RECORD VERSION

STATEMENT BY
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Chairman Rogers, Ranking Member Lowey, and distinguished members of the subcommittee, thank you for the opportunity to tell the Army Medicine story and highlight the incredible work of the dedicated men and women with whom I am truly honored to serve.

I would like to start by acknowledging America's sons and daughters who are still in harm's way – today nine of ten Active Army and two Army National Guard division headquarters are committed in support of Combatant Commanders across the globe. More than 141,000 Soldiers are deployed or forward stationed and 18,000 Reserve Soldiers are mobilized, sacrificing for our freedom. And to the thousands of Army Medicine personnel currently deployed in support of global engagements – they and their Families are in my thoughts, making me proud to serve as The Surgeon General of the Army. In the past we spoke of interwar periods, a time to recover, to take a knee. I do not see this recovery period on the horizon…as reflected in our current deployment levels, the op-tempo around the world is accelerating with an ever changing security environment.

Since 1775, America's medical personnel have stood shoulder-to-shoulder with our fighting troops in harm's way, received them at home when they returned, and worked tirelessly to restore their health, both mental and physical. Our world-class combat casualty care, which extends from the medic on the front lines to our CONUS-based medical centers, has resulted in the highest survivability rates in the history of modern warfare. Throughout the most challenging times our Nation has faced, our Soldiers remained confident and mission-focused, knowing when they looked over their shoulder, an Army Medic would be following in their footsteps. While the wounds of war have been ours to mend and heal, our extraordinarily talented medical force also has cared for the non-combat injuries and illnesses of our Soldiers and their Families, in theater as well as at home.

Army Medicine is comprised of a committed team of over 150,000 Active Duty, Reserve Component, Civilian and Contract professionals who serve in over five continents, across 18 time zones, providing cutting edge medical readiness and healthcare throughout the world. Army medicine is so much more than a civilian healthcare system; we are national leaders in medicine, dentistry, medical research, education, and training, and public health. It is an honor to lead this outstanding enterprise, earning the trust and caring honorably and compassionately for our 3.9 million Soldiers, Family Members, and Retirees across the globe.

Today, Army Medicine provides high quality, safe healthcare, while working tirelessly to optimize the readiness, resilience, and performance of our Forces. We continue to focus our efforts across our enduring four priorities: deployment medicine and casualty care; readiness and health of the force; a ready and deployable medical force; and the health of Families and Retirees. These four priorities are engrained in our DNA and drive all that we do; they span the entire spectrum of health readiness delivery from medics saving lives on the battlefield to researchers discovering new vaccinations in our labs across the globe.

Over the last few years, we have made great strides in improving the health readiness of the force, leading the Army's cultural change towards a more ready and resilient Soldier. This success was achieved by promoting the Performance Triad, comprised of healthy sleep, activity, and nutrition, and increasing the impact on our readiness touch points to include embedded providers, Soldier Centered Medical Homes, dental clinics, and garrison medical facilities. Our medical force has remained ready and deployable, leveraging lessons learned in theater to improve care in garrison, and using evidenced-based practice and cutting edge research to improve care delivered far forward.

Clearly, now is not the time to waver in the support we provide to our Nation's heroes. We not only have to keep the faith and provide for those who are still recovering from the visible and invisible wounds of war, but we also need to remain trained and ready to respond to emerging crises around the world, from Ebola to the Ukraine. The increasing instability across the globe demands that we ensure the health readiness of our Soldiers while sustaining our ready medical force. Our Military Treatment Facilities (MTFs) are vital to this as they are our Health Readiness and Training platforms where our medical teams work together to hone their critical wartime skills and remain ever ready.

These complex and uncertain times require that we continue our unwavering dedication to our enduring missions, transform from a healthcare system to a System for Health, persist in our efforts to demonstrate the characteristics and behaviors of a high reliability organization, and lead the way with innovative research, diplomacy, and collaboration. However, all the lessons learned and progress we have made as a result of the last 13 plus years of persistent conflict and our focused efforts at continuous improvement along our four priorities are at risk of being slowed, halted, and reversed, given an unstable funding environment and the detrimental second- and third-order effects of sequestration.

Consequences of Sequestration

There is no doubt sequestration has had and will continue to have a significant negative impact on the Army Medical Command (MEDCOM). This impact is felt particularly hard with our dedicated and absolutely essential civilian staff. While many think of MEDCOM as green suit healthcare providers, the reality is civilian employees comprise 60% of the MEDCOM workforce. They are the backbone, stability, and glue of our system.

Sequestration in FY13, combined with the furlough and hiring freeze, had a profound impact on MEDCOM. Our valued civilian employees were extremely sensitive to the tumult and uncertainty caused by sequestration. Many high performing and valued civilian employees experienced burn out, lost faith, and left the MEDCOM for employment with organizations that were not affected by sequestration, such as the VA. The remaining workforce was challenged to absorb the work of departed personnel. In some cases, reduced staffing led to a negative cycle of decreased access for some beneficiaries resulting in a corresponding reduction in patient loyalty. In addition, the hiring freeze instituted from January through December 2013 inhibited our ability to replace the employees who departed the MEDCOM. Despite aggressive hiring actions since 2014, MEDCOM has not yet regained the lost civilian personnel. As of January 2015, we continue to have a shortfall of over 1,800 civilians.

Sequestration would force us to suspend all discretionary spending, including capital equipment, facility restoration & modernization, sustainment and procurement. Additionally, this would place significant constraints on all non-healthcare delivery spending, such as training, education and public health. Every effort would be made to protect primary care, behavioral health (BH), specialty care, surgical capabilities, inpatient services, and healthcare delivery at our largest MTFs, in addition to world-wide public health/veterinary services (food and water source inspections) to protect required go-to-war clinical capabilities. Based on our experience from the 2013 Sequester, we expect to lose an additional 3,000 civilians across the command.

With a reduced civilian workforce, sequestration will also lead to reductions in military end-strength in the MEDCOM. The Army is preparing to drawdown to an Active Duty end strength of 450,000 Soldiers that will result in a reduction of more than 800 active duty MEDCOM personnel. If sequestration returns, the Army may be compelled to reduce active duty end-strength to 420,000, leading to an anticipated reduction of greater than 3,000 active duty MEDCOM personnel.

We will not compromise the safety of our patients as a result of sequestration; however, the combination of military and civilian reductions will cause the MEDCOM to close inpatient and ambulatory surgical centers at a number of MTFs. This would severely impact our ability to support the health readiness of our Soldiers, impact the readiness of our providers, and break trust with our Soldiers, Families, and Retirees, by forcing them to the TRICARE network.

I have grave concerns essential programs for rebuilding our Soldiers after over a decade of conflict will take the brunt of these cuts. The impacts will be visible in decreased resources to sustain initiatives in BH and Traumatic Brain Injury (TBI); a decrease in access to care; and extended appointment wait times for our Soldiers, Families, and Retirees at our health readiness platforms. MEDCOM would reduce research and training programs throughout the Command to "must-fund" levels. This will significantly reduce progress that has been made in medical programs over the last few years both in the areas of research and training of the force.

With this said, we have every intention to work diligently to maintain our progress, and act as faithful stewards of all that we are provided.

Unwavering Dedication to Enduring Missions

Even as the Army shifts from years of continuous war, ongoing operations demand that Army Medicine sustains the enduring missions essential to the health and wellness of our Soldiers. These enduring missions include Warrior Care, BH, Tele-health, TBI, the role of women in the Army, and Sexual Harassment / Assault Response and Prevention (SHARP).These programs are the backbone for restoring and then optimizing the health readiness of our Soldiers and preparing them for future global engagements or transition to their post-Army careers.

<u>Warrior Care</u>

Caring for our wounded, ill, and injured is our highest calling. We must continue to ensure they are provided the best healthcare possible to remain on active duty or to successfully transition out of military service back to Hometown, USA. Warrior Care is an enduring mission for the Army and Army Medicine. It remains fully funded despite budget turmoil.

Over the past seven years, there has been significant investment in the development of the Warrior Care and Transition Program (WCTP). WCTP personnel are committed to providing the best care and treatment for every wounded, ill, or injured Soldier. As of February, 2015, a total of 66,113 Soldiers have completed the WCTP with 29,492 of these Soldiers

returning back to the force. This unprecedented 45% return-to-duty rate is a direct result of the dedication of our Wounded Warrior cadre, clinical providers, and support staff.

From February 2014 through February 2015, the overall Wounded Warrior population decreased by more than 40%, from 7,008 to 3,996. This is largely attributed to the drawdown of forces in Afghanistan. The Warrior Transition Command (WTC) conducts an analysis twice yearly to ensure that Warrior Transition Units (WTU) are properly structured to provide optimal care for our wounded, ill, and injured Soldiers. As the wounded, ill and injured population continues to decline, we will make recommendations to the Army to right size the WCTP footprint to meet the population needs while still sustaining the high quality care we provide today, regardless of the population.

As a result of the analysis completed during FY13, The WTC successfully inactivated five WTUs and all nine Community Based WTUs (CBWTU) in FY14. Additionally, 11 Community Care Units (CCUs) were activated. CCUs improve care for assigned Soldiers, provide better access to resources on installations, and reduce delays in care. Soldiers re-assigned to a CCU from an inactivating CBWTU maintained continuity of care with their same primary care team within their local community. In addition, no Soldiers receiving care within the WCTP had to move or PCS due to an inactivating or activating CCU. As of February 1, 2015, a total of 677 Soldiers (17% of the total population) were assigned to a CCU receiving care in their home communities.

The WCTP remains committed to returning Soldiers to duty. However, when Soldiers are unable to return to duty, we are dedicated to supporting a seamless transition to ensure their continued success. Approximately 60% of Soldiers in the WTUs are enrolled in the Integrated Disability Evaluation System (IDES). MEDCOM, in collaboration with the VA, continues to improve guidance to increase standardization and reduce variation within the Medical Evaluation Board (MEB) phase of the IDES process. In 2014, Army Medicine launched the Medical Evaluation Board Remote Operating Centers (MEBROCs) to increase IDES enterprise capacity. As a result of this monumental effort, the total Army average for the MEB Phase has remained below the 100-day active duty and a 140 day Reserve Component standard across all components for 16 consecutive months. Additionally, the efficiencies created by the IDES Service Line led to an overall savings of $12.8M in 2014. These improvements not only benefit

our wounded, injured, or ill Soldiers and their Families, but also maintain the overall medical readiness of our total force enabling the Army to fully support future global engagements.

As the WCTP shifts to aiding a population more likely to be ill or injured rather than wounded, our Cadre training is continuously refined to meet the needs of the Soldier. The WTC recently finalized a draft Army Regulation as a single source document which consolidated all existing WCTP policies. The draft Army Regulation is being staffed and will be released in the coming months. A newly created WCTP Soldier and Leader Guide offers practical guidance to facilitate the recovery and transition of Soldiers and their Families. The Army Medical Department Center & School (AMEDDC&S), in coordination with the WTC, provides a comprehensive, blended-learning training program to better prepare Soldiers from all Military Occupational Specialties (MOSs) to serve as cadre in the WTUs. The training program orients new cadre and nurse case managers to this very unique environment where physical injuries, PTSD and other BH issues, and Family concerns are commonplace.

Career and Education Readiness activities are the centerpiece of an effective transition from the Army for Wounded, Ill and Injured Soldiers. WTC's coordination of enhanced WTU vocational, career opportunities and programs in coordination with Army G-1's Soldier for Life (SFL) Transition Assistance Program (TAP) and other external resources, is successfully preparing Soldiers for post-Army employment, education, and independent living services. SFL TAP provides robust transition assistance as part of the new Veterans Opportunity to Work initiative which is available to all eligible Soldiers. Soldiers complete a 12 month post-transition budget, identify any skill gaps during a Military Occupational Specialty crosswalk with civilian occupations, and complete career assessments in order to effectively make future career decisions.

The Soldier will always be the center of gravity for our Army and Army Medicine. The optimized WCTP will remain an enduring program that helps fulfill the Army's commitment to never leave a fallen comrade.

Behavioral Health (BH)

The longest period of conflict in our Nation's history has undeniably inflicted physical, mental and emotional wounds to the men and women serving in the Army—and to their Families. The majority of our Soldiers have been extremely resilient during this period and are thriving. However, Army Medicine is keenly aware of the unique stressors facing Soldiers and

Families today, and continues to address these issues on several fronts. Taking care of our own—mentally, emotionally, and physically—is the foundation of the Army's culture and ethos, and is unquestionably an enduring mission.

Army Medicine anticipates sustained growth in BH care requirements. In FY15, the Army will resource an estimated $350M to support BH and sustained implementation of BH initiatives. These funds specifically support the 11 recognized enterprise BH Service Line (BHSL) clinical programs under each MTF's standardized Department of Behavioral Health.

The Army's continued emphasis to extend BH care to Soldiers and Families and decrease stigma is likely to increase the use of BH care. The readiness of the force is contingent upon providing access to high-quality BH care to Soldiers and Family Members. The Army's BH System of Care (BHSOC) standardizes and integrates the best clinical practices into a single, interconnected system. It supports the readiness of the force by promoting health, identifying BH issues early, delivering evidence-based treatment, and leveraging all resources in the Army community to decrease risk for suicide and other adverse events.

The Army screens Soldiers for BH conditions, including PTSD, at several points in the Force Generation cycle. The Army's screening program includes assessments before and after every deployment and annually, exceeding the DoD requirements. The Army also screens for BH conditions at primary care visits and has placed BH professionals in Patient Centered Medical Homes (PCMHs) to expedite consultation and treatment. As MEDCOM expanded access to the BHSOC, utilization of outpatient BH increased from approximately 900,000 encounters in FY07 to over 2.1 million in FY14. Soldiers with BH conditions used outpatient BHcare more frequently to address BH issues and fewer acute crises have occurred. Soldiers required 173,000 inpatient BH bed-days in 2012, but only 112,000 in 2014. We are also confident the BHSOC, along with the Army's Suicide Prevention Programs, contributed to the decrease in suicides from 2012 to 2014.

The Army is removing the stigma associated with seeking BH care with programs such as Embedded BH (EBH) that provides targeted care in close proximity to Soldiers' unit areas and in close coordination with unit leaders. As of January 2015, Army Medicine has 49 EBH teams, including 10 that were established in 2014. Of these, 36 directly support Brigade Combat Teams (BCTs), while the remaining 13 support non-BCT operational units including military police and combat engineers. By FY16, we expect to have 65 EBH teams operational.

In 2014, Army Medicine implemented the BH Data Portal (BHDP) at every MTF. BHDP is a web-based application that gathers standardized, automated clinical data from Soldiers receiving care for BH conditions. It tracks patient outcomes, satisfaction, and risk factors to improve program assessment and treatment efficacy. This innovative program was identified by the DoD as a best practice and selected to be implemented across the other Services. Additionally, it was cited in the August 2014 President's executive actions on improving BH services throughout the DoD.

We continue to use complementary and alternative therapies to decrease the use of psychotropic drugs. The use of psychotropic drugs in Soldiers is trending down. From 2012 to 2014, the rate of prescribed psychotropic drug use decreased from 23.15% to 20.7%. This is a direct result of our BH support programs and management of these conditions through evidence based non-medication regimens.

Due to the significant national shortage of child and adolescent BH providers, traditional models of care have been unsuccessful in delivering services to Family Members. In response, Army Medicine implemented the Child and Family Behavioral Health System (CAFBHS) in March 2014, a new and innovative method to deliver BH care to Army Families. The CAFBHS more efficiently delivers care by consulting and collaborating with primary care teams in the PCMH, placing BH providers in on-post schools, and using regional tele-consultation to increase access to BH care. In addition, primary care managers are trained in the screening and treatment of common BH disorders within the PCMH. There are currently 150 BH providers working in the CAFBHS, including 50 providers in 46 schools at 8 installations. Over the next two years, CAFBHS will increase to 381 BH providers supporting 107 schools across 32 installations delivering comprehensive BH support to Army Families.

Tele-health

The expansion of Tele-health (TH) capability is a vehicle for Army Medicine to expand our influence into the Lifespace of our Soldiers, Families, Retirees, and Civilians. TH is the future of medicine and a core clinical capability of Army Medicine that can increase access to care, reduce cost, and alleviate quality and readiness challenges. Army TH currently provides clinical services across the largest geographic area of any TH system in the world including 18 time zones in over 30 countries and territories across all five Regional Medical Commands

(RMCs) and in active theaters of operation. Army TH accounts for over 95% of all clinical TH encounters in the DoD.

During FYs 08-14, Army TH provided over 150,000 provider-patient encounters and provider-to-provider consultations in garrison and operational environments across 30 specialties. Tele-BH (TBH) currently accounts for 88% of total TH volume in garrison and 58% in the operational environment. Army Medicine currently executes approximately $21 million per year on clinical uses of TH such as TBH. Additionally, the Army developed and uses mobile health applications for beneficiaries with TBI and is expanding its use of educational systems as a force multiplier for Pain Management.

In FY15, Army Medicine is introducing a three-year expansion plan for TH to create a Connected, Consistent Patient Experience (CCPE). The CCPE will create a 360º care continuum around patients using advanced TH modalities. The core elements of the CCPE include establishing a Virtual PCMH, optimizing provider-to-provider tele-consultations systems, expanding clinical video-teleconferencing systems to new specialties, piloting remote health monitoring, and continuing to mature Army TH in operational environments.

Traumatic Brain Injury

Another enduring mission is our focus on providing our Soldiers and other beneficiaries the very best TBI care in the Nation. From January 1, 2000, through June 2014, approximately 307,283 Service Members have been diagnosed with TBI, with 253,350 (82%) of these injuries being classified as mild TBI (mTBI), or concussions. Since 2000, Army Soldiers comprise approximately 58% of all DoD TBI cases, making this issue a clear priority for Army Medicine. The number of Soldiers diagnosed with concussions has steadily increased among all Army components, with the sharp increases beginning in 2006 attributable, in part, to screening efforts and other early detection initiatives.

The Army TBI Program continues to build on innovations, partnerships, and research to better prevent, diagnose, treat and track mTBI and concussion as we transition from a conflict-focused to garrison-focused program. This program focuses on five essential elements: A mandatory education component for all Army personnel; one worldwide standard of care for assessing and treating Soldiers who may have been exposed to a potentially concussive event; an expansive garrison clinical care program to meet the medical and rehabilitation needs of patients with all severities of TBI; baseline neurocognitive testing of all deploying Soldiers; and an

aggressive research program to advance mTBI and concussion diagnosis and treatment. Through collaborations with the National Football League and the National Collegiate Athletic Association, the Army is increasing awareness, reducing stigma associated with seeking care, and changing the culture regarding brain injuries on the battlefield and at home.

The Army accepted a proffer from the Intrepid Fallen Heroes Fund to build six centers devoted to advanced treatment of complex mTBI. These Intrepid Spirit clinics will provide advanced integrative care and intensive outpatient programs for patients with multiple diagnoses (to include TBI, chronic pain, and BH conditions). Intrepid Spirit Fort Campbell opened on September 8, 2014, and facilities at Fort Hood and Fort Bragg are expected to be completed by November 2015. Army Intrepid Spirit Clinics are programmed for Joint Base Lewis-McChord and Forts Carson and Bliss.

The Army manages the largest portfolio of TBI-related research in the world, with an investment of over $800 million since 2007. For FY15, the total expenditures are estimated at $96M, with the bulk of TBI funding from DHP Congressional Special Interest (CSI) funding. As of June 2014, over 590 research projects have been awarded or are pending award. Research is ongoing across the continuum of care from prevention, early screening and identification, to better diagnostic tools, imaging, and treatment options, to rehabilitation and return to duty determinations. From a treatment perspective, the Medical Research and Materiel Command is dedicated to developing FDA-approved therapies designed to assess and treat the injured brain. These innovations will ensure those without injury can stay in the fight, while those who are diagnosed are effectively treated to preserve their future health.

Additionally, we are leveraging the strength of multiple agencies, including the Defense Centers of Excellence for Psychological Health and TBI (DCoE), the Defense and Veterans Brain Injury Center (DVBIC), our sister Services and the VA to translate research findings into the latest guidelines, products, and technologies.

Women in the Army

Women have played a key role in America's military efforts since the Revolutionary War. Time and time again they have proved their value in all operational and garrison environments. From the medic on the battlefield, to the civil affairs officer, women in uniform have been an irreplaceable asset to our Nation. Advances in medical care and research that

enhance the health, performance and readiness of female Soldiers and Family Members are improving the readiness of our Total Army Family.

The Army continues to open previously closed positions and occupational specialties to women. Over the past 27 months, the Army opened six previously closed MOSs and over 55,000 positions across all Army components. Army Medicine is providing direct support to the Soldier 2020 initiative led by the US Army Training and Doctrine Command (TRADOC) and Army G-1 to identify, select, and train the best-qualified Soldiers for each MOS.

The US Army Research Institute of Environmental Medicine (USARIEM) supports TRADOC in conducting the "Physical Demands Study" to establish occupational-specific accession standards for the combat arms specialties currently closed to women. The goal is to develop valid, safe, legally defensible physical performance tests that predict a Soldier's ability to perform the critical, physically demanding occupational tasks of currently closed MOSs. The Army's scientific approach for evaluating and validating MOS-specific performance standards aids leadership in selecting and training Soldiers, regardless of gender, to safely perform the physically demanding tasks of their Army occupation. This approach will ensure that standards are maintained and will give every Soldier the opportunity to serve in positions where he or she is capable of performing to standard.

In July of 2011, I had the distinct honor to deploy in support of the International Security Assistance Force in Afghanistan to examine healthcare in the Central Command Area of Responsibility. Specifically, the team focused on readiness, resilience, MEDEVAC enhancements, medical information technology, education and training, and enhancements to Body Armor. Recently, the lessons learned were adopted by 15 NATO partners at the Military Medicine World Conference in Budapest, Hungary.

Our work on the ground served as the foundation for the Women's Health recommendations in the Health Services Support Assessment in May 2012, the establishment of the Women's Health Task Force, and the creation of 26 tasks focused on supporting female Soldiers in austere deployed environments. We established standardized education for healthcare providers and treatment algorithms throughout theater to avoid unwarranted movement of women inside a combat zone for care allowing Soldiers to focus on the primary mission. These and other efforts across the Army served as the preamble for integrating women into expanded roles and opportunities while protecting them from illness and disease.

The Women's Health Task Force is now issuing its final report after making significant progress on a number of fronts and transitioning their work to our institutional organizations. Key accomplishments include: helping develop female specific body armor, introducing devices and exploring the feasibility and utility of self-diagnosis kits, updates to training curriculum, establishing a women's health internet portal, and addressing mental health and SHARP issues in a deployed environment. I am very proud of the team and the tremendous contributions they have made to our Army.

The Women's Health Service Line (WHSL) is dedicated to ensuring safe, quality patient care and a consistent patient experience across the enterprise. Their efforts focus on wellness and readiness, perinatal, and operational medicine in areas such as group prenatal care, cancer prevention, and postpartum readiness have been instrumental in improving healthcare outcomes and patient satisfaction. Human Papillomavirus (HPV) is the primary causative agent for cervical cancer and, according to the National Cancer Institute, is responsible for nearly of all vaginal cancers. Partnered with an education component, WHSL has taken the lead in the effort to vaccinate both boys and girls beginning at age 11 and as late as 26 years old to stamp out this preventable disease.

Sexual Assault / Sexual Harassment Prevention

The Army and Army Medicine continue to attack the complex challenges of sexual assault. While we have made much progress, much work remains. Sexual assault and harassment directly contradict Army Values. These acts degrade our readiness by negatively impacting the male and female survivors who serve within our units; it also negatively impacts other Soldiers exposed to this behavior.

As an integral participant in the Army's Sexual Harassment/Assault Response and Prevention (SHARP) program, Army Medicine continues to be at the forefront of the management, regulatory guidance, and oversight of care for all sexual assault victims. Regardless of evidence of physical injury, all patients presenting to our health readiness platforms with an allegation of sexual assault receive comprehensive and compassionate treatment. They are offered a Sexual Assault Forensic Examination (SAFE) by a trained and competent Sexual Assault Medical Forensic Examiner (SAMFE) within our military health system or at a local facility through a memorandum of agreement. Seamless follow-on care is

coordinated and managed through the sexual assault medical management team who are a designated multidisciplinary group of healthcare providers who coordinate with the Sexual Assault Response Coordinators (SARCs) and Victim Advocates (VAs) to develop a care plan based upon the patients input and needs. Army Medicine has 217 SARCs and VAs. Furthermore, there are 118 qualified SAMFEs supporting 32 MTFs, meeting the 2014 NDAA requirement to have a Sexual Assault Nurse Examiners at each of our 20 MTFs with a 24-hour emergency room capability.

The AMEDD SAMFE training meets CENTCOM pre-deployment requirements for healthcare providers assigned to Role II and Role III healthcare facilities. To support pre-deployment and local SAMFE requirements, the MEDCOM SHARP Program Office hosted and trained 141 SAMFEs in FY14. Army Medicine is in the process of aligning our SAMFE training in the AMEDDC&S and developing a certification process for all SAMFEs. The 2015 NDAA directs that our SAMFEs are trained and certified; with these changes to our curriculum, not only do we meet the requirements of the NDAA 2015, but we establish ourselves as a lead and benchmark for the DoD.

Transitioning from a Healthcare System to a System for Health

Army Medicine has made great progress over the last three years in our transition from a Healthcare System to a System for Health (SFH). Health is a critical enabler of readiness, and Army Medicine is a valuable partner in making our Force "Army Strong." In 2012, we began our journey to aggressively transition from a healthcare system—a system that primarily focused on injuries and illness—to a System for Health that now incorporates and balances health, prevention and wellness as a critical enabler for readiness. This also moves our health activities outside of the “brick and mortar” facility, brings it outside of the doctor’s office visit, and into the Lifespace where more than 99% of time is spent and decisions are made each day that truly impact health. Our efforts to transform to a System for Health are aligned along three lines of effort focusing on the Performance Triad, Delivery of Health, and Healthy Environments.

<u>The Performance Triad</u>

The strength of the Army and the cornerstone of landpower’s historical and future success hinges on the human dimension— the Soldier. Yet, daily, over 43,000 Soldiers, or the equivalent of 12 Brigade Combat Teams, are non-deployable; annually, 10 million duty-days are limited or lost related to injuries, 80% of which are preventable. As the Army faces a draw

down, it remains obligated to provide a Total Force that is ready for any mission in a complex world with an ever changing geopolitical landscape.

The impacts of restful sleep, regular physical activity, and good nutrition are visible in both the short- and long-term. The Performance Triad is a solution and key enabler to augment individual and unit readiness. It optimizes Soldier performance, and tackles the non-deployable and injury challenges by teaching, coaching, and mentoring Soldiers and Families to improve health related behaviors. The Performance Triad empowers them to take personal responsibility for the betterment of their health readiness, resilience and performance. The Performance Triad is a lifestyle, a way of being, and represents how to impact the Lifespace of the Total Force - where people live, work, and play.

The Performance Triad is aligned with the Army Warfighting Challenges, the Human Dimension, and the Chief of Staff of the Army's Soldier optimization efforts. The Performance Triad enhances readiness by promoting sleep, physical activity, and nutrition through health literacy campaigns delivered through a variety of channels including traditional print, digital and social media. These efforts are targeted to meet the needs of our Soldiers, Families, DA Civilians, and Retirees where they live and work. When individuals and units adopt the tenets of the Triad, they optimize the physical fitness, cognitive dominance, and emotional resilience of the Total Army Family.

Over the past year, the Army completed a six-month pilot program that tested the Performance Triad curriculum across three active duty battalions, including one deployed to Afghanistan. The results of the pilot project revealed that the majority of Soldiers are not meeting the basic Performance Triad targets essential for readiness, health, and performance. More detailed FY14 Performance Triad pilot results revealed that few Soldiers understand how to properly train to be tactical athletes, only 4-5% of Soldiers met the sleep targets, only 2-4% met all of the nutrition targets, and despite unit physical training, only 29-42% met the activity targets. After completion of the program, positive changes included: Soldiers who slept eight hours during the weekends improved from 33% to 46%, refueling after exercise and fish consumption improved, and overall, 26 to 40% of Soldiers improved on the Performance Triad targets. Over 50% of Soldiers reported they liked the program, felt the program influenced readiness, would use the information in the future, felt the program was successful, and would

recommend Army-wide implementation. From a small unit leadership perspective, Soldiers believed their squad leaders became better coaches over the course of the program.

The feedback and lessons learned from the FY14 pilot informed the FY15 Performance Triad curriculum revision. Utilizing the revised content, a second pilot will provide training to up to 30,000 active duty Soldiers across Forces Command, the US Army Reserve and National Guard. As part of this pilot, Army Medicine initiated a pilot at the AMEDDC&S in January 2015 within the Basic Officer Leader Course, the Captain's Career Course, and the Non-Commissioned Officer School to teach leaders the importance of practicing the tenets of the Triad in all environments and to be able to impart knowledge within their spheres influence. For military units, the Performance Triad is a squad-leader-led program that provides first-line supervisors easy-to-use tools required to coach, teach, and mentor the tenets of human performance optimization. In support of mission command, the Performance Triad curriculum influences health readiness and serves as a forcing function to synchronize efforts across installations and operationalize policies and programs offering a whole-of-Army approach.

The Army continues to invest in the Performance Triad to achieve the collective vision set forth in the Army Warfighting Challenges, the Human Dimension, and the Ready and Resilient Campaign. The successful Army-wide implementation of Performance Triad tenets will optimize the health readiness, resilience and performance of the Total Force.

Delivery of Health

The Delivery of Health domain focuses on restoring health through providing early access to evidence-based, safe, high quality, person-centered, predictive, proactive and collaborative healthcare while focusing on restoring health and wellness after an injury or illness. Integration of PCMH, SMCH and our health service lines, such as the Physical Performance Service Line, with tools, resources, and pathways to facilitate health, wellness, and readiness is imperative, as are critical programs such as the Army Wellness Centers, Dental "GO First Class," and our focus on optimizing Brain Health.

Musculoskeletal injuries (e.g., low back pain) are the leading reason for Soldiers seeking medical care. Outpatient medical encounter rates for active duty members across all Services nearly doubled between 2002 and 2012. These types of injuries negatively impact military readiness. At any time, 10% of active duty Soldiers are non-deployable due to physical profiling

for musculoskeletal issues. More than 75% of non-battle medical evacuations from Iraq and Afghanistan were for musculoskeletal conditions.

Given the magnitude of this problem, MEDCOM established the Physical Performance Service Line (PPSL) to implement a standardized system of care to address such musculoskeletal health. This service line is focusing on four lines of effort to track the Soldier across the spectrum of musculoskeletal health, from human performance optimization (HPO) and injury prevention (IP) through early identification and expert management of musculoskeletal injuries, and subsequently through rehabilitation and reintegration processes.

PPSL's initial areas of effort included development of an operational training course for embedded physical therapists in the BCTs, development and oversight of musculoskeletal action teams (MATs), standardized Physical Readiness Training-based e-profile templates for upper and lower body injuries, acute and traumatic musculoskeletal injury screening, referral tools for primary care providers, and a standardized aquatic rehabilitation pilot program. They are leading the way in ensuring we are delivering the very best standardized and far forward musculoskeletal care to our Soldiers, Families and Retirees across our System for Health.

Army Wellness Centers (AWC) are also instrumental in assessing and improving the health of the force, especially those who are at increased risk for obesity or other chronic conditions. In FY 2014, the AWC served 27,964 clients of all beneficiary type in 22 locations. An analysis of clients who visited AWCs between October 1, 2010, and September 30, 2014, revealed that of the 7,464 clients who had at least one follow-up BMI assessment (with at least 30 days between assessments), 59% saw a statistically significant decrease in BMI. These clients averaged a 4% decrease in BMI during this same timeframe.

Another health delivery domain initiative is the dental "GO First Class" readiness program. This has spearheaded dental readiness compliance by combining dental exams with cleanings resulting in a 50% reduction in oral disease related to caries (cavities) among active duty Soldiers. The cost savings associated with this initiative has recovered the equivalent of 61 man-years and $13.5 million in treatment costs across the Army Dental Command.

We also placed a special emphasis on brain health to improve Soldiers' cognition, emotional, and physical strength. Brain health rehabilitation and reconditioning programs assist Soldiers as they return to highest possible level of fitness and readiness. Our goal is to also optimize cognitive and emotional fitness enriched by training, learning, and improving

performance in all human domains through attention, reasoning, decision making, problem solving, learning, communicating, and adapting. These programs are an integral step in helping Soldiers and beneficiaries return to a full state of health readiness and performance.

Healthy Environments

Healthy Environments diffuses the SFH into the Lifespace of our beneficiaries through environmental, occupational, and public health programs that promote healthy lifestyles to reduce the likelihood of illness or injury. This requires a "whole Army" approach where everything from physical layouts, installation services, and command policies at installations support this focus on readiness and transition to health. SFH maintains health in safe, sustainable communities which support informed choices and healthy lifestyles through the promotion of Healthy Environments.

Recently on a visit to Fort Campbell, I saw this in action. The hospital has done an outstanding job in focusing on the nutritional aspects of the Performance Triad in addition to sleep and activity. They have a garden where young children come to help tend and are educated on the nutritional aspects of different vegetables. They also took out soda machines and replaced them with healthy drink options. In six weeks they eliminated 600 pounds of sugar being consumed by our Service Members, employees and Family Members. They also moved the dessert bar which was the first thing you saw when you walked into the dining facility to the rear and replaced it with a salad bar. The results were nearly a 50 percent reduction in sales of desserts and a 40 percent increase in sales of salads.

These are only a few examples of the impactful changes our SFH is having across our Army. This momentum absolutely must continue, and will surely pay readiness dividends in the future.

Continuous Journey to a High Reliability Organization

While our transition to a SFH is relatively new, we have been on a longstanding, continuous journey to fully demonstrate the characteristics and behaviors of a high reliability organization (HRO), and serve as the Nation's leader in creating a culture of safety in healthcare.

HROs exceed the standards for their industry by having well-established policies and systems in place that ensure consistency of practice and enable them to reach their goals of zero preventable harm, a paramount of patient safety. A HRO is committed to achieving zero preventable harm by successfully limiting the number of errors in an environment where normal

accidents can occur due to the risk factors and complexity of the practice. The success of a HRO relies on leadership, an established culture of safety, and robust process improvement initiatives leading to enhanced efficiencies and effectiveness of health care delivery culminating in positive patient outcomes.

Recently, Army Medicine completed four of five HRO Regional Command Summits across the United States and Europe. The theme was educating and developing a collective mindfulness on "what we can do today to become an HRO tomorrow." Command teams were charged with determining actions that can be executed immediately to empower their teams in prioritizing safety in a deliberate approach to patient-centered care and positive outcomes. This effort is a cornerstone to the future of not just Army Medicine, but to healthcare across the globe.

SECDEF MHS Review

In May 2014, the Secretary of Defense ordered the Military Health System (MHS) Review to assess the state of health care, patient safety, and quality of care within the MHS. We electively chose to compare ourselves to the best facilities by utilizing quality and safety benchmarks employed by other high performing civilian hospitals. The review concluded that the Army provides high quality care that is safe and timely, and is comparable to the healthcare found across the civilian sector. However, we are not satisfied and will continue to strive to lead American healthcare specifically in the area of patient safety.

This extensive report clearly validated that our transformation to a HRO is the correct course in providing safe and quality care to our Soldiers, Families and all entrusted to our care. Over the next year, transparency will be increased regarding patient safety metrics so our patients and external stakeholders can measure our system against the best in the Nation. The journey to become a HRO will not be complete in the next few years, but will take a generation to achieve our pursuit of zero preventable harm.

Operating Company Model

Army Medicine accelerated our transformation into a HRO with the implementation of the Operating Company Model (OCM) methodology as a means of decreasing variance and improving consistency, clarity, and accountability. Within the OCM framework, we established seven service lines, as previously described in this testimony, that are aligning capabilities to improve patient safety, quality, efficiency, productivity, and financial optimization across

multiple clinical domains. The utilization of these service lines and the OCM was a necessary step to further the principles and imperatives of a HRO across the enterprise.

Integrated Resourcing and Incentive System

During these challenging fiscal times, Army Medicine must continue to enhance value across the enterprise and drive the adoption of OCM practices. We have achieved this through the use of a financial incentive model called the Integrated Resourcing and Incentive System (IRIS). IRIS is the vehicle for Army Medicine to ensure that our MTFs are resourced for value production at an adequate level to improve access to care, recapture care, improve satisfaction, improve quality of care and incentivize for improved health outcomes. IRIS is MEDCOM's tool to adequately fund MTFs based on their performance plan to produce quality outcomes and safe delivery of healthcare.

Patient-Centered Medical Home

As part of our ongoing movement to become a HRO, we have focused on not just delivering care, but ensuring superior health outcomes. A major proponent of successful health outcomes for our Soldiers, Families, and beneficiaries is our PCMH model. Army Medicine is a clear leader in transforming primary care within the Military Health System. The PCMH model encompasses all primary care delivery sites in the direct care system, under the umbrella of the Army Medical Home (AMH), including our MTF- based Medical Homes, Community-Based Medical Homes and SCMHs.

Primary Care is delivered through an integrated healthcare team of professionals that proactively engages patients as partners in health. It relies upon building enduring relationships between patients and their provider – doctor, nurse practitioner, physician assistant and the extended team – and a comprehensive and coordinated approach between providers and community services. The AMH is the foundation of Readiness and Health and represents a fundamental change in how we provide comprehensive care to our beneficiaries including primary care, BH, clinical pharmacy, dietetics, physical therapy, and case management. Currently, 137 AMHs across the United States, Europe, and the Pacific are caring for 1.3 million beneficiaries supported by a budget of $74.3M. All of the AMHs have been recognized by the National Committee for Quality Assurance (NCQA) representing the gold standard of patient-centered medical care.

Army Medical Homes consistently perform better than the historical Army clinic model. They distinctly focus on quality and safety outcomes, medical readiness categories, polypharmacy and BH admission rates, as well as cost containment by decreasing emergency room utilization, medical board timelines, and per capita cost while increasing patient continuity with a focus on wellness. Their overall patient and staff satisfaction is exponentially higher than the historical Army clinic model.

A major initiative introduced in the PCMH to improve readiness of the force and Family health is the integration of clinical pharmacists. Army Medicine recognizes the expanded role of clinical pharmacists to address polypharmacy risk, the use of multiple medications to treat chronic conditions, and adverse drug events that lead to a higher rate of hospital admissions. Integrating clinical pharmacists into PCMHs improves patient quality, safety, and efficiency by decreasing overall healthcare costs, minimizing adverse drug events, reducing hospital admissions and improving patient outcomes. In 2014 Army Medicine programmed $16M for FY16 to support this critical initiative. This funding is significant because it provides a clinical pharmacist for every 6,500 enrolled beneficiaries, fully integrating clinical pharmacists into medical homes.

Additionally, the MEDCOM Primary Care Service Line initiated a six-month pilot program at two medical homes to compare the effectiveness of digital versus traditional paper BH screening for depression, PTSD, anxiety, and alcohol misuse. The pilot revealed that digital screening was more than twice as sensitive as paper screening (30% versus 12% positive response rate). In the digital group, twice as many positive screens were addressed by their primary care manager (PCM) when compared to the paper group. The digital record also provides seamless access by the PCM to review historical response trends resulting in a comprehensive plan of care to more effectively address the condition. On average, there are 25,000 primary care visits per day across Army medicine; this tool could potentially increase access to thousands of patients with unaddressed BH concerns each day. Based on these results the primary care service line is developing a strategy to deploy digital BH screening to all medical homes.

Recognizing a need for increased, confidential interaction between patients and medical providers, the Army Medicine secure messaging system (AMSMS) was developed to provide both patients and providers with additional convenient means of communication through online

messaging. Messages from patients are triaged and answered by staff without the challenges of navigating telephonic processes. AMSMS has been deployed throughout all Army Medical Homes. As of September 30, 2014, Army Medicine had nearly 305,000 uniquely connected patients (some could be multiple members in a single Family) with approximately 3,400 registered providers and 6,500 registered support staff, supporting approximately one million messages since its inception. Secure messaging has a 97% satisfaction rating. The MHS Review specifically highlighted secure messaging as a powerful tool to help the MHS improve in access, safety, and quality. We are actively conducting a marketing campaign to promote this critical initiative aimed at increasing the number of beneficiaries enrolled in secure messaging.

Surgical Services Line

The Surgical Services Service Line (3SL) is focused on a surgical services model that optimizes the productive, efficient and financially sustainable delivery of surgical care, increasing access to value-based, quality care for beneficiaries across all MTFs. 3SL's success is measured not only by increased access to care for our beneficiaries, cost savings to MEDCOM and higher quality outcomes, but in a ready and deployable medical force, enhanced Soldier readiness and improved combat casualty care. In 2014, 3SL implemented the National Surgical Quality Improvement Program (NSQIP) at all 25 surgical MTFs. Less than 10% of all US hospitals that provide surgical care utilize NSQIP. The initiatives spearheaded by 3SL realized an estimated cost savings of $38M for in FY 2014. These and many other advances have been the catalyst to move Army Medicine forward and serve as a blueprint to become a HRO.

Clinical Performance Assurance Division

As part of our transition to a HRO, the Clinical Performance Assurance Division (CPAD), containing the Patient Safety Program, was established in 2012 and aligned under the MEDCOM Deputy Commanding General for Operations. The MEDCOM Patient Safety Program, in coordination with regional and MTF Patient Safety Leaders, works to engage leadership at all levels to cultivate a culture of safety environment of trust, transparency, teamwork and communication to improve safety and prevent adverse events. They frequently conduct scheduled and unscheduled visits at the MTF level to address system issues potentially affecting patient safety through training and clinical process review. Since the establishment of CPAD, Army Medicine has made significant progress in the reporting, investigation and mitigation of issues that could cause patients harm.

Partnership for Patients

In 2014, the continued implementation of Partnership for Patients, a national program sponsored by the Centers for Medicare and Medicaid, resulted in a 26 percent decrease in preventable harm events over the last two quarters and a 37 percent decrease overall since Army Medicine implemented the program in 2012. The CPAD medication safety team provided an analysis of workload, resulting in the hiring of 21 clinical pharmacists and 17 pharmacy technicians to increase the oversight of medication safety across Army Medicine. They also petitioned the Drug Enforcement Agency to provide DoD an exemption to allow our pharmacies to take back unused medications including scheduled medications in an effort to provide an increased level of safety for our Army Families.

Team Approach

MEDCOM continues to build a culture of safety through the further incorporation of Team Strategies and Tools to Enhance Performance and Patient Safety (Team STEPPS) to enhance team communication and collaboration so that every team member has a voice in providing health. TeamSTEPPS is an evidence based teamwork system that employs group huddles to encourage open dialogue and synchronization of efforts to optimize the use of information, people, and resources to achieve the best clinical outcomes for patients. TeamSTEPPS was initially deployed across the MEDCOM in 2011 and has led to significant improvements in teamwork and collaboration in critical areas such as our surgical suites and inpatient care areas. The TeamSTEPPS program facilitated the training of over 400 trainers through virtual training programs leading to over 60K medical and dental personnel trained. Additionally, TeamSTEPPS simulation based Operating Room Team training program was facilitated at 12 MTFs since 2012, resulting in the identification and avoidance of potential patient safety incidents while safely increasing operating room efficiency.

Patient CaringTouch System

To reduce variance and improve patient outcomes, the Army Nurse Corps developed and implemented the Patient CaringTouch System (PCTS). The PCTS is a strategic, patient-centered framework for nursing, founded on evidence-based practice and collaboration with America's top performing hospitals. It provides a framework which focuses on patient advocacy, enhanced communication, evidenced based practice, capability building, and healthy work environments.

The PCTS methodology is the foundation for the delivery of high quality, evidence-based care that includes the Family and is driven by patient-centric outcomes. When the five elements are combined synergistically, PCTS improves patient outcomes and nursing staff effectiveness, as well as decreases clinical practice variance. The focus on the patient experience through the implementation of PCTS resulted in a decrease in wait times, increase in attentiveness to patient and Family needs, and increase in patient engagement to discuss symptoms and medications.

Leading the Way

Army Medicine is leading the way in the areas of innovative medical research, diplomacy, and collaboration. History is replete with examples of war serving as a catalyst for medical innovation and of battlefield medicine producing advances in civilian healthcare. For more than 200 years, the Army's efforts to protect Soldiers from emerging health threats have resulted in significant advances in medicine. The U.S. Army Medical Research and Materiel Command (MRMC) is the Army's medical materiel developer responsible for medical research, development, and acquisition and medical logistics management. MRMC's role is to research and develop technologies and tools to ensure our Soldiers remain in optimal health and are equipped to protect themselves from disease and injury, particularly on the battlefield. Research conducted at MRMC thru joint efforts leads to medical solutions—therapeutics, vaccines, diagnostics, and actionable information—that benefit both military personnel and civilians.

More than a decade of war has led to tremendous advances in knowledge and care of combat-related wounds, both physical and mental. Our decisions today must preserve the Army's core medical research competencies and, through continued medical research investments, ensure strategic flexibility to respond to future operational threats. The DoD stands alone as the world's leading organization for trauma research and development.

The Joint Trauma System (JTS) was established in 2006 and is located at the U.S. Army Institute of Surgical Research (ISR), Joint Base San Antonio. Its mission is to improve trauma care delivery and patient outcomes utilizing continuous performance improvement and evidence-based medicine driven by analysis of data maintained in the DoD Trauma Registry. The JTS has collected data from more than 130,000 combat casualty care records from Iraq and Afghanistan. The data have resulted in 39 Clinical Practice Guidelines (CPGs) to provide enduring evidence-based, best-practice recommendations for trauma care. The continuous monitoring and evaluation of outcomes after implementation of the CPGs provides evidence necessary to turn

results into improved outcomes for combat casualties. The success of the JTS is clearly reflected through sustainment of the lowest lethality rate ever recorded during our current conflicts.

In conjunction with delivering rapid and effective combat casualty care, the Army continues to refine surgical and hospital capabilities based on lessons learned from the past thirteen years of conflict. These initiatives complement our advances in combat casualty care at the point-of-injury to sustain and to increase battlefield survival rates. Lessons learned from the Iraq and Afghanistan theaters of operations led to the clear requirement to make fundamental changes to the design of the Forward Resuscitative Surgical Team (FRST) and the Field Hospital (FH). The key changes to the FRST and FH designs include modularity, scalability, and the ability to conduct split-based operations. The new structure, approved in August 2014 by the Vice Chief of Staff of the Army, will meet the needs of both conventional and non-conventional forces. These enhanced capabilities will be critical to rapidly supporting future operations in various conflict environments across the globe.

MRMC will expertly manage and execute congressional special interest (CSI) funds to meet the intent of Congress, to seek and fund the best science with a keen focus on military relevance, where applicable. The CSI funds are executed through established, highly effective, efficient, and low cost processes using only approximately 15% in research management support costs for the MRMC and the remaining 85% of all the CSI funds being placed on awards to maximize the science and the taxpayers' investment.

Historically, infectious diseases are responsible for more US casualties than enemy fire. Continued progress to address these emerging threats requires ongoing commitment to funding, developing personnel with expertise in infectious diseases, and maintaining stateside and overseas laboratory infrastructure and overseas field sites for clinical studies and response to contingencies. The coordinated and swift response to the Ebola virus outbreak demonstrated the value of continued funding in this area.

Army Medicine closely partnered with interagency partners including the Centers for Disease Control and Prevention (CDC) in the domestic and global Ebola virus response. The US Army Medical Research Institute of Infectious Diseases (USAMRIID) Diagnostic Systems Division provided Ebola testing capability for the National Laboratory Response Network (LRN), qualification testing for other LRN laboratory use of the FDA Emergency Use Authorization (EUA) Ebola diagnostic assay, and pre-deployment training for laboratory

personnel staffing mobile laboratories in Liberia. USAMRIID laboratory personnel, in collaboration with National Institute of Allergy and Infectious Diseases personnel have continuously staffed the Liberian National Reference Laboratory at the Liberian Institute of Biomedical Research, in a host nation capability and capacity development initiative to provide lasting enhancements to laboratory capability that will endure beyond the current outbreak.

MRMC overseas laboratories, the US Army Medical Research Unit-Kenya and Armed Forces Research Institute of Medical Sciences in Thailand, are providing technical support to their host nations' laboratory preparedness and Ebola virus disease (EVD) response planning efforts. Additional EVD research and development efforts executed at MRMC including the Walter Reed Army Institute of Research (WRAIR) and USAMRIID, funded by the Chemical and Biological Defense Program (CBDP), have contributed to the development of investigational EVD therapeutics, vaccines and diagnostics. Vaccine development efforts are being accelerated in response to the current West African outbreak to include several CBDP-funded candidates projected to enter Phase 2-3 clinical testing in early 2015. The MRMC Ebola Response Management Team has developed a proposed organizational framework for DoD and HHS elements to partner and collaborate with other US Government agencies involved in the EVD outbreak, the World Health Organization, non-governmental agencies, and foreign governments (i.e. Liberia, Sierra Leone, and Guinea) to collaboratively engage West Africa in the conduct of clinical trials at the strategic, operational, and tactical levels. The WRAIR HIV program is currently conducting an early Ebola Vaccine Trial in collaboration with National Institutes of Health (NIH)-National Institute of Allergies and Infectious Diseases (NIAID) to test the safety and immunogenicity of an experimental vaccine candidate.

As we globally rebalance to the Pacific, our Soldiers will deploy to areas plagued with endemic infectious diseases such as malaria and dengue, as well as emerging disease threats across 105 million square miles. Experts predict that infectious diseases will be the primary cause of hospitalization of US military in the Asia-Pacific region. In an effort to combat this distinct threat to the force, USAMRMC laboratories continue to build on partnerships with Navy Medicine, Federal agencies, academia, non-governmental organizations, other private entities, and foreign Governments. These relationships leverage resources for continued development of endemic infectious disease treatments, preventive drugs, vaccines, vector control, and diagnostic tools essential to preserving the readiness of the force.

Examples of recent successes include a rapid diagnostic test for cutaneous leishmaniasis, developed by MRMC and industry partners under the US Army Small Business Innovation Research program. This device received FDA clearance in November 2014 and is now commercially available. Additionally, two malaria treatment drugs are expected to be licensed in 2018 and two malaria vaccine candidates are scheduled to be transitioned to advanced development in FY17-18. Early clinical trials have begun on the effectiveness of vaccines targeting hemorrhagic fever and organisms causing bacterial diarrhea.

It is imperative we sustain funding to finalize these revolutionary advances that will not only ensure the safety of our global force, but ultimately save millions of lives across the world.

Education and Training

Army Medicine continues to lead the nation in attracting and educating the best medical minds. Our Graduate Medical Education (GME) programs and education programs receive high praise from accredited bodies, and our trainees routinely win military-wide and national level awards for research and academics. Currently, we have 1596 Health Professionals Scholarship Program students in medical, dental, veterinary, optometry, nurse anesthetist, clinical psychiatry and psychiatric nurse schools. Additionally, the Uniformed Services University of the Health Sciences is a critical institution dedicated to developing and training clinicians in leadership, clinical, and combat casualty care as well as operational medicine. Our GME training programs have 1,476 trainees in 148 programs located across 10 of our MTFs. Our GME graduates have continued to exceed the national average pass-rate of 87% for specialty board certification exams, with a consistent pass rate of approximately 92% for the last 10 years with 95% first-time board pass rate last year.

Our education programs have been recognized nationally. The Army Medicine's Physical Therapy Program at Baylor University is currently the 5th ranked program in the country out of over 210 national programs; our graduates have a 100% licensure pass rate in the past 3 years and have advanced the science through numerous peer-reviewed journal article publications. US News and World Report most recent survey of graduate schools ranked the US Army Graduate Program in Anesthesia Nursing (USAGPAN) as the number one program in the Nation out of 113 nursing anesthesia programs. Furthermore, it ranked the Army-Baylor University Graduate Program in Health Administration program as the 11th out of 75 national

programs. Overall, we not only have the largest training program in the military, we are one of the largest medical education systems in the country.

Global Health Diplomacy

Demand for Army capabilities and presence continues to increase across all Combatant Commands in response to growing and emerging threats. We continue to develop key relationships with our interagency partners and our allies to enhance security cooperation, provide foreign humanitarian assistance, build partner capacity, and participate in multi-lateral exercises. Army Medicine is a key combat multiplier that increases access and collaboration with military medical activities in partnerships across the globe. Increasing health diplomacy offers a collegial and non-threatening means of engaging with partner countries, states and foreign groups. Health in many instances offers access and opens gateways not otherwise available through conventional means.

Establishing and maintaining medical partnerships is crucial to supporting the Army's Regionally Aligned Forces (RAF) construct. Many RAF engagements during 2014 were focused primarily on medical support and humanitarian assistance, especially in Africa, South America and across the Asia Pacific regions. Furthermore, health diplomacy facilitated by Army Medicine personnel has opened dialogues and shaped early working relationships with China, Vietnam and other foreign militaries and groups. These engagements have strengthened our relationship with many of our allied partners throughout the world. For example, just one unit, the 30th Medical Brigade, will complete engagements with 19 partner nations this year alone.

Sustaining the Force through Collaboration

Just as Army Medicine increases engagement with our global partners, we are increasing collaboration with the Department of Veterans Affairs, as well as supporting the establishment of the Defense Health Agency (DHA) to ensure our Soldiers and Veterans have improved access to the care and support they have earned through their distinguished service.

Over the past decade, the Army has increased partnerships with the VA through sharing agreements that provide care to VA beneficiaries in various healthcare facilities that have excess capacity. This enables VA beneficiaries to receive high quality, cost effective, and timely care in locations where the VA may have limited capability or resources. In FY14, Army Medicine provided $49 million in healthcare services to VA beneficiaries at 19 locations across the

country. The range of services varies by location and is the result of matching VA's needs with the Army's excess capacity. In some locations, such as Honolulu and El Paso, we provide a broad spectrum of inpatient and outpatient specialty services.

Although Army Medicine does not have any joint facilities with the VA, there are locations where the Army and VA facilities are located in close proximity or connected, but remain distinct organizations with close collaboration. In a new collaborative effort, the Army will occupy a portion of the Major General William H. Gourley VA-DoD Outpatient Clinic in Marina, California. At this location Army staff will provide care to DoD beneficiaries in a DoD clinic imbedded within the larger VA facility. The clinic is expected to open in FY17.

Operating as a joint team allows us to share best practices and lessons learned across the services. Together with Dr. Woodson, the Service Surgeons General are working to organize and lead the MHS into the future by building a stronger, even more integrated team. The establishment of a DHA in October 2013 represented a major milestone towards modernization and integration of military medical care.

Army Medicine has been a key contributor to the transition and integration of the ten shared services by providing 643 personnel to the DHA thus far. In the last year, all ten shared services have reached initial operating capability and are expected to reach full operating capability by October 1, 2015, with some possibility of establishing full operating capability ahead of schedule. The AMEDD will continue to drive fundamental changes within the MHS and support these transformation efforts that improve readiness and quality of healthcare while containing costs.

As part of Governance reform, six enhanced Multi-Service Markets (eMSM) were also established covering San Antonio, the Puget Sound, Hawaii, Colorado Springs, Tidewater, and the National Capital Region. The MHS expects substantial savings from these markets because they enable the market manager to cross Service boundaries and shift health care from the private sector to military treatment facilities, which are our readiness platforms. This workload recapture directly impacts the readiness of the Army by ensuring providers, nurses, and other clinicians are able to sustain their clinical combat trauma care skills and capabilities. The Army currently is the Service Lead in three markets: Hawaii, Puget Sound, and San Antonio.

Conclusion

Army Medicine provides certainty in an uncertain world. We have always been a force enabler, assuring and caring for Soldiers on the battlefield and at home. We have also always been a leader in healthcare and health, contributing enormously to solving military, national, and global health concerns. To adapt from a World War I song lyric: "When we are needed – we are there!"

During these uncertain times, Army Medicine must continue to provide certainty to our Soldiers, Families, and our Retirees. We must deliver on our Nation's obligation to care for our Soldier's needs, restore full function, promote readiness, and optimize their performance. These efforts will provide the foundation for the effectiveness of our entire Army, and play an important role in contributing to global stability.

It is during this time, as we draw down from over 13 years of conflict, that we must ensure that Soldiers and their Families are strengthened with resiliency built to carry them through future global conflicts and hardships. It is during this vital period that Army Medicine will play an essential role as the Army's health readiness platform. I am committed to ensuring that during these drawdown years, our ability to carry out the readiness mission does not diminish. Together, we must keep the momentum going and remain proactive, ensuring our enduring missions, transition to a System for Health and progress toward a high reliability organization with our innovative research, diplomacy, and collaboration continuing full speed ahead.

The fiscal challenges that loom ahead are daunting. However, we will continue to support the Army in any austere environment at home or abroad. These are times of great uncertainty and opportunity, and while there will be many challenges, anything less than our top performance will cost lives. As partners with Congress, I am confident that none of us will allow that to happen on our watch.