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STATEMENT BY

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

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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.