials have now been approved by the FDA. This NF research could potentially save federal, state, and local governments, as well as school districts billions of dollars annually in special education costs resulting from a treatment for learning disabilities. It also holds enormous implications for understanding and treating associated social and behavioral problems in children who suffer from learning disabilities.

Memory Loss – Researchers have also determined that NF is closely linked to memory loss and are now investigating conducting clinical trials with drugs that may not only cure NF's cognitive disorders but also result in treating memory loss as well with enormous implications for patients who suffer from Alzheimer's disease and other dementias. Indeed, one leading Army funded researcher is pursuing parallel research into both NF and Alzheimer's simultaneously.

Deafness – NF2 accounts for approximately 5 percent of genetic forms of deafness. It is also related to other types of tumors, including schwannomas and meningiomas, as well as being a major cause of balance problems.

The Army's Contribution to NF Research
Recognizing NF's importance to both the military and to the general population, Congress has given the Army's NF Research Program strong bipartisan support. After the initial three-year grants were successfully completed, Congress appropriated continued funding for the Army NF Research Program on an annual basis. From FY96 through FY09, this funding has amounted to $200.3 million, in addition to the original $8 million appropriation in FY92. In addition, between FY96 and FY08, approximately 223 awards have been granted to researchers across the country.

The Army program funds innovative, groundbreaking research which would not otherwise have been pursued, and has produced major advances in NF research, including conducting clinical trials in a nation-wide clinical trials infrastructure created by NFRP funding, development of advanced animal models, and preclinical therapeutic experimentation. In addition, the program has brought new researchers into the field of NF. Unfortunately, despite this progress the number of awards has decreased over the last several years due to a decrease in funding levels, resulting in many highly qualified applications going unfunded. Army officials administering this program have indicated that they could easily fund more applications if funding were available because of the high quality of the research applications received.

In order to ensure maximum efficiency, the Army collaborates closely with other federal agencies that are involved in NF research, such as the National Institutes of Health (NIH). Senior program staff from the National Institute of Neurological Disorders and Stroke (NINDS), for example, sit on the Army's NF Research Program Integration Panel which sets the long-term vision and funding strategies for the program. This assures the highest scientific standard for research funding, efficiency and coordination while avoiding duplication or overlapping of research efforts.

Because of the enormous advances that have been made as a result of the Army's NF Research Program, research in NF has truly become one of the great success stories in the current revolution in molecular genetics. Accordingly, many medical researchers believe that NF should serve as a model to study all diseases. Indeed, since the discovery of the NF1 gene in 1990, researchers are now on the threshold of developing a treatment and cure for this terrible disease.

Thanks in large measure to this Subcommittee's support; scientists have made enormous progress since the discovery of the NF1 gene. Major advances in just the past few years have ushered in an exciting era of clinical and translational research in NF with broad implications for the general population. These recent advances have included:

- Phase II and Phase III clinical trials involving new drug therapies for both cancer and cognitive disorders;
- Creation of a National Clinical and Pre-Clinical Trials Infrastructure and NF Centers;
- Successfully eliminating tumors in NF1 and NF2 mice with the same drug;
- Developing advanced mouse models showing human symptoms;

- Rescuing learning deficits and eliminating tumors in mice with the same drug;
- Determining the biochemical, molecular function of the NF genes and gene products;
- Connecting NF to more and more diseases because of NF's impact on many body functions.

Future Directions
NF research has now advanced to the translational and clinical stages which hold incredible promise for NF patients, as well as for patients who suffer from many of the diseases linked to NF. This research is costly and will require an increased commitment on the federal level. Specifically, future investment in the following areas would continue to advance research on NF:

- Clinical trials;
- Funding of clinical trials network to connect patients with experimental therapies;
- DNA Analysis of NF tissues;
- Development of NF Centers, tissue banks, and patient registries;
- Development of new drug and genetic therapies;
- Further development of advanced animal models;
- Expansion of biochemical research on the functions of the NF gene and discovery of new targets for drug therapy; and
- Natural history studies and identification of modifier genes – studies are already underway to provide a baseline for testing potential therapies and differentiate among different phenotypes of NF.

Fiscal Year 2010 Request
Mr. Chairman, the Army's highly successful NF Research Program has shown tangible results and direct military application with broad implications for the general population. The program has now advanced to the translational and clinical research stages, which are the most promising, yet the most expensive direction that NF research has taken. The program has succeeded in its mission to bring new researchers and new approaches to research into the field. Therefore, increased funding is now needed to take advantage of promising avenues of investigation, to continue to build on the successes of this program, and to fund this promising research thereby continuing the enormous return on the taxpayers' investment.

I respectfully request an appropriation of $20 million in your FY10 Department of Defense Appropriations bill for the Army's Neurofibromatosis Research Program.

Mr. Chairman, in addition to providing a clear military benefit, the DOD's Neurofibromatosis Research Program also provides hope for the 100,000 Americans who suffer from NF, as well as the 175 million of Americans who suffer from NF's related diseases such as cancer, learning disabilities, memory loss, heart disease, and brain tumors. Leading researchers now believe that we are on the threshold of a treatment and a cure for this terrible disease. With this Subcommittee's continued support, we will prevail.

Thank you for your support of this program and I appreciate the opportunity to submit this testimony to the Subcommittee.

Testimony of the
American Museum of Natural History
presented to the
House Appropriations Subcommittee on Defense

April 17, 2009

Overview

Recognizing its potential to aid the Department of Defense in its goal to support research to prepare for and respond to the full range of threats, the American Museum of Natural History seeks in $3.5 million in FY10 to contribute its unique resources to the advancement of molecular and computational biology, fundamental physics, and optics in support of national security.

About the American Museum of Natural History

The American Museum of Natural History (AMNH) is one of the nation's preeminent institutions for scientific research and public education. Since its founding in 1869, the Museum has pursued its mission to "discover, interpret, and disseminate—through scientific research and education—knowledge about human cultures, the natural world, and the universe." The AMNH research staff numbers over 200, with tenure track faculty carrying out cutting-edge research in fields ranging from molecular biology and genome science to earth and space science, anthropology, and astrophysics. Museum scientists publish nearly 450 scientific articles each year and enjoy a success rate in competitive (peer reviewed) scientific grants that is approximately double the national average. The work of its scientists forms the basis for all the Museum's activities that seek to explain complex issues and help people to understand the events and processes that created and continue to shape the Earth, life and civilization on this planet, and the universe beyond.

Advancing Research Aligned With National Security Goals

The Department of Defense (DOD) ensures the nation's security and its capacity to understand and respond to threats in this new era of complex defense challenges. DOD is committed to the research, tools, and technology that will achieve these goals. The American Museum of Natural History (AMNH), in turn, is a preeminent research museum, home to leading research programs in molecular and systematic biology and bio-computation that are uniquely positioned to advance the Nation's capacity to prepare for and respond to threats such as bioterrorism. In addition, its Physical Sciences Division conducts leading research programs in observational, theoretical, and computational astrophysics, which align with DOD interests in key areas of physics, including optics.

The AMNH is an internationally recognized research and education institution with unique research capacity; a superbly qualified scientific staff, and unparalleled facilities, including a 700 CPU parallel computing cluster, high throughput sequencing capacity, an ultra-cold tissue collection that stores specimens with preserved DNA, and one of the world's largest and most important natural history collections, as well as expertise in using remote sensing and Geographical Information System (GIS) technologies to applied research questions.

In FY05, the Museum and DOD launched a multi-faceted research partnership via DARPA that leverages the Museum's unique expertise and capacity. Since that time, the AMNH has been carrying out research that directly relates to the Defense Research Sciences' goals by increasing our capacity to predict where disease outbreaks might occur and to effectively monitor disease-causing agents and their global spread—which is vital for national security. This research project is developing a computational system to rapidly compare genetic sequences of pathogens, then generate a global map showing over time and place the spread of disease-causing viruses that may develop drug resistance and spread from animals to humans.

Throughout this partnership, DARPA program managers have supported AMNH's work, have sought to make it known to DOD-supported scientists working on related problems, and have invited AMNH scientists to participate in DARPA conferences. With DARPA support to date, the project has advanced understanding of emerging infectious disease through analysis of the zoonotic origins and genomic evolution of SARS coronavirus, studied influenza re-assortment and developed methods for assessing the quality of disease surveillance, and convened a special working group of physicians, epidemiologists, policymakers, agency representatives, and public health experts from around the country to explore how the tools and techniques of evolutionary and systematic biology benefit the study and containment of infectious disease for the protection of global health. We are now able to track global evolution of pathogenic viruses such as avian flu, and can also identify, for any geographic region, the major and minor sources of pathogenic viruses.

In FY10, the Museum seeks to continue DARPA support to advance its critical work in the study of the evolution and global spread of infectious disease by investigating even more complex systems, moving from viruses to the study of bacteria and including ecological data. At the same time, we seek to extend the existing DOD research partnership into new areas of investigation, including the physics of light, optical physics, adaptive optics and imaging, and—which have important implications for surveillance and fundamental physics. With this support, which the Museum will leverage with funds from nonfederal and federal sources, we will be able to continue to draw on the Museum's unique research capabilities to advance research important to defense goals and our national security.

Testimony Submitted

by

Dr. Raymond Bye, Jr.

Director of Federal Relations

The Florida State University

Before the Subcommittee on Defense

Committee on Appropriations

US House of Representatives

April 28, 2009

Summary: Florida State University is requesting $4,300,000 from the Army University and Industry Research Centers Program (PE61104) for the **Nanotubes Optimized for Lightweight Exceptional Strength (NOLES)/Composite Material Program**; $5,000,000 from the Defense RDT&E, Navy, Force Protection Applied Research Account (PE 0602123N) for the **Integration of Electo-kinetic Weapons into the Next Generation Navy Ships Program**; $4,000,000 from the Navy—Research, Development, Test and Evaluation, Navy, Warfighter Sustainment Applied Research (PE#0602236N, Line 9) for the **Integrated Cryo-cooled High Power Density Systems,** and $3,500,000 from the Air Force Office of Scientific Research (PE61102) for the **Developing Active Flow and Noise Control Systems for Subsonic to Near Hypersonic Flight** program.

Mr. Chairman, I would like to thank you and the Members of the Subcommittee for this opportunity to present testimony before this Committee. I would like to take a moment to briefly acquaint you with Florida State University.

Located in Tallahassee, Florida's capitol, FSU is a comprehensive Research university with a rapidly growing research base. The University serves as a center for advanced graduate and professional studies, exemplary research, and top-quality undergraduate programs. Faculty members at FSU maintain a strong commitment to quality in teaching, to performance of research and creative activities, and have a strong commitment to public service. Among the current or former faculty are numerous recipients of national and international honors including Nobel laureates, Pulitzer Prize winners, and several members of the National Academy of Sciences. Our scientists and engineers do excellent research, have strong interdisciplinary interests, and often work closely with industrial partners in the commercialization of the results of their research. Florida State University had over $200 million this past year in sponsored research awards.

Florida State University attracts students from every state in the nation and more than 100 foreign countries. The University is committed to high admission standards that ensure quality in its student body, which currently includes National Merit and National Achievement Scholars, Rhodes and Goldwater Scholars, as well as students with superior creative talent. Since 2005, FSU students have won more than 30 nationally competitive scholarships and fellowships

including 3 Rhodes Scholarships, 2 Truman Scholarships, Goldwater, and 18 Fulbright Fellowships. At Florida State University, we are very proud of our successes as well as our emerging reputation as one of the nation's top public research universities.

Mr. Chairman, let me summarize our primary interest today. The first project involves improving our nation's fighting capabilities and is called the Nanotubes Optimized for Lightweight Exceptional Strength (NOLES)/Composite Materials Project.

The U.S. Army's objective of developing effective personnel protection and a lighter, stronger fleet of fighting vehicles may be achieved through the diminutive nanotubes that 1) are the strongest fiber known, 2) have a thermal conductivity two times higher than pure diamond, and 3) have unique electrical conductivity properties and an ultra-high current carrying capacity [1996 Nobel Laureate Richard Smalley]. For producing lightweight multifunctional composites, resins impregnated with nanotubes hold the promise of creating structures, which, pound for pound, will be the strongest ever known, and hence offer maximum personnel and vehicle protection. Benefits are apparent not only to defense, but also throughout the commercial world.

Partnered with the Army Research Laboratory and the top five U.S. defense companies – Boeing, General Dynamics, Lockheed Martin, Northrop Grumman and Raytheon – as well as Armor Holdings, one of the nation's largest armor manufacturers, Florida State University's team of multi-disciplinary faculty and students has developed unique design, characterization and rapid prototyping capabilities in the field of nano-composite research, leading to vital defense applications. For instance, in a partnership with Lockheed Martin Missiles and Fire Control-Orlando, FSU researchers delivered more than 150 square feet of nanotube/polycarbonate (CNT/PC) composites for armor evaluation. The NOLES research team is working with the technical staff of General Dynamics in developing high performance thermal management materials utilizing nanotubes. The NOLES team is collaborating with Boeing and Northrop Grumman to use nanotube composites for shielding against electromagnetic interference (EMI). In addition, FSU's nanotube composites are being tested for missile wings, UAVs and missile guidance systems by several defense contractors.

Two core programs are envisioned for FY10: 1) develop nanotubes as a material platform for a new generation of devices, structures and systems, giving special attention to the design and demonstration for defense applications; and 2) utilize nanotube buckypapers and vertically grown nanotube arrays initially for liquid crystal display backlighting and eventually for flexible displays. We are requesting $4,300,000 for this important program.

Our second project is also important to our nation's defense and involves our capabilities at sea and is called the Integration of Electro-kinetic Weapons into the Next Generation Navy Ships program.

The U.S. Navy is developing the next-generation integrated power system (NGIPS) for the future war ships that have an all-electric platform of propulsion and weapon loads and an electric power systems with rapid reconfigurable distribution systems for integrated fight-through power (IFTPS). On-demand delivery of the large amounts of energy needed to operate these types of dynamic loads raises issues that must be addressed including the appropriate topology for the ship electric distribution system for rapid reconfiguration to battle readiness and the energy supply technology for the various dynamic load systems. The goal of this initiative is to investigate the energy delivery technologies for dynamic loads, such as electro-kinetic

weapons systems, and investigate the integration and interface issues of these loads on the ship NGIPS through system simulations and prototype tests in hardware-in-the loop simulation. The results will provide the Navy's ship-builders with vital information to design and de-risk deployable ship NGIPS and load power supplies.

With significant support from the Office of Naval Research (ONR), FSU has established the Center for Advanced Power Systems (CAPS), which has integrated a real time digital power system simulation and modeling capability and hardware test-bed, capable of testing IPS power system components at ratings up to 5MW, offering unique hardware-in-the-loop simulation capabilities unavailable anywhere in the world. FSU is partnering with the University of Texas-Austin and General Atomics to combine the best talents for modeling and simulation of ship power systems, hardware-in-the -loop testing, power supplies for present and future electro-kinetic systems, and interfacing the weapon to a power system. UT-Austin will work with FSU to provided validated models of system performance and in subscale testing to provide more complete model validation where needed. General Atomics will provide the power requirements on each side of the weapons interface to the shipboard power distribution system to better define the interface effort. The National High Magnetic Field Laboratory (NHMFL) will utilize its research expertise and infrastructure for the proposed development. FSU's partnership with University of Florida and Los Alamos National Laboratory is a key part of the NHMFL. General Atomics is currently involved in the design and development of the pulse forming network for the Electromagnetic Rail Gun program for the US Navy and the design and development of power distribution architectures (i.e., NGIPS and IFTP) for future US Navy all-electric combatants. We are seeking $5,000,000 for this important work.

Third, the objective of this program is to approach the goal of achieving cryo-cooled high power densities through systems integration, management of heat generation and removal in the electrical system. The systems approach begins with identifying heat sources and managing them to minimize energy consumption and capital expenditures of large scale advanced power systems.

The research activities are as follows:

1. **Systems Analysis:** Extensive system modeling and simulation of the integrated electrical and thermal systems to understand dynamic performance under normal and adverse conditions is necessary to achieve an optimal system configuration. Develop prototypes of key technologies and test in hardware-in-the-loop simulations at levels of several megawatts (MW) to validate and demonstrate the advanced technologies.
2. **Materials – Advanced Conductors, Semi-conductors and Insulation:** Characterization of conductor materials (both normal and superconducting), semi-conductors (for use in power electronic components) and insulating materials (both thermal and electrical) at cryogenic temperatures to obtain the data needed to model system performance and design components. Thorough understanding of the materials and their characteristics is important.
3. **Cryo-thermal Systems:** Optimize thermal system options, including conductive heat transfer and gas phase and fluid phase heat transfer systems. Minimizing heat leaks from the ambient to the low temperature environment are critical to successful performance and quite sensitive to cryogenic system design and fabrication. Adaptability to economical fabrication technologies is a major issue for investigation.

System Components: Consider new concepts for design of system components and interfaces to achieve optimum system integration, such as AC and DC power cables, motors, transformers, actuators, fault current limiters, and power electronics operating at cryogenic temperatures. High power density cryo-cooled systems require the use of new families of materials. We are seeking $4,000,000 for this project.

Finally, our newest project is entitled, "**Developing Active Flow and Noise Control Systems for Subsonic to Near Hypersonic Flight**". Recent research has shown that *Active Flow Control* (AFC) is a key enabling technology that can provide significant benefits and can offer substantial performance gains for a range of internal and external flows for the next generation of military and civilian aircraft a launch vehicles. In subsonic flows, AFC application range from their use in reducing or eliminating flow separation over aircraft wings to distortion reduction at the engine inlet and other internal flows. Supersonic (& hypersonic) flow, applications include control of flow oscillations in cavity flows, supersonic impinging jets, and jet noise--areas where active flow control may dramatically increase performance.

However, for such gains to be realized in practical aircraft, there is a need for 1) developing actuator systems that have the requisite performance in terms of *control authority, robustness* and efficiency; 2) the output should be 'tunable', both in terms of amplitude and frequency over a large dynamic range, and 3) a development process to occur in the context of *real applications* and *testing under realistic conditions*. Currently, the availability of such actuator systems is severely lacking. We propose developing and implementing such flow control systems for a range of applications; one such application will be their use in 'smart and adaptive' supersonic engine inlets.

The design of supersonic inlets that operate efficiently over the entire flight envelope is one of the challenges in the next generation of aircraft. In this project, we will utilize a novel inlet design which will generate and modulate oblique shocks through the actuation of fluidic microjet-based actuator arrays. Utilizing this "active-adaptive inlet shock shaping" technique will provide higher total pressure recovery, low flow spillage drag, and much improved flow at the engine face. It may considerably reduce the intake weight and provide a simple, robust, cost-effective geometry. Using a systematic approach, we will a) develop microjet-based (steady and pulsed) actuator systems; b) test and refine these systems in canonical/building block geometries in the supersonic wind tunnel facility; c) integrate and test the refined actuator system in an inlet configuration; and d) develop scaling and design laws through the above studies to develop systems for full-scale applications.

Given our past successes in developing and transitioning AFC for realistic applications, we hope to develop AFC technologies that can be rapidly transitioned to aircraft systems (and space/launch applications in some cases) for military and commercial applications. We are requesting $3,500,000 in FY10 to initiate this effort.

Mr. Chairman, we believe this research is vitally important to our country and would greatly appreciate your support.

Written Testimony of Cara Tenenbaum, Policy Director
Ovarian Cancer National Alliance
Regarding Fiscal Year 2010 Ovarian Cancer Related Funding
House Subcommittee on Defense
April 17, 2009

On behalf of the Ovarian Cancer National Alliance, I thank the Subcommittee for this opportunity to submit comments for the record regarding the Ovarian Cancer National Alliance's fiscal year (FY) 2010 funding recommendations. We believe these recommendations are critical to ensure that advances can be made to help reduce and prevent suffering from ovarian cancer. For 12 years, the Ovarian Cancer National Alliance has worked to increase awareness of ovarian cancer and advocated for additional federal resources to support research that would lead to more effective diagnostics and treatments.

As an umbrella organization with numerous state and local groups, the Ovarian Cancer National Alliance unites the efforts of more than one million grassroots activists, women's health advocates, and health care professionals to bring national attention to ovarian cancer.

As part of this effort, the Ovarian Cancer National Alliance advocates for continued federal investment in the Department of Defense Congressionally Directed Medical Research Programs (CDMRP). **The Ovarian Cancer National Alliance respectfully requests that Congress provide $30 million for the Ovarian Cancer Research Program (OCRP) in FY 2010.**

Ovarian Cancer's Deadly Statistics

According to the American Cancer Society, in 2008, more than 21,000 American women were diagnosed with ovarian cancer, and more than 15,000 lost their lives to this terrible disease. Ovarian cancer is the fifth leading cause of cancer death in women. Currently, more than half of the women diagnosed with ovarian cancer will die within five years. When detected early, the five-year survival rate increases to more than 90 percent, but when detected in the late stages, the five-year survival rate drops to less than 29 percent.

In the more than 30 years since the War on Cancer was declared, ovarian cancer mortality rates have not significantly improved. A valid and reliable screening test – a critical tool for improving early diagnosis and survival rates – still does not exist for ovarian cancer. Behind the sobering statistics are the lost lives of our loved ones, colleagues and community members. While we have been waiting for the development of an effective early detection test, thousands of our mothers, daughters, sisters and friends -- including one-third of our founding board members, have lost their battle with ovarian cancer.

In 2007, a number of prominent cancer organizations released a consensus statement identifying the early warning symptoms of ovarian cancer. Without a reliable diagnostic test, we can rely only on this set of vague symptoms of a deadly disease, and trust that both women and the medical community will identify these symptoms and act promptly and quickly. Unfortunately, we know that this does not always happen. Too many women are diagnosed late

due to the lack of a test; too many women and their families endure life-threatening and debilitating treatments to kill cancer; too many women are lost to this horrible disease.

The Ovarian Cancer National Alliance exists to ensure that women are diagnosed early, receive appropriate treatments, are active participants in their care and not just survive, but thrive. All women should have access to treatment by a gynecologic oncology specialist. All women should have access to a valid and reliable screening test. We must deliver new and better treatments to patients and the physicians and nurses who treat them. Until we have a test, we must continue to increase awareness and educate women and health professionals about the signs and symptoms associated with this disease.

The symptoms of ovarian cancer are:

- Bloating
- Pelvic or abdominal pain
- Difficulty eating or feeling full quickly
- Urinary symptoms (urgency or frequency)

Women who have these symptoms almost daily for more than a few weeks should see their doctor, preferably a gynecologist. Prompt medical evaluation may lead to detection at the earliest possible stage of the disease. Early stage diagnosis is associated with an improved prognosis.

The Ovarian Cancer Research Program

The aim of the OCRP is to conquer ovarian cancer by promoting innovative multidisciplinary research efforts on understanding, detecting, preventing, diagnosing and controlling ovarian cancer. In support of this, the OCRP has distributed $121.7 million from 1997 to 2008 for research on topics ranging from diagnosis to treatment to quality of life.

Since 1997, research conducted through the OCRP has been published and presented widely, helping bolster and expand the limited body of scientific knowledge of ovarian cancer. Further, the program attracts and retains investigators to the field of ovarian cancer research. The OCRP has ample use for increased funds; in FY 2008, the program funded less than 20 percent of the successful research proposals due to insufficient funds. Only with increased funding can the OCRP grow and continue to contribute to the fight against ovarian cancer.

Today, ovarian cancer researchers are still struggling to develop the first ovarian cancer screening test. With traditional research models largely unsuccessful, the innovative grants awarded by the OCRP are integral in moving the field of research forward. The OCRP has been responsible for the only two working animal models of ovarian cancer – models that will help unlock keys to diagnosing and treating ovarian cancer. Only with sufficient funding will the realization of a desperately-needed screening test be possible.

The OCRP received a $20 million appropriation in FY 2009, an increase from the $10 million appropriation made in the six previous years. However, the OCRP remains a modest program compared to the other cancer programs in the CDMRP, and has made vast strides in fighting ovarian cancer with relatively few resources. With more resources, the program can support more research into screening, early diagnosis and treatment of ovarian cancer. In light of this, we request that Congress appropriate $30 million for FY 2010 to the OCRP.

Scientific Achievements

Since its inception, the Ovarian Cancer Research Program has developed a multidisciplinary research portfolio that encompasses etiology, prevention, early detection/diagnosis, preclinical therapeutics, quality-of-life, and behavioral research projects. The OCRP strengthens the federal government's commitment to ovarian cancer research and supports innovative and novel projects that propose new ways of examining prevention, early detection and treatment. The program also attracts new investigators into ovarian cancer research, and encourages proposals that address the needs of minority, elderly, low-income, rural and other under-represented populations.

The program's achievements have been documented in numerous ways, including 371 publications, 431 abstracts/presentations and 15 patents applied for/obtained as FY 08. The program also has introduced and supported 25 new investigators in the field of ovarian cancer research, 18 of whom are still active in ovarian cancer research as of FY 08. Investigators funded through the OCRP have produced several crucial breakthroughs in the study of prevention and detection, including:

- Creation of a human ovarian tissue bank
- Development of chicken model to study susceptibility to ovarian cancer
- Use of rhesus monkey model to study contraceptives and vitamin A analog in prevention of ovarian cancer
- Detection of a possible biomarker (BCL-2) screening tool to detect ovarian cancer through urine samples
- Development of a potential screening tool to determine chemotherapy sensitivity in ovarian cancer patients
- Use of new bioinformatics tools to identify different sets of genes for different types of ovarian cancer tumors
- Development of radio-therapeutics for advanced ovarian cancer treatment
- Discovery of a receptor expression level as a possible indicator of aggressive ovarian cancer tumor behavior
- Discovery of potential method to overcome oncogene-associated chemoresistance in ovarian cancer cells
- Continued focus on ovarian cancer screening tools
- Development of radiation therapies for metastatic ovarian cancer
- Discovery of production of certain enzymes by ovarian cancer cells; this discovery may lead to the development of vaccines for recurrent ovarian cancer

Recent research has focused on immunotherapy, ovarian cancer stem cells, and the microtumor environment. The OCRP has made grants to research projects such as: Dr. Rebecca Liu's study of the anti-ovarian cancer properties of resveratrol, found in grapes, nuts, and wine; Dr. Patricia Kruk's study of the detection of protein Bel-2 in urine samples as a means early detection of ovarian cancer; and Dr. Touradj Solouki's study of biomarkers found in exhaled breath as a means of early detection of ovarian cancer. Further, the OCRP supports mentored training and research experience for promising scientists at Historically Black Colleges and Universities and Minority Institutions.

Ovarian Cancer National Alliance

Summary

The Ovarian Cancer National Alliance maintains a long-standing commitment to work with Congress, the Administration, and other policymakers and stakeholders to improve the survival rate from ovarian cancer through education, public policy, research and communication. Please know that we appreciate and understand that our nation faces many challenges and that Congress has limited resources to allocate; however, we are concerned that without increased funding to bolster and expand ovarian cancer research efforts, the nation will continue to see growing numbers of women losing their battle with this terrible disease.

On behalf of the entire ovarian cancer community – patients, family members, clinicians and researchers – we thank you for your leadership and support of federal programs that seek to reduce and prevent suffering from ovarian cancer. Thank you in advance for your support of $30 million in FY 2010 funding for the Ovarian Cancer Research Program.

Submitted on behalf of the Ovarian Cancer National Alliance by:

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Public Witness Testimony for the Record

Receipt Reply requested:

To: House Committee on Appropriations Subcommittee on Defense

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Email: **sherry.young@mail.house.gov**

-

From: Jay Alexander, Founder of the grassroots citizens action group "We Can Take It!"

-

Address: 3301 58th Ave N#102,

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Contacts:

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Phone: 727-412-5792 cell, 727-525-8769 home

Associates: Ken Bynum in Jay , FL (850) 675 6108 and Bill Reed in Altus, OK (580)-480-0519

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Website: www.wecantakeit.org

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Re: Written Public testimony for the Reactivation of the Civilian Conservation Corps (CCC) on Native American Lands, Public (Federal and Military Reservation) Lands.

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We ask this committee to reactivate the United States Civilian Conservation

Corps.

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In the future, we respectfully request amount of $500 million dollars to be appropriated over a period of ten years for the reactivation of the CCC on sovereign Native American Lands. Monies would be distributed to the Native Tribes with oversight provided by the Departments of the Interior and Agriculture., to fund and carry out shovel ready work projects similar to the template of FDR's CCC under a separate Indian Division for Native American Lands. The CCC would enable enrollement for all unemployed First American adults aged from 17 to 35. They would be able to work from their homes on infrastructure and ecosystem work projects on their sovereign tribal and adjacent lands. The CCC program worked for our first Americans in the past and can work for the entire nation again.

We also in the future request the appropriation up to of 5 billion a year or to 50 billion over next decade (to include the allotment for the request above for our First Americans) for employment recovery for the rest of our Nation's fit young Americans and Veterans. (The estimated cost of the program is based on the 1942 dollar.) The program would again be conducted by the the Departments of Interior, Agriculture. the US Army (Defense) and the Department of Veterans Affairs and Labor, to avoid the creation of another government bureaucracy. This program would provide shovel ready projects and put up to a half a million enrollee work boots on the ground every year.

Shovel Ready projects as in FDR's time, work projects in general include forest, park , watershed, erosion control and grazing management. New projects would involve vocational training in solar and wind power, training and work for hazardous waste removal and projects involving phytoremediation, organic farming, new wildlife habitat and new areas for recreation.

The requested appropriation would include the purchase of acreage adjacent to government owned lands for the purpose of creating new green space for wildlife habitat and recreation.

Seventy-six years ago, the 73rd Congress and President Roosevelt faced a similar situation banking crisis. FDR was, personally interested in preserving the environment and providing temporary employment for the nation's youth and veterans. Legislation to establish the U.S. Civilian Conservation Corps was also introduced March 21, 1933 in a message to Congress he wrote...

"It is essential to our recovery program . . . the first of these measures . . . can and should be immediately enacted. I propose to create a civilian conservation corps to be used in forestry, the prevention of soil erosion, flood control and similar projects . . . but also as a means of creating future national wealth. . . . More important, however, than the material gains from their labors will be the

moral and spiritual value of such work."

The president himself shepherded the legislation through both houses. It was signed into law 10 days later. Over the next nine years, almost 4 million young men were put to work reclaiming the country's natural resources. The men lived in government camps, food and clothing were provided, the Army supervised the camps, and the men were required to send 80 percent of their pay of $30 back to their families. ($30 in 1933 is equivalent to $451.48 in 2007.) It became the largest mobilization of civilian workers and the most popular government program in American History. In 1942, the 77th congress cut the CCC funding, but the program was never abolished by the 77th Congress and it only needs reactivated and the dust removed from the books.

The current rise in unemployment and poverty among unskilled young adults, war veterans (25% of the entire US homeless population today is our Veterans) and Native Americans (many reservations have as much as 50% unemployment). Global warming and our environmental need our stewardship. Our infrastructure is now rated at a D grade by the American Society of Engineers.

The time is right to reactivate the US Civilian Conservation Corps for our First Americans. It is by far the best "Shovel Ready" program to date to put thousands of work boots on the ground within a matter of weeks. This program is proven cost effective and would give the U.S. Taxpayer more 'Bang for the Buck!'

"We Can Take It!" urges the House Committee on Appropriations Subcommittee on Interior, Environment, and Related Agencies to give serious consideration to remobilize this 'Shovel Ready' workforce to salvage First American Lands and to salvage the lives of many young Native American citizens and Native American Veterans, now in jeopardy. They would be given jobs in the CCC if they qualify from the state of Maine to the US Territory of American Samoa.

Similar federal, state, and local government work programs for Native Lands should be re-absorbed into the Civilian Conservation Corps to avoid waste in overlap, fraud and abuse and insure government accountability to the people of the United States.

This program would now be open to women and also offer individuals an alternative to military service. Those who fulfill their obligation would have access to the GI Bill. The military would have fit men and women to enter if they choose to further serve their country.

Dr Neil M. Maher, author and associate professor of history at Rutgers University, said, "Brazil has recently begun looking back to Franklin Roosevelt's CCC to help solve that country's economic and environmental problems. Plagued by high unemployment rates approaching ten percent, local, state, and federal governments in cooperation with non-governmental organizations and corporations have begun putting jobless Brazilians to work planting trees. The goal of Brazil's CCC-like program, which the Nature Conservancy helped initiate, is

to plant one billion trees over the next ten years across the country's Atlantic Forest. Rather than funding the program solely by increasing taxes and federal spending, Brazil will rely on novel market mechanisms including the sale of sequestration vouchers on the international carbon market, obtained through the program's reforestation efforts, as well as the collection of water use fees in the reforested regions. Similar tree-planting programs reminiscent of FDR's CCC are also now operating in China along the Yangtze River and through Wangari Maathai's Greenbelt Movement in Kenya. Even war-torn Afghanistan has created its own "Afghan Conservation Corps. The United States needs to follow suit, and Barrack Obama's first 100 days in office is one place to start. Like Roosevelt, Obama should ask Congress to create a Civilian Conservation Corps, but with a twist. Along with planting trees, this new and improved Corps should put young Americans, both men and women, to work planting windmills across the former Dust Bowl, solar energy panels throughout the Sunbelt, and energy-efficient biofuels on farms in every corner of the country, all in an effort to reduce both unemployment and the production of greenhouse gasses that lead to global warming. While Roosevelt funded the New Deal's CCC with federal dollars, public spending for Obama's new program could be greatly reduced through market mechanisms like those embraced by Brazil; by collecting carbon vouchers and water use fees from the new program's reforestation efforts, and by selling clean, green energy generated from new windmills, solar panels, and biofuels. The young men and women enrolling in this market-driven Corps would also benefit. Not only would they gain valuable training, skills, and experience in the expanding green economy, but they could also be encouraged to put their enrollment stipend towards a college education."

The US Civilian Conservation Corps over the years would enroll young men, women, and veterans. They will all gain strong civic, work and conservation ethics. They would also be trained and skilled in disaster relief and on call.. This program would be of the people, by the people, and for the people.

Contact us for additional information and we are available for any future hearings.

Thank you.

Jay Alexander

Founder of WE CAN TAKE IT

Receipt Reply requested

Written Statement of

Jackie S. Rowles, CRNA, MBA, MA, FAAPM, President of the AANA

On behalf of the

AMERICAN ASSOCIATION OF NURSE ANESTHETISTS (AANA)

to the

HOUSE APPROPRIATIONS COMMITTEE
SUBCOMMITTEE ON DEFENSE

May 19, 2009
WASHINGTON, DC

Chairman Murtha, Ranking Member Young, and Members of the Subcommittee:

The American Association of Nurse Anesthetists (AANA) is the professional association that represents over 40,000 Certified Registered Nurse Anesthetists (CRNAs) across the United States, including more than 500 active duty and over 750 reservists in the military reported in 2009. The AANA appreciates the opportunity to provide testimony regarding CRNAs in the military. We would also like to thank this committee for the help it has given us in assisting the Department of Defense (DoD) and each of the services to recruit and retain CRNAs.

CRNAs AND THE ARMED FORCES: A TRADITION OF SERVICE

Let us begin by describing the profession of nurse anesthesia, and its history and role with the Armed Forces of the United States.

In the administration of anesthesia, CRNAs perform the same functions as anesthesiologists and work in every setting in which anesthesia is delivered including hospital surgical suites and obstetrical delivery rooms, ambulatory surgical centers, health maintenance organizations, and the offices of dentists, podiatrists, ophthalmologists, and plastic surgeons. Today, CRNAs administer some 30 million anesthetics given to patients each year in the United States. Nurse anesthetists are also the sole anesthesia

providers in the vast majority of rural hospitals, assuring access to surgical, obstetrical and other healthcare services for millions of rural Americans.

Our tradition of service to the military and our Veterans is buttressed by our personal, professional commitment to patient safety, made evident through research into our practice. In our professional association, we state emphatically "our members' only business is patient safety." Safety is assured through education, high standards of professional practice, and commitment to continuing education. Having first practiced as registered nurses, CRNAs are educated to the master's degree level, and some to the doctoral level, and meet the most stringent continuing education and recertification standards in the field. Thanks to this tradition of advanced education and clinical practice excellence, we are humbled and honored to note that anesthesia is 50 times safer now than in the early 1980s (National Academy of Sciences, 2000). Research further demonstrates that the care delivered by CRNAs, physician anesthesiologists, or by both working together yields similar patient safety outcomes. In addition to studies performed by the National Academy of Sciences in 1977, Forrest in 1980, Bechtoldt in 1981, the Minnesota Department of Health in 1994, and others, Dr. Michael Pine, MD, MBA, recently concluded once again that among CRNAs and physician anesthesiologists, "the type of anesthesia provider does not affect inpatient surgical mortality " (Pine, 2003). Thus, the practice of anesthesia is a recognized specialty in nursing and medicine. Most recently, a study published in *Nursing Research* confirmed obstetrical anesthesia services are extremely safe, and that there is no difference in safety between hospitals that use only CRNAs compared with those that use only anesthesiologists (Simonson et al, 2007). Both CRNAs and anesthesiologists administer anesthesia for all types of surgical procedures from the simplest to the most complex, either as single providers or together.

NURSE ANESTHETISTS IN THE MILITARY

Since the mid-19th Century, our profession of nurse anesthesia has been proud and honored to provide anesthesia care for our past and present military personnel and their families. From the Civil War to the present day, nurse anesthetists have been the principal anesthesia providers in combat areas of every war in which the United States has been engaged.

Military nurse anesthetists have been honored and decorated by the U.S. and foreign governments for outstanding achievements, resulting from their dedication and commitment to duty and competence in managing seriously wounded casualties. In World War II, there were 17 nurse anesthetists to every one anesthesiologist. In Vietnam, the ratio of CRNAs to physician anesthetists was approximately 3:1. Two nurse anesthetists were killed in Vietnam and their names have been engraved on the Vietnam Memorial Wall. During the Panama strike, only CRNAs were sent with the fighting forces. Nurse anesthetists served with honor during Desert Shield and Desert Storm.

Military CRNAs also provide critical anesthesia support to humanitarian missions around the globe in such places as Bosnia and Somalia. In May 2003, approximately 364 nurse anesthetists had been deployed to the Middle East for the military mission for "Operation Iraqi Freedom" and "Operation Enduring Freedom." When President George W. Bush initiated "Operation Enduring Freedom," CRNAs were immediately deployed. With the new special operations environment new training was needed to prepare our CRNAs to ensure military medical mobilization and readiness. Brigadier General Barbara C. Brannon, Assistant Surgeon General, Air Force Nursing Services, testified before the Senate Defense Appropriations Subcommittee on May 8, 2002, to provide an account of CRNAs on the job overseas. She stated, "Lt. Col Beisser, a certified registered nurse anesthetist (CRNA) leading a Mobile Forward Surgical Team (MFST), recently commended the seamless interoperability he witnessed during treatment of trauma victims in Special Forces mass casualty incident."

Data gathered from the US Armed Forces anesthesia communities reveal that CRNAs have often been the sole anesthesia providers at certain facilities, both at home and while forward deployed. For decades CRNAs have staffed ships, isolated US Bases, and forward surgical teams without physician anesthesia support. The US Army Joint Special Operations Command Medical Team and all Army Forward Surgical Teams are staffed solely by CRNAs. Military CRNAs have a long proud history of providing independent support and quality anesthesia care to military men and women, their families and to people from many nations who have found themselves in harms way.

In the current mission, CRNAs are deployed all over the world, on land and at sea. This committee must ensure that we retain and recruit CRNAs for now and in the future to serve in these military deployments overseas. **This committee must ensure that we retain and recruit CRNAs now and in the future to serve in these military overseas deployments and humanitarian efforts, and to ensure the maximum readiness of America's armed services.**

NURSE ANESTHESIA PROVIDER SUPPLY AND DEMAND: SOLUTIONS FOR RECRUITMENT AND RETENTION

In all of the Services, maintaining adequate numbers of active duty CRNAs is of utmost concern. For several years, the number of CRNAs serving in active duty fell short of the number authorized by the Department of Defense (DOD). This is further complicated by strong demand for CRNAs in both the public and private sectors.

It is essential to understand that while there is strong demand for CRNA services in the public and private healthcare sectors, the profession of nurse anesthesia is working effectively to meet this workforce challenge. The AANA anticipates growing demand for CRNAs. Our evidence suggests that while vacancies exist, the demand for anesthesia professionals can be met if appropriate actions are taken. As of January 2009, there are 108 accredited CRNA schools to support the profession of nurse anesthesia. The number of qualified registered nurses applying to CRNA schools continues to climb. The growth in the number of schools, the number of applicants, and in production capacity, has yielded significant growth in the number of nurse anesthetists graduating and being certified into the profession, while absolutely maintaining and strengthening the quality and competence of these clinicians. The Council on Certification of Nurse Anesthetists reports that in 2008, our schools produced 2,161 graduates, double the number since 2000, and 2,110 nurse anesthetists were certified. The growth is expected to continue. The Council on Accreditation of Nurse Anesthesia Educational Programs (COA) projects that CRNA schools will produce over 2,417 graduates in 2009.

This Committee can greatly assist in the effort to attract and maintain essential numbers of nurse anesthetists in the military by their support to increase special pays.

INCENTIVE SPECIAL PAY FOR NURSES

According to a March 1994 study requested by the Health Policy Directorate of Health Affairs and conducted by DOD, a large pay gap existed between annual civilian and military pay in 1992. This study concluded, "this earnings gap is a major reason why the military has difficulty retaining CRNAs." In order to address this pay gap, in the FY95 Defense Authorization bill Congress authorized the implementation of an increase in the annual Incentive Special Pay (ISP) for nurse anesthetists from

$6,000 to $15,000 for those CRNAs no longer under service obligation to pay back their anesthesia education. Those CRNAs who remained obligated receive the $6,000 ISP.

Both the House and Senate passed the FY03 Defense Authorization Act Conference report, H.Rept. 107-772, which included an ISP increase to $50,000. The report included an increase in ISP for nurse anesthetists from $15,000 to $50,000. The AANA is requesting that this committee fund the ISP at $50,000 for all the branches of the armed services to retain and recruit CRNAs now and into the future. Per the testimony provided in 2006 from the three services' Nurse Corps leaders, the AANA is aware that there is an active effort with the Surgeons General to closely evaluate and adjust ISP rates and policies needed to support the recruitment and retention of CRNAs. In 2006, Major General Gale Pollock, MBA, MHA, MS, CRNA, FACHE, Deputy Surgeon General, Army Nurse Corps of the U.S. Army stated in testimony before this Subcommittee,

> "I am particularly concerned about the retention of our certified registered nurse anesthetists (CRNAs). Our inventory of CRNAs is currently at 73%. The restructuring of the incentive special pay program for CRNAs last year, as well as the 180 (day)-deployment rotation policy were good first steps in stemming the loss of these highly trained providers. We are working closely with the Surgeon General's staff to closely evaluate and adjust rates and policies where needed."

There have been positive results from the Nurse Corps and Surgeons General initiatives to increase incentive special pays for CRNAs. In testimony before the House Armed Services Committee in 2007, Gen. Pollock stated, "We have ... increased the Incentive Special Pay (ISP) Certified Registered Nurse Anesthetist, and expanded use of the Health Professions Loan Repayment Program (HPLRP). The ... Nurse Anesthetist bonuses have been very successful in retaining these providers who are critically important to our mission on the battlefield." She also stated in that same statement, "In 2004, we increased the multi-year bonuses we offer to Certified Registered Nurse Anesthetists with emphasis on incentives for multi-year agreements. A year's worth of experience indicates that this increased bonus, 180-day deployments, and a revamped Professional Filler system to improve deployment equity is helping to retain CRNAs."

There still continues to be high demand for CRNAs in the healthcare community leading to higher incomes widening the gap in pay for CRNAs in the civilian sector compared to the military. However, the ISP and other incentives the services are providing CRNAs has helped close that gap the past three years, according to the most recent AANA membership survey data. In civilian practice, all additional skills, experience, duties and responsibilities, and hours of work are compensated for monetarily. Additionally, training (tuition and continuing education), healthcare, retirement, recruitment and retention bonuses, and other benefits often equal or exceed those offered in the military. Therefore, it is vitally important that the Incentive Special Pay (ISP) be supported to ensure retention of CRNAs in the military.

AANA thanks this Committee for its support of the annual ISP for nurse anesthetists. AANA strongly recommends the continuation in the annual funding for ISP at $50,000 or more for FY 2010, which recognizes the special skills and advanced education that CRNAs bring to the DOD healthcare system, and supports the mission of our U.S. Armed Forces.

BOARD CERTIFICATION PAY FOR NURSES

Included in the FY 1996 Defense Authorization bill was language authorizing the implementation of a board certification pay for certain clinicians who are not physicians, including advanced practice nurses.

AANA is highly supportive of board certification pay for all advanced practice nurses. The establishment of this type of pay for nurses recognizes that there are levels of excellence in the profession of nursing that should be recognized, just as in the medical profession. In addition, this pay may assist in closing the earnings gap, which may help with retention of CRNAs.

While many CRNAs have received board certification pay, some remain ineligible. Since certification to practice as a CRNA does not require a *specific* master's degree, many nurse anesthetists have chosen to diversify their education by pursuing an advanced degree in other related fields. But CRNAs with master's degrees in education, administration, or management are not eligible for board certification pay since their graduate degree is not in a clinical specialty. Many CRNAs who have non-clinical master's degrees either chose or were guided by their respective services to pursue a degree other than in a clinical specialty. The AANA encourages DOD and the respective services to reexamine the issue of restricting board certification pay only to CRNAs who have specific clinical master's degrees.

DOD/VA RESOURCE SHARING: US ARMY – VA JOINT PROGRAM IN NURSE ANESTHESIA FT. SAM HOUSTON, SAN ANTONIO, TX.

The establishment of the joint US Army-VA program in nurse anesthesia education at the U.S. Army Graduate Program in Anesthesia Nursing, Ft. Sam Houston, in San Antonio, TX holds the promise of making significant improvements in the VA CRNA workforce, as well as improving retention of DOD registered nurses in a cost effective manner. The current program utilizes existing resources from both the Department of Veterans Affairs Employee Incentive Scholarship Program (EISP) and VA hospitals to fund tuition, books, and salary reimbursement for student registered nurse anesthetists (SRNAs). This joint program also serves the interests of the Army.

This VA nurse anesthesia program started in June 2004 with three openings for VA registered nurses to apply to and earn a Master of Science in Nursing (MSN) in anesthesia granted through the University of Texas Houston Health Science Center. In the future, the program is granting degrees through the Northeastern University Bouve College of Health Sciences nurse anesthesia educational program in Boston, Mass. At a time of increased deployments in medical military personnel, this type of VA-DOD partnership is a cost-effective model to fill these gaps in the military healthcare system. At Ft. Sam Houston, the VA faculty director has covered her Army colleagues' didactic classes when they are deployed at a moments notice. This benefits both the VA and the DOD to ensure the nurse anesthesia students are trained and certified in a timely manner to meet their workforce obligation to the Federal government as anesthesia providers. We are pleased to note that the Department of Veterans' Affairs Acting Deputy Under Secretary for Health and the U.S. Army Surgeon General approved funding to start this VA nurse anesthesia school in 2004. In addition, the VA director has been pleased to work under the direction of the Army program director LTC Thomas Ceremuga, CRNA, PhD to further the continued success of this US Army-VA partnership. With modest levels of additional funding in the VA EISP, this joint US Army-VA nurse anesthesia education initiative can grow and thrive, and serve as a model for meeting other VA workforce needs, particularly in nursing.

CONCLUSION

In conclusion, the AANA believes that the recruitment and retention of CRNAs in the armed services is of critical concern. By Congress supporting these efforts to recruit and retain CRNAS, the military is able to meet the mission to provide benefit care and deployment care - a mission that is unique to the military.

The AANA would also like to thank the Surgeons General and Nurse Corps leadership for their support in meeting the needs of the profession within the military workforce. Last, we commend and thank this committee for their continued support for CRNAs in the military.

Thank you. If you have further questions, please contact the AANA Federal Government Affairs Office at 202-484-8400.

# # # #

Written Testimony Submitted to the House
Defense Appropriations Subcommittee
Regarding FY 2010 Funding for Malaria Related Programs
Sally Finney, M.Ed., CAE
Executive Director, American Society of Tropical Medicine and Hygiene
April 17, 2009

Overview: The American Society of Tropical Medicine and Hygiene (ASTMH) appreciates the opportunity to submit written testimony to the House Defense Appropriations Subcommittee. With nearly 3,300 members, ASTMH is the world's largest professional membership organization dedicated to the prevention and control of tropical diseases. We represent, educate, and support tropical medicine scientists, physicians, clinicians, researchers, epidemiologists, and other health professionals in this field.

Because the military operates in and deploys to so many tropical regions, reducing the risk that tropical diseases present to servicemen and women is often critical to mission success. Malaria is a particularly important disease in this respect, because it is both one of the world's most common and deadly infectious diseases, and the U.S. military has a long history of deploying to regions endemic to malaria and suffering malaria casualties as a result.

For this reason, we respectfully request that the Subcommittee expand funding for the Department of Defense's longstanding and successful efforts to develop new drugs, vaccines, and diagnostics designed to protect servicemen and women from malaria while deployed abroad. Specifically, we request that in Fiscal Year (FY) 2010, the Subcommittee ensure that the Department of Defense spends $30 million on malaria research and development. Furthermore, we request that the Subcommittee provide annual increases such that total military spending on malaria research is $76.5 million in FY 2015. This funding will support ongoing efforts by military researchers to develop a vaccine against malaria and to develop new anti-malaria drugs to replace older drugs that are losing their effectiveness as a result of parasite resistance. Increased malaria research will help ensure that our soldiers, sailors, airmen, and marines are protected from this deadly disease when deployed to tropical regions.

We very much appreciate the Subcommittee's consideration of our views, and we stand ready to work with Subcommittee members and staff on these and other important tropical disease matters.

ASTMH

ASTMH plays an integral and unique role in the advancement of the field of tropical medicine. Its mission is to promote global health by preventing and controlling tropical diseases through research and education. As such, the Society is the principal membership organization representing, educating, and supporting tropical medicine scientists, physicians, researchers, and other health professionals dedicated to the

prevention and control of tropical diseases. Our members reside in 46 states and the District of Columbia and work in a myriad of public, private, and non-profit environments, including academia, the U.S. military, public institutions, federal agencies, private practice, and industry.

The Society's long and distinguished history goes back to the early 20th century. The current organization was formed in 1951 with the amalgamation of the National Malaria Society and the American Society of Tropical Medicine. Over the years, the Society has counted many distinguished scientists among its members, including Nobel laureates. ASTMH and its members continue to have a major impact on the tropical diseases and parasitology research carried out around the world.

The central public policy priority of ASTMH is reducing the burden of infectious disease in the developing world. To that end, we advocate implementation and funding of federal programs that address the prevention and control of infectious diseases that are leading causes of death and disability in the developing world, and which pose threat to US citizens. Priority diseases include malaria, Dengue fever, Leishmaniasis, Ebola, cholera, and tuberculosis.

Malaria and Military Operations

Servicemen and women deployed from the U.S. military comprise a majority of the healthy adults traveling each year to malarial regions on behalf of the U.S. government. For this reason, the U.S. military has long taken a primary role in the development of anti-malarial drugs, and nearly all of the most effective and widely used anti-malarials were developed in part by U.S. military researchers. Drugs that have saved countless lives throughout the world were originally developed by the U.S. military to protect troops serving in tropical regions during WWII, the Korean War, and the Vietnam War.

Fortunately, in recent years the broader international community has stepped up its efforts to reduce the impact of malaria in the developing world, particularly by reducing childhood malaria mortality, and the U.S. military is playing an important role in this broad partnership. But military malaria researchers are working practically alone in the area most directly related to U.S. national security: drugs and vaccines designed to protect or treat healthy adults with no developed resistance to malaria who travel to regions endemic to the disease. These drugs and vaccines would benefit everyone living or traveling in the tropics, but are particularly essential to the U.S. for the protection of forces from disease during deployments.

Unfortunately, the prophylaxis and therapeutics currently given to U.S. servicemen and women are losing their effectiveness. During World War II, the Korean War, and Vietnam, the quinine-based anti-malaria drug chloroquine was the chemoprophylaxis and therapy of choice for the U.S. military. Over time, however, the malaria parasite

developed widespread resistance to choloroquine, making the drug less effective at protecting deployed troops from malaria. Fortunately, military researchers at the Walter Reed Army Institute of Research (WRAIR) achieved the scientific breakthroughs that led to the development of mefloquine, which quickly replaced chloroquine as the military's front-line drug against malaria.

The malaria parasite has consistently demonstrated a notorious ability to quickly become resistant to new drugs, and the latest generation of medicines is no exception. Malaria parasites in Southeast Asia have already developed significant resistance to mefloquine, and resistant strains of the parasite have also been identified in West Africa and South America. In addition, there are early indications that parasite populations in southeast Asia may already be developing limited resistance to arteminisin, currently the most powerful anti-malarial available. Indeed, the most deadly variant of malaria - *Plasmodium falciparum* - is believed by the World Health Organization to have become resistant to "nearly all antimalarials in current use." This resistance is not yet universal among the global *Plasmodium falciparum* population, with parasites in a given geographic area having developed resistance to some drugs and not others. But the sheer speed with which the parasite is developing resistance to mefloquine and arteminisin - drugs developed in the 1970s - reminds us that military malaria researchers cannot afford to rest on their laurels. Developing new anti-malarials as quickly as the parasite becomes resistant to existing ones is an extraordinary challenge, and one that requires significant resources. Without new anti-malarials to replace existing drugs as they become obsolete, U.S. military operations in regions endemic to malaria may be compromised.

Unfortunately, our limited ability to protect forces from malaria infection is not hypothetical: overseas operations are already being impacted. A 2007 study by Army researchers found that from 2000 through 2005, at least 423 U.S. service members contracted malaria while deployed overseas, with the vast majority of these cases the result of deployments to South Korea (where malaria has recently remerged along the demilitarized zone with North Korea), Afghanistan and, to a lesser extent, Iraq. Notably, none of these countries are thought of by experts as being especially dangerous in terms of malaria, as opposed to the many countries in Sub-Saharan Africa and Southeast Asia where malaria is much more prevalent, and where more deadly strains of the parasite thrive. For example, a 2003 peacekeeping operation in Liberia resulted in a 44 percent malaria infection rate among Marines who spent at least one night ashore.

Clearly, U.S. service members are insufficiently protected from malaria. The reasons for this are many, and include drug resistance as well as ongoing issues with compliance by soldiers who have difficulty maintaining a malaria prophylaxis regimen under combat conditions, or who have contraindications to the use of mefloquine or other

drugs.[1] Regardless of the cause for continuing vulnerability to malaria, however, the outlook is the same: until a malaria vaccine is finally developed, ensuring the safety and health of U.S. troops deploying to one of the more than 100 countries where malaria is endemic will require the constant development of new malaria drugs, in a race against the parasite's ability to develop drug resistances.

To ensure that as many American soldiers as possible are protected from tropical and other diseases, Congress provides funding each year to support Department of Defense programs focused on the development of vaccines and drugs for priority infectious diseases. To that end, the Walter Reed Army Institute of Research and the Naval Medical Research Center coordinate one of the world's premier tropical disease research programs. These entities contributed to the development of the gold standard for experimental malaria immunization of humans, and the most advanced and successful drugs current being deployed around the world.

The need to develop new and improved malaria prophylaxis and treatment for U.S. service members is not yet a crisis, but it could quickly become one if the U.S. were to become involved in a large deployment to a country or region where malaria is endemic, especially sub-Saharan Africa. Fortunately, a comparatively tiny amount of increased support for this program would restore the levels of research and development investment required to produce the drugs that will safeguard U.S. troops from malaria. In terms of the overall DOD budget, that malaria research program's funding is small - approximately $23.1 million in FY 2008 - but very important. Cutting funding for this program would deal a major blow to the military's work to reduce the impact of malaria on soldiers and civilians alike, thereby undercutting both the safety of troops deployed to tropical climates, and the health of civilians in those regions.

FY 2010 DOD Appropriations

To protect U.S. military personnel, research must continue to develop new anti-malarial drugs and better diagnostics, and to identify an effective malaria vaccine appropriate for adults with no developed resistance to malaria. Much of this important research currently is underway at the Department of Defense. Additional funds and a greater commitment from the federal government are necessary to make progress in malaria prevention, treatment, and control.

In FY 2008, the Department of Defense spent only $23.1 million on malaria research, despite the fact that malaria historically has been a leading cause of troop impairment and continues to be a leading cause of death worldwide. As the 2006 Institute of Medicine report *Battling Malaria: Strengthening the U.S. Military Malaria Vaccine Program*

[1] The aforementioned 2007 Army study found that of 11,725 active duty Army personnel deployed to Afghanistan during the study period, 9.6 percent had contraindications to the use of mefloquine, the Army's first-line malaria treatment.

noted, "Malaria has affected almost all military deployments since the American Civil War and remains a severe and ongoing threat." ASTMH agrees that malaria remains a severe and ongoing threat to U.S. military deployments to countries and regions endemic to malaria, and we believe that increased support for efforts to reduce this threat is warranted. A more substantial investment will help to protect American soldiers and potentially save the lives of millions of individuals around the world.

Therefore, we request that the Subcommittee take support a FY 2010 Department of Defense malaria research funding level of $30 million. Furthermore, we request that the Subcommittee provide annual increases to this account such that total military spending on malaria research is $76.5 million in FY 2015.

By way of comparison with this request, in March of 2007 the Department of Defense estimated that it would spend $23.1 million on malaria research in FY 2008. Unfortunately, neither an estimated level of FY 2009 spending nor a FY 2010 request is available, because the Department of Defense does not typically report these numbers. However, recent funding trends suggest that military spending on research in this vital area is falling steadily.

The role of infectious disease in the success or failure of military operations is often overlooked, but even a cursory review of U.S. and world military history underscores the fact that keeping military personnel safe from infectious disease is critical to mission success. The drugs and prophylaxis used to keep our men and women safe from malaria during previous conflicts in tropical regions are no longer reliable. Ensuring the safety of those men and women in future conflicts and deployments will require research on new anti-malaria tools. Thank you for your attention to this matter. We appreciate the opportunity to share our views, and please be assured that ASTMH stands ready to serve as a resource on this and any other tropical disease policy matters.

WITNESSES