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FINDINGS OF THE INDEPENDENT REVIEW GROUP AND AN IN-PROGRESS REVIEW OF ACTIONS AT WALTER REED

HEARING

BEFORE THE

MILITARY PERSONNEL SUBCOMMITTEE

OF THE

COMMITTEE ON ARMED SERVICES
HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

HEARING HELD
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FINDINGS OF THE INDEPENDENT REVIEW GROUP AND AN IN-PROGRESS REVIEW OF ACTIONS AT WALTER REED

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ARMED SERVICES,
MILITARY PERSONNEL SUBCOMMITTEE,
Washington, DC, Tuesday, June 26, 2007.

The subcommittee met, pursuant to call, at 1:05 p.m., in room 2118, Rayburn House Office Building, Hon. Vic Snyder (chairman of the subcommittee) presiding.

OPENING STATEMENT OF HON. VIC SNYDER, A REPRESENTATIVE FROM ARKANSAS, CHAIRMAN, MILITARY PERSONNEL SUBCOMMITTEE

Dr. SNYDER. The hearing will come to order.

The purpose of today's hearing is for members to get an update on what has happened at Walter Reed and in the military medical program since the full Armed Services Committee hearing in March.

To refresh everybody's memory, in late February, *The Washington Post* published a story titled, "Soldiers Face Neglect, Frustration at Army's Top Medical Facility."

In the following weeks, a series of shortcomings at Walter Reed were revealed, such as substandard living conditions, inadequate management of outpatient medical care, and poor follow-up from the ill, recovering or wounded soldiers' chain of command.

Many members were concerned that these problems were not limited to Walter Reed, but this was actually a sentinel event that raised a possibility of similar features across the military medical system.

This concern was heightened by the fact that both this subcommittee and the full committee had expressed concern, though in less dramatic manner, during earlier hearings dating back to 2005 about some of the same issues found at Walter Reed.

Since then, the Independent Review Group (IRG) set up by Secretary Gates following the revelation at the Walter Reed Army Medical Center has completed its review and released its findings.

We are fortunate to have both of the Independent Review Group's co-chairs with us today: Mr. Togo West, the former secretary of Veterans Affairs, as well as the former secretary of the Army. Mr. John Marsh is also a former secretary of the Army, as well as a former member of this body.

Gentlemen, we appreciate you being here.

During this hearing, we will also get an update on what steps the Army has taken to remedy conditions at Walter Reed and to

hear how the Army plans to address or preclude similar problems at other medical facilities.

I should also mention that, while we have had Army leaders testify about Walter Reed before the committee previously, we have here today new leaders.

With us on our second panel are: General Cody, vice chief of staff of the Army, who has been tasked by the acting secretary of the Army with oversight of the Army's medical action plan; Major General Gale Pollock, the acting Army surgeon general; Major General Eric Schoomaker, commander of the North Atlantic Regional Medical Command and Walter Reed Army Medical Center; Brigadier General Michael Tucker, deputy commander of the North Atlantic Regional Medical Command and Walter Reed Army Medical Center; and Colonel Terrence McKenrick, commander of the Warrior Transition Brigade.

This entire episode has demonstrated the power of focus. Throughout this process, virtually everyone—wounded soldiers, ill soldiers, recovering soldiers, family members, commissioners—have had nothing but good things to say about the quality of inpatient care our wounded and ill soldiers have received at Army hospitals. Our military hospitals are among the best in the world.

However, once soldiers leave the focused care environment of the hospital and continue their treatment as outpatients, the system has appeared unable to provide the same level of support.

The challenge for all of us to is to make sure the military healthcare system remains focused on the recovery of our wounded and injured and ill soldiers across the continuum of care, not just at the time of injury, not just at the time of public and press scrutiny, not just at the time of great individual leadership and personality, but all the time. And this hearing is part of that ongoing oversight.

I would now like to yield to my partner for the last several years, Mr. McHugh.

[The prepared statement of Dr. Snyder can be found in the Appendix on page 61.]

STATEMENT OF HON. JOHN M. MCHUGH, A REPRESENTATIVE FROM NEW YORK, RANKING MEMBER, MILITARY PERSONNEL SUBCOMMITTEE

Mr. MCHUGH. Thank you, Mr. Chairman. Let me, first of all, thank you, Vic, for the great leadership that you have provided in your time as chairman of this, I think, critical subcommittee, but also for the partnership that you and I have shared over the previous six years, prior to that, in a leadership role.

And I have mixed emotions. I am excited about Ms. Davis, the gentlelady from California, taking over the gavel, as she will here in short order, but clearly we will miss the kind of insight that you bring with your medical degree, with your compassion and your passion for these issues. And I wish you all the best.

I don't want to sound like we are saying something that is sending you on to the next life, but it is a different life. And you can leave this subcommittee, Mr. Chairman, knowing that you have made a tremendous difference, and the men and women who bravely serve this nation and its families that stand beside them are far better off than when you came to your post.

So, thank you for that.

I also want to congratulate you on your decision to hold this hearing.

I think we can all agree that the conditions and problems uncovered at Walter Reed are a dark chapter in what, as the chairman suggested, is an otherwise stellar history and tradition of the fine military medical institution that has served our nation's warriors so ably since 1909.

With that in mind, certainly, my goal today is to get a sense as to whether or not the immediate issues have been resolved, but beyond that, also, that the policies and resources have been put in place to prevent these problems from occurring again at Walter Reed or, more to the point, any other military medical facility.

I have to tell you I am encouraged by the immediate—and I think it is fair to describe them as aggressive—responses by the Department of Defense (DOD), by the Army to the deficiencies that existed, particularly in the outpatient medical system.

Secretary Gates is to be commended for establishing the Independent Review Group to identify those shortcomings and to make the recommendations to improve the quality of life for our wounded combat veterans and their families as they recover at Walter Reed and the National Naval Medical Center at Bethesda.

I certainly look forward to hearing the findings and recommendations from, as you described so very aptly, Mr. Chairman, the distinguished members of the Independent Review Group for our first panel.

I have to tell you that I have had the honor of serving on this committee now for 15 years, and we have a habit of describing every panel as distinguished, and most often they are. But rarely have we assembled a group of individuals on both panels who have served this nation more effectively and in more important times and important roles than the first panel.

Gentlemen, thank you so much—and the second panel is not just gentlemen, but in the first panel it is—for your service on this panel, but also for what you have done for our nation and its warriors in your so-called previous lives.

I am equally encouraged by the Army medical action plan that appears to be a roadmap for short-and long-term solutions to the problems encountered by wounded and injured soldiers.

And with that said, my enthusiasm, I have to tell you, is tempered by continuing to hear from soldiers, as I suspect many of us are, in the wounded transition units about problems, particularly with the medical evaluation board (MEB) and physical evaluation board (PEB) systems.

Most recently, during a session with committee and member staff at Walter Reed, I heard about the kinds of challenges that continue to persist. And I know we all want to try to overcome those, and I look forward to discussing the details of the plan with the members of our second panel.

So with that, Mr. Chairman, I would yield back.

I would say, as a brief note, I do have to make an apology at the firsthand. I have an amendment on the appropriations bill that is on the floor presently that will come up that I do have to present. When I get the call, I will have to slip out. I hope everyone under-

stands, but I assure you I will be continuing to follow this issue very, very closely.

And, again, Vic, Mr. Chairman, thanks for holding this hearing, and more importantly, thank you for your service.

A special note of welcome back to Joe Schwarz, a former distinguished member of this august committee, who, too, has great background in the medical field. And it is good to see him with us here again today.

I yield back, Mr. Chairman.

[The prepared statement of Mr. McHugh can be found in the Appendix on page 64.]

Dr. SNYDER. Thank you, Mr. McHugh.

I want to give Susan Davis, our colleague from California, who will be the incoming chair of this subcommittee when I take over for Mr. Meehan when he leaves at the end of this month, for any comments she might want to make at this time.

Ms. Davis.

Ms. DAVIS. Thank you, Mr. Chairman.

I really just want to take this opportunity, and I am sure I will have several more, to thank you for your steady leadership of the committee.

This is such a critical committee. Representing a community, a military community like San Diego, I know how important it is that we honor and respect our families and those who are serving in the armed services. And we can only do that through our actions and through what we actually produce on their behalf and the way that we relate, and this committee is a very important vehicle for that.

So I want to thank you for that leadership.

I want to thank Mr. McHugh, who I believe had to leave quickly, but I will look to both of you, because you have been a tremendous mentor. And I know that we are going to deliberate as we have in the past, and I just look forward to all the work that we will be doing on the committee.

And I know that the support is across the board in a very bipartisan fashion on this committee, and I welcome that as well.

Thank you all for the work that you have done, as it relates to this issue. We know that, probably more than any other issue that came before the citizens of this country, I think that Walter Reed really captured people, made them think again about what the impact, what the consequences of going to war really are and how we have to care for our troops.

And so you have brought that forward with, again, a very deliberate way, and we appreciate that. And I look forward to the hearing.

Thank you very much.

Dr. SNYDER. Thank you, Ms. Davis.

Let me introduce the first panel.

I understand that, Secretary Marsh and Secretary West, you will be the two having formal opening statements. Is that correct? Then you have got your sidekicks on each side when you get in trouble. Is that the way we will handle this?

I want to introduce everyone: the Honorable John O. Marsh, Jr., former secretary of the Army and co-chair of the Independent Re-

view Group; the Honorable Togo D. West, Jr., former secretary of the Army and former secretary of Veterans Affairs, the co-chair of the Independent Review Group; accompanied today by our friend—it says John Schwarz, but it is Joe Schwarz, just to the folks here.

Joe, it is great to see you and have you back here.

Joe Schwarz, former Member of Congress and an Doctor of Medicine (M.D.) and a former member of this House Armed Services Committee; Mr. Arnold Fisher, senior partner of Fisher Brothers; General John Jumper, former Air Force chief of staff, now retired; Command Sergeant Major Lawrence Holland, also retired, former senior enlisted advisor to the assistant secretary of defense for reserve affairs.

Gentlemen, we are glad you are all here.

And, Secretary Marsh, is that the order we will go in? You all decide that one.

Gentlemen, we have got six people with four microphones. If you will pull that right in close to you, it will enable people like me to hear you.

STATEMENT OF HON. JOHN O. MARSH, JR., FORMER SECRETARY OF THE ARMY, CO-CHAIR, INDEPENDENT REVIEW GROUP

Secretary MARSH. Thank you, Mr. Chairman. I appreciate your opening comments and the attention and interest of the committee.

We are very fortunate to have as our co-chair Togo West, who has a very distinguished career both in law, in the Department of Defense, in the field of legal affairs, as the secretary of the Army, and then as a Cabinet officer in Veterans Affairs. And he brought to our efforts, I think, an unusual combination of knowledge and also interest and background.

I would like to thank you for doing this, for holding this hearing.

Ultimately, the armed forces of the United States is a joint responsibility between the executive branch and the congressional branch and providing for some of the things that need to be done in the American medical community of the Army cannot be accomplished by the Department of Defense nor can it be accomplished by the executive branch, because they will require changes in law in a number of instances to achieve the kind of medical delivery systems that we would like to have.

I should mention to you that in pursuing this effort, we had complete cooperation from every area of the Department of Defense, every service, the military. The departments fully cooperated in our investigation, which really occurred in less than 40 days. We had 45 days to do that.

I would like to point out that it has been my experience, both having served in the armed forces and having been associated in civilian leadership, there is an American ethic in our armed forces about care of wounded. And it is the finest care that is given to members of the military of any nation in the world—the American ethic of care of the wounded.

Now, I don't want to diminish the role of the active forces, because we have to understand the enormous hardships that are being visited on the families of guard and reservists. Their needs are different sometimes than the needs of the active force, and I

would ask you to investigate and look into that. Their family support structures are different than those of the active force. But they also play an equally important role in support of our soldiers and sailors, Marines and airmen. And they also play a significant role in sharing the burdens and hardship of being wounded.

We on the committee often referred in our deliberations to what had happened at Walter Reed. It had encountered the perfect storm, and by that we meant there came into confluence several unforeseen difficult to deal with issues, not wholly the responsibility of the hospital.

The first of those is an increased casualty load of Iraq, which is a very heavy casualty load, and you will find that the bulk of casualties are moved to Walter Reed Hospital.

Then there was the A–76 contracting out requirement which comes from Office of Management and Budget (OMB), which, oh, six or seven years ago, required Walter Reed to contract a series of civilian occupations and jobs that were very integral to the operation of the hospital, and that competition dragged on and on and on. And the hospital first won the bid, and it was appealed, and then it lost the bid. But it introduced an era of uncertainty.

And then, finally, the Walter Reed Hospital, a decision was made by the base re-alignment and closure (BRAC)—we did not take issue to that; we did not get into that. But the BRAC decision had significant impacts on the quality of medical care. It impacted on issues that related to certification of physicians and retaining essential physicians on the staff of the hospital.

It boiled down to that we divided the issue and it would evolve into sort of two issues.

One of those was trauma care, which occurred first on the battlefield, then the hospital in Baghdad, then evacuation to Landstuhl, Germany, then evacuation to the United States, frequently to Walter Reed. Sometimes that occurred in less than 36 hours, unbelievably. That care was outstanding, and Walter Reed maintained the standard of the trauma care. As Dr. Schwarz said, finest trauma operation in the world.

But where the system broke down was for those soldiers who had completed their hospitalization, ready for discharge from the hospital, but continued to have care needs, and they will become known as holdovers. This was the major problem, and this was not handled well. It was not sufficient, and it created enormous problems.

To correct this, as I pointed out, is not just the Department of Defense. It is OMB, it is the Veterans Administration, and other departments and agencies of government.

Now, ultimately, the Congress, in my view, can do more to correct this problem than anyone. I ask you to devote your time and effort to pursue it, to have the persistence to pursue it, and to have commitment. And through that congressional interest, which I place enormous emphasis on, we will have a great American medical community and we will meet that standard of the American ethic.

If I could close with—if you will forgive a personal statement, but it gives some insights. Both of our sons were recalled to active duty in Marine combat in the first Persian Gulf War. Our oldest son,

who had been a Green Beret, Special Forces 18 medic, had decided to come back and study medicine. And he was with one of our very significant lead forces in Somalia, and he was terribly wounded.

I went down to Andrews, and my wife, when the Medical Evacuation (MEDEVAC) arrived at Andrews. That MEDEVAC comes in several times a week. If you have not done that, I would ask you to do that and to go on and see on that aircraft. The care that those young soldiers are receiving is awesome. The Air Force does an enormous job on that.

I recall my son said to me, he said, "Dad, they told you this flight was 11 hours." He said, "It was 13 hours for us." He is a doctor. He said, "The last two," he said, "we were strapped in two hours before flight time."

The care that we get from the Air Force, their efforts to alleviate the pain of those they bring back here to this hospital is a very significant thing.

Also, I invite you to go down to Andrews sometime and meet one of those MEDEVACs and follow them out to Walter Reed. It will be a very rewarding experience, and they will deeply appreciate it.

And I deeply appreciate the fact that you are demonstrating your interest in this subject.

[The prepared statement of Secretary Marsh can be found in the Appendix on page 67.]

Dr. SNYDER. Secretary West.

STATEMENT OF HON. TOGO D. WEST, JR., FORMER SECRETARY OF THE ARMY, FORMER SECRETARY OF VETERANS AFFAIRS, CO-CHAIR, INDEPENDENT REVIEW GROUP

Secretary WEST. Thank you, Mr. Chairman and members of the committee, for holding this hearing, and for not just your interest today but for your continuing interest in the care and support of our men and women in uniform, both as they perform their duties, whether on the training fields or in the fields of combat, and once they have completed their duties.

It is a pleasure to appear before you, appear before this subcommittee again, and for several of you with whom I have had the opportunity to have interaction before.

Taking up from where my distinguished colleague, Secretary Jack Marsh, left off, that plane, of course, comes in every day at Andrews, about mid-afternoon, 3 or 4, except on Thursdays. And it is one of several factors that has simply lent the weight of numbers to the problem you address as much as anything else.

The numbers who come in, the plane comes in every day, except one, the numbers, the percentages of those who are able to be saved, who, in the past, could not have been saved, the numbers of those who are saved but with complicated, more complicated injuries and more injuries and more of a variety of injuries than at any other time of war in our history.

And perhaps just as significant as anything is the number three, that we are able to get service members back from the theater of combat in as little as three days from the time that they suffered their injury on the field.

As Secretary Marsh said, the bulk of those come directly to Walter Reed, others to Bethesda, because that is where the most com-

plicated, most sophisticated medical assistance, both whether civilian or military, is available to them.

And when their time, their clinical service, their clinical time is done, many remain there in what we call an outpatient circumstance, but what is really a kind of outpatient/inpatient. They are held nearby right on the campus for continuing rehabilitation and for the beginning of their process.

That is at the heart of the report that we produced and at the heart of what you review today.

You have my written statement. I will just touch on a few things, because much of it has already been done by Secretary Marsh, and, that way, I won't take up your time with prepared statements and you can get right to questions.

I would like to say a word about what is in our report, which we published at the completion of our review, findings and recommendations on a wide range of things which I have lumped, for convenience, into four groupings of four questions.

First, who are we as a country, as an Army, as an Army Reed Medical Center, a place where care is delivered?

If you consider the reports that were being carried in the paper and the press and elsewhere about the lapses in care, we would not have been happy with the image that was produced. Indeed, we do say much about ourselves as a nation by the way in which we display our care and our concern for those who have given of themselves in support of this nation, especially during the most vulnerable times of their lives.

And so, included in our report are a number of findings and recommendations in how we address that, assignment and training of case workers, increases in the numbers of case workers, adjustment of the case worker-patient ratio, assignments of primary care physicians, and attention to the nursing shortages.

Second, what are we to become or, perhaps more accurately, and a larger question that requires study, what is our military health-care system to become?

In this instance, I refer to something already raised by Secretary Marsh, but I remind you of that larger question, and that is the impact of A–76 and the BRAC recommendation on Walter Reed.

The twin effects of those caused almost incalculable damage certainly at Walter Reed. Obviously, we have concluded in our report that the BRAC decision should proceed for a host of reasons, but we have expressed concern and made recommendations with respect to the coordinated efforts between the two installations and an increase for the pace of the transition to what would be the new Walter Reed.

Third, the question of, how are our service members doing?

There are four signature injuries of this conflict that we identify in our report and that are routinely discussed whenever one discusses what is happening in the two theaters of conflict in Afghanistan and Iraq: traumatic brain injury (TBI), post-traumatic stress disorder (PTSD), amputations and burns.

And it is fair to say—in fact, it is an understatement to say—that both our health-care system for veterans and our health-care system for active military are still wrestling and having a great deal of trouble with addressing traumatic brain injury and post-

traumatic stress disorder. They are challenging both in terms of how DOD and Department of Veterans Affairs (DVA) diagnose, evaluate and treat them.

We believe there is need for greater and better coordinated research in this area. And we have made a detailed recommendation in our report with respect to a center of excellence and increased attention to cooperative efforts by both Cabinet departments.

And, I might say, there is evidence that the cooperative efforts are at least resumed, if not perhaps reinvigorated. They have been under way for some time and may have been reinvigorated.

The fourth I call, "how long?" I refer to this in my formal written statement as one of the areas on which there is the greatest amount of unanimity on an Independent Review Group that I think can claim quite a bit of unanimity in what we have done. And that is what I refer to as the horrors that are inflicted on our wounded service members and their families in the name of physical disability review processes, known at the Department of Defense as the MEB/PEB process, must be stopped. The horrors must be stopped; that is, the process must be significantly improved.

It is no surprise to you and it was no surprise to us that every part of government can make sound arguments to defend and explain why three—in the case of the Army, four—separate board proceedings, with associated paperwork demands on service members and family, accompanied by delays and economic dislocation for family members who are assisting, and characterized primarily by differences in standards and results, could be justified.

We are a Nation to trust the common sense of our citizens, and that common sense would say that this is simply too complicated a process for wounded service members and their families to be asked to tangle with, at least without significant assistance. And even then, we have recommended that one combined physical disability review process for both DOD and VA be the objective of planning by this government, this executive branch and with support from you.

Thus, every finding and recommendation we have made can be traced back to these four concerns: leadership and attitude; the transition from Walter Reed Army Medical Center to Walter Reed National Medical Center, as commanded by BRAC; the extraordinary use of improvised explosive devices (IED) in the current theaters and their impacts on the brains and psyches of our service members; and, fourth, the longstanding and seemingly intractable problem of reforming the disability review process.

Let me remind us all, Mr. Chairman and members of the subcommittee, our report was issued in April. This is now late June. That means that the Defense Department and the Army have been able to get a number of steps under way in response not only to our recommendations, but the recommendations of other review bodies which have reported since then.

Much has been done, and I anticipate that you will hear much about that as you proceed.

Certainly, from our point of view, three factors are important.

One, Secretary Gates has made this a personal priority. He said so when he impaneled us. He said it again when he received our

report. And all of the Department of Defense, especially the Department of the Army, have taken that to heart.

Second, as I referred to earlier, the Department of the Army has stepped out smartly in ways that I expect you will be hearing shortly.

And, third, we are not the only body that has been doing this review and that I suspect is reporting to you. You are getting a lot of attention to a problem that is much needed.

There is so much to do, Mr. Chairman and members, and, in many ways, we are only part of the way along the road to our improved process, an ability to provide better care for service members and families, both for their health, but also for their futures. This they are entitled to, and this you and I and we and the Department of Defense I believe are committed to helping them find.

Thank you.

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

Dr. SNYDER. Thank you both, Secretary Marsh, Secretary West.

What we will do, we will all go on the five-minute clock, including me and Mr. Kline. Mr. McHugh had to go to the House floor. And the five-minute clock is for our benefit. If you all have something to say, we want you to say it. Don't be constrained by that.

I want to start.

General Jumper, I want to start with you, if I might. I figure if I call on the people who didn't do opening statements, it will kind of keep you keyed up there for future questions.

One of the issues, as you know, that you have had to deal with in your career is, we Members of Congress are always willing to try to fix things, and the hammer that can come down can be legislation. And we are aware that sometimes legislation can get in the way of fixes.

And so you have the situation of you can bring in good people, outstanding leaders to correct a problem. As time goes by, it may not get the same kind of leadership focus in the military, and things can slide.

As you look at this issue, as somebody who has just recently been part of this whole system, do you see this as—well, how do you think this can be solved? Is there a need for Congress to be stepping forward in a statutory way, oversight role? Or do you think that the military, particularly the Army, is on the right track?

How do you see this, as we are looking ahead?

General JUMPER. Well, thank you for that question, Mr. Chairman. I think that is probably the relevant question in this entire issue.

I will tell you, sir, that there is a role for legislation here, and I will cover that in just a second.

First, though, I would like to say that the leadership of the United States Army, as we have just been briefed, members of the committee were briefed this morning, has done a magnificent job of stepping out with what I call the first part of the continuum of care, and that is the primary care. And the inpatient care we all know and understand well what the faults were, that included taking care of families.

The medical care was never in question. It is that second part, when you get to the outpatient and the rehabilitation, that all of a sudden that system, to the average soldier, sailor, airman or Marine going through the process, that system turned suddenly adversarial and without explanation, and that is because we introduced this process of disability evaluation.

And this process, to the soldier who is looking up at this mountain of bureaucracy, that bureaucracy has never been tackled or cleaned up by the policy level of our government that would be charged to do that.

In order to do that, Mr. Chairman, is where the legislative part of this comes in. If you go through what they call the Veterans Administration Schedule for Rating Disability (VASRD) process and you look at how diseases are coded, you discover very quickly that the signature diseases discussed by Secretary West are not properly coded in the reference manuals that all of our medical teams have to refer to, and this is a matter of legislation.

So I would implore the committee, sir, to stay after this in a persistent way to make sure that the signature diseases, once they are properly understood, are indeed coded properly and put in a way that you can reference these things and tie them to the disability process.

This will require the committee's attention.

As far as the steps taken by the Army, sir, I think that you will hear today from the United States Army a very thorough system that has been put into place that takes care of the issues that we had addressing the families and the soldiers that had been lost track of and the scheduling problems. I think those have been addressed in a commendable way.

I would also, and I discussed this with General Cody this morning, I would pay special attention to watching the budget of the United States Army. The fixes that you will hear about from General Cody later on this morning were put in out of the Army's budget.

These are resources that are taken from other places in the United States Army. There will, no doubt, over time, be a call to get those resources back, because they are not part of the health affairs budget. So that visibility will, I think, require constant attention.

Also, the final thing is the visibility that the services, the uniformed services have over the health affairs budget in the Department of Defense has been greatly improved and I think that visibility will help get through things like the building of the new hospital and issues that were difficult when we didn't have—the uniformed services didn't have the visibility they should have had over the health affairs budget. I think those things are a lot better.

So that is, I think, the great improvement, sir. There are certain things that legislation can help with.

Dr. SNYDER. Mr. Kline, for five minutes.

Mr. KLINE. Thank you, Mr. Chairman.

I would like to take several minutes to add my praise to your work as the chairman. We are going to miss you. We will be delighted to work with Ms. Davis when she comes in.

But since I am on the five-minute clock, I am going to limit that to just that.

Thank you, gentlemen, for being here. I have a number of questions, but I am going to cut to the chase here in just a minute, beyond the comment——

Dr. SNYDER. Mr. Kline, I should have pointed out we are going to go around at least a second round, because I know members will have more than one set of questions.

Mr. KLINE. Thank you. Ten seconds of my five minutes.

There was a conclusion, a finding and recommendation having to do with fatigue, compassion fatigue of the nurses at Walter Reed. I found that to be striking.

My wife started her Army nursing career in Walter Reed, in the amputee ward, in the Vietnam era, working on a dirty ward. And so I am very sensitive to that issue, and I guess that is probably better for the next panel, but I just found that surprising that this group noticed that and picked up on that.

And so I will not ask about that now, but just to you, to this particular group, I just want to point out that I found that to be very striking and we have a compassion fatigue on nurses working at Walter Reed.

What I do want to ask about is this issue of the evaluation boards. Clearly, you all agree that it is a mess. We agree that it is a mess.

I think you put your finger right on it, General Jumper, when you said that this is an adversarial relationship. One of the things that we have done with legislation in Congress was worked to put into place these wounded warrior regiments and wounded warrior battalions, in part, because we thought it was important that our servicemen and women, as they go through this process, had an ally, had people that knew them and understood their situation and would be an ally for them as they go through this process, because it ought not to be adversarial, although I understand that it is.

We have issues of compensation that go on for years and we have people trying to be good stewards of the taxpayers' dollar and we have all of those things going on. But clearly we need to fix it.

Your recommendation is we overhaul it. I know there is a temptation probably for us just to tomorrow pass legislation that says make one system and be done with it. I would guess that there is some peril with that and I would like to ask any one of you to address that approach.

Your recommendation is overhaul it. I am not sure what that means. We all know it is broken.

But I would like any comment, perhaps from the command sergeant major or General Jumper, anybody, about how this advocacy on the part of the wounded warrior battalions might be working as you saw in Walter Reed or anywhere and if you have any specific recommendation about what we might do to "overhaul" it, and we only have about a couple of minutes left.

Major HOLLAND. Sir, thank you very much for that question.

I gather the microphone is not working.

And I see a lot of change in the care and the attention at Walter Reed, and as General Cody and them will tell you later, they have spread this throughout the entire Army.

But please understand this is a total—as General Jumper laid it out and Secretary West laid it out, this is total care from start to finish, whether we send them back to duty, whether we send them to the VA, whether we send them back to civilian life.

This is long care term and, you know, our cost of going to war needs to be this kind of medical care and, in my opinion, from what we have seen, that part was sort of left out.

When we look at the evaluation systems, they are so convoluted, they are so complicated, there is only most probably a handful of folks in the military that understand it. I just retired after 37 years and do not ask me a question about them, because I have no clue. That is an honest assessment, sir.

And so the message is let's keep it simple, let's keep it right on target. I mean, an amputee that loses a hand through an explosion and an amputee that loses a hand from burns is coded completely different on the regular system.

In the VA system, it is characterized completely different, also. So I think we need to look at the total system. I think our panel, for sure, would like to see one system. Make it simple, make it fluent, and take them from one category to the other, but we must have a very good, easy handoff between the services and the VA.

If we do that, we can make lots of improvements in whatever and being the NCOIM, we are going to err on the side of the service member and their family and take care of them, because these families must care for this service member for the rest of their life.

And when you look at the wounded we have and the age groups of the wounded, 19 to 25, you look at that, that is a long life they are going to have. That is a lot of care that that family—that we are putting on that family to have, sir.

Mr. KLINE. Thank you, Sergeant Major.

Secretary MARSH. Mr. Congressman, let me mention something to you, because it can be——

Mr. KLINE. Pull your microphone in there a little bit, if you would, please, Mr. Secretary.

Secretary MARSH. A national guardsman is different than a reservist and a reservist is different from an active duty person and the laws relating to them can be very, very difficult in handling or administering medical care, particularly if you let the guardsman or reservist, after a deployment, come back and be demobilized with some lingering medicals.

He cannot get back into the system without great difficulty. So whatever you do, please keep those distinctions in mind.

Dr. SNYDER. Ms. Drake.

Mrs. DRAKE. Thank you, Mr. Chairman. And I am not going to take time thanking you.

First of all, gentlemen, thank you for your work, and you did it very quickly, and we are very anxious to have you in here today.

Mr. Marsh, you have said it repeatedly that there is a distinction between the guard and the reserve and we talk about that a lot in this subcommittee and one thing I learned in 2005 was the military thought they were doing what the guard and reserve wanted by

getting them close to their homes, where what we heard from the guard and reserve is they felt like they were being gotten rid of.

And I did see, in some of our materials, that there is an effort to make sure we get them as close to home as possible. And I would just like to ask you to make sure you ask that service member what do they want. Do they want to remain at Walter Reed or do they want to go back to their local communities, because I was quite surprised by that conversation in this subcommittee a couple of years ago.

But my question is for Secretary West and I am delighted that you are here, as a former secretary of the VA, because one of the things that we did in 2005 that I thought was very good was additional funding so that there would be a better interaction between DOD and VA.

Now, this year, in the Defense Authorization Bill, we have also addressed that issue. So my question is, what is wrong? What do we need to do differently? Is it a matter of funding? Is it a matter of, like we were talking about, both have a set that can work together?

Can you tell us what we need to do and how we bring that about?

Secretary WEST. Thank you, Congresswoman Drake. There are several different elements in that, and the first is this: the issue of medical records and of getting them from the active duty components to the VA, the sort of seamless transfer we hope for.

The money that the Congress put into the VA a few years ago did, in fact, help the VA and it has made significant strides in putting the medical records under its control, the ones that it has for veterans, on computers. They have taken the off of papers.

It is a paperless process now and the records can be available. Veterans don't have to carry them around from place to place.

That system is trying to interface with the system at DOD that is still a bit balkanized. Each of the services has a system, the Army has two, and those systems don't work as well with each other.

Now, that is not to say that somehow VA has moved out smartly and the department has not. The Department of Defense has a much bigger problem to be resolved and it has to do with, frankly, getting rid of legacy systems and doing the steps and exercising the discipline to cause each of the systems at the department to standardize and make themselves able to be interoperable.

That will go a long way toward moving across from one status to another.

I think your other question has been, "Well, but what about the point Mr. Kline raised," and that is the disparities in the disability review processes, the fact that VA apparently is more liberal in its criteria than, say, the services and that one service may be more liberal than the other.

I think those are misleading terms. I apologize for using them, but that is the impression that is out there. The fact is that, though I mentioned it in my comments, that everyone can make an explanation as to why their system has to be different, there actually are reasons.

Each of the services has a different need as it looks to the question of who can be returned to active duty from being wounded and who cannot. The services do that well, each one for its own people.

It is then that the determination as to the percentage of disability, if they are not being returned to active duty, that has all the disparities. If there was something we could do, if there was something you could do, it would be if we let the services and DOD do what they do best and what they need to do—make the determination as to who can return to the jobs they have.

Once that determination is made, force the VA to do what it was established to do—determine the percentage of disability and how much this nation needs to provide to each of those service members who can no longer serve to make their lives in the future lives they can live, lives that can be productive, and in which they can continue to be citizens who can make a contribution in their neighborhoods.

Mrs. DRAKE. Thank you for that.

And I see I have used up my time. Thank you, Mr. Chairman.

Secretary WEST. I apologize for using it up.

Mrs. DRAKE. No, no. Thank you. That is very important, and we appreciate your straightforwardness.

Dr. SNYDER. Our little clock seems to go straight from green light to red light today, doesn't it, without a warning sign?

Ms. Davis, for five minutes.

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

And, again, thank you to all of you for your commitment to this effort.

I wanted to follow up on the issue that we have just been discussing in terms of the different services and their evaluation. Do you believe, and for any of you to respond, are we evaluating all of the injuries that a service member brings?

And if that is a problem, and I think it might be—I want to talk a little bit about traumatic brain injury (TBI) and post-traumatic stress disorder—how do we get there?

Secretary WEST. I think it is a great question, and Congressman Schwarz is waiting on it.

Ms. DAVIS. I am delighted to hear from the congressman.

Dr. SCHWARZ. Congresswoman Davis, nice to see you again.

The injuries that have resulted from this war are different of a magnitude great enough that they have to be treated differently than the chairman's and my war, Mr. Kline's war, and the traumatic brain injury, which we called closed head injury when I was coming up through the resident ranks, probably is, of the signature injuries of this war, the signature injury.

Most of the injuries are from blasts. It has been estimated that 80 percent of the casualties in this war in one way or another result from blast injuries. They could be soft tissue injuries and we are doing a fabulous job of saving people who have wounds which, in previous wars, would have been fatal within minutes.

The non-penetrating head injuries are the ones that I think are the greatest conundrum and they all fall under the rubric of traumatic brain injury.

You have someone who loses cognitive abilities, loses memory, loses ability in some ways to speak logically and coherently, is un-

able to find their way from point A to point B, families say something is wrong, we are not quite sure what it is, sleep incessantly.

In the case of one reserve brigadier general who the panel encountered, he was found to have an IQ that—and, by the way, in the civilian world, he is a judge—was found to have an IQ that would be considered below normal now.

Work is being done, and I have to single out Dr. Maria Mouratidis at the National Naval Medical Center, on improving the cognitive skills of people who have this diagnosis. The problem is that the diagnosis is not made quickly enough and frequently the diagnosis is not made at all.

And in the end, when, two or three decades from now, a reassessment is done of the signature injuries of this war, I believe that the TBI, the traumatic brain injury and all of its sequella, lasting years and years and years, will prove to be the most serious and the most long lasting, have the most effect on the people who suffer from it and, from the standpoint of the Congress and the health-care providers, be the most expensive.

So if you are going to emphasize one, just one of the signature injuries of this war, the concept promoted by Mr. Fisher and myself and other members of this committee that we have a center of excellence established as soon as possible to deal with people with TBI, that would be job one, and I hope that is something not only that this committee and the Congress says should be considered, I truly hope it is something that you mandate.

Ms. DAVIS. Thank you. I appreciate that, and I hope you would include PTSD with that, as well, in terms of the kind of signature injury that we don't see readily apparent.

I think my concern and my question, also, though, is, how do we make certain that the boards evaluate not just one injury but a group of injuries, several injuries at one time?

Because traditionally, as I understand it—and please correct me—that really is what they have done. And so we have missed a lot of the injuries that people must be compensated for as they leave the service and as they move on to the VA system.

So is this the kind of thing that we really have to address as we address that transition with the VA system?

And I know my time is up.

Dr. SCHWARZ. Congresswoman, my response to that is that your premise is correct.

Ms. DAVIS. Thank you.

Dr. SNYDER. Thank you.

Ms. Shea-Porter.

Ms. SHEA-PORTER. Thank you very much, Mr. Chair. And we certainly will miss you and look forward to a productive relationship continuing. So congratulations.

My first question is addressed to Mr. West. I am concerned, as all of us are here, about what has happened, but I picked up on a particular statement that reserve component members face unique challenges in the military health-care system.

And I have a particular interest in the national guard. They are in my state, of course, and I have heard some conversation along those lines and I wanted to ask you to please elaborate and address

some of those particular concerns and what your solutions would be.

Secretary WEST. I think you may want to hear Secretary Marsh on that. He has devoted a lot of time to that, if I might.

Ms. SHEA-PORTER. I actually was going to ask both, but, yes, feel free, anybody. Thank you.

Do you want me to repeat it?

Secretary WEST. Your question is to elaborate on the problems that the guard and reserves are facing——

Ms. SHEA-PORTER. Right.

Secretary WEST [continuing]. That we have alluded to in terms of the care that they are receiving.

A couple things. One is that, in doing our review at Walter Reed, we came across the fact that they are actually separately organized in the rehabilitation process. That is, once they have finished their clinical part, the immediate part and are held there for rehabilitation and for perhaps processing, the active duty are kept in something called the medical hold. The reserve components are part of something called the holdover.

And so from the outset of their status there, they find themselves segregated for reasons that are not clear to them. Now, although every process like that starts with a reason, the fact is that the more that we looked at it and the more we observed it, it seemed far better to treat them all as one group.

There are different rules, and that is what Secretary Marsh was referring to earlier, in terms of how they are treated when they return to their organizations.

So there is a great concern there and we have pointed to it in our report and our belief is, for one thing, as Secretary Marsh said, that it is simply something that everyone has to look at more closely. There is great concern in the reserve components.

Do you want to say anything further?

Secretary MARSH. I might comment that the support structures for the active force and for reserve components are quite different. When a unit is mobilized, say, at Fort Bragg, the support structure centers on Fort Bragg, the dispensary, the post exchange (PX), and all these things.

When a reserve or guard unit is activated, that network of support does not exist like you have on an active duty force. So it must be implemented and you must develop a separate support system for people who live in rural areas or who are far distant from other communities.

Frequently, wives don't know other wives in the reserve components, but they might in the active.

I think it is an area that we need to look to generally. I am not certain that we have fully utilized the capabilities of our reserve components, and I will give you an example in medical care.

We are beginning to see some problems on getting qualified physicians into the guard and reserves. It is beginning to show. If we were to waive the requirement on the age above 50, and Joe can speak to this, and not require——

Dr. SCHWARZ. I can speak to being above 50, for sure. [Laughter.]

Secretary MARSH [continuing]. And not require an eight-year commitment, we could probably fill very quickly many of the vacancies that exist today in the Reserve community medical area.

Joe, do you want to comment on that?

Dr. SCHWARZ. Yes. There is an eight-year requirement now if someone decides to return to the military or enter the military for medical professionals. And the estimation is, and I believe it is probably quite correct, that there are numbers of older medical professionals who would serve and willingly and with great skill, but they are probably not of an age where eight years is practicable, but perhaps three years or five years would be practicable.

And I believe that some of the positions, especially guard and reserve positions, where the individual could be at home, except for deployments, would help fill some of those vacant slots for physicians, for nurses, for physicians assistants (PA), for other medical professionals.

So I think changing that requirement to a shorter term of duty would be a good thing and would allow a greater number of medical professionals to participate, especially in the guard and reserve.

Ms. SHEA-PORTER. Thank you all.

Major HOLLAND. Ma'am, one additional point is the Army has taken and gone back to having one medical hold company, so both the guard and reserve fall into it.

All I ask everyone to think of is those guard and reserve members are on active duty until the day they are discharged. They need to be considered that way, evaluated that way and handled that way, and their care needs to be the same.

There need not be a priority or a stair-step system, and if we can do that, we would make lots of strides, ma'am.

Ms. SHEA-PORTER. Thank you.

Dr. SNYDER. Thank you, Ms. Shea-Porter.

I wanted to point out the Defense Bill that passed the House that will go to conference with the Senate when they pass the bill gives the Secretary of Defense permission to lower that eight-year obligation to two years, but it is at the discretion of the secretary.

Ms. Sanchez.

Ms. SANCHEZ. Thank you, Mr. Chairman.

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

In reading the report, one of the issues that came up was the challenges that were going on because of BRAC actions, A–76 competitions and funding constraints over at Walter Reed. And I think that all the members of the subcommittee are concerned that Walter Reed not remain, as the report described it, in a state of limbo until the new facility is completed.

And so my question is, how confident are you that Walter Reed will be able to run at optimal levels while the facility is, in fact, being closed down, until we get the new facility, et cetera?

And more importantly, and this comes from a visit I made myself, as you know, if we pay money, Members of Congress can go over for some outpatient care there. I was over there talking to one of the doctors, being seen by a doctor and talking to her. And she was talking about movement and how doctors are leaving and how, for her own personal career, it probably would be better if she took a new position somewhere else. But she didn't want to look like she

was jumping ship, because there was so much poor morale among the troops right now—the troops, meaning the people who work at Walter Reed—not just over what had happened, but, in particular, because so many doctors and others are choosing to leave the facility.

So the second question is, how are we going to be able to retain the best and the brightest to serve our service members during this time, when, just on a personal basis, people have talked to me about it?

Secretary MARSH. I could mention several things, but I am not sure I have the whole answer, and Dr. Schwarz or others can contribute to that.

You mentioned the competition and A–76, because Walter Reed could not control that. They were directed to do that.

When the BRAC came out and Walter Reed began to have problems on maintenance that related to the old hospital, a memo was directed from the Department of the Army, as I recall, that you could not request the appropriations to improve a facility that was being closed by BRAC.

Now, I am sure that will be changed, because that is one of the problems. I think the way that we are going to handle the Walter Reed thing to achieve the goals that you are talking about is going to require, one, a commitment to build a new hospital in a timely way and currently fund the operation at Walter Reed at full tempo up until you come to the time that you want to close its doors.

And I think others may want to add to that.

Mr. FISHER. I have never understood how you would sell a house before you bought a new one, and we are talking about people leaving Walter Reed because there is no future. There is no date of a new hospital. There is no reason, no reason at all, why the second and a new hospital is not being started right this minute.

It has been three years since the BRAC Commission came out. Where are the plans? Where is the date of starting the new hospital? I am a developer. When I am ready to build something, we get started on it. We are talking—I have heard dates of 2012 before the new hospital is built. I just don't understand this.

The reason people are leaving, they have no future. If the date was established, this hospital is being started, maybe then the people working in the hospital know that they will leave this hospital and go to the new one. But to leave this thing up in the air for so long, to me, is unconscionable.

Six-hundred-thousand Americans paid to have a center for the Intrepid in San Antonio that DOD had promised to build for four years. American people put together $50 million and, in 14 months, built that center for the Intrepid in San Antonio.

There is no reason why the government can't start this new hospital now. Maybe that would alleviate a lot of the problems of people leaving and people not knowing what is going on next.

I think that is Congress's duty, to start this process now.

Ms. SANCHEZ. Anybody else have a comment on the panel?

Dr. SCHWARZ. Yes, I do.

Ms. SANCHEZ. I see that the light is red.

Dr. SCHWARZ. I have a very short comment, if I may, Mr. Chairman.

I agree with Mr. Fisher. Walter Reed Army Medical Center was built 30 years ago. Thirty years in chronological age is not much; 30 years in medical advancement is an eon. A replacement hospital needs to be built as soon as possible.

The concept of marrying Walter Reed with the National Naval Medical Center in Bethesda, perhaps a consummation devoutly to be wished, but I know that there are at least two and perhaps three members on the panel who are very aware of the differences in culture between the Army on one side and the Navy and the Marine Corps on the other. And I believe that is the reason that things have not progressed as rapidly as they should. And I guess there are several others of us down here who understand that difference, as well.

So they need a new hospital. They need the new hospital yesterday. And if the Army needs simply to build a hospital on its own for whatever that hospital might cost, perhaps $2 billion, I would remind all that we are spending $8 billion a month in Iraq and Afghanistan right now. It does not seem to be too high a price to pay to get going on a new hospital for 25 percent of what we pay on a monthly basis to carry on the military activities we are involved in overseas now.

Build the hospital, build it now, and a lot of these problems will be solved. Otherwise, the personnel problems will go on forever and the facility itself will continue to superannuate to the point where it is not anything any of us will be proud of.

There is no malign intent on the part of any member of the uniformed services, especially the Army. The staff, the physicians, the nurses, and the ancillaries at Walter Reed are the best in the world. The trauma care, as we have noted, is the best in the world.

These people are thorough professionals, but they need a facility and I believe that that facility should be built as soon as possible. And I think there are quite a few people on this side who would support me on that, although the BRAC is the BRAC and, as all of you know, the BRAC is a pretty difficult thing to get around.

I am sorry I took so long, Mr. Chairman——

Ms. SANCHEZ. Thank you, Mr. Chairman.

Dr. SCHWARZ [continuing]. But I wanted to say that.

Ms. SANCHEZ. Thank you, Mr. Chairman, for your indulgence.

Dr. SNYDER. Mr. Murphy, for five minutes.

Mr. MURPHY. Thank you, Mr. Chairman. And we are sorry to see you go, as well.

Gentlemen, thank you for being part of the panel.

I have made personal visits to wounded soldiers at the Malone House, and, as you know, the Malone House helps soldiers with their mental, medical or psychological problems.

And when I was there, I always met with soldiers that had undergone serious surgeries. And one nice young solder in particular had one of his legs amputated—one of those signature injuries, Mr. West, Secretary West, that you mentioned in your testimony.

He was going back under the knife for an operation on one of his eyes—again, injuries, sir, that resulted from his service in Iraq. And although he was in good spirits, he imparted to me that he was dissatisfied with the level of care he was receiving.

And soldiers like him, as you know, are the future of our country and of our military.

And the question I have for the panel there is, how can this Congress prioritize the Independent Review Group's recommendations to have the greatest impact to improve our system for such service members?

I would like your comments on that. Thank you.

General JUMPER. Well, I will start, and I think everybody has an opinion on that, but I think that we have heard from distinguished members of this panel today the importance of the traumatic brain injury as a signature injury of this conflict.

And to be able to prioritize that properly, to be able to create a center of excellence that can go back and research the history of this, do the case studies on those that probably date back to the Korean War or Vietnam War, to be able to distribute and identify the cutting-edge diagnostics as they emerge, be able to distribute those system-wide, and then be able to come up with the cutting-edge treatments and distribute those treatments system-wide would be a great service to this nation, and also be able to reach back to previous conflicts for those who we all know suffer from these diseases from the past.

That, in my mind, would be the greatest service that we could provide.

But second and close on its heels is to be able to attack this bureaucracy associated with the evaluation business. And Mr. Kline pointed out that we do have advocates that the United States Army have put with each of the injured members, and they are doing a magnificent job. But it doesn't keep the system from being adversarial, and it doesn't keep that soldier from being impacted morale-wise, seeing this system appear to turn against him or her as they progress through the process.

So to be able to attack this process, to be able to do one physical examination, the data of which is acknowledged and used by all, to be able to have a code of identifying tables within the literature that does the best it can to categorize the TBI and the PTSD injuries, to be able to proceed with the leadership at the policy level, to, in good faith, wrestle these bureaucratic problems to the ground, to have the Congress give them times and dates certain for results that wrestle these problems to the ground would be, Mr. Chairman, sir, would be a great contribution to this nation, I believe.

Secretary MARSH. Mr. Congressman, one of the things that came up as we began this effort was a recognition that we were only dealing with a piece of the pie, and the piece that we had was defined specifically to Walter Reed and, to a lesser extent, to Bethesda.

I was of the view then, and I am of the view now, that some of the things that we are discussing that apply to Walter Reed apply to other military hospitals in the United States, and I think the Command Sergeant Major would confirm that.

The other thing that we realize, dealing here with some mammoth bureaucracies, we cannot solve this solely in the Department of Defense. We are dealing in an inter-Cabinet thing.

If you are getting into A–76, you get into a whole different field. You are getting into OMB. But we also know there is a consideration that relates to veterans and veterans affairs and the group that is being chaired by former Senator Dole and also Mrs. Shalala. So that is another shoe that has to drop.

But I am telling you this is a mammoth sort of task that you are looking at. I think the Army is seeking to address a number of things, the military hospitals, but you would do well to inquire what the statuses are in Fort Bragg and Fort Gordon and Fort Lewis and other places.

Secretary WEST. I don't want to drag this out, Congressman and Mr. Chairman, but I have to offer an alternative viewpoint. I think the priorities are pretty clear.

One of the things that we are helped with is that some of the things that provoked this investigation have now been moved out on by Department of Defense and Department of the Army.

The question of facilities is very carefully being looked at. The question of getting some people there, the brigade and the people who can help our service members and their families get through the process is being acted on.

But PTSD and TBI, Walter Reed, in its new format, and the bureaucratic process for physical disability evaluation are three big issues that need a lot of attention right now.

Each one of them is a long-range effort and a long impact, but we have to start it. And if you ask me where we would put priorities and where the emphasis seems to be, it is right there in our report.

Mr. MURPHY. Thanks, gentlemen.

Thank you, Chairman.

Dr. SNYDER. Ms. Boyda for five minutes. Then we will go to Mr. Wilson.

Mrs. BOYDA. Thank you, Mr. Chairman, and thank you so much for the leadership. We will miss you on this committee, and looking forward to the leadership of Mrs. Davis.

I just wanted to state one thing for the record. We kind of spoke about it a little bit earlier, but I have a guard that was just injured this weekend, and I would just like to go on the record as saying that his wife would certainly appreciate the ability to choose where he and his family go.

She is going to have to pay to get herself down to Fort Bliss, and I would just like to go on the record as saying we certainly can do better. Give them a choice. We don't want them to feel like they are being pushed out. Give them some control of their lives, and it would mean a lot. And I heard you speak about that earlier.

But I would like to just address the whole A–76 process. And I apologize that I was a little late, so if I have, in fact, missed this discussion, I apologize for that. But the statement was made that the A–76 directive was really placed on Walter Reed.

Could you describe what that is and just, again, the whole A–76 process as a whole and what it is meaning certainly——

Secretary MARSH. General Jumper has probably dealt with A–76 more than any of us.

Do you want to respond to that, General?

Mrs. BOYDA. Its ins, its outs, its goods, its bad, are we overseeing it? What is happening?

General JUMPER. Well, there are varied and wide opinions on A–76. And, of course, I tell you, as a guy who came out of uniform, I am one of the biased ones.

I think that we have over-outsourced in many ways, and the direction to over-outsource was done with criteria that probably didn't always work to the best interest of the people in uniform.

At Walter Reed, again, the A–76 process required outsourcing that put certain critical functions into the hands of—it took them out of the hands of very experienced people that were used to working with a very old infrastructure at Walter Reed and put them into the hands of lowest bidders that cut the services, cut the number of people attending the facilities in ways——

Mrs. BOYDA. In your mind, why do you think that was done?

General JUMPER. Because of savings. You saved money by outsourcing those——

Mrs. BOYDA. Short-term savings anyway.

General JUMPER. Yes. Well, many of us would believe it is only short-term savings. The process of A–76 believes it is long-term savings. But to those of us who experience it, we believe that the savings are only short-term, if at all, and certainly not long-term.

Secretary WEST. The A–76 process is never one that an organization chooses for itself. It is almost always told by a higher headquarters or a higher authority during the budget process or the resourcing process, as part of putting together your plan for the future, go through the A–76 process, which is simply another way of saying, "Compute all your functions." That is, compute your cost as a government function versus the cost of contracting it out.

Mrs. BOYDA. What do you think that the A–76 process does to morale, in addition to not knowing where the building is going to be on a given day or just the physical timing of the move? What does the A–76 process do on top of that for morale?

Secretary WEST. In the several positions I have had in the Department of Defense and others elsewhere, I have never seen an organization or its people welcome the onset of the A–76 process.

Mrs. BOYDA. Do you think it affects morale negatively?

Secretary WEST. I am sorry?

Mrs. BOYDA. Do you think it affects morale negatively?

Secretary WEST. Oh, surely, surely.

Mrs. BOYDA. So it is not just that it is not welcomed; it has a negative affect on morale.

As you might guess, I am a little concerned about A–76.

Secretary WEST. I don't want to be unfair to those who conceived of the process. But from the point of view of one who has actually been part of organizations going through it, it proceeds from the assumption that there is a good chance that someone other than the people we have recruited for the government in civilian positions could do the job just as effectively and cheaper.

It proceeds from that assumption. That is not a good morale——

Mrs. BOYDA. Do you have any recommendations to this committee as we move forward?

I will say that the—who are the top medical people? Surgeon generals of all three branches basically have suggested that A–76s may not be having a positive impact, and I will put that politely.

Do you have any recommendations for this panel as it regards A–76 and our health-care system?

Secretary WEST. That the medical centers and the health care in the department, those institutions, be exempted from the process.

Mrs. BOYDA. Thank you.

Dr. SNYDER. Mr. Wilson.

Secretary MARSH. A–76 is quite old. A–76 was begun in the 1960's, and it applies to many areas of government, and there is a lot of controversy about it.

Dr. SNYDER. Mr. Wilson, for five minutes.

Mr. WILSON. Thank you, Mr. Chairman.

And thank you, Secretary West, for being here with Secretary Marsh, your colleagues. We appreciate your service.

I am particular happy to see my fellow Washington and Lee (W&L) University graduate, Secretary Marsh. You are certainly a distinguished graduate, and those of us of W&L appreciate your service and success.

Additionally, I want you to know how honored I was to serve with Congressman Schwarz, who is sitting right next to you. What a fine gentleman and a great patriot for our country.

As we look at this issue—and you all have really looked out for the soldiers and sailors and Marines of our country, and I appreciate that very much—the Defense Health Board has recommended that a specific individual be tasked with carrying out the recommendations of the Independent Review Group.

Would you support that recommendation? And who would you recommend within the Department of Defense be tasked to carry out the recommendations?

Secretary WEST. Our recommendation, of course, in our report was that the important thing was that there be some entity, whether it was an individual or a committee, responsible directly to the Secretary of Defense, whose position it was or responsibility it was to monitor compliance with our recommendations and action taken.

The Secretary of Defense informed us in our exit interview with him that he had designated a committee consisting of senior people to meet each week and to carry out that function.

And so, from my point of view, we thought that he had acted immediately in response to our recommendations.

Your question is about an individual, and I am going to let any of my colleagues who want to address that speak to it. I think that he has acted in a way which we think is responsible.

Mr. FISHER. I had originally suggested that a, for want of a better word, czar be appointed to make sure that this is the second or third committee that has come up with these suggestions. There is a committee following us. That is the Presidential committee. That we have had enough investigation. We need to get it implemented.

And whether it takes a czar or a committee or whatever it takes, it should get started right away.

Mr. WILSON. And then, Secretary West, could the committee, in fact, have the function of the czar?

Secretary WEST. That is certainly I think the intent of the Secretary of Defense, and it would, we hope, be the way it would work.

Mr. WILSON. Thank you very much.

And, additionally, Secretary Marsh and Secretary West, the Army Medical Action Plan (AMAP) appears to be a systematic approach to addressing the problems regarding the care of covering wounded combat veterans identified at Walter Reed.

What are your thoughts on this plan? And, in particular, do you think successful implementation of the plan will significantly improve the quality of life for recovering service members and their families?

Secretary MARSH. I think it will be helpful.

When this effort began several months ago, we learned that the Army, about a year ago, had begun an inspector general's (IG) report that looked at some of the same issues that we had. It was a very comprehensive thing.

We received a briefing this morning, and the Army is taking steps to address the issues that are raised in our report and, also, the issues that were raised in its own IG report.

They have not completely addressed all of them. Some of them go beyond their capabilities to remedy, for example, the evaluations under the disability systems.

Incidentally, there is incompatibility in the evaluation systems in the Army, inside the Army, and there are differences between the Army and the Department of Defense and between the Department of Defense and the Navy and the Department of Defense and the Air Force.

So they are not going to resolve that in that regard. One, it is beyond their capabilities. It is going to have to be done by law, in my view.

But I think you are going to get a report here just very shortly that gives you a summary of the actions taken under the IG report, which is sometimes called the Army action plan.

Mr. WILSON. And, again, I would like to thank you. I want to thank all of you.

I have the perspective of being a veteran myself, 31 years in the Army Guard and Reserves, and I have four sons serving in the military, including one who is a doctor in the Navy, three in the Army National Guard.

Thank you very much for your service.

Dr. SNYDER. Gentlemen, you have teed us up well for the second panel.

Members may have questions for the record. If they do, I hope you will get those back to us in a timely fashion.

I also want to give members any chance, if they have a question that they want to ask.

Mr. Kline, anything further?

Mr. KLINE. No.

Dr. SNYDER. Ms. Drake.

Mr. Wilson.

Ms. Davis.

Ms. Shea-Porter.

I wanted to hold up the report. The title, I think, is great, "Rebuilding the Trust," and you have the Purple Heart on here.

I just want to make one point. We sometimes make mistakes referring to wounded warriors. And, obviously, everything in here applies to people who become ill or injured through non-combat means. We care about them all.

As somebody who got the sickest I have ever been in my life was when I was working in a refugee camp in Sudan, I appreciate the kinds of things that can happen overseas.

I also appreciate the comment, a couple things that didn't come up in the discussion, you specifically are critical of the so-called efficiency wedges and the military-to-civilian conversion amongst medical services, which this committee has been very concerned about. And I appreciate your calling attention to that and, also, your vocal commitment in the report to medical research.

Secretary MARSH. Mr. Chairman, in that regard, the funding streams inside the Department of Defense on the medical budgets was changed and no longer comes from the service secretaries of the three services, but has been moved up into the Department of Defense. And it, in my view, is not as effective or as efficient, and it needs to be reviewed.

And I am very pleased to learn that you all are going to look at that, because it is one of the sources, in our view, or certainly in my view, of the problems that we have on financing.

Dr. SNYDER. And the surgeon generals have been very candid about that.

Gentlemen, we appreciate you for being here, appreciate your service, appreciate this report, which was put together very, very quickly. I think you did a very thorough job.

We will be in recess for about three minutes while we are changing name tags, and anybody who wants to run to the restroom can.

Thank you. Thank you, gentlemen.

[Recess.]

Dr. SNYDER. Mr. Kline and I want you to realize we are talking about Marine Corps three minutes, not congressional three minutes. [Laughter.]

So we are about ready to start here. I am going to go ahead.

I wanted to formally welcome you all and formally introduce you all.

I don't know if you were able to watch this or not, but Mr. McHugh has been called to the floor to do an amendment on the floor. That is why he is not here with us.

We are pleased to have with us on our second panel General Richard Cody, vice chief of staff of the Department of the Army; Major General Gale S. Pollock, acting surgeon general for the Department of the Army; Major General Eric Schoomaker, commander, North Atlantic Regional Medical Command and Walter Reed Army Medical Center; Brigadier General Michael Tucker, deputy commanding general, North Atlantic Regional Medical Command and Walter Reed Army Medical Center; and Colonel Terrence McKenrick, commander of the Warrior Transition Brigade at the Walter Reed Army Medical Center.

General Cody, you have an opening statement.

Does anyone else have an opening statement you want to present? General Pollock.

General Cody, if you would begin.

STATEMENT OF GEN. RICHARD A. CODY, VICE CHIEF OF STAFF, DEPARTMENT OF THE ARMY, U.S. ARMY

General CODY. Thank you, Chairman, distinguished members of the subcommittee. I appreciate this opportunity to discuss with you our continuing efforts to improve the outpatient care and the administrative support of our wounded soldiers and their families.

In February of this year, I made a commitment to our soldiers, our families, the American people and to you that I would personally oversee the needed fixes to the care and support we provided our wounded soldiers. We are here today as a group to provide you, our soldiers, the American people an update on our progress to date on that continued way forward.

In the last several months, we have done much to improve the outpatient care conditions and support for our warriors-in-transition and their families both at Walter Reed Army Medical Center and across our Army. In my written statement, I describe a number of the immediate fixes we have taken, but would like to highlight two of the most critical for you now.

First, to provide the caring, purpose-driven leadership our soldiers and families deserve, we have transformed and formed up 37 warrior transition units to replace the medical hold and medical holdover companies. Established at locations with significant warriors-in-transition populations, we are working aggressively to man these units with the right leaders in the right numbers with the right training down to the squad level.

Second, we have established the transition triad, consisting of the squad leader, nurse care manager and the primary care manager, all linked with each warrior-in-transition. This triad will work closely together to ensure the medical, the administrative, and the outpatient support requirements of our warriors-in-transition and their families, so that we ensure a positive, timely and fair manner of medical care.

Of the initiatives we have implemented to date, I consider these two to be the most important and most critical. They provide the focused leadership and personalized care that our soldiers require to expedite their rehabilitation and return to duty or timely and fair disposition as they work through the physical disability evaluation process.

While we have done much already, there is still much to do. Our way ahead is captured in the Army Medical Action Plan. Several weeks ago, I sent out a Department of the Army operations order to all of our subordinate commands and supporting agencies directing specific actions required to address 120 issues identified in our action plan.

This order was received and acknowledged by our three-and four-star commanders, our assistant chiefs of staff, and our hospital commanders. The order specifies tasks, timelines and reporting requirements to ensure full implementation and enduring implementation of our Army Medical Action Plan and to sustain the momentum we have already gained.

Warrior-in-transition care is truly, at its heart, an issue of leadership, from squad leader all the way up to the chief of staff and secretary of the Army. I assure you that nothing is more important to the Army's leadership than ensuring quality care for our soldiers and families, and we are fully engaged to achieving that end.

Our acting secretary, Pete Geren, and I are principal participants in the senior oversight committee, chaired by the Deputy Secretary of Defense, that meets weekly to coordinate the Department of Defense efforts to improve medical care processes, disability processing and transition activities with the Department of Veteran Affairs.

Over the last several months, I have chaired several video teleconferences with our hospital commanders to receive direct feedback from them on the progress and challenges they are having out there in our medical treatment facilities. These monthly video teleconferences have proven crucial to developing and disseminating and implementing the Army Medical Action Plan and have been invaluable to focusing and synchronizing our efforts across the Army.

Our senior mission commanders, our two-star and three-star commanders of our posts, camps and stations participated during the most recent teleconference and provided their respective insights as to how we are doing in taking care of their soldiers.

I can't emphasize enough how important the care of our soldiers and our families are to this Army, an all-volunteer force that is making incredible sacrifices every day during this time of war.

Our nation could not ask our soldiers and their families to make these sacrifices and not ensure that their medical care and overall quality of life is at least equal to the quality of their service and their sacrifice. We cannot ask our soldiers to ensure the rigors of combat and then endure an under-resourced or bureaucratic system when they come home.

This Army is many things, but ultimately it is about people and it is about our soldiers. The entire Army leadership is committed to getting this right for them and their families.

And I look forward to your questions.

[The prepared statement of General Cody can be found in the Appendix on page 76.]

Dr. SNYDER. General Pollock, we will go to you.

And then, General Schoomaker, you have an opening statement also.

General Pollock, for as long as you need.

STATEMENT OF MAJ. GEN. GALE S. POLLOCK, ACTING SURGEON GENERAL, DEPARTMENT OF THE ARMY, U.S. ARMY

General POLLOCK. Mr. Chairman and distinguished members of the subcommittee, thank you for the opportunity to update you on the Walter Reed Army Medical Center and the noteworthy achievements of the Army Medical Action Plan.

In the last four months, the Army and the Army Medical Department have taken significant actions improving the management and care of soldiers in an outpatient status. We are committed to getting this right and providing a level of care and support to our warriors and their families equal to the quality of their service.

As you have heard, the Vice Chief of Staff, General Cody, the G–1, Lieutenant General Rochelle, and the commander-Installation Management Command, Lieutenant General Wilson, have been personally invested in finding solutions.

Shortly after publication of the media reports, General Cody reached out to the Armor School at Fort Knox and tapped Brigadier General Mike Tucker to be our bureaucracy buster and to serve as the deputy commanding general of North Atlantic Regional Medical Command.

We have put Mike in charge of the Army Medical Action Plan, the AMAP, and he has been diligently pursuing a comprehensive plan to improve outpatient management at Walter Reed and across our Army.

At the same time, Medical Command (MEDCOM) established a tiger team composed of ten subject-matter experts, led by Colonel Ben DeKoning, and charged them to determine if any of our other medical facilities were experiencing issues similar to those at Walter Reed.

This multidisciplinary team spent a month on the road visiting 11 different installations, inspecting soldier welfare, infrastructure quality, medical administrative processes, and soldier and family information sharing.

The team identified some concerns similar to those at Walter Reed, but also found best practices that could be shared across the Army Medical Command. The tiger team's findings and recommendations became one of nine different source documents used by the AMAP team to develop a detailed and comprehensive action plan.

In its 90 days of existence, the AMAP team conducted an initial analysis, developed lines of operations, codified the requirements, conducted personal reconnaissance and assessments, hosted a synchronization conference, and established a bevy of quick wins, short-range goals, and long-term goals.

Although the team has "medical" in its title, its composition and focus is much broader. Permanent team members came from Manpower and Reserve Affairs, the Installation Management Command, the Army G–1, the Army G–3, and Medical Command. Other participants include the Army Corps of Engineers, the TRICARE Management Activity, Veterans Affairs, and other Federal agencies.

The team has already provided several updates to Acting Secretary Geren and received clear senior Army direction and leadership. Everyone is working toward the same goal, and we are all working with urgency.

The AMAP succeeded in meeting all of its quick wins, many of which I detail in my written testimony. I would like to highlight and elaborate on just two of them now.

We have been very focused on family support. As we analyze each aspect of the soldier support, we ask ourselves, "But what about the family?"

First, we heard concerns about how loved ones were supported upon arrival at the airport. In response to those concerns, we implemented a program of family escorts whose mission is to greet the families at the airport, transport them to the hospital, and

bring them to the soldier family assistance center. There they meet with counselors or chaplains and relax a bit before they go to the ward to see their loved one for the first time.

It sounds like a simple thing, but to pull it off required some serious bureaucracy-busting. It is absolutely the right thing to do, and the families deserve this special treatment.

Another quick win that seems rather simple but that we expect to be of enormous benefit to our families is the trained ombudsmen we have assigned to each facility.

Although all of our facilities have had patient representatives for years, they were seen by some of the stakeholders as inadequate. We evaluated and agreed it was time for a transformation.

We combined the ombudsman with a patient representative, developing an empowered patient advocacy office with a direct line to the hospital commander and to me. They no longer sit in their offices waiting for a distressed person to find them. They are required to get out and meet every warrior-in-transition and proactively engage family members. They are further charged as local bureaucracy busters to implement immediate fixes and work every problem through to resolution.

We will maintain a central database of their case work so we can spot trends early and take responsive action. Patient advocacy will not be a buzzword in the Army Medical Command. It is a required mindset and an ever-present attitude. We are here for our patients.

I want to ensure the Congress that the Army Medical Department (AMED) places high priority on caring for these warriors-in-transition and their families. I am proud of the AMED's efforts over the last four months, and I am convinced that, in addition to our quick wins, we are setting the stage for long-term solutions that will significantly enhance the rehabilitative care and support of our warriors and their families.

Thank you for allowing me to be present at the hearing, and thank you for your continued interest and support of the warriors and families that we in the Army Medical Department are honored to serve.

I look forward to your questions.

[The prepared statement of General Pollock can be found in the Appendix on page 81.]

Dr. SNYDER. Thank you, General Pollock.

And this committee likes having Schoomakers around. So, General Schoomaker, go ahead.

STATEMENT OF MAJ. GEN. ERIC B. SCHOOMAKER, COMMANDER, NORTH ATLANTIC REGIONAL MEDICAL COMMAND AND WALTER REED ARMY MEDICAL CENTER, U.S. ARMY

General SCHOOMAKER. Thank you, sir.

Mr. Chairman, distinguished members of the subcommittee, thank you for this opportunity to address the committee. I am speaking today as the commanding general of the North Atlantic Regional Medical Command (NARMC), commander of eight hospitals and eight clinics in the North Atlantic, to include our premier medical center in the North Atlantic, Walter Reed Army Medical Center.

Approximately three months ago, my command sergeant major and I stepped into what you have heard described as a perfect storm that had affected Walter Reed and really all of Army medicine in the Army. My arrival really was the one part of a very aggressive plan on the part of the Army and the Army Medical Department to track that storm and to wrestle it to the ground.

Since that time, we have been unremitting with the incredible support of the Army, the Department of Defense and this Congress to solve those problems. We have used Walter Reed and its campus to harvest problems really and to seek across the Army solutions and best practices and, where those weren't available, to create new solutions with the leadership and assistance, of course, of my deputy commanding general, Mike Tucker, our bureaucracy buster that you have heard described by General Pollock.

Rather than to enumerate all of what is written in my statement, I will just highlight a few things that we have worked on.

First of all, almost immediately we moved all of the patients that were in Building 18 out of Building 18. No patients have been put back in Building 18. I dare say we might not have any other patients, soldiers or civilians in Building 18 until the campus is BRAC'ed and we turn the facility over.

We have roofed the Building 18 so that our equity is conserved, but we have elected not to use that as a domiciliary or administrative building.

Second of all, as you have heard General Pollock describe, we have a plan of receiving families at the airport. So just as we receive their warrior, sons, daughters, husbands, wives, grandchildren, through the Air Force's assistance at Andrews, we receive them and bring them to Walter Reed.

We have a program of sending letters to each of the units that these warriors have left back behind. There is a hole left, literally and figuratively, in that warfighting unit and those commanders and first sergeants. And the squad leaders and squad members lose track of where these soldiers are, and they need some sense that the system is working for them and that their teammate, their comrade has not been lost.

And so Colonel Terry McKenrick and his staff in the Warrior Transition Brigade have already started with the outpatient group, and we are moving toward the inpatient population, as well, to immediately alert the unit to where their soldier is.

We have created the Warrior Transition Brigade. This is the commander of the first Warrior Transition Brigade at Walter Reed, Colonel Terry McKenrick, a combat veteran. And he has done a superb job with his command sergeant major, Jeff Hartless, in standing up that brigade and really breaking down all the boundaries between med hold, med holdover and building that triad that you have heard described by the vice and the acting surgeon general.

We have many other things—ombudsmen, patient advocacy, the creation of a soldier and family assistance center in the hospital—that will be duplicated across the Army.

Let me focus this on one soldier, though, that some of you have heard about before, a soldier that was featured in an article on the sixth of April, when he wrote about the problems that he had. And I raise him because we have used soldiers like him and others to

go back and ask the question today: If we had what we have going now, would we have the problems or would they have encountered the problems that they encountered then?

This soldier was a mobilized national guardsman from Mississippi, a great kid, slow-talking, plain-speaking Mississippian who joined the Army because he wanted to do something meaningful with his life, became a military police (MP), was deployed.

On one of his trips on the main supply route (MSR) into Baghdad, he was hit by an improvised explosive device (IED). It took the legs off his driver. He was in the turret as a gunner. He was knocked back. It broke his leg, the upper thigh. He also had a laceration of one of the major arteries in an arm, and he had a traumatic brain injury, a mild form of traumatic brain injury.

He complained about the problems, not with his care—his care was excellent, and, as many of our patients, and you have heard from families and service members alike, the care he received in the hospital was excellent. He got a rod put in his leg. He got a repair to his arm.

But what he had problems with is when he transitioned to the outpatient arena in a facility on a campus that has no primary care, no robust care for folks like that.

And we now have the Warrior Transition Brigade, with a squad leader, primary care manager and nurse case manager.

He had problems with a wheelchair. He had a mechanical wheelchair, with a broken leg and a bum arm, and we gave him a mechanical wheelchair. I am embarrassed. I was humiliated, talking to this soldier with my sergeant major, about how we could have done something like that. But we didn't have squad leaders who could look out for the soldiers. We didn't have a case manager who would have identified a big hole in our plan for that soldier.

He complained about the fact that he had mild traumatic brain injury, and so he was putting Post-It notes all over his room in the Malone House, a great place to live. And he was well-supported, but he didn't have a mother with him. His mom, a nurse, was down in Mississippi taking care of a husband who was dying of Lou Gehrig's disease. So he was alone in a room, with mild traumatic brain injury.

We now have a squad leader and a case manager and primary care manager who tracks our soldiers and who is going to be able to keep up with their problems, and a primary care manager who is going to be trained in managing mild traumatic brain injury. So we are not going to have problems unrecognized and untreated.

And he had problems with the personnel system. How could he get promoted? How could he get an invitational travel for his mom to come and visit when she could? Again, we have a soldier and family assistance center in the hospital that handles all of those issues, a one-stop shop that is focused on the soldier.

So I like to believe that we have solved his problems. And, frankly, Colonel McKenrick and his people have identified problems that we never knew existed.

A soldier who has a large number of boxes and baggage that he has to get back home, who is going to pay for his own shipment of goods back home? His squad leader jumps on it, figures out a way to get the Army to pick that up appropriately, and the soldier

is on the plane and his boxes aren't, and you don't hear about it, and we don't have a disgruntled soldier and family on our hands.

You know, 107 years ago today, an Army major physician named Walter Reed started his experiments in Cuba, the 26th of June, 1900, to find the cause and transmission of Yellow Fever. His studies, which are landmark studies, changed the face of America and changed the face of global health.

His name is associated with military health care of the highest order and caring for soldiers and the world population. We feel very strongly that we are restoring his name to the place it should be in history and that we are here to restore the confidence of the American people, the Army, and you in what we are doing at Walter Reed.

Thanks, sir, for the opportunity to speak today.

[The prepared statement of General Schoomaker can be found in the Appendix on page 91.]

Dr. SNYDER. Thank you all for being here.

General Cody, we will start with you, but I would like to just briefly go to each one of your team there. You five people are remarkable folks. You have risen to high levels of leadership within the Army. But like all good people in the military, somebody is going to replace you at some point and you will be moving on.

And one of the concerns we have is what is being built into this system, that, one or two or three years from now, your successors won't somehow be lured off to other topics and that the concerns that you are dealing with, very energetically dealing with, may not be the same focus of those that come after you.

What are you all and what are your successors going to be following to be sure that we don't repeat some of the problems that you all are correcting?

If we could start with you, General Cody, then I would just like to hear from each of the four people.

General CODY. Thank you, Chairman. That is a great question and one that, when I started this, you know, my expertise is not in this area, but I learn pretty quick.

When we looked at this, that was the first thing that the Secretary and I discussed, as well as when I brought Eric Schoomaker in and Gale Pollock. We all sat down.

The one question—we knew how to fix it very fast, some of these things, but our real concern was, how do we make this stick and how do we make it enduring? Because we believe that, one, it is the right thing to do, but more importantly, we are going to be with this all-volunteer force—I believe we are going to be in a prolonged struggle for some time.

That is why we did an executive order and an operations order. I can't remember when we have ever sent out a headquarters Department of the Army operations order. It has been a long time. I will go back and find out when. In fact, we can give you one for the record.

But in doing that, and it was signed by a four-star, this thing becomes a requirement for all our two-star generals, our three-star, our four-star generals, the Department of the Army staff, and it is enduring and it lays out the plan.

The second piece of it—and so as the G–1 changes out, he still has to comply with this. As the new vice chief comes in or a new commanding general at Eisenhower or some other place, this thing, with 120 of the tasks and purpose, is very directive in nature.

The second piece—and you know this oh-so-well—if you don't put money against it, it doesn't become enduring. And so, as we laid this out, some of the money clearly up front has been done with global war on terror (GWOT) supplemental dollars. But in the 2009–2013 Program Objective Memo (POM), we are putting in an average—and I have to look on my cards so I get it right for the record—an average of $370 million each year in the 2009–2013 POM.

And this will cover the things at different installations that we build up for the warrior transition units, the operations tempo (OPTEMPO) dollars required, the operations & maintenance Army (OMA) dollars required, to cover the salaries of the behavioral people that we are contracting out for, as well as to take care of the operations of these warrior-in-transition units and the additional piece that the Army is providing for our hospitals and our garrisons.

In part of that is $168 million right now that we need to do in military construction to become Americans with Disabilities Act (ADA)-compliant for the warrior-in-transition barracks, as well as some other construction that we need to put in.

So that has been our way, Chairman, to make sure that this becomes enduring.

The last thing I will say is the warrior-in-transition units have been documented in the Army's personnel structure. And so we have a brigade at Walter Reed. Most of the other warrior-in-transition units are battalion level and then in the smaller posts, camps and stations, they are company level. But they are now in our personnel documents and in our Army unit documentation. And so, that is another way of doing it to make sure it is enduring.

Dr. SNYDER. Does anyone else have any comment on that issue? General Tucker or General Pollock?

General POLLOCK. Yes, please.

Dr. SNYDER. General Pollock.

General POLLOCK. I think that it is very, very important to the Army Medical Department to get this right and to sustain it because of the concerns that we have for setting the bar for the nation, particularly in rehabilitative care.

Because what we are dealing with now is something that the rest of the Nation has never needed to. And should we have to deal with any kind of large terrorist events in the United States, the same struggles that we had at Walter Reed could be repeated anywhere in the country. So if we have figured out the best way to manage these men and women and their families, we will be able to serve as a resource for the nation.

The other reason that I believe that we will sustain the focus on this is the morale of the Army Medical Department was very badly affected by all of this media presentation and the awareness that we had let a single soldier down.

We can't recruit and retain if we are not proud of what we do. So it is absolutely essential that we recover from this so that we

can continue to do what we have an obligation to do in support of the warfighter.

So there is no question, in my mind, that the professionals that I work with in the Army Medical Department want to have this corrected for the long term.

Dr. SNYDER. Any comment, General Tucker?

General TUCKER. Sir, I will just say that at my level in the Army Medical Action Plan, I do a lot of fixing out there in terms of people who have been subjected to the former system. And every time we fix and we do that very quickly, we automatically go into, was that a problem of policy, was it a problem of regulation or law, because we need to fix that so we don't have this gap that someone else could fall into.

So I think that is part of the bridging strategy, as well, sir, to sustain.

Dr. SNYDER. General Schoomaker.

Colonel McKenrick.

General SCHOOMAKER. I think Colonel McKenrick would like to describe some of the things that we are doing in the way of developing doctrine that is going to be a part of the Army and enduring legacy of this work.

Dr. SNYDER. Go ahead, Colonel.

Colonel MCKENRICK. Sir, one of the initial charters from General Cody was for us to not only stand up this new organization and brigade here at Walter Reed, which would be the pilot across the Army, but also to write the doctrine, what we do, what our mission is, the tasks that we have to accomplish on a daily basis for the squad leader, the case manager, and then to describe in detail how we do that, put those systems, those procedures in a document.

We have just finished that. Today we are hosting a warrior transition unit conference for 150 warrior transition unit commanders. First sergeants, battalion commanders, command sergeants major from across the Army are here at Walter Reed, and we are running them through two days of training on those systems and procedures, talking to them about PTSD, TBI, much of the training that we did for our own cadre over the last three months.

Now, those are the kind of things make this system enduring. The TDA, the table of distribution and allowances, the manning document that General Cody referred to, for us, is an enduring document. It requires that we have four companies' worth of troops on the document. We are only manned and authorized for manning for three of those companies. That gives us the flexibility to increase capacity for our cadre if that is required. And, of course, our goal is that, before I leave command, to be able to deactivate, to be able to take that down to two companies.

But that table of distribution and allowances, that doctrine, those are the enduring systems that we have in place for Walter Reed and for across the Army.

Dr. SNYDER. Mr. Kline, for five minutes.

Mr. KLINE. Thank you, Mr. Chairman.

Thank you, gentlemen and lady, for being here today.

Speaking to the morale of the personnel at Walter Reed, that was immediately raised to me as a concern when the Building 18 issue came up. And I really hated that that happened, because no-

where in this process has anyone really questioned the extraordinary professionalism and care that those professionals, doctors and nurses and medics and technicians have provided to the soldiers at Walter Reed, and not only the soldiers, the active-duty soldiers, but some of my close friends. I am at the age now where a lot of my retiree friends are going to Walter Reed for care and getting outstanding care.

And so I think it is important that we remind ourselves and those professionals at Walter Reed that they really are world-class and some would say the best in the world.

The issue has been around transition, evaluation boards, outpatient and all of those sorts of things. And so I have a question, and I think it is going to be for Colonel McKenrick maybe more, because I am a little bit confused.

I am very anxious that we do this right, but I have listened to the testimony and I have heard words like triad, soldier and family transition office, trained, ombudsmen, patient representatives, advocacy office, a care manager, a Warrior Transition Brigade with subordinate warrior transition units. And I am trying to decide or understand what fits where.

What, Colonel, or to anybody who wants to answer, what is the relation of all of this stuff that I just listed? It all sounds important and sounds like it is taking care of soldiers, but is it all coordinated? Is it all you, Colonel? What is that?

Colonel MCKENRICK. Sir, I will take the first stab at that, and what I don't answer I am sure someone else will help me out with.

It is a coordinated effort, and it starts with that triad of warrior support: the squad leader, the case manager, the primary care physician. Those three individuals form a network that take care of that warrior, their family, any of the needs that they have.

In addition to those are a variety of other systems at Walter Reed, around the Army.

Mr. KLINE. Excuse me. Hang onto that thought.

They do not all work for the Warrior Transition Brigade, though, right? You have a physician, he is doing something, and you have—who is in charge?

Colonel MCKENRICK. Sir, I am in charge, but in my brigade, down in my company, I will have a company commander. In his company, he will have 12 case managers taking care of his 200 warriors. He will have 18 squad leaders and 6 platoon sergeants all taking care of those warriors. And then he will also have a primary care physician that is part of our warrior care clinic.

So you have got that teamwork down at the company level, and that will be throughout the Army, where you have the primary care physician, the doctor, working with the nurse case manager, working with the squad leader, all there to make sure that this soldier, whatever problems they have, they get to their appointments, the care plan is set, everybody understands the warrior, the family member understands that care plan, have a say in it, a vote in it, and we help them through the process.

Mr. KLINE. That sounds good. Do they all work for one person?

Colonel MCKENRICK. Sir, at the company level, those case managers work for the company commander. The squad leaders——

Mr. KLINE. And the physician and the nurses, they work for somebody else.

Colonel MCKENRICK. Sir, they are all in my brigade. They all work for me. Ultimately, they work for me. But down at the company level, that doctor is working for that company commander. All those warriors in that company, that doctor is there to take care of them.

Mr. KLINE. Super. And so the advocacy for the patient, for the wounded warrior, comes through you.

Colonel MCKENRICK. Yes, sir.

Mr. KLINE. If the wounded warrior now enters this morass that we discussed with the previous panel of evaluation boards, are you the advocate or your organization the advocate?

What was described in the last panel and which we have heard a lot about and I think all of you are very familiar with is you have an adversarial relationship between the soldier and the evaluators in this board process. And we don't want that soldier, Marine, airman, sailor to be out there sort of adrift and feel like the system is working against him.

So it has been my belief that we ought to have a Warrior Transition Brigade, or the Marines call it a wounded warrior regiment, or somebody who understands that soldier and is the advocate and who the soldier knows is their advocate. So when they run up against a problem, they are turning to somebody.

Is that you?

Colonel MCKENRICK. Yes, sir, that is us. That is our brigade. When the warrior first comes in the hospital and is an inpatient, that squad leader and case manager go over and introduce themselves. Now, they have a social worker and they have doctors and nurses taking care of them in the hospital, but our cadre come over and introduce themselves.

When they become an outpatient, that squad leader is interacting daily with that warrior and their family. The case manager is meeting them at least weekly to review their care plan. The doctor is seeing them for all their needs, referring them to specialists.

When that warrior is going through rehab treatment, that squad leader is going up there with them to their appointments, motivating them through their rehab.

When that warrior goes to the review board, their medical evaluation board or their physical evaluation board, that squad leader goes there with them and talks to them, understands their issues and concerns. And that squad leader's job is to answer all their questions; if they can't answer them, to go find the answer and bring that back to them.

The same with the family, to help them understand all the issues, understand all the questions, and be able to answer everything.

General SCHOOMAKER. I would say, sir, that you have identified one of the problems we have had all along, which is these are fundamentally, in the private sector, what you would call, or the academic sector, what you would call multidisciplinary teams, and we would call them combined arms teams in our business.

But we are trying to exercise unity of command and control whenever possible to ensure that the soldier, warrior and his fam-

ily, his or her family, are under the care of an accountable commander.

And when those teams are multiple in number that have to interact with an individual patient—I mean, you are going to have physicians and occupational therapists and physical therapists, you are going to have a psychiatrist, psychologist—those department chiefs who supervise those individual practitioners all fall under the hospital commander, and that hospital commander falls under me.

So ultimately there is unity of command that is going to pull all these together. And what we focus upon is what the individual warrior-in-transition requires.

Mr. KLINE. Thank you.

Thank you, Mr. Chairman.

Dr. SNYDER. Ms. Drake, for five minutes.

Mrs. DRAKE. Thank you, Mr. Chairman.

First of all, thank you all for being here, and it is quite impressive what you have just described.

And I have got two questions, but, first, I want to comment. Kind of maybe a model is what we hear in Special Ops with Navy SEALS, how they assign someone to stay with that person for their team member. And yours is kind of a little different process, but probably along the same thoughts.

But from listening to what you have just described to Congressman Kline, my first question would be, do we have the resources and the manpower to do what you are talking about? Do you need more from us? Do you need more from DOD? And how we are going to do all of this?

And then, second, for you, General Cody, is there built into all of this a feedback mechanism so someone at your level, at the four-star level, would know if there is a problem, that our soldiers would be willing to go up that chain of command somehow and let you know there is a problem?

Because typically we see our military members don't want to complain, it is not part of who they are. And so I want to make sure there is a feedback mechanism, how that would work not only for the military member, but also for their families, because often they are the ones that see that something is going on and they don't know how to get that information to you.

So the two questions on the feedback and on do we have the resources and the manpower to do what you have just described.

General CODY. Thank you for those questions, because I think it is important for us to discuss them.

First, on the resources, this Congress and Office of the Secretary of Defense (OSD) has allowed the Army now to, after the temporary growth of 30,000, to make it a permanent growth of 65,000 to the active-duty force.

I am taking some of that 65,000 and redirecting it. We were taking at a high prior to it and over 2,000 personnel spaces. The other piece of the resourcing—and that is just for these warrior-in-transition units and I believe they are enduring.

You heard Colonel McKenrick say that we have got them on the tables of distribution and allowances, and that means we can resource to it. When we don't have to resource to it based upon de-

mand at different places, we can ratchet it back. But we always have the authorization document, which means that we put on the personnel system that requirement. So we have enough resources now with the 65,000 Army to be able to do that.

The resources in terms of the operational maintenance dollars and the Military Personnel (MILPER) dollars we are doing with GWOT dollars this year and next year and I am putting it into the budget as we build the 2009–2013 program. And I believe that, one, with the help of Congress and OSD, we will be able to put that much money in. It is about $368 million to $370 million a year to be able to run at the level we are operating at right now, with about 5,000 warriors-in-transition across our Army on any given day.

So I believe that we have got the right resources right now, and I am watching it closely.

Now, the feedback mechanism is one that we have established with the executive order that we sent out from the Department of the Army, with the tasks that I have given to the Department of the Army IG to go back and to look at everything that the panel before you went out and looked at, as well as what we are executing here.

They have scheduled looks. The medical community have their scheduled looks. But at the same time, we have put in these soldier and family hotlines, 1–800 number, and we get—those command 24/7, being manned, and that is part of the resourcing that we did. And so we are getting feedback there.

We also are training ombudsmen so that they can bring forward those issues to us.

But I firmly believe that the best feedback we are going to get is the investment we are making in the training of the squad leaders, platoon sergeants and these company commanders and first sergeants who are part of that triad of care with the case manager, and that is where we are going to get the feedback.

And I am convinced that with the right training that we are putting in right now, the selection process of who we are putting in these warrior-in-transition units to take care of these soldiers, that is where we are going to get most of our feedback from.

Mrs. DRAKE. Thank you very much.

Thank you, Mr. Chairman. I yield back.

Dr. SNYDER. Ms. Davis.

Ms. DAVIS. Thank you, Mr. Chairman.

And thank you all very much for tackling what are some very difficult issues, and we appreciate that.

I wanted to go a little further along with the combat support arms personnel that you are working with. And my first question really was, when I had a better understanding of how this triad was coming together, is there something that is not being done, because these folks are being recruited and actively involved in this way?

What roles were they performing before and how do you recruit them? Some criticism might be that, in that position, they might not be as sympathetic perhaps as someone might be. And how does the culture that they bring with them from the military, how does that interface with the hospital culture?

General POLLOCK. I will take that for starters, because we tasked from across the Army Medical Department to bring in nurse case managers to Walter Reed, which did cause us to abruptly take nurses out of other facilities. So we have been doing local hires there, and we are looking at how we need to assign.

So the fact that we brought medical/surgical (MED/SURG) nurses in from other facilities, they were accustomed to dealing with patients and their families. They know how to coordinate all of those pieces.

But it is a challenge for us because we do have a shortage of nurses in the Army nurse corps, and so when you need to move them, you have second-and third-order effects on other places.

We are actively recruiting, but with the national nursing shortage, we aren't always able to rapidly fill.

Ms. DAVIS. I appreciate that, and that is a great concern, because we know that that is true in the general sector, as well.

How is that working?

Colonel MCKENRICK. Ma'am, I will add to the portion that deals with our cadre. They have come in to be the squad leaders and platoon sergeants. Many of them are combat veterans. Most of them have led in combat. They are used to taking care of soldiers, taking care of their fellow comrades. They are honored to be selected for this mission to take care of our fallen comrades.

They have all been through training that we conducted when they first came on board that taught them how to deal with TBI and PTSD and the medications that the warriors are on.

They are used to training their soldiers to high standards of performance in preparation for combat. They have changed that focus for this mission to take care at the highest standards of care for their warriors and their family members.

So it is the same energy, the same high level of professionalism and competence, but directed in a different way toward taking care of those warriors and all their needs.

Ms. DAVIS. And they are tapped to do this. Is there a call for volunteers, essentially, among the group of people that would be eligible?

Colonel MCKENRICK. I don't think that most of our cadre were—they were assigned this duty, but if you had asked them if they could volunteer for this duty, they would have. It is an honorable mission.

Like I said, most of them have been deployed and they enjoy the opportunity to provide energy and effort into taking care of those who desperately need their help.

General SCHOOMAKER. Let me put a very resounding exclamation point on what Colonel McKenrick is saying.

Physicians and nurses and administrators in the hospital business do not have a corner on the market of caring for soldiers. It starts with the young non-commissioned officer (NCO) who is caring for his or her soldiers and the officer corps that cares for them, as well.

And I am very impressed with what this Warrior Transition Brigade has brought to us and how they have applied their NCO and soldier-leading skills to this task. It is part of the warrior ethos

that we not leave a fallen comrade, and that is very clear in Walter Reed today.

In fact, this might be the best place to insert this. It derives from what Congressman Kline said, as well. You list all the people who now are lined up to give support to these warriors-in-transition. I have now the concern that we have too many folks, all, in many respects, beginning to take responsibility and accountability for things across all these disciplines.

I would make the very strong plea that we not be micromanaged on the individual ratios of folks, so that we have some latitude to take experiences and take lessons learned from this new enterprise and apply them logically.

Ms. DAVIS. I know you certainly recognize the perfect storm that our last panel talked about. Just very quickly, and you can perhaps answer this at another time, do you think that we are truly prepared for that next perfect storm as we see large deployments coming back, perhaps not with physical injuries so much but certainly with mental health issues and TBI? Do we have that transition in place?

General CODY. I think we do from a leadership aspect. The medical piece, I think that there is work to be done research-wise on PTSD and TBI. And we are aggressively moving forward, and with the help of Congress, with the inject of the money for TBI research and PTSD, it is very helpful.

We are going out and chain-teaching right now in the whole Army, starting in July, how to look at PTSD and TBI. It was started with our AMED and with our other experts. We have got it vetted now.

And, again, reinforcing what General Schoomaker said, this is about first sergeants and company commanders teaching their leadership and their soldiers what to look for in terms of the stressors of combat, how to take care of each other, how to recognize whether you have the symptoms of PTSD or TBI, and educating our force.

We are also going to take it to the family members.

So if we don't do that, I think there is a real part of the perfect storm that we would have to catch up on very quickly. So we are moving out on that in July.

The further piece about will we have enough case managers and enough behavioral clinicians and some of the other people that are my doctors on my left and right are worried about hiring, because there is a national shortage of them, I think it is something that we are all going to have to work toward.

And I would defer to General Pollock and General Schoomaker to talk to you about that piece.

General SCHOOMAKER. Well, I would just say real quickly I think that one of—I can't answer your question, because I don't have that crystal ball. I will tell you, as General Pollock has alluded to and General Tucker and the Vice, that we are putting in place processes that will be there, that will be enduring and that are addressing the right questions and the right needs once they do arise.

One important one that we haven't talked about, but the first panel did, was our interagency handoffs between the DOD and the VA, for example. We have a very large capacity in this nation to

respond to health threats and health requirements. And I think one thing that we are beginning to do far better than we have ever done in my career in the Army is to begin this discussion in battle handoff with the VA and with other elements of the private sector, for example, in rehabilitative medicine.

Those are the things that we need to do, and do far better than we have done historically, and I think those processes are being established.

Dr. SNYDER. Ms. Shea-Porter.

Ms. SHEA-PORTER. Thank you very much.

Major General Pollock, I would like to start with you, please. I remember in March you came before us and had a discussion about efficiency wedges, and I would appreciate if you would give us an update, the impact that these were having and what you see as problems that are fixable versus we are stuck in for the while.

General POLLOCK. Thank you.

Congress did come back and support us. So the Department of Defense received $200 million to refund the efficiency wedge, for which I am very grateful, because in fiscal year 2008, my efficiency wedge was $142 million, which is equivalent to a large facility like Fort Hood.

So in the short term, because Congress has basically funded what we hadn't had funded, we are okay in the short term. But it is something that we need to stay attuned to as we move forward.

So thank you very much for that support.

Ms. SHEA-PORTER. Thank you.

But could you tell us what will happen, what you anticipate? Because we are going to continue to see more soldiers, as you know, coming and requiring these services and more problems inside the personnel system. What do you forecast for us, if you want to just tell us what we need to know in four years, in six years?

General POLLOCK. I think one of our shortage areas that will be a challenge for us to fill will be behavioral health.

The good news, when we look at behavioral health, though, is we know so much more now than we did immediately after Vietnam. Now, we know that there are certain symptoms that are very, very normal for people to display after being in the stress of combat, being stressed by a traumatic event, where they potentially could have lost their lives or they saw others lose their lives. Those symptoms are very normal for us as human beings and the majority of us will work through them, but we almost need permission to know that the thoughts and the emotions that we are having are normal.

Then, as we give people permission to have those experiences, to admit those experiences, it increases the likelihood that they will work through the symptoms and it will not develop into a full-blown disorder like we have seen so many people from Vietnam suffer.

So we are very hopeful that with the changes in therapy, with a recognition of symptoms, we will be able to prevent that onslaught of all of these disabled people that we keep hearing about, because we think that we know enough now that we are going to be able to reduce a significant amount of that.

We won't prevent it all, because we don't all have the resiliency and the coping mechanisms that we need sometimes to get through things, but I think that, with what we know, we are going to really make a lot of progress in that.

And then, again, as I mentioned before, there are certain areas that we will step out and lead the nation. And I think as we start to destroy the stigma that is associated with asking for and receiving behavioral health, we are going to make inroads into the concerns for depression, which are now predicted to be the leading cause of illness and lost time by 2010 for our nation.

Ms. SHEA-PORTER. Thank you very much.

And, Major General Schoomaker, could you please tell me, what are the records like at this point and the communication records between the VA and the active-duty military, DOD?

My understanding is that they still have some problems, soldiers accessing their records and the different people involved in the case being able to have instant access to records. How are we doing there?

General SCHOOMAKER. Well, I mean, for the movement of patients into the four polytrauma centers for the VA—in Tampa, in Richmond, in Palo Alto and in Minneapolis—that is going extremely well. In fact, I think the latest is to try to move very large digital records of scans and the like. But routine records I think has been moving now fairly easily.

There has been a project in place to move bidirectional flow of digital information from the VA into the DOD's electronic health record. We have a system called Armed Forces Health Longitudinal Technology Application (AHLTA), they have a system called Vista, and there is a bidirectional flow.

I believe by the end of summer, ma'am, is that correct?

General POLLOCK. The TMA, the TRICARE Management Activity, is telling us that by the first of October, all of our facilities will have access to the bidirectional health information exchange.

Ms. SHEA-PORTER. Thank you very much. I am happy to hear that.

Dr. SNYDER. Mr. Wilson.

Mr. WILSON. Thank you, Mr. Chairman.

And I would like to thank all of you for your service, Generals and Colonel, here today.

The reason I stayed in the National Guard of South Carolina for 31 years, and the Army Reserves too, is because the people that I served with I felt were the most competent, capable and patriotic people I know.

And so I just want to thank you for your service and I know your passion and commitment for our wounded warriors and for their families.

I have the perspective, I have visited the field hospital in Baghdad. I have been to Landstuhl, I have been to Bethesda, I have been to Walter Reed. The people that you have working with you I believe are just extraordinarily capable. And with your leadership, the changes that needed to be made after identifying Building 18 I think can be made.

I also have the perspective and appreciation for what you are doing because I have three sons in the Army National Guard who

could be in your care, and I have faith that in your care they would do well.

I also have the perspective of another son who is a Uniformed Services University of Health Sciences (USUHS) graduate, who is currently a doctor in the Navy. And so I learn firsthand from him of the commitment and dedication of the military medical professionals.

General Cody, could you explain how the Army will evaluate the success or failure of the Army Medical Action Plan?

General CODY. As I said earlier, Congressman, one of the things that we have set in place with the executive order that went out, we also put in an inspection program with the Department of the Army IG, as well as internal to each one of the military medical treatment facilities. They have their own internal inspections. All of this is reportable back up to the Department of the Army.

And what we are going to do right now, because we just put it out—and it is a five-page program. In January of 2008 is when we hit phase five. In stride with that, the teams will go back out to look at each one of the medical treatment facilities.

I am personally going out and looking at 18 of the largest ones. I start here next week. I have had General Tucker out. And I carry with me the action plan. And then each place—and I am hesitant to say which ones I am going to, because three of them are surprises, and they will sit down and tell me where they are.

And so we have a pretty aggressive feedback and inspection program. Clearly, we have to change the inspection program of the Department of the Army IG, as well as General Pollock's leadership in the AMED, they have to change their inspection, because we have 120 items that we are looking across the board at.

So that is how we are tackling it, and I feel pretty confident that we will get it right.

Mr. WILSON. And, General Tucker, I appreciate that General Pollock has identified you as the bureaucracy buster. I can't imagine a more difficult job. And indeed I know it was with great intent the Med hold units, but it didn't seem to work. And so I am very hopeful that your efforts, according to the Army Medical Action Plan, that you have been appointed by General Cody, that has been identified as the action officer.

And in this position, do you feel that you have the necessary resources and manpower to get the job done successfully? Are there changes to the Army or DOD policies or legislative authority that may help you succeed in your mission?

General TUCKER. Sir, without question, I have all those things. I have been given enormous authority by the Army leadership.

And I can tell you that in my travels—I have gone to eight different installations, and I have briefed all over the Pentagon—I foresee no pushback from any person at all. They welcome all these changes, as dynamic as they are. We are bending some pretty thick metal here in the Army.

I think it is just testimony to the warrior transition company itself, the baseline organization.

Just to give you a comparison, sir, before, this organization was manned with nine members in its cadre. Today that is 39. So that

gives you an appreciation that a 75 percent increase in leader-to-led ratio.

And when the Army commits to something, we put boots on the ground. And, sir, this is putting boots on the ground in a big way across our entire Army, and I think it is going to serve us well.

Mr. WILSON. As I conclude, again, I want to thank you for your service and as a Member of Congress, as a parent, as a fellow veteran, just thank you for what you have done and what you will be doing in the future for our wounded warriors.

Thank you. God bless you.

General TUCKER. Thank you, sir.

General CODY. Thank you, sir. And, by the way, you know, at least three of your sons got it right. And we are just as proud of Hunter, who just joined Reserve Office Training Corps (ROTC). So we look forward to getting him in our ranks.

Dr. SNYDER. I have a 13-month-old son, but he has not expressed any interest yet, General Cody. [Laughter.]

General CODY. I still may be around, so I might be able to influence him. [Laughter.]

Dr. SNYDER. General Clark lives just down the street from us, so he has been trying to indoctrinate him in West Point. [Laughter.]

I don't know if other members will have many questions, but we are going to go ahead and start a second round.

A quick question, Colonel McKenrick, for you, before I go back to General Cody. Your unit is an integrated unit of both reserve component and active component and both guard and reserve.

Have you had any issues dealing with the fact that you have got a bunch of people that are working under different personnel policies and promotion policies? Has that been an issue for you or has that all gone very smoothly?

Colonel MCKENRICK. Sir, that has been a challenge for us. We recognized early on the need, when we integrated those, to make sure that we had expertise in each one of our units, each one of our warrior transition companies.

Dr. SNYDER. Personnel expertise?

Colonel MCKENRICK. Yes, sir. Personnel, promotions policies, pay policies, all those issues that are different between the different components of the service.

So we currently have one expert that we have got working in a cell that we are going to establish at brigade, put down in amongst those companies. We have got, at Human Resources Command (HRC), some paperwork to pull in a second person. And we are working an initiative to get a third, so that we have three personnel that are national guard-reserve experts that focus on the very difficult orders process that deals with national guard and reservists and the pay and promotions and other personnel issues.

So it is a challenge for us that we currently have one person. We need to get two more, and we are working that aggressively.

Dr. SNYDER. General Cody, I am not a big one for rehashing old history, but I wanted to ask a lessons-learned question, if I might, because I know when you first heard about this, you were very concerned about it.

I guess when I first read *The Washington Post* story, I first heard about all the details that were in the story, I thought back. If I was

Ike Skelton, I would be able to tell you the name of the general, but it was one of Ulysses Grant's predecessors, in his capacity, who was quite an old man at the time, but they would find him in the middle of the night, when all the troops were sleeping, going tent to tent, opening flaps, making sure people actually were on dry ground, that they had their clothes dried out. He was kind of old-timey, "I am going to take care of my troops, even if they don't want to be taken care of" kind of soldier.

And it seemed to me that—my question is in terms of lessons learned. It seemed to me that somebody wasn't doing that, that somebody should have been going, at a high level of rank, door to door, room to room, talking to people, looking in the showers and that kind of thing.

Has this created any apprehension amongst you in other areas other than medical that maybe there is not that kind of attitude about leadership? I mean, do we have people out there sticking their head in the boiler room, sticking their head in the air conditioning rooms at all these different facilities?

What have been your thoughts about that? Because I know you were very concerned when you first heard about this in terms of the leadership.

General CODY. Clearly, my biggest angst was the fact that this should not have happened. It was a failure of leadership, and, as you know, we relieved a lot of people and we moved people out, and we quickly—my assessment up front was we didn't have people going to each one of those rooms.

I went through each one of those rooms at Building 18, but, quite frankly, there should have been lieutenant colonels and majors and captains and sergeant majors and other people checking those things out.

We have asked that question, is this indicative of an Army that is stretched pretty thin by repetitive combat tours and everything else? What I am seeing outside of that in our combat units is not the same. We have got very, very good, engaged leadership.

The decision that we made four years ago that company, battalion and brigade and division commanders and their sergeant majors and first sergeants would train a unit up during the reset period, build the team, deploy with that team to combat and stay in command positions and bring them home was a pretty smart thing that we did, unlike what we did during Vietnam, where you could have three company commanders in one tour or three battalion commanders in one tour.

And so when the units come back, you have got a well-rested first sergeant—well, maybe not first sergeant, but a well-rested new company commander getting ready to take command, a battalion commander and a brigade commander. And the handoff between those commanders and the lessons learned are being passed very, very aggressively.

Plus, our two-star commanders I have great trust and confidence in, and our two-star sergeant majors. They all know that they have to pay very, very close attention and walk around into the barracks, walk around into the motor pools, because they only have 12 months to reset that outfit, assess their leaders, build the team, get the training done, and then they are going right into combat.

So that is happening.

The failure at Walter Reed at Building 18 was just an unfortunate failure of people being—I don't want to say out of sight, out of mind, but they were across the street.

We did not resource the AMED at Walter Reed with the ratios that you just heard Mike Tucker talk about. They were forced to take it out of clinics. They were taking medical NCOs and other people. So they were doing double jobs, and, quite frankly, it caught up to us. They went from 300 to 400 to 500 to 600 outpatients. But some leader should have caught it, and it is unfortunate.

But the net result of all of this is we have revamped everything, and I feel very, very confident that the young men and women that we have asked to go, over 2,000 of them that we will build into these warrior transition units, the care that our soldiers and the families get is going to be wonderful. And it is going to be what you and I would want for our son or daughter, and America will be proud of it.

It is unfortunate that it took Building 18 for us to get there, but I see something good coming out of this. And so I am committed, as all the other people here.

But more importantly, the question you asked, are our commanders below us cognizant, and the answer is yes. And I feel pretty good about it, but we will continue to check.

Dr. SNYDER. Mr. Kline.

Mr. KLINE. Thank you, Mr. Chairman.

Colonel McKenrick, I want to echo some of the thoughts and comments that the chairman made, having to do with personnel issues. That seems to be at the heart of the problem. What are the policies? Not only for guard and reserve and active, but you have to somebody who really knows that. So I would encourage the Army and you to work hard to make sure you have got people with the requisite skills.

A quick question for you: Who signs your Officer Evaluation Report (OER)?

Colonel MCKENRICK. Sir, I work for General Tucker as the deputy commanding general for North Atlantic Regional Medical Command (NARMC), and my senior rater is General Schoomaker.

Mr. KLINE. Okay, great, good idea. Thanks. It is amazing. That was the right answer to the question.

I want to go back to something that I raised very briefly with the earlier panel, and realized I was probably talking to the wrong people, but there was a finding in their report that says, "Walter Reed Army Medical Center and National Naval Medical Center staff members, especially those in the nursing field, are showing signs of compassion fatigue."

And so I want to ask you probably, General Pollock, General Schoomaker, and perhaps Colonel Horoho, hiding in the back there, if you agree with that, and if so, what you are doing about it.

General POLLOCK. I will change hats here and put on the chief of the Army nurse corps hat.

And, yes, they are absolutely struggling. Unfortunately, the Army has not made mission for the Army nurse corps since 1999, and each year our junior officers are fewer and fewer. As a result,

we are asking them, as the junior officers, to do more and more work.

And, unfortunately, when there is a civilian nursing shortage and you either can't fill your general schedule (GS) positions or the contractors don't come to work, and the civilians have the option of refusing over time, who do you turn to to provide care? It is the military nurse.

They are also the same nurses that deploy. So we put them in a combat environment for a year, and then we come back and we work them perhaps harder than they were working in a combat theater.

Mr. KLINE. So, if I can interrupt, this isn't just a matter, as the recommendation and the findings say, a formal study of stress, immediate action, provide stress reduction programs for all personnel, that is maybe a decent idea, but that is not at the heart of the problem.

You have got a resource and personnel problem, is that right?

General POLLOCK. Correct, sir. And Colonel Horoho has done a fabulous job working with some compassion fatigue and stress management initiatives at Walter Reed, but the cause of the problem is the nursing shortage and our inability right now to bring those nurses into the military.

Mr. KLINE. Well, as I have said before, we are doing our part in our family. My niece is an Army nurse down in San Antonio right now. My wife is a retired Army nurse. I try to keep this information from her, because she is going to have this desire to run back and put the uniform back on again. So don't even go there. [Laughter.]

General POLLOCK. Well, we would welcome that, sir.

Mr. KLINE. I am afraid that would be the case. So we will keep this little secret.

General POLLOCK. Because if we could each attract one, sir, we wouldn't have a nursing shortage.

General SCHOOMAKER. Sir, if I could make one comment.

Mr. KLINE. Yes, General?

General SCHOOMAKER. Because like General Pollock, I served as the chief of the Army Medical Corps until last October for four years. And I have thought about that phrase and that notion that we are suffering from compassion fatigue for some time, and I have asked people to help me understand better what that means. Because, frankly, most people, as you know from your wife, go into medicine and nursing knowing that they are going to see a lot of human misery and they are going to see suffering.

Frankly, we also get reports from people who have even deployed to the theater of operation that this is some of the most rewarding work they have ever performed in uniform, and they seek opportunities to go out again and take care of these soldiers.

So what exactly are we talking about when we talk about compassion fatigue?

I think what I hear most people talk about is the fatigue not of taking care of the most severely injured and most challenging patients, it is the fatigue of a system that doesn't allow us to transfer records to the VA very successfully, a system that puts a physician or a nurse in a position of being an adversary of a patient they are

trying to take care of. Because why? The patient is frustrated with a physical disability and evaluation system that the physician or the nurse has no control over.

Mr. KLINE. So you don't see a lack of compassion as the——

General SCHOOMAKER. Absolutely.

Mr. KLINE. What I found striking, I guess that is what had me going down this road, is I was just struck that they said there is compassion fatigue. I can understand where fatigue would wear on you and perhaps you would be a little bit sharper in your response or something, but I was having difficulty understanding how they concluded that this was compassion fatigue.

General SCHOOMAKER. I think it is bureaucracy fatigue.

General CODY. Absolutely. That is why we took on the bureaucracy first. I echo what General Schoomaker said. I have gone out and talked to these doctors at the caches that had second tours or third tours. I have talked to them up on the intensive care units (ICU), the nurses.

I agree with General Pollock that we have a nurse shortage. We need to fix it. But everywhere I go, it is not one of not wanting to take care of and not wanting to do the best in terms of compassionate care of our soldiers. The frustration is with our bureaucracy, our system, and, in some cases, our personnel assignments, and, in some cases, it is the OPTEMPO.

But when you put a nurse or when you put a doctor with a patient or a family, you don't see that. What frustrates them has been the bureaucracy and that is, quite frankly, what we have tackled.

Mr. KLINE. Thank you.

Colonel Horoho, I didn't mean to single you out back there, but congratulations on the command, as well. Did you have something?

Colonel HOROHO. Thank you, sir, very much.

All of our clinicians, I would say, remain extremely compassionate when they are providing care. And they are providing care 24/7 to all of our warriors and their beneficiaries. We as a command have worked very, very hard.

We just got approval to be able to put in a retention bonus so that we can retain those quality nurses that have been providing care for the last several years at Walter Reed.

We have also been working very aggressively with the intercardiac health promotion program, to work with a stress-reduction program, to provide not only for our nurses but all of our healthcare providers, because it is not just taking care of our warriors, but there are multiple stresses in people's daily lives. So we want to keep them all very, very healthy.

We have also gotten approval to be able to fund the 100 unfilled positions that we had, so that we can recruit and be much more competitive as we are competing with all the hospitals in the Washington, D.C. area.

Mr. KLINE. Thank you.

And thank you for your indulgence, Mr. Chairman. I do think that is something that we as a Congress and we as a committee need to continue to look at, those items like retention bonuses and things to fill that shortage, because we have heard it continually in this vein.

I yield back.

Dr. SNYDER. Mr. Kildee tells me it was General Winfield Scott. It was a Civil War general that I knew you all wanted to know that I couldn't remember.

Ms. Davis.

Ms. DAVIS. Thank you, Mr. Chairman.

And I certainly look forward to working with all of you.

What is a fair amount of time for us to try and go back and evaluate the system that has now been put in place?

General CODY. I think, ma'am, I will take it first.

We are in phase two of our five-phase plan. I think you ought to ask us back probably October-November timeframe, and then we ought to be called back probably in February, right after the State of the Union and other things get out of the way. We will be pretty much closure on execution of phase five. Those are the timelines.

So I think somewhere in the fall, and then bring us back in here right after the first of the year.

Ms. DAVIS. Thank you.

General CODY. Because we are going to continue to go out and measure. There will be some changes. If we have any drastic changes, we go out there and find something that we had not been able—or we didn't anticipate, clearly, we will transmit that to you all. But I think those two timeframes.

Mike, what do you think?

General TUCKER. Yes, sir, I agree 100 percent. We have got a good glide path. We are being resourced as we should be to facilitate and set the conditions for this plan to be successful and, like General Cody said, along those timelines October and then again in February. February, we see ourselves as wheels up, air speed and altitude, gaining momentum.

General POLLOCK. The other piece that I will add to that is each of the tasks that we have identified for the AMAP is actually listed on a scoreboard for me so that I can constantly monitor it. So once a week, they do an update for me that identifies whether anything has changed. So if there is a change, say, an amber has gone to green, then I get a little thumbs-up next to it so I know that it is a recent change.

But we are monitoring that very carefully, because I want to make sure that because we fix this piece, that one doesn't then break. So we have oversight of the entire process.

So I am comfortable saying that we can move forward.

Ms. DAVIS. Thank you.

While you are all here, I know we are trying to get a handle on the evaluation systems so that people are fairly compensated for their injuries, for their disabilities, as they transition.

And I know, General, that you have asked the judge advocates to help with some of that transition. Is that a large enough effort that we would be able to see some suggestions, I guess, coming out of that?

What I am trying to determine is, is this a system that really needs a whole overhaul? Is it built on the idea that somehow people are going to try and fraud the system, as opposed to seeking reasonable compensation from it? And can we learn from the judge advocates, if they are working?

Is there a way out there, is there a mechanism that we can begin to perhaps have good information and move forward with this over the next, I would hope, two years?

General CODY. I think, one, we understand now where the friction points are. We are talking about the physical disability evaluation system.

Before the war started, ma'am, we averaged about 6,000 cases a year. I think we are averaging now about 12,000, which tells you that we need to—we should have been a little bit quicker in responding to that case load, that plus the amount of wounded that we have had in this war.

We have gone back and looked at the MEB and the PEB process. We have identified the liaison officer (LNO) as the clutching mechanism and a crucial part of that for the soldier, and we are training those people.

We also looked at extensively the legislative changes that we needed to pass through Congress and say we and the OSD—now, I am part of the steering committee at OSD that meets once a week with the Veterans Administration, led by Secretary Gordon England and the deputy of the VA. We have put five or six now recommended changes that will help eliminate that friction point and, to your point, the issue of having a soldier almost have to ask for something that we should give them as a country anyways.

And right now, I think some of the laws are such that, with minor changes, we could eliminate that friction point, and the Physical Disability Evaluation System (PDES) and the movement through adjudication would be much, much smoother.

But we have created a situation in some cases, especially with our national guard soldiers and our reserve soldiers, where, quite frankly, with a law change, this will all go away.

Ms. DAVIS. I look forward to working with you on that. Thank you very much.

Thank you, Mr. Chairman.

Dr. SNYDER. Mr. Wilson.

Mr. WILSON. Thank you, Mr. Chairman.

General Schoomaker, the Independent Review Group reported a finding that the philosophical and operational differences between Walter Reed Army Medical Center and the National Naval Medical Center are hampering the efforts to transition to the Walter Reed National Military Medical Center, as required by the BRAC decision.

It is further reported that the leadership and personnel time devoted to planning the integration of clinical services have detracted from the time required to manage the medical center.

How are you addressing these issues today? What are your views on the IRG's recommendation for a general or flag officer to be placed in charge of the transition team?

General SCHOOMAKER. Well, sir, first of all, I would have to concur with the group that there are within the national capital area, where you are talking about two medical centers operating in a somewhat coordinated fashion, but in two different locations, in two different somewhat distinct cultures, I would have to agree that that is occurring today.

But I want to make clear that I am not trying to throw stones at the Navy here. The Navy has a different culture about how and a different process by which they manage severely injured Marines, largely Marines. They do it in a decentralized fashion. They do not keep them at the National Naval Medical Center Bethesda. They try to get them back to Camp Lejeune or Camp Pendleton, close to their units and close to civilian or the VA system, and they are much more rapid in moving that way.

On the other hand, the Army, with a larger burden of these severely injured soldiers, especially amputees and more severely brain injured soldiers, tends to keep them at Walter Reed.

We have created, for all intents and purposes, what we lost after Vietnam, which is a rehabilitative medicine capability. We have moved toward a civilian model of acute inpatient medicine and ambulatory care and no intermediate rehab service.

We have now built, for all intents and purposes, de facto, a stepped-down rehab center, called the Malone House. It was never designed to be that, but that is what it effectively does for families and soldiers.

And we keep them together because we in the Army have adopted a very aggressive ethos of maintaining and retaining as many of those soldiers as possible. We are now returning 20 percent of our amputees to active duty. That is about five times higher than we have historically. We now have soldiers fighting—we have at least one soldier fighting with a prosthesis in Afghanistan today. That is a very strong part of our ethos and our ambition.

Frankly, I think the future Warrior Transition Brigades and companies and battalions will contain as a part of their cadre soldiers who are severely injured and are fully recovered and returned to duty.

So what we are trying to do is move these two cultures together in a way that involves also the VA system, so that we more rapidly and proactively identify who is going to return to duty and we ought to keep on campus and keep in active rehabilitative medicine programs and research, and who ought to be transitioned more rapidly to the VA system and to home care, and that has got to be a part of that blending.

As far as the overarching command and control, I think our vice has worked out with the vice chief of staff of the Navy a method by which that transition will take place.

Mr. WILSON. And, indeed, I am glad you brought up about assisting persons to return to duty.

Last week, I had the extraordinary opportunity—a hero of mine is Major David Roselle, and so I had the great privilege and opportunity to host them for a tour of the Capitol. What a wonderful young fellow he is and his wife, Kim, and their children, two little guys, Jackson and Forrest. What a role model that he has been. It was just chilling to see, again, the quality of the young people serving in the military of the United States.

General Cody, as a former member of the national guard, I was interested as you pointed out that the wounded warriors, say, who return to a base, as General Schoomaker mentioned, the Marines returning to their bases—and I appreciate that there is not being a difference between serving guard members and active duty.

But what type of coordination is there of Guard members who return home with their adjutant general, their state adjutant general? Are they kept informed of their release, of their return to home state? How is that handled?

General CODY. First off, they stay on active duty. Clearly, their unit, as I think General Schoomaker may have said, or Colonel McKenrick, when a soldier arrives into a warrior training unit, they have an aggressive program to notify the unit that your warrior is here.

In the case of national guard units, the The Adjutant General (TAG) is notified. But that soldier is still on active duty as he goes through that care. And then when you talk about transitioning back either in a still active-duty status while he is rehabilitating, he could go to a civilian health-care organization. At that time, the handoff, he still has that triad of care of a squad leader who is assigned and a case manager and his unit is notified.

Now, if his unit is deployed, like with the Minnesota Guard right now, they have their own rear detachment that takes care of that. So it is a little bit different, but the concept is the same.

But the most important thing is we don't discharge them from active duty until we are assured that we have got that young soldier on the right path, either returned to full duty; if he has to be medically retired, he is so or she is so. But we make sure of that handoff, or go through a handoff to the veterans hospital.

So it is a little different, but the safety nets are still there.

And I would ask General Tucker, he just went through this going out there, he could probably give you a couple anecdotes of how it is working.

General TUCKER. Sir, we have LNOs from the national guard at our medical treatment facilities, and they immediately hook up arm-in-arm with these warriors as they come back. And so they are with them as one of their national guard brothers to help them through that process and link them back to their unit and all their needs and specific requirements that they have, sir.

Mr. WILSON. Again, thank you for what you are doing for our troops and their families.

Dr. SNYDER. I had two final questions I wanted to ask.

General Tucker, you mentioned earlier this afternoon that when you have a soldier that has a specific problem, that you get together with the soldier, your folks do, and get the problem resolved fairly quickly.

In the course of doing that, do you run across things that you think, "You know, that really ought to be a statutory change. I need to let somebody know in the Armed Services Committee that we have got a problem with statute?" Is that something that you all have your feelers out for?

Because we are certainly aware that we can be part of the problem.

General TUCKER. Sir, absolutely. The Army has provided me—when I said they give me pretty good latitude, they allow me to build a team. So I have a team of about 22 personnel that work up here at Skyline up at Falls Church. And, sir, I have expertise in there from all the branches of the Army and some of the levels within the VA.

And so when we see those things, we quickly begin to crack the nut as to, at what level does this problem reside? Can we fix it within the MEDCOM, or is it an Army problem, or is it a DOD problem or a VA problem or legislative problem?

And we have got a pretty good battle drill that we get things channeled into the right venues, sir, so that they get addressed rapidly.

Dr. SNYDER. I hope all of you will feel free to let us know if you think that there are things that we need to do differently.

My last question, General Pollock, we have had complaints at some point recently from M.D. types that are saying that there is variation from specialty to specialty in the length of deployments overseas, and it is creating some heartburn amongst folks, that they feel that they are not being treated fairly.

Is that an issue that you are familiar with? Is that an accurate——

General POLLOCK. Yes, it is, sir. It is an area I am familiar with, and it is an area that I am working with the Army now because the deployment strain on the Medical Department, because we are not as large as we need to be, in support of a long war, in support of a growing Army. The Army G–3 and the Army G–1 are working with me on both deployment issues and the size of the force.

Dr. SNYDER. But the specific issue that certain specialties of physicians are treated differently because of their—you have need for——

General POLLOCK. Yes, sir. We currently have a group of 13 specialties that do a 6-month deployment, and that had to do with how small and how intense the demand would be on that specialty.

We would not have been able to provide them what is now called an adequate dwell time at all. So by decreasing the deployment period compared to the rest of the group, we were able to do a better job at retaining them so that it didn't get worse.

But we are looking at some modifications so that there would be more equity across the system.

Thank you.

Dr. SNYDER. Mr. Kline, anything further?

Mr. Wilson, anything further?

Yes, General Cody, did you have a final comment?

General CODY. Chairman, to get to your point that you asked General Tucker, Congress has been very, very good here in the last year, two years, assisting us with any type of legislation. And Mike Tucker and General Pollock and General Schoomaker and the rest of the people working this have gotten with our legislative people and gotten with OSD, and we are putting some of those things forward.

I would like to comment, though, that there are significant medical provisions in H.R. 1585. And I have scanned through it, I have had my staff look at it, and we think this is absolutely the right direction to go on many of the items in H.R. 1585.

However, there are some things in there that would cause more bureaucracy for us. I will just be honest with you.

One of them is prescribing ratios. You have heard Colonel McKenrick today and you have heard General Tucker talk about, listen, we know how to do this, and it would not be helpful if you

prescribe ratios, and it may become bureaucratic as we wrestle through 37 warrior transition units to get them up to speed. Now you make it law, and that could be problematic for us.

So I would ask your indulgence, if we could help by commenting on how that particular section should be written.

Another one that may cause us problems is congressional notification. The phrase is in there for congressional notification. We clearly, as an Army, want to let every one of the elected officials know exactly when a wounded warrior is wounded, where he or she is going to be taken care of. But, again, making it law and making it very prescriptive may require us to have another bureaucracy, and I worry about some of the specificity there.

And so I would ask your indulgence as we comment back on H.R. 1585. The rest of it is fine, and there is a lot of great things in there about the efficiency wedges and pre-and post-deployment cognitive assessments, and all those things are all moving in the right direction. But I just worry sometimes about being too prescriptive and it becomes law.

Dr. SNYDER. I share your concerns. We in Congress, with good intention, can certainly create problems. We are very much aware of that.

On the other hand, with regard to those two issues, if you and I had had a conversation a year ago about how do you think the ratios are at Walter Reed, you would have told me you thought they were about right, and it clearly turned out that they were not right.

And so what you are seeing is, when we drafted that, and I had a role in drafting that legislation——

General CODY. Unfortunately, I would have said two years ago I don't know, I will have to get back to you, because I didn't know, which is another problem.

Dr. SNYDER. I think things clearly are moving in the right direction.

The issue of notification came about. That has been a frustration for Congress. And we had this discussion, both at the member and staff level, at length, because if the notification issue language had been different under law, so that we would actually know in a timely fashion when someone from our district ends up at one of these facilities or has a severe wound, I don't think we would be dealing with the kind of problems we had at Walter Reed.

Now, why do I say that? Because just like General Tucker resolves problems when he runs into them, that is what our congressional offices do. Maybe we don't do it, but our staffs do. We get a call.

If we had a notification that this person was wounded and is at this facility, our staff would check on him, we would be in touch with him, give us a call. And every congressional office in the country now has that frequently occur, where they get phone calls.

I have had it—you make a courtesy call when someone has lost a loved one overseas, and it is almost pro forma to say, "If we can do anything, give us a call," and the next day they call back and say, without ever anticipating that they would need to get hold of them.

So that is why that language was put in there, that we think we can be a part of the solution, that when we get a call from somebody, when we hear about somebody, if we can have us or a staff member go by and put a business card on their hospital table that says, "If you have got any problems, if your family has got any problems, give us a call."

And at the time, they may think, "Well, that congressman is the last person I am going to call," until something happens that frustrates them. And that is the kind of calls we get, and then we would be calling you, and then you would have known there was a problem, General Cody.

And because what was happening, the staff was going over there, and every soldier they ran into with a problem, they were taking care of the problem. The issue was there were people that were lost, that had just left the campus that weren't running into staff members in the hallways, and we didn't know they were having problems.

So that was the purpose of that language. It may not be the most artfully written, but that is the intent of it, is that we would be part of kind of having the feelers out there for where there are problems.

But I appreciate your comment.

General CODY. We want everybody on the team, Chairman, and, again, every one of these are helpful and we understand the purity of the intent. I would just say because we are going to make it law, I think we could have a good discussion to make sure that we get it right.

Dr. SNYDER. I share your concerns, and that was one of the questions I asked General Jumper earlier, from his perspective on being both sides of this thing. We are always willing to pass laws, but we all want to do stuff that is helpful and not become part of the problem down the line.

We appreciate you all. And if I picked up future Chairwoman Davis's intent, we will probably see you somewhere around the October timeframe.

Thank you.

We are in recess.

[Whereupon, at 4:11 p.m., the subcommittee was adjourned.]

A P P E N D I X

JUNE 26, 2007

PREPARED STATEMENTS SUBMITTED FOR THE RECORD

JUNE 26, 2007

Chairman Snyder's
Opening Statement

The purpose of today's hearing is for members to get an update on what has happened at Walter Reed since the full Armed Services Committee hearing in March.

To refresh everybody's memory, in late February the Washington Post published a story titled, "Soldiers Face Neglect, Frustration at Army's Top Medical Facility." In the following weeks a series of shortcomings at Walter Reed were revealed, such as substandard living conditions, inadequate management of outpatient medical care, and poor follow-up from the wounded soldiers' chain of command.

Many members were concerned that these problems were not limited to Walter Reed, but that this was actually a sentinel event that raised the possibility of similar failures across the military medical system. This concern was heightened by the fact that both this subcommittee and the full committee had expressed concern during earlier hearings, dating back to 2005, about many of the same issues found at Walter Reed.

Since then, the Independent Review Group set up by Secretary of Defense Gates following the revelation at the Walter Reed Army Medical Center has completed its review and released its findings. We are fortunate to have both of the Independent Review Groups co-chairs with us today. Mr. Togo West is a former Secretary of Veterans Affairs, as well as a former Secretary of the Army. Mr. John Marsh is also a former Secretary of the Army, as well as a former member of this body. Gentlemen, welcome.

During this hearing we will also get an update on what steps the Army has taken to remedy conditions at Walter Reed, and to hear how the Army plans to address or preclude similar problems at other medical facilities.

I should also mention that while we have had Army leaders testify about Walter Reed before the Committee previously, we have here today new leaders. With us are General Cody, Vice-Chief of Staff of the Army, who has been tasked by the Acting Secretary of the Army with oversight of the Army's Medical Action Plan; Major General Gale Pollock, the Acting Army Surgeon-General; Major General Eric Schoomaker, Commander of the North Atlantic Regional Medical Command and Walter Reed Army Medical Center; Brigadier General Michael Tucker, Deputy Commander of the North

Atlantic Regional Medical Command and Walter Reed Army Medical Center, and; Colonel Terrence McKenrick, Commander of the Warrior Transition Brigade.

This entire episode has demonstrated the power of focus. Throughout this process, virtually everyone, wounded soldiers, family members, commissioners, have had nothing but good things to say about the quality of inpatient care wounded soldiers have received at Army hospitals: our military hospitals are among the best in the world. However, once soldiers leave the focused care environment of the hospital and continue their treatment as outpatients, the system has appeared unable to provide the same level of support and focus.

The challenge for all of us is to ensure that the military health care system remains focused on the recovery of our wounded soldiers across the continuum of care. They deserve no less.

Opening Remarks – Congressman McHugh
Military Personnel Subcommittee Hearing
Walter Reed In Progress Review and Results of the Independent Review Group
June 26, 2007

Thank you Dr. Snyder. Before I begin I'd like to thank you for holding this very important hearing to follow up on the issues raised at Walter Reed Army Medical Center earlier this year regarding the care of injured and wounded troops as they recover and transition either back to duty or to civilian life.

I also want to congratulate you on your selection as chairman of the Oversight and Investigation subcommittee and thank you for your leadership during the short time as the distinguished chairman of this subcommittee.

I think we would all agree that the conditions and problems uncovered at Walter Reed are a dark chapter in the stellar history and tradition of a fine military medical institution that has served

our nations warriors since 1909. With that in mind, my goal today is to get a sense as to whether not only the immediate issues have been resolved but the policies and resources have been put in place to prevent these problems from occurring again at Walter Reed or at any other military medical facility.

I am encouraged by the immediate and aggressive response by the Department of Defense and the Army to the deficiencies that existed in the outpatient medical system. Secretary Gates is to be commended for establishing the Independent Review Group to identify shortcomings and make recommendations to improve the quality of life for our wounded combat veterans and their families as they recover at Walter Reed and the National Naval Medical Center at Bethesda. I look forward to hearing the findings and recommendations from the distinguished members of the Independent Review Group on our first panel. I

would note that the Wounded Warrior Assistance Act of 2007, passed by the House of Representatives in March of this year, most of which has been included in the National Defense Authorization Act for Fiscal Year 2008, legislatively addresses many of the recommendations offered by the IRG.

I am equally encouraged by the Army Medical Action Plan that appears to be a road map for short and long term solutions to the problems encountered by wounded and injured soldiers. With that being said, my enthusiasm is tempered by continuing to hear from soldiers in the Warrior Transition Units about problems, particularly with the MEB and PEB system, most recently during a sensing session with committee and member staff at Walter Reed. I look forward to discussing the details of the plan with the members of our second panel.

Again, I thank Chairman Snyder for holding this hearing.

The Honorable John O. Marsh Jr.

Opening Statement
U. S. House of Representatives
Armed Services Committee
Subcommittee on Military Personnel
June 26, 2007

I thank the Chair and the Committee for holding this hearing to consider matters raised in the report of the Independent Review Group. This report addressed a number of issues on medical services in the Armed Forces, particularity at Walter Reed Hospital and to a lesser extent Bethesda Naval Hospital.

The Review Group was established by the Secretary of Defense on or about the 1st of March of this year and tasked to report by the 10th of April, which was accomplished. I would point out that the Review Group received full cooperation in the investigation from the Department of Defense, and all the Military Services.

I especially call to your attention the final report, which I feel speaks for itself. I hope you will study and read it because I think it will be helpful to you in carrying out your responsibilities as a Member of Congress with oversight and responsibilities for our Armed Forces.

Based on my experience of service and association with the American military, I am of the view that outstanding care of those wounded is a part of our national ethic. It is important we keep and add to this tradition of care, and reaffirm that America does take care of her wounded. We must ensure that we, as a people, continue to emphasize that ethic.

While not to diminish the role of the active force, we must remember and understand the hardships placed on our Reservists and Guardsmen by calling them to duty; they have special needs and we must be mindful of those needs.

Families! The men and women who serve – whether from the Active or Reserve components – have families who need our help, particularly when their husband or wife or child becomes wounded. We must help them.

Others have described what occurred **at Walter** Reed as the "perfect storm" The confluence of three forces that compromised the ability of the hospital to deliver to some patients the standard of care consistent with the traditions of its past. These forces were:

1 The unexpected casualty load of the Iraq War

2 The "contracting out requirements" imposed by the A 76 program, which is administered by OMB, and dragged on for over five crucial years

3 The decision to close Walter Reed pursuant to BRAC action. An action that was ratified by the Congress

It's important to note that there were two major dimensions of medical care that Walter Reed was delivering. One might be called "trauma" care and the other "holdover" care. Trauma care is treating the wounded soldier and goes from wounding on the battlefield to treatment at the hospital in Baghdad, thence evacuation by air-evac to Landsthul thence on to the United States, often to Walter Reed for further treatment. Then on conclusion of hospitalization at Walter Reed the wounded person will be discharged from the hospital, or if out-patient treatment is necessary they will go into "holdover" status

The Review Group found the trauma care at Walter Reed was outstanding.

A position generally affirmed by the wounded patient, and often their dependents. However, the 'holdover care' was inadequate, and was the major source of the justified complaints there are a number of reasons for this inadequacy.

The IRG spent the majority of its effort looking at the systemic issues at Walter Reed and Bethesda, and made recommendations to correct those areas that we believed were substandard. The remedies to the problems associated with the medical community, including those within Physical Disability Evaluation System, are not confined to the Department of Defense. Servicemembers and veterans are also going to need the help of the Department of Veterans Affairs, OMB, and OPM to fully address all the facets of this problem.

Since the submission of our report I understand the Army has made a major effort to try and correct many of the deficiencies noted, and they will report to later in this hearing.

Ultimately, it is the Congress that can address and fix the shortcomings that exist in our medical services in order that members of Armed Forces can receive the care they deserve. You have the authority under the Constitution to raise and maintain the forces, including Militia, necessary for our National Defense. This will require commitment and perseverance to achieve, but it is vitally important. I am confident you will rise to the challenge.

Thank you and on behalf of the other IRG members present with me today, we look forward to answering your questions.

The Honorable Togo D. West, Jr.
Opening Statement
U. S. House of Representatives
Armed Services Committee
Subcommittee on Military Personnel
June 26, 2007

Walter Reed Army Medical Center bears the most distinguished name in American Military Medicine. It, along with its equally well-known colleague to the North – the National Naval Medical Center in Bethesda, Maryland – is the acknowledged flagship installation of DOD Medicine.

Our review – by the Independent Review Group – suggested, however, that although Walter Reed's rich tradition of flawlessly rendered medical care of the highest quality remains unchallenged, its highly prized reputation had nonetheless been justifiably, but not irretrievably, called into question in other respects. Fractures in its continuum of care, especially as it pertains to care and support for its out-patient service members have been reported and are being reviewed not only by us but by a veritable cavalcade of panels, organizations, officials, and, those who report upon our daily national life electronically and in daily or periodic publications – and justly so. Failures of leadership, virtually incomprehensible inattention to maintenance of non-medical facilities; and a reportedly almost palpable disdain for the necessity of continuing support for recovering patients and their families led the list of indictments of this once and still proud medical facility.

Our report is replete with findings and recommendations covering a wide range of issues and circumstances which have come to our attention. They converge around four core concerns. Let me pose them as questions.

Firstly, who are we – as a country, as an Army, as a health care center here at Walter Reed? Unfortunately, if one considers reports we have heard from service members and their families about the lapses in support to them during their rehabilitation phase of care, we would conclude that we may be answering that question in ways that are not attractive to us as an Army or as a Nation. We say so much about ourselves by the attitudes we display towards those who look to the Nation for support during the most vulnerable times of their lives. We have included a number of findings and recommendations involving the assignment and training of caseworkers, increases in the numbers of caseworkers and adjustment of the caseworker to patient ratio, assignments of primary care physicians, and attention to the nursing shortages.

Secondly, who and what are we to become? The Base Realignment and Consolidation (BRAC) process and the A-76 process have caused incalculable dislocation in Walter Reed operations and threaten the future of both installations. BRAC should proceed for a host of reasons; but the transition process is lagging, important coordinative efforts between the two installations do not appear promising, and an increased pace for the transition is urgently needed.

Thirdly, how are our service members doing? At every turn, the IRG has encountered service members, their families, health care professionals, and thoughtful observers who point out how challenging the traumas associated with TBI (traumatic brain injury), and PTSD (post traumatic stress disorder) have become; and how challenging they have been in terms of both DOD and Department of Veterans Affairs diagnosis, evaluation, and treatment. We believe there is a need for greater and better coordinated research in this area. We have made a detailed recommendation with respect to a center of excellence and increased attention to cooperative efforts by both Cabinet departments.

Fourth, how long? The IRG has operated with what is, for me, a rare sense of unity and consensus in our effort. If there is one issue, on which we are even more unified than all others, it is that the horrors that are inflicted on our wounded service members and their families in the name of the physical disability review process, known in the Department of Defense as the MEB/PEB process, simply must be stopped.

It is no surprise to you on the Committee, or to us on the IRG, that each part of the governmental process can make sound arguments to defend and explain why three, and in the case of the Army four, separate Board proceedings -- with associated paperwork demands on the wounded service member and family, accompanied by delays and economic dislocation for assisting family members, and characterized prominently by inexplicable differences in standards and results -- are justified. We, however, are a Nation which values the every day good sense of the common man or woman – that is why we call it common sense. And common sense says that from our service members' and families' point of view this must seem a wildly, incomprehensible way to settle for service members and families the question of whether the member must leave the service and, if so, under what conditions. We recommend one combined physical disability review process for both DOD and VA.

Virtually every finding and recommendation we make, then can be traced to these four concerns; (1) leadership and attitude; (2) the transition from Walter Reed Army Medical Center to Walter Reed National Medical Center; (3) the extraordinary use of IED (improvised explosive devices) in the current wars and their impacts on the brains and psyches of our service members; and (4) the long-standing and seemingly intractable problem of reforming the disability review process.

To be sure, it was the degradation in facilities that first caught the eye of media reporters. Important as that is, however, we believe that there is far more to be dealt with here than applying paint to rooms or even in crawling around basements to deal finally with electrical problems. We had experts of every sort assigned to us, and talented and experienced health professionals as part of the Independent Review Group itself who are available to discuss all these areas as we turn to the discussion portion of your agenda.

None of these concerns, however, is our bottom line: not BRAC, not facilities, not even the search for failures, breakdowns, or culprits. Rather our bottom line is this:

(1) We are the United States of America.

(2) These are our sons and daughters, brothers and sisters, uncles and aunts, even a grandparent or two who lie and sit wounded before us.

(3) Their families are our families, we are their neighbors, and we, their fellow citizens and residents.

(4) Their anguish is our anguish.

(5) We can and must do better.

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RECORD VERSION

STATEMENT BY

GENERAL RICHARD A. CODY
VICE CHIEF OF STAFF
UNITED STATES ARMY

BEFORE THE

COMMITTEE ON ARMED SERVICES
SUBCOMMITTEE ON MILITARY PERSONNEL
UNITED STATES HOUSE OF REPRESENTATIVES

FIRST SESSION, 110TH CONGRESS

ON WALTER REED ARMY MEDICAL CENTER PROGRESS REVIEW

JUNE 26, 2007

NOT FOR PUBLICATION
UNTIL RELEASED BY THE
COMMITTEE ON ARMED SERVICES

STATEMENT BY
GENERAL RICHARD A. CODY
VICE CHIEF OF STAFF
UNITED STATES ARMY

Mr. Chairman, Mr. McHugh and distinguished members of the subcommittee, thank you for this opportunity to discuss with you our continuing efforts to improve the outpatient care and administrative support of our wounded Soldiers and their Families. In February, I made a commitment to our Soldiers and Families, the American people, and you that I would personally oversee the needed fixes to the care and support we provide our wounded Soldiers and their Families. We are here today to provide you, our Soldiers, and the American people an update on our progress to date, and the continued way forward.

In the last several months, we have done much to improve outpatient care and support for our "Warriors in Transition" and their Families both at Walter Reed Army Medical Center and across the Army. The "immediate fixes" we have initated include: formation of Warrior Transition Units (WTU) at 37 locations with significant Warrior in Transition populations; staffing of WTU leadership with caring, purpose-driven leaders down to squad level; creation of the squad leader, primary care manager, and nurse case manager "transition triad;" prioritization of medical appointments for Warriors in Transition; activation of 18 Reserve Component lawyers and paralegals to provide additional legal advocacy for Warriors undergoing the Physical Evaluation Board (PEB) process; resource prioritization for maintenance and repair of WTU infrastructure; establishment of a Soldier Family Assistance Center (SFAC); funding of Family Readiness Support Assistants (FRSA) to facilitate wounded Soldier Family Readiness Groups; and adjustment of guest housing policies to accommodate non-family-member care attendants. While we have done much to improve the quality of care and support for our Warriors in Transition and their Families, there is still much to be done.

The way ahead is captured in the Army Medical Action Plan (AMAP), the Army's holistic effort to identify issues and implement solutions to improve the quality of care, support, and benefits for our Warriors in Transition and their Families. AMAP was developed and is being implemented jointly by Army Medical Command (MEDCOM), Installation Management Command (IMCOM), the Department of Veterans Affairs (VA), the Army Staff, and other support agencies. Brigadier General Mike Tucker, whom I brought in specifically to be our "bureaucracy buster" and who is serving as the Deputy Commanding General of the North Atlantic Regional Medical Command, is helping lead this effort.

Last week I sent out a Department of the Army Operations Order to all medical personnel, installation commanders and senior mission commanders outlining more than 120 medical issues that will be addressed through the AMAP. Short term objectives of the AMAP, beyond the "immediate fixes" already achieved, include co-locating Veteran's Health Administration and Veterans Benefit Administration liaisons with WTU case managers, improving patient advocacy services, and standardizing training for the "transition triad" and Physical Disability Evaluation System (PDES) enablers – Medical Evaluation Board doctors, PEB liaison officers, and benefits coordinators. Significant long-term AMAP goals include streamlining the PDES and enabling seamless transfer of medical data and separation documents between the Department of the Army and the Department of Veterans Affairs. We are working towards full implementation of the AMAP by January 2008.

Another very important Army goal is improving our understanding, diagnosis, and treatment of both Post-Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI). We recognize that many of our Warriors are suffering the effects of combat stress and brain injuries, the symptoms of which can range from mild to severe. During her testimony, Major General Gale Pollock, the acting Surgeon General, will explain our

initiatives to address these issues on the medical side of the Army, to include our effort to add 200 additional mental health care providers. But medical professionals are not alone in their responsibility to care for our injured Warriors—commanders and leaders are equally responsible for the mental and physical health care of their Soldiers.

Army leaders are being aggressively trained to recognize the signs of PTSD or TBI and encourage their Soldiers to seek care. Last week, our Chief of Staff, General George Casey, initiated a chain teaching program with our four-star commanders that will be required training for every Soldier in the Army. The message and commitment from the Army leadership should be clear to everyone—PTSD and TBI are serious concerns that require the attention and action of every member of the Army team.

Warrior in Transition care is at its heart an issue of leadership—from squad leader, all the way up to and through me. I assure you that nothing is more important to the Army's leadership than ensuring quality care, support, and benefits for our Soldiers and their Families, and that we are fully committed to this effort.

Our Acting Secretary of the Army, Pete Geren, and I are principal participants in the Senior Oversight Committee, chaired by the Deputy Secretary of Defense, that meets weekly to coordinate the Department of Defense effort to improve the medical care process, disability processing, and transition activities to the Department of Veterans Affairs. A significant aspect of the committee's work is the consideration of potential legislative proposals intended to streamline the care, evaluation, and transition processes.

Over the last several months, I have chaired video-teleconferences with our hospital commanders to receive direct feedback from them on their progress and challenges in implementing the AMAP. Our senior mission commanders participated in the most recent teleconference, and

they were unanimous in their opinion that the AMAP is working and having a significant impact.

The other witnesses on this panel can also describe the positive impact that AMAP is beginning to have on the quality of care, support, and benefits provided to our Warriors in Transition. Major General Pollock and Brigadier General Tucker, whose role I have already explained, will discuss our Army-wide efforts and initiatives. Major General Eric Schoomaker, the Commander of Walter Reed Army Medical Center and the North Atlantic Region, and Colonel Terry McKenrick, the Commander of the WRAMC Warrior Transition Brigade, will detail the specific actions we have taken at WRAMC, many of which we are exporting to the rest of the Army.

I cannot emphasize enough how important the care of our Soldiers and Families is to your Army – an all-volunteer force that continues to make incredible sacrifices every day during this time of war. Our Nation cannot ask our Soldiers and their Families to make these sacrifices and not ensure that their medical care and overall quality of life is at least equal to the quality of their service and sacrifice. We cannot ask them to endure the rigors of combat and then endure an under-resourced or bureaucratic system when they get home. Your Army is many things, but ultimately, it is about people, it is about our Soldiers. We and the entire Army leadership are committed to getting this right for them and their Families.

UNCLASSIFIED

FINAL VERSION

STATEMENT BY

MAJ0R GENERAL GALE S. POLLOCK
ACTING THE SURGEON GENERAL OF THE UNITED STATES ARMY
AND CHIEF, ARMY NURSE CORPS

COMMITTEE ON ARMED SERVICES
SUBCOMMITTEE ON MILITARY PERSONNEL

UNITED STATES HOUSE OF REPRESENTATIVES

FIRST SESSION, 110TH CONGRESS

WALTER REED PROGRESS REVIEW

26 JUNE 2007

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COMMITTEE ON ARMED SERVICES

Mr. Chairman, Congressman McHugh, and distinguished members of the sub-committee, thank you for the opportunity to discuss the current state of affairs at Walter Reed Army Medical Center (WRAMC) and the noteworthy achievements of the Army Medical Action Plan (AMAP). In the 4 months since the February 18th revelations in *The Washington Post*, the Army and the Army Medical Department have taken significant actions to improve the management and care of Soldiers in an outpatient status. We are committed to getting this right and providing a level of care and support to our Warriors and Families that is equal to the quality of their service.

I will focus my comments on actions taken across the Army and the Army Medical Command (MEDCOM) over the last 4 months. Starting with Acting Secretary Geren and General Casey, Army leadership has been actively engaged in working to do what is best for our Soldiers and Families. The Vice Chief of Staff, General Cody, the G-1, LTG Rochelle, and the Commander, Installation Management Command, LTG Wilson, have been personally invested in finding solutions. Shortly after publication of the media reports, General Cody reached out to the Armor School at Fort Knox and tapped Brigadier General Mike Tucker to be the "Bureaucracy Buster" and to serve as the Deputy Commanding General North Atlantic Regional Medical Command. We put Mike in charge of the Army Medical Action Plan (AMAP) and he has been diligently pursuing a comprehensive plan to improve outpatient management at Walter Reed and across our Army.

At the same time, MEDCOM established a Tiger Team composed of 10 subject-matter experts led by Colonel Ben DeKoning and charged them with determining whether any of our other medical facilities were experiencing issues similar to those at Walter Reed. This multi-disciplinary team spent a month on the road visiting 11 different installations to inspect Soldier Welfare, Infrastructure Quality, Medical Administrative Processes, and Soldier and Family Information Sharing. The team identified some failings similar to those at Walter Reed, but also found a number of best practices that could be shared across the Army Medical command. Key failings included: (1) no common command and control standards or models for Medical Hold

or Medical Holdover units; (2) the current institutional Army force structure design does not support convalescent care requirements; (3) barracks and support facilities generally do not accommodate the unique requirements of our injured Warriors; and (4) limited access to care in some health care markets impedes recovery timelines. The Tiger Team also detailed numerous complaints related to the Physical Disability Evaluation System.

The Tiger Team also identified a number of best practices for dissemination across the command. For instance, at Fort Lewis the medical center dedicated two physicians to the Medical Evaluation Board (MEB) process. These dedicated physicians relieved some of the MEB workload from the rest of the medical staff while becoming so adept at MEBs that they were able to care for Soldiers more efficiently and with fewer administrative delays. At Fort Sam Houston, Brooke Army Medical Center Medical Hold and Medical Holdover Soldiers were successfully managed under the same command and control structure, and at several locations care management was handled by a primary care manager, nurse case manager, and platoon sergeant team (called the care triad in the Army Medical Action Plan). Additionally, the Tiger Team made a number of valuable recommendations for Department of the Army as well as the Department of Defense (DoD). These recommendations included:

- Allowing Active Component Soldiers to receive treatment and rehabilitation at a location of their choice when clinically appropriate, as is done for the Reserve Component through the Community Based Health Care Initiative.
- Removing Warriors in Transition from deployable unit personnel rosters so Soldiers can focus on healing and units can focus on training.
- Establishing standardized training programs for cadre to educate them on the special needs of Soldiers with complex medical conditions.
- Establishing integrated teams of Physical Evaluation Board Liaison Officers, nurse-case managers (NCM), primary care managers (PCM) and unit leadership.
- Establishing dedicated and trained MEB physicians at sites with sufficient patient populations.

The Tiger Team's findings and recommendations became one of nine different "source" documents used by the AMAP team to develop a detailed and comprehensive action plan. The team was established at the direction of General Cody on March 13th. In its 90 days of existence, the AMAP team has conducted an initial analysis, developed lines of operation, codified requirements, conducted personal reconnaissance and assessment, hosted a synchronization conference, and established a bevy of "quick wins", short-range goals, and long-term goals. The AMAP mission statement declares:

The United States Army establishes an integrated and comprehensive continuum of care and services for Warriors and their Families being treated at Department of the Army Treatment facilities in conjunction with the Department of Defense, Department of Veterans Affairs (VA), and civilian medical facilities not-later-than 1 January 2008 in order to provide world class care and service that match the quality of service the Warriors and their Families provide the Nation.

Although the Army Medical Action Plan has "medical" in its full title, its composition and focus is much broader. Permanent team members came from Manpower & Reserve Affairs, the Installation Management Command, the Army G-1, the Army G-3, and Medical Command. Other participants include the Army Corps of Engineers, the TRICARE Management Activity, Veterans Affairs, and other federal agencies. The team has already provided several updates to Acting Secretary Geren and received senior Army leadership direction and support. Everyone is working toward the same goal and we are all working with urgency. The AMAP is on track to meet all of its "quick wins" which have been categorized as follows:

1. **Establish Command and Control**. MEDCOM has consolidated Medical Hold and Medical Holdover into single Warrior Transition Units (WTU) and assumed command and control of these provisional units.

2. **Institutionalize the Structure**.

a. MEDCOM has established a provisional multi-component WTU command and control structure centered on a triad of a Soldier's primary care manager, nurse case manager, and squad leader.

b. Provisional WTU staffing has incorporated existing installation assets managing present Medical Hold and Medical Holdover activities

3. **Prioritize Mission Support & Create Ownership.**

a. The Senior Mission Commander (SMC) will prioritize Warrior in Transition facilities and furnishings as top priority for needed repairs and improvements.

b. SMC will conduct monthly Town Hall meetings for Warriors and their Families, ensuring that Military Treatment Facility (MTF), WTU, and Garrison commanders and staffs attend.

c. ACSIM will establish new facilities codes for WTU facilities to expedite funding for renovation/repair projects to improve accessibility for Warriors in Transition.

4. **Flex Housing Policies.** G1 has directed installation commanders to:

a. Allow Warriors in Transition, to include single Warriors with supporting designated attendees, to live in guest housing.

b. Designate Warriors in Transition on par with "key and essential" personnel.

5. **Focus on Family Support**.

a. MEDCOM has trained and assigned ombudsmen to medical treatment facilities.

b. G1 has drafted consolidated guidance for Warriors in Transition and their Families (Basic Allowance for Housing, Awards, Permanent Change of Station tracking).

c. G1, in coordination with MEDCOM, Installation Management Command, and the National Guard Bureau has developed the concept and G3 has validated the requirement to provide Family escorts to MTFs.

d. MEDCOM has authorized and funded Family Readiness Support Assistants in order to establish Family Support Groups for Warriors in Transition at locations where deemed appropriate by local WTU Commanders.

6. **Develop Training & Doctrine.**

a. MEDCOM has drafted a Standard Operating Procedure to govern operations of Warrior Transition Units and conducted an orientation for new WTU commanders.

b. MEDCOM has identified and funded universal Post Traumatic Stress Disorder (PTSD) training for 100% of social work personnel, WTU nurse case managers, and psychiatric nurse practitioners.

c. MEDCOM has established a Traumatic Brain Injury (TBI) and PTSD awareness training package (Chain-Teach) for all commanders and Soldiers.

7. **Create Full Patient Visibility.**

a. MEDCOM has established policy for notification and reception of ambulatory patients being transported by commercial air.

b. MEDCOM has implemented Joint Patient Tracking Application at all Army MTFs to improve visibility and tracking of patients.

c. MEDCOM will notify the Soldier's commander and the rear detachment commander within 24 hours of Soldier's arrival at MTF.

8. **Facilitate the Continuum of Care and Benefits.**

a. MEDCOM, in cooperation with Office of the Judge Advocate General (OTJAG), G1, and VA, will develop a process consistent with law and policy that improves the information flow between Army and the Veterans Benefits Administration (VBA).

b. G1 has established a web-based Defense Personnel Records Retrieval system able to transfer Certificate of Release or Discharge from Active Duty (DD 214) between DA and VA.

9. **Improve the MEB.**

a. MEDCOM has improved Warrior in Transition visibility of their MEB status by creating a "My MEB" website on Army Knowledge Online (AKO).

b. MEDCOM will assign one dedicated MEB physician per WTU.

c. MEDCOM has established enhanced access to care standards for Warriors in Transition to ensure they receive expeditious care within the Direct Care System.

d. MEDCOM has implemented standardized Physical Evaluation Board Liaison Officer (PEBLO) training as a condition of employment.

10. **Enhance Physical Evaluation Board (PEB) Representation.** OTJAG has mobilized Reserve Component Judge Advocates and paralegals to augment the PEB system in order to act as legal advocates for Warriors in Transition.

The remaining phases of the Army Medical Action Plan will address the development and implementation of an efficient and timely system for completing physical disability evaluations, full operational capability of all Warrior Transition Units, smooth transfer of medical data between DA and VA, adequate and accessible housing for Warriors in Transition and their Families, and vocational rehabilitation. We will also develop a seamless transition process for Warriors in Transition and their Families from military to civilian life, to include transitioning to the Department of Veterans Affairs for care and services, as well as transitioning into civilian employment. These phases, scheduled for completion between July 2007 and February 2008, will also incorporate ongoing monitoring and oversight to maintain program efficiency and effectiveness.

Throughout development of the AMAP, Army leadership has emphasized the need to address the behavioral health of our Warriors, particularly in regard to Post Traumatic Stress Disorder. Army leadership is similarly concerned about the effects of Traumatic Brain Injuries on our Soldiers and their Families. Our processes and policies have been designed with these invisible disorders and injuries in mind so as not to aggravate conditions or cause discomfort. The Medical Command has invested significant effort, intellect, and resources into developing a holistic approach to PTSD

and TBI that includes research, education, prevention, screening, treatment, and transitional care. Some of our "quick wins" address PTSD and TBI, and across the MEDCOM we have taken aggressive, far-reaching steps to ensure Warriors and their Families are getting the treatment they need.

Our emphasis on TBI has led to the following achievements in the last 12 months: we have issued an ALARACT message to heighten awareness of mild TBI; published and exported the Military Acute Concussion Evaluation tool for use in theater; published clinical practice guidelines for acute management of mild TBI in military operational settings; and provided education for theater medics on acute evaluation of concussions. In the last 30 days we've prepared guidance to theater to document all blast exposures/injuries in medical records; initiated pre-deployment TBI education and neuro-cognitive baseline testing at Fort Campbell; and stood up a proponency office to address health integration and rehabilitation. Our Warriors with more severe TBI will continue to receive the same cutting edge medical care delivered every day at our military medical centers and at VA Polytrauma Centers. Furthermore, our MTFs are working with the Defense and Veterans Brain Injury Center to create a seamless TBI care network that provides the right level of care at the best location for every Soldier.

We have been no less active in addressing PTSD. You are likely familiar with the Post Deployment Health Assessment, Post Deployment Health Re-Assessment, and the Mental Health Advisory Teams since these initiatives are no longer new. In addition to these valuable programs, we have already accomplished the following initiatives in 2007:

- initiated and funded a contracting strategy to bring on an additional 200 behavioral health care professionals
- implemented the RESPECT-MIL program at 15 sites across the Army after a successful pilot program last year at Fort Bragg
- expanded our innovative BATTLEMIND post-deployment training program with a pre-deployment training module and a spouse training module

- established a new Combat and Operational Stress control course for all deploying BH providers
- offered Provider Resiliency training for health care providers
- developed a new PTSD training course for providers
- established a Behavioral Health Proponency Office and Army Medical Department Suicide Prevention Office
- produced a suite of family reintegration materials that include an animated video program for 6 to 11 year-olds and a teen interview video for 12 to 19 year-olds

The reintegration tool kit provides a simple, direct way to help reduce tension and anxiety and to promote healthy coping mechanisms for children of deployed Warriors. Our TBI and PTSD initiatives—much like the Army Medical Action Plan--recognize that caring for the needs of Family is as important as caring for our Warriors.

I want to ensure the Congress that the Army Medical Department's highest priority is caring for our Warriors in Transition and their Families. To emphasize that point, I recently established heightened access standards for our Warriors in Transition to ensure they get the timely care that they require. In some locations and with some specialties we will face a stiff challenge meeting these standards, but we need to set the bar high and then do everything possible to achieve our goals. In addition, as you are aware, there have been number of other commissions and task forces established to look at the overall care to our Nation's service members and veterans. Some of these groups have finished their work and submitted recommendations which DOD is reviewing and in some cases, we have already implemented. The Army will continue to work with the Secretary to implement proposals that will improve the care given to our warriors.

I am proud of the Army's effort over the last 4 months and I am convinced that in addition to the "quick wins" we have already accomplished, we are setting the stage for establishing long-term solutions that will significantly enhance the care and support of our Warriors and Families.

Thank you for holding this hearing and thank you for your continued support of the Army Medical Department and the Warriors that we are honored to serve. I look forward to your questions.

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FINAL VERSION

STATEMENT BY

MAJOR GENERAL ERIC B. SCHOOMAKER
COMMANDING GENERAL, NORTH ATLANTIC REGIONAL MEDICAL
COMMAND AND WALTER REED ARMY MEDICAL CENTER

COMMITTEE ON ARMED SERVICES
SUBCOMMITTEE ON MILITARY PERSONNEL

UNITED STATES HOUSE OF REPRESENTATIVES

FIRST SESSION, 110TH CONGRESS

WALTER REED PROGRESS REVIEW

26 JUNE 2007

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COMMITTEE ON ARMED SERVICES

Mr. Chairman, Congressman McHugh, and distinguished members of the sub-committee, thank you for the opportunity to discuss the current state of the command at Walter Reed Army Medical Center (WRAMC). Walter Reed is named for an Army physician whose contributions to understanding tropical diseases after the Spanish-American War and especially to combating Yellow Fever saved countless lives world-wide and made his name a household figure throughout the world. Over the course of its 100 year history, the hospital named in his honor has frequently found itself in the news— providing cutting-edge medical care for uniformed service members and their Families, caring for Presidents and Members of Congress, and being lauded as one of the top medical institutions in the nation.

This sterling reputation and legacy of premier health care is one reason the expose published in February came as such a shock to us all. When I arrived with my trusted CSM Althea Dixon in early March the sense of shock was wearing off but sorrow and regret hung heavy in the halls of the wards and clinics; in some corners it had been replaced by denial. What no one denies is that the Warriors we care for deserve nothing less than the best medical care, the best administrative processing, and the best support systems—including living conditions--available. With BG Mike Tucker—a career soldier and distinguished Armor officer at my side and countless other leaders throughout the organization, we have set out to correct identified deficiencies and provide the best of everything for our Warriors and their Families. We have received extraordinary support from the U.S. Army Medical Command and the entire Army.

In just 90 days we have identified problems and, where appropriate, taken immediate corrective actions. Many involved the creation of support services which are present at larger Army installations but were not available at WRAMC before the events of mid-February. Some of our accomplishments include:

- Immediate relocation of Soldiers from Bldg 18 to the highest quality barracks space available in Abrams Hall on the WRAMC Campus
- Installation of telephone, cable television, and internet in each Warrior in Transition room
- Provision of Family Counselors who are available 24 hours-a-day/7 days-a-week
- Establishment of a one-stop Soldier and Family Assistance Center (SFAC) that is centrally located in the Hospital providing all necessary services for family assistance, finance, and personnel actions
- Centralized management of Non-Governmental Organization and Private Voluntary Organization donations at the SFAC
- Establishment of a program to greet Family Members upon arrival at Andrews Airfield and civilian airports and escort them to WRAMC
- Implementation of Monday welcome briefs and Thursday town hall meetings for Soldiers and Families
- Distribution of informational handbooks and Warrior and Family Hotline cards to Soldiers and Families
- Creation of a Warrior Transition Brigade (WTB) with a combat experienced Commander, COL Terry McKenrick, and Command Sergeant Major Jeff Hartless and implemented the Triad concept of care for WTB Soldiers and Families consisting of:
  - A Nurse Case Manager (assigned at a ratio of 1 per 17 patients)
  - Primary Care Manager (assigned at a ratio of 1 per 200 patients)
  - Squad Leaders (assigned at a ratio of 1 per 12 patients)
- Elimination of the backlog of awards and decorations, in part through a series of frequent--now monthly—Purple Heart ceremonies in the Walter Reed auditorium attended by a standing room only audience of Soldiers, Families, hospital staff and fellow warriors
- Employment of an Ombudsman to give Wounded Soldiers a source to resolve issues and combined the Ombudsmen and Patient Representatives to form a Patient Advocacy Center

- Enhanced Accessibility to the Hospital Dining Facility for Wounded Warriors
- Creation of a Clothing Issue Point (CIP) to issue new uniforms to Wounded Warriors

I would like to elaborate on a few of these accomplishments because they really reflect a profound change in the way we do business and care for our Warriors. As every review panel and investigating team found, medical centers and hospitals across the nation—especially those in the Army--no longer provide the sort of convalescent and rehabilitative care that was common during our Nation's earlier wars. One former Army Surgeon General still remembers his assignment as the Chief of Orthopedics and Rehabilitation at the Valley Forge Army Hospital as the highlight of his 3-decade career. Senator Inouye fondly recalls the months he spent as an inpatient at Walter Reed following World War II. The Senator, among other things, was taught ballroom dancing.

As health care shifted to outpatient focused health care delivery systems in the 1980s and 90s, the Army Medical Department did the same. Just as new moms and their babies are discharged from the hospital in as little as 24 or 36 hours, and many surgeries like gallbladder surgery and even joint surgeries are followed by rapid transition to outpatient status, so are some of our wounded soldiers discharged to outpatient status in a matter of days—well before their complete recovery is effected. While we view this ability to discharge to outpatient status as a success (who wants to live in a hospital for extended periods?) it has shifted some burdens to the outpatient setting that most hospital campuses are not designed to handle. So while inpatient-based care remains state-of-the-art, reflected in part by the many testimonials of Wounded Warriors and their Families and by a very successful no-notice survey conducted by the Joint Commission—a nationally renowned accrediting body for America's healthcare organizations--soon after the Washington Post articles were published, coordination of outpatient care, navigating the many clinic appointments and managing the administrative hurdles of the physical disability

system were very onerous and fragmented. Many Warrior-patients were temporarily lost in the shuffle or confused by the transition.

As you are all well aware, for the last several years the Walter Reed campus has been home to hundreds of Warriors in Transition—formerly known as Medhold and Medholdover Soldiers--and to hundreds of their Family members. We've been running what essentially amounts to a fully-occupied intermediate or step-down rehabilitation complex on the grounds of Walter Reed Army Medical Center without the structure, design, or manpower to support it. Individuals were putting forth Herculean efforts to patch things together and make it work. Platoon sergeants—many of whom were former patients or medics tasked with new roles--were responsible, on average, for the care of 55 Warriors in Transition. They had no platoon leaders, they had no squad leaders—the small unit leaders closest to the individual Soldier and more intimately familiar with their problems in every other unit in the Army. The well-being of 55 Soldiers is an enormous burden to place on one individual, especially when those Soldiers all have significant, life altering medical concerns.

The most important step we've taken to address these shortfalls is to establish the Warrior Transition Brigade (WTB) and the concept of a triad of a primary care manager (usually a physician), a nurse case manager and a small unit Army leader or squad leader. With the Warrior Transition Brigade we've provided the necessary leadership structure to allow our Warriors to focus on healing. Each squad leader is responsible for no more than 12 Warriors to ensure that each warrior can get personalized, one-on-one attention on a daily basis. Each squad leader has a close working relationship with the nurse case manager assigned to that squad. The squad leader and case manager work as a team in conjunction with the third member of the triad, the primary care manager. Each part of the triad has clearly delineated responsibilities to care for the needs of the Warrior. These responsibilities overlap enough to provide a safety net of support that will not allow any Warrior to fall through the cracks. I

am convinced that the power of a fully-staffed WTB along with the synergy of the triad will generate enormous contributions to the well-being of our Warriors.

One other accomplishment that I'd like to highlight is the establishment of the Soldier Family Assistance Center (SFAC) at WRAMC. The family is an integral part of the recovery process for all our Warriors. We need to have support systems in place for Family members much like we do for the Soldiers. The SFAC is designed to support every need of our suffering Family members. The staffing of an SFAC includes social workers, military finance and personnel experts, Morale, Welfare and Recreation specialists, liaisons to service organizations, and, most importantly, a caring person to listen to concerns. This is where we will escort our newly arrived Family members so that they can have a warm cup of coffee and talk to a chaplain or counselor before seeing their Soldier for the first time. The SFAC is a concept that has worked with great success at Brooke Army Medical Center (BAMC) and we hope to expand upon that success with the establishment of a SFAC here at WRAMC.

As with the example of the SFAC concept taken from BAMC and the triad concept borrowed from other installations, we have aggressively harvested best clinical and administrative practices from a variety of settings or are developing them de novo and are then standardizing them across the Army Medical Department.

We are justifiably proud of all our accomplishments over the last 90 days, but I am most proud of the way the Walter Reed workforce has come together during these difficult, stressful times and performed like superstars. In the face of widespread criticism, they redoubled their efforts and embraced the changes and culture of change that I tried to instill. We believe that these trying times will ultimately make Walter Reed and the Army Medical Department stronger organizations more committed to the Warriors we serve. We need to continue to

address our shortfalls, we need to continue to focus on serving our Warriors and their Families, and we will continue to improve.

We very much appreciate the support this subcommittee has provided WRAMC over the last 90 days. Your distinguished Members and hard-working staff have spent a lot of time there since the war began, visiting our Warriors, meeting with our leaders, and assisting in every way possible. Thank you for holding this hearing and giving us the opportunity to share our accomplishments and to re-emphasize our unyielding commitment to provide the best care available to all our Warriors and their Families.

DOCUMENTS SUBMITTED FOR THE RECORD

JUNE 26, 2007

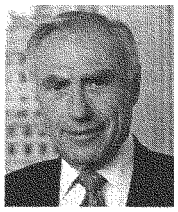
Independent Review Group Members

The Honorable Togo D. West, Jr., Co-Chair
Mr. West served in President Clinton's administration as Secretary of Veterans Affairs and also as Secretary of the Army. He is currently in the private practice of law in Washington, DC, and serves as the President of the National Learning for Life Program for the Boy Scouts of America.

The Honorable Jack Marsh, Co-Chair
Mr. Marsh served in President Reagan's administration as Secretary of the Army and previously in the U.S. House of Representatives (R, VA). He is an Army veteran and currently a Distinguished Professor of Law at George Mason University.

The Honorable Jim Bacchus
Mr. Bacchus served in the U.S. House of Representatives (D, FL) and, also, as chairman of the Appellate Body of the World Trade Organization. He is currently chairman of the Global Trade Practice Group of Greenberg Traunig, P.A. He is also a visiting Professor of Law at the Vanderbilt University Law School

The Honorable Joe Schwarz, MD
Dr. Schwarz served in the U.S. House of Representatives (R, MI), as mayor of Battle Creek, Michigan, and in Vietnam as a U.S. Navy combat surgeon. He currently practices medicine and surgery in Battle Creek and serves on several college and university boards.

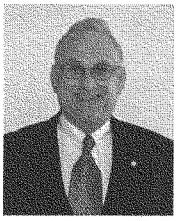


Arnold Fisher
Mr. Fisher served as Chairman & CEO of the Zachary & Elizabeth Fisher House Foundation from 1999 until 2003 and is an Honorary Knight of the British Empire. He is currently a senior partner at Fisher Brothers, a leader in New York City real estate.

John Jumper, General, U.S. Air Force (Retired)
General Jumper served as Chief of Staff, U.S. Air Force from 2001 until his retirement in 2005. A combat veteran of Vietnam and Iraq, he currently serves on several public, private, and charitable boards and as a strategic policy consultant.

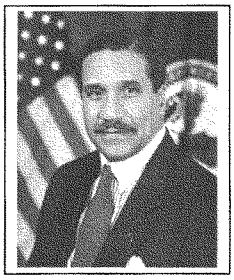
Chip Roadman, MD, Lieutenant General, U.S. Air Force (Retired)
General (Dr.) Roadman served as Surgeon General, U.S. Air Force, until his retirement in 1999. He is currently Chairman of the Board of Altarum Institute, a non-profit health systems research group, and is a scientific board advisory member for IBM and LSTAT and a director for Assisted Living Concepts.

Kathy Martin, Rear Admiral, U.S. Navy (Retired)
Admiral Martin served as Deputy Surgeon General, U.S. Navy, from 2002 until her retirement in 2005. Her previous assignment was as Commander, National Naval Medical Center in Bethesda, Maryland. She is currently CEO of Vinson Hall Corporation in McLean, Virginia.



Larry Holland, Command Sergeant Major, U.S. Army (Retired)
CSM Holland served as Senior Enlisted Advisor to the Assistant Secretary of Defense for Reserve Affairs before retiring from the U.S. Army with 37 years of active and reserve service. He is currently the CEO of LWH, Inc., a supply chain management consulting company.

Togo D. West, Jr.



Chairman, TLI Leadership Group
Chairman, Mitretek Systems Inc.

Secretary of Veterans Affairs	(1998-2000)
Secretary of the Army	(1993-1998)
General Counsel of the Department of Defense	(1980-1981)
General Counsel of the Department of the Navy	(1977-1979)
Associate Deputy Attorney General	(1975-1976)

Togo Dennis West, Jr. is an Eagle Scout. In 1995, the Boy Scouts of America designated him a Distinguished Eagle Scout. He has had a career as a partner and as of counsel to two of the nation's most distinguished law firms. He has been a senior officer in one of the nation's largest aerospace corporations and he has served his country as military officer, senior Defense leader, Justice Department official, and Cabinet officer. The common thread woven throughout this singular career has been his commitment to the service of the nation and her people.

Secretary West has held senior positions in three presidential administrations. He served in the administration of President Gerald R. Ford as Associate Deputy Attorney General in the U.S. Department of Justice. In the administration of President Jimmy Carter, he was General Counsel of the Navy, later the Special Assistant to the Secretary and Deputy Secretary of Defense, and, thereafter, General Counsel of the Department of Defense. He served in President Bill Clinton's administration as Secretary of the Army. In the second Clinton administration he was Secretary of Veterans Affairs and a member of the President's Cabinet. While Secretary of the Army, he also served as Chairman of the Board of Directors of the Panama Canal Commission.

Secretary West received the Bachelor of Science degree in electrical engineering from Howard University in 1965, and in 1968, a degree in law from the same university, where he was Managing Editor of the Howard Law Journal, graduating cum laude and first in his class. He served as law clerk to Judge Harold R. Tyler, Jr. of the U.S. District Court for the Southern District of New York. Secretary West practiced law with Covington & Burling in Washington, D.C., from 1973 to 1975, from 1976 to 1977, and from 2000 to 2004. In 1981, after a period of government service, he joined the New York law firm of Patterson, Belknap, Webb & Tyler as managing partner of its Washington office. In 1990, he became Senior Vice President for Government Relations of the Northrop Corporation, and served until his appointment as Secretary of the Army. From 2004-2006, he served as President and Chief Executive Officer of the Joint Center for Political and Economic Studies.

Secretary West serves on the Board of Directors of Krispy Kreme Doughnut Corporation and is Chairman of the Compensation Committee; he is a member of the Board of Directors of Bowater, Inc. and Chairman of the Human Resources and Compensation Committee; he is Chairman of the Board of Trustees of Noblis Systems, Inc. Secretary West is immediate past chairman of the Board of Directors of the Washington Hospital Center; former Chairman of the National Capital Area Council of the Boy Scouts of America; and member of the Senior Council of the Greater Washington Board of Trade and its former Chairman; former member of the Boards of Trustees of the Aerospace Corporation and of the Institute for Defense Analysis; former member of the Board for Center for Strategic and International Studies. He is a member of the Council on Foreign Relations; the World Affairs Council; the Atlantic Council; and the Visiting Committee of the Memorial Church of Harvard University. He is a member of the Council of Trustees of the Association of the United States Army and of the Board of Trustees of the

Center for the Study of the Presidency. He is a member of the Advisory Committee to Mount Vernon and a member of the Advisory Board of The Century Council.

Secretary West was commissioned a second lieutenant in the U.S. Army Field Artillery Corps and served on active military duty in the Army's Judge Advocate General Corps. For his military service, he was awarded the Legion of Merit and the Meritorious Service Medal, and for his public service, he has received decorations for distinguished service from the Departments of Defense, Army, Air Force, Navy, and Veterans Affairs. The Boy Scouts of America have awarded him the Silver Buffalo and Silver Beaver Awards for his national contributions to America's youth. He has received numerous awards from veterans, military, and community organizations; has been awarded the degree Doctor of Laws by Gannon University and Winston-Salem State University; and has been awarded the Alumni Achievement Award for Distinguished Postgraduate Achievement in the fields of law and public policy.

Secretary and Mrs. West, also a lawyer, live in Washington, D.C., and are members of St. John's Church, Lafayette Square, where he has served as senior warden, member of the standing committee of the Episcopal Diocese of Washington, and of the Board of Directors of the protestant Episcopal Cathedral Foundation. They have two daughters, who are lawyers, and two grandchildren, who are not.

JOHN O. MARSH, JR.

John O. Marsh, Jr., a native of Virginia, is a former Secretary of the Army and former Virginia Representative in Congress. He was a cabinet rank Counsellor to President Ford.. Currently he serves as a Distinguished Professor of Law at George Mason University, and teaches in the field of Cyber Law, Terrorism and National Security Law.

Marsh was born August 7, 1926, in Winchester, Virginia. He received his LL.B. degree in 1951 from Washington and Lee University and began the practice of law in Strasburg, Virginia. He was elected to four terms as a Representative in Congress from the Seventh District of Virginia (1963-1971) and was a member of the House Appropriations Committee. Choosing not to seek a fifth term, he resumed the practice of law.

In March 1973, he returned to federal service as Assistant Secretary of Defense (Legislative Affairs). In January 1974, he became Assistant for National Security Affairs to Vice President Ford, and, in August of that year, Counselor, with Cabinet Rank, to President Ford. He returned again to private law practice in January 1977, as a Washington, D.C. resident partner of a major Virginia law firm.

For President Ford, he had oversight of the Amnesty program and directed the Legislative Affairs program for the Ford White House. He chaired a panel of cabinet ranked members to make recommendations to the President for the reform and reorganization the United States Intelligence community. This resulted in an Executive Order by the President relating to the reform and reorganization of the Intelligence community in 1976. At the request of President Ford he chaired the transition of the Ford Administration to the Carter Administration.

On January 30, 1981, Marsh was sworn in as Secretary of the Army. When he retired from that post on August 14, 1989, his tenure was the longest of any Secretary of the Army or Secretary of War in the history of the Republic. In a rare move the United States Senate adopted a resolution commending his stewardship as Army Secretary.. During 1988, pursuant to an enactment of Congress, he served concurrently, and for an interim period as the first Assistant Secretary of Defense (Special Operations/Low Intensity Conflict), to organize that office in the Department of Defense. On completing his service as Secretary of the Army, he undertook a special assignment as Legislative Counsel to Secretary of Defense Cheney for the development of legislative recommendations relating to streamlining of the defense procurement process. By appointment of former Secretary of Defense Cheney, he also served 1989-1994 in the position of Chairman of the

Reserve Forces Policy Board, an advisory body in the Department of Defense relating to all the U.S. National Guard and Reserve Forces. Subsequently, for Secretary of Defense Perry, he chaired the panel on Quality of Life for members of the Armed Forces and their families, and also a study for greater utilization of Reserve Components in the military intelligence programs

He has been awarded, on six occasions, the Department of Defense Distinguished Public Service Award, and has been decorated by the governments of France and Brazil. He holds the Presidential Citizens Medal.

Mr. Marsh enlisted in the United States Army in 1944, during World War II, and was commissioned a second lieutenant at age nineteen, upon graduation from Infantry Officer Candidate School. He served in the Army of Occupation of Germany He later served in the Army Reserve and the Virginia National Guard from 1954 to 1976, much of the Guard service being in the 116th Infantry Regiment. He graduated from the Army Airborne and Jumpmaster Schools and earned Senior Parachutist Wings. While in Congress, he served a 30-day voluntary National Guard tour of active duty in Vietnam as a major. The only seated member of Congress to do so. He retired as a lieutenant colonel.in the Virginia Guard

In 1990, Mr. Marsh was selected by the Virginia Press Association to receive its "Virginian of the Year" Award. Thirty years before he had been named by the Virginia Jaycee's the "Outstanding Young Man in Virginia". He was chosen by the Association of the United States Army as recipient of its George Catlett Marshall Medal for public service.

The John O. Marsh, Jr. Armory, a Virginia National Guard facility in Woodstock, Virginia, was named in Marsh's honor and dedicated in November 1996.

In 1998, Mr. Marsh served as Visiting Professor of Ethics at the Virginia Military Institute in Lexington, Virginia.

On October 25, 2002, Mr. Marsh received the first Harry F. Byrd, Jr. Public Service Award.

Marsh is married to the former Glenn Ann Patterson, and they have three children: Rob, a physician, Rebecca, a former high school counselor, and graduate of William and Mary and Scot, a surveyor, and graduate of the Virginia Military Institute

. Both Rob and Scot Marsh were called to active duty in Desert Storm, and took part in combat operations in the Gulf War. Rob Marsh, a Special Forces combat physician serving with Delta

Force, was seriously wounded while serving in a special operation in Somalia. Presently he is a country doctor in the village of Middlebrook, Virginia, and also an assistant professor of medicine at the University of Virginia.

General Richard Cody- Vice Chief of Staff Army

General Richard A. Cody became the 31st Vice Chief of Staff, United States Army, on June 24, 2004.

General Cody was born in Montpelier, Vermont, on 2 August 1950. He was commissioned a second lieutenant upon graduation on 6 June 1972 from the United States Military Academy. His military education includes completion of the Transportation Corps Officer Basic and Advanced Courses; the Aviation Maintenance Officer Course; the AH-1, AH-64, AH-64D, UH-60, and MH-60K Aircraft Qualification Courses; the Command and General Staff College, and the United States Army War College. General Cody is a Master Aviator with over 5,000 hours of flight time, and is an Air Assault graduate.

Prior to his current assignment, General Cody spent 32 years in a variety of command and staff assignments, most recently serving as Deputy Chief of Staff, G-3, United States Army. Other key assignments include Commanding General, 101st Airborne Division (Air Assault) and Fort Campbell; Director, Operations, Readiness and Mobilization, Office of the Deputy Chief of Staff for Operations and Plans, Headquarters, Department of the Army; Deputy Commanding General, Task Force Hawk, Tirana, Albania; Assistant Division Commander for Maneuver, 4th Infantry Division, Fort Hood, Texas; Commander, 160th Special Operations Aviation Regiment, Fort Campbell, Kentucky; Commander, 4th Brigade, 1st Cavalry Division; Aide-de-Camp to the Commanding General, Combined Field Army, Korea; and Director, Flight Concepts Division.

General Cody has served several tours with the 101st Airborne Division (Air Assault) as Commander, 1st Battalion, 101st Aviation Regiment (Attack) during Operation Desert Storm; Aviation Brigade Executive Officer, 101st Aviation Brigade; Battalion Executive Officer and Company Commander in the 229th Attack Helicopter Battalion, and Battalion S-3 in the 55th Attack Helicopter Battalion. He served as a Platoon Commander in the 2nd Squadron, 9th Cavalry and A Company (Attack), 24th Aviation Battalion and as Commander, E Company (AVIM), 24th Infantry Division (Mechanized), Fort Stewart, Georgia.

Awards and decorations which General Cody has received include the Distinguished Service Medal, Defense Superior Service Medal, the Legion of Merit (with 4 Oak Leaf Clusters), the Distinguished Flying Cross, the Bronze Star Medal, the Meritorious Service Medal (with 4 Oak Leaf Clusters), the Air Medal (with numeral device "3"), the Army Commendation Medal (with 2 Oak Leaf Clusters), the Army Achievement Medal, the Southwest Asia Service Medal (2 battle stars), the Humanitarian Service Medal, the NATO Medal, and the Southwest Asia Kuwait Liberation Medal.

General Cody and his wife have two sons, both serving as commissioned officers in the United States Army.

Major General Gale S. Pollock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Commander USAMEDCOM/Acting The Surgeon General
Chief, Army Nurse Corps

MG Gale S. Pollock became the Commander US Army Medical Command/Acting The Surgeon General on March 20, 2007.

MG Pollock is also Chief, Army Nurse Corps.

MG Pollock received a Bachelor of Science in Nursing from the University of Maryland. She attended the U.S. Army Nurse Anesthesia Program and is a Certified Registered Nurse Anesthetist (CRNA). She received her Master of Business Administration from Boston University; a Master's in Healthcare Administration from Baylor University, a Master's in National Security and Strategy from the National Defense University, and an honorary Doctorate of Public Service from the University of Maryland. She is also a Fellow in The American College of Healthcare Executives (FACHE).

MG Pollock was Commanding General, Tripler Army Medical Center, Pacific Regional Medical Command, U.S. Army Pacific Surgeon; and Lead Agent, TRICARE Pacific, Honolulu, Hawaii. MG Pollock's military education includes the Department of Defense CAPSTONE Program; the Senior Service College at the Industrial College of the Armed Forces; the U.S. Air Force War College; the Interagency Institute for Federal Health Care Executives; the Military Health System CAPSTONE program; the Principles of Advanced Nurse Administrators; and the NATO Staff Officer Course.

MG Pollock's past military assignments include Special Assistant to the Surgeon General for Information Management and Health Policy; Commander, Martin Army Community Hospital, Fort Benning, Ga.; Commander, U.S. Army Medical Activity, Fort Drum, N.Y.; Staff Officer, Strategic Initiatives Command Group for the Army Surgeon General; Department of Defense Healthcare Advisor to the Congressional Commission on Service Members and Veterans Transition Assistance; Health Fitness Advisor at the National Defense University; Senior Policy Analyst in Health Affairs, DoD; and Chief, Anesthesia Nursing Service at Walter Reed Army Medical Center, Washington, D.C.

MG Pollock's awards and decorations include the Distinguished Service Medal, Legion of Merit (with 2 oak leaf clusters), the Defense Meritorious Service Medal, the Meritorious Service Medal (with 4 oak leaf clusters), the Joint Service Commendation Medal, the Army Commendation Medal, and the Army Achievement Medal. She earned the coveted Expert Field Medical Badge, and is proud to wear the Parachutist Badge. She received the Army Staff Identification Badge for her work at the Pentagon and earned the German Armed Forces Military Efficiency Badge "Leistungsabzeichen" in gold.

Last updated March 23, 2007.

Major General Eric B. Schoomaker, M.D.
Major General, Medical Corps, United States Army

Commanding General, North Atlantic Regional Medical Command
and
Walter Reed Army Medical Center
Washington, DC

Major General Eric B. Schoomaker has been selected to become the commander of Walter Reed Army Medical Center and the North Atlantic Regional Medical Command. Before this selection, MG Schoomaker served as the Commanding General U.S. Army Medical Research and Materiel Command and Fort Detrick, MD.

MG Schoomaker was born into an Army family in Detroit, Michigan. In 1970 he graduated from the University of Michigan in Ann Arbor, was commissioned a Second Lieutenant as a Distinguished Military Graduate, and awarded a Bachelor of Science degree. He received his medical degree from the University of Michigan Medical School in 1975 and completed his Ph.D. in Human Genetics in 1979.

He completed his internship and residency in Internal Medicine at Duke University Medical Center in Durham, North Carolina, from 1976 to 1978, followed by a fellowship in Hematology at Duke University Medical Center in 1979. He is certified by the American Board of Internal Medicine in both Internal Medicine and Hematology. His military education includes completion of the Combat Care Casualty Course, Medical Management of Chemical Casualty Care Course, AMEDD Officer Advanced Course, Command and General Staff College, and the US Army War College.

MG Schoomaker has held a wide variety of assignments. From 1979 until 1982, he was a research hematologist at Walter Reed Army Institute of Research. He served as Assistant Chief and Program Director, Department of Medicine, Walter Reed Army Medical Center, 1982 - 1988; Medical Consultant to Headquarters, 7th Medical Command, Heidelberg, Germany, 1988 - 1990; Deputy Commander for Clinical Services, Landstuhl Army Regional Medical Center, Landstuhl, Germany, 1990 - 1992; Chief and Program Director, Department of Medicine and Director of Primary Care, Madigan Army Medical Center, Tacoma, WA, 1992 - 1995; Director of Medical Education for the Office of The Surgeon General/HQ USAMEDCOM conducting a split operation between Washington, DC, and Fort Sam Houston, TX, 1995 - 1997; and Director of Clinical Operations at the HQ USAMEDCOM, February to July 1997. From July 1997 to July 1999, he commanded the USA MEDDAC (Evans Army Community Hospital) at Fort Carson, CO.

He attended the US Army War College in Carlisle Barracks, PA, from 1999 to 2000 followed by assignments as the Command Surgeon for the US Army Forces Command (FORSCOM) from July 2000 to March 2001, and Commander of the 30th Medical Brigade headquartered in Heidelberg, Germany, from April 2001 to June 2002.

In August 2002, The Army Surgeon General appointed General Schoomaker to the position of Chief of the Army Medical Corps. Prior to commanding at Fort Detrick, he was the Commanding General of the Southeast Regional Medical Command/Dwight David Eisenhower Army Medical Center from June 2002 to June 2005.

His awards and decorations include the Distinguished Service Medal, the Legion of Merit with four oak leaf clusters, the Meritorious Service Medal with two oak leaf clusters, the Joint Service Commendation Medal, the Army Commendation Medal, the Army Achievement Medal and the Humanitarian Service Medal. He has been honored with the Order of Military Medical Merit and the "A" Proficiency Designator and holds the Expert Field Medical Badge.

BRIGADIER GENERAL MICHAEL S. TUCKER

Deputy Commander , North Atlantic Regional Medical Command

Brigadier General Tucker entered the United States Army as a private in 1972 and served as a cavalry scout for 1st Battalion, 35th Armor in Erlangen, Germany until he departed as a staff sergeant 1977. He then served the next two years as a drill sergeant in the 3rd Basic Combat Training Brigade at Fort Leonard Wood, Missouri.

He was accepted in 1979 for Officer Candidate School where he graduated as a Distinguished Military Graduate. After being commissioned in armor, his first assignment was tank platoon leader, B Company, 1st Battalion, 35th Armor, Germany. During this tour from January 1980 until July 1984 he served as a Tank Company Executive Officer, Battalion Motor Officer, commanded the Battalion's Combat Support Company and C Company.

After a short tour in the states to attend school, he returned to Germany in January 1986 to command Headquarters and Headquarters Company, 1st Battalion, 35th Armor, then served as the Battalion Adjutant, Deputy Sub-Community Commander of Ferris Barracks, and finally as the S3, 1st Battalion, 35th Armor in OPERATION DESERT SHIELD and DESERT STORM.

Brigadier General Tucker attended Command and General Staff College in 1991-92 and was then assigned as an Assistant Professor, United States Military Academy, West Point, New York. He was then selected to serve as a joint staff officer, and was assigned as Chief, Joint Network Simulations at the Air Command and Staff College, Maxwell Air Force Base, Montgomery, Alabama.

Brigadier General Tucker commanded 1st Battalion, 64th Armor, 3d Infantry Division (Mechanized) from June 1996 to June 1998 and following attendance at the U.S. Army War College, was assigned as the G3, 3d Infantry Division (Mechanized) from June 1999 to February 2001.

In March 2001, he assumed command of 1st Brigade, 1st Armored Division, which culminated in support of OPERATION IRAQI FREEDOM, he then assumed duties as Executive Officer, Commanding General U.S. Army Europe and Seventh Army.

After completing his tour as Executive Officer, he assumed duties as the Assistant Division Commander (Maneuver) for the 1st Armored Division from August 2004 to August 2005. He then moved over to be the Assistant Division Commander (Support) from August 2005 until June 2006. From July 2006 until March 2007, he served as the

Deputy Commanding General/Assistant Commandant, United States Army Armor Center and Fort Knox. He is currently serving as the Deputy Commanding General, North Atlantic Regional Medical Command and Walter Reed Army Medical Center.

His civilian education includes a Bachelor of Science Degree in Psychology from the University of Maryland, a Master's Degree in Military Arts and Sciences from the U.S. Army Command and General Staff College, and a Master's Degree in Public Administration from Shippensburg University.

His awards and decorations include the Legion of Merit (3 OLC), Bronze Star with "V" device (1 OLC), Defense Meritorious Service Medal, Meritorious Service Medal (3 OLC), Army Achievement Medal (2 OLC), Good Conduct Medal - 3d award, National Defense Service Medal with 1 Star, Southwest Asia Service Medal with 2 Stars, Global War on Terror Expeditionary and Service Ribbons, Noncommissioned Officer Professional Development Ribbon with "3", Army Service Ribbon, Overseas Service Ribbon with "3" and the Kuwait Liberation Medal (Kuwait), Kuwait Liberation Medal (Saudi Arabia). Brigadier General Tucker has earned the Expert Infantry Badge, the Drill Sergeant Identification Badge, the Parachutist Badge, and the German Ranger Badge

Colonel Terrence J. McKenrick
Commander
Warrior Transition Brigade
Walter Reed Army Medical Center

Colonel McKenrick has been serving as the Commander of the Warrior Transition Brigade since his assignment to Walter Reed Army Medical Center March 2, 2007.

He graduated from the United States Military Academy in 1986 with a Bachelor of Science Degree. He also holds a Master of Arts Degree in Human Resources from Hawaii Pacific University. His military education includes the Infantry Officer Basic and Advanced Courses and the Army Command and General Staff College.

Prior to his current assignment, Colonel McKenrick spent 21 years in a variety of command and staff assignments with both conventional and special operations forces. He participated in deployment operations, including Uphold Democracy in Haiti and two tours in Iraq.

Early in his career, Colonel McKenrick was a Platoon Leader in the 3rd Infantry Regiment (The Old Guard) at Fort Myer, Virginia. He then served as a Rifle Company Commander with 4th Battalion, 87th Infantry, and a Headquarters Company Commander with the 25th Infantry Division in Hawaii, followed by a tour as an Infantry Assignment Officer with the Army Personnel Command. Following Army Command and General Staff College, he served as the Regimental Personnel Officer for the 75th Ranger Regiment at Fort Benning, Georgia. He then served as the Battalion Executive Officer for 2nd Ranger Battalion at Fort Lewis, Washington. In 2001, he served as a J36 staff operations officer in US European Command in Germany. From 2003-2005, he commanded the 4th Ranger Training Battalion at Fort Benning, Georgia. His most recent assignment was serving as a G3 staff operations officer in V Corps, including deployment to Iraq and serving as the Officer-in-Charge of the Joint Operations Center for Multi-National Corps-Iraq.

Colonel McKenrick's awards and decorations include the Bronze Star Medal, Defense Meritorious Service Medal, five Meritorious Service Medals, three Army Commendation Medals, Joint Service Achievement Medal, four Army Achievement Medals, Expert Infantryman Badge, Master Parachutist Badge, Air Assault Badge, Pathfinder Badge, and the Ranger Tab. His foreign decorations include the Canadian and German Parachutist Badges.

QUESTIONS AND ANSWERS SUBMITTED FOR THE RECORD

JUNE 26, 2007

QUESTIONS SUBMITTED BY MR. MCHUGH

Mr. MCHUGH. The AMAP includes the requirement for a command and control structure along with primary care managers, nurse case managers and squad leaders for Warrior Transition Units with thirty-five or more soldiers. Given the present number of warriors in transition throughout the Army: How many of each of these required personnel will be needed to staff all of the Warrior Transition Units that will be established by the Army?

General CODY, General POLLOCK and General SCHOOMAKER. Given the projection of approximately 8,000 Warriors in Transition (WTs), the Army estimates a requirement for 2,408 personnel (1,498 military and 910 civilians) to staff the Warrior Transition Units, to include 40 primary care managers, 345 nurse case managers, and 680 squad leaders.

Mr. MCHUGH. What are the planning factors for determining the number of personnel needed?

General CODY, General POLLOCK and General SCHOOMAKER. The following Army-approved staffing ratios were used to determine the personnel requirements for each Warrior Transition Unit.

- 1 company for every 200 Warriors in Transition (WTs)
- 1 company commander and first sergeant for every company
- 1 executive officer for each company of at least 150 WTs
- 1 platoon sergeant for every 36 WTs
- 1 squad leader for every 12 WTs
- 1 nurse case manager for every 18 WTs (medical centers)
- 1 nurse case manager for every 36 WTs (community hospitals or health centers)
- 1 human resource sergeant for every 200 WTs
- 3 human resource specialists for every 200 WTs
- 1 finance sergeant for every 200 WTs
- 1 supply sergeant for every 200 WTs
- 1 supply specialist for every 200 WTs
- 1 patient administration sergeant/specialist for every 200 WTs
- 1 medical evaluation board physician for every 200 Soldiers in the MEB process
- 1 primary care manager for every 200 WTs
- 1 social worker (family therapist qualified) for every 100 WTs (1 for every 50 at Walter Reed and Brooke Army Medical Centers)
- 1 training specialist for every 200 WTs
- 1 occupational therapist for every WT brigade or battalion
- 1 occupational therapy technician/recreation specialist for every 200 WTs
- 1 physical evaluation board liaison officer for every 30 Soldiers in the MEB/PEB process
- Ombudsmen are "earned" as follows:
  - >35 WTs-200 WTs = 1 Ombudsman
  - 201 WTs-400 WTs = 2 Ombudsman
  - 401 WTs-600 WTs = 3 Ombudsman

Mr. MCHUGH. How will the Army obtain the personnel?

General CODY, General POLLOCK and General SCHOOMAKER. Department of the Army Execution Order (EXORD) 118–07, Healing Warriors, dated June 2, 2007, directs the establishment of Warrior Transition Units (WTUs), to include primary care managers, nurse case managers, squad leaders, and command and support staff at 35 locations worldwide. The EXORD also calls for 55 ombudsmen at these locations, as well as 130 physical evaluation board liaison officers. This represents a total re-

quirement of 2,408 personnel. A significant planning factor in enabling the Army Medical Department to attain 50% strength in all WTUs by September 3, 2007, is the availability of mobilized Reserve Component personnel assigned to Medical Readiness Processing Units (also referred to as Medical Holdover Units) as a result of consolidation of these units and Medical Hold Units into WTUs. Additionally, positions will be filled from the available population of qualified personnel (those Soldiers already serving in Medical Holdover and Medical Hold units) to attain 90% strength in WTUs by January 1, 2008. The Army intends to source these positions for the long term with the planned increases in Army end strength.

Mr. MCHUGH. Will the increased requirement for these individuals affect future military to civilian conversions and if so, how?

General CODY, General POLLOCK and General SCHOOMAKER. Staffing Warrior Transition Units will result in increased military requirements but many of them are non-medical. An in depth review of military medical positions identified for conversion is on-going to determine the feasibility and advisability of continued conversions.

Mr. MCHUGH. The House version of the National Defense Authorization Act for Fiscal Year 2008 mandates ratios for case managers, service member advocates and PEBLO personnel to service members undergoing outpatient treatment. How many additional personnel would the Army require for the Warrior Transition units if the conference report includes the ratios in the House version?

General CODY, General POLLOCK and General SCHOOMAKER. The House version of the National Defense Authorization Act for Fiscal Year 2008, HR 1585 would set the ratio of case managers to Wounded Warriors at 1:17. The Army Medical Action Plan (AMAP) calls for nurse case managers at a ratio of 1:18 Warriors in Transition (WTs) at Army Medical Centers where the acuity of care required is high and to 1:36 at those Army treatment centers where the acuity is much lower. HR 1585 calls for service member advocates at a ratio of 1:30 WTs. The AMAP establishes that ratio at 1 ombudsman for every 200 WTs. The House version would establish the ratio for PEBLOs at 1:20, while the AMAP sets this ratio at 1:30. The difference in requirements between these two approaches is presented in Table 1 below.

TABLE 1

Position	HR 1585 Requirement	AMAP Requirement	Delta
Case Manager/Nurse Case Manager	500	345	155
PEBLO	195	130	65
Advocate/Ombudsman	240	55	185
TOTAL	935	530	405

Table 1 summarizes these differences which are based on a current WT population of 3,903 undergoing a Medical Evaluation Board (MEB) to calculate the PEBLO requirement, 7,189 WTs currently in WTUs to determine the ombudsman requirement, and a projected total capacity of approximately 8,000 WTs to project the case manager/nurse case manager requirements.

It should be noted that these numbers do not include the command and support positions required to staff all WTUs. The U.S. Army Medical Command established the number of medical unit personnel required according to the Army Medical Action Plan at 2408. It should be noted that this does not include the requirement to staff Community Based Health Care Organizations (CBHCOs) with nurse case managers (48) or other required CBHCO personnel.

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