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The Honorable Adam Smith
Chairman
House Armed Services Committee
United States House of Representatives
Washington, D.C. 20515

The Honorable Mike Rogers
Ranking Member
House Armed Services Committee
United States House of Representatives
Washington, D.C. 20515

May 3, 2021

Dear Chairman Smith and Ranking Member Rogers:

I write to submit for the record testimony regarding two areas I believe the Fiscal Year 2022 National Defense Authorization Act needs to address: the evolution of the Defense Health Agency and the status of podiatrists in the United States Medical Corps.

The Evolution of the Defense Health Agency (DHA) and the Military Health System (MHS)

The Military Health System (MHS) is a vital component of our national security strategy, and the Defense Health Agency (DHA) is a critical element of the MHS that was established as part of a larger effort to reorganize military healthcare programs and services. Since its inception in 2013, DHA was established to serve as a combat support agency (CSA) to enable the medical services to provide a medically ready force and ready medical force to combatant commands. But since its inception, as Congress has asked DHA to take on an increasingly larger role in the MHS, DHA remains limited by its construct as an integrated Combat Support Agency (CSA).

Prior to the COVID-19 pandemic, concerns were being raised with the direction of the MHS transformation and, specifically, DHA's evolving role.

There are five key areas of concern regarding the current DHA.

1. Lack of clarity of authority within the current DHA structure. In November 2019, the Department of Defense (DoD) transmitted a report to Congress, pursuant to Section 711(c) of the Fiscal year 2019 NDAA the feasibility of establishing a Defense Health Command (DHC). In this report, researchers found that "[i]nterviewees invariably lamented a lack of clarity in the assigned responsibilities of DHA as a source of concern." Additionally, "[a] separate clarity issue raised by multiple interviewees was the need to identify a clear decision-making authority to ensure that authority is recognized."

COVID-19 has especially highlighted the issue of unsynchronized demands and processes within and between the Services, DHA, Joint Staff, and the Office of the Assistant Secretary of Defense for Health Affairs. Each command addresses its needs and aligns its limited resources without taking in to account greater needs elsewhere. With COVID-19, DoD components and the Services were also competing amongst themselves for resources, and while medical capability limitations were known before the pandemic, they have been exacerbated during this time. Additionally, when the Services recall their personnel to support operational needs, the MTFs will likely suffer.

The use of a CSA to support combatant command requirements, the Services' medical training requirements, and delivery of a healthcare benefit is organizationally limited. While a CSA will be able to communicate with the Services to identify personnel gaps and coordinate manpower adjustments (i.e., joint staffing models or TRICARE network providers), the Director of the current model, by nature, lacks the proper authority to make centralized personnel adjustments.

2. Need for better integration and communication across the Services. Under the current construct, DHA is unable to execute joint deployment solutions. For example, if an Air Force Reservist wants to deploy, but the Department of the Air Force has a policy not to deploy Reservists, or is absent a service-specific requirement for that individual or skillset, the servicemember would be denied such an opportunity to deploy. Alternatively, the servicemember could transfer to another Service in order to take advantage of another Service's deployment opportunities. In this scenario, which did occur, an overseeing Health Commander could more easily coordinate with the Joint Staff and facilitate personnel deployments based on identified need and servicemember availability. Joint deployment flexibility is an area of need that the current system, with or without the involvement of a CSA, is unable to efficiently accomplish.

3. Enhanced Military-Civilian Trauma Training Opportunities. There is a broad need for a unified expansion in military-civilian medical combat readiness training opportunities for both active and reserve medical personnel, especially for trauma. Servicemember and public reports indicate that active duty medical personnel stationed on safe, stateside installations are still not getting the exposure to and repetitions of trauma care that are needed in theater and that this has been observed in field hospitals. In addition to medical combat readiness, these military-civilian partnerships provide critical relationships for population health in the event of a mass casualty event where DoD medical capabilities may need to be engaged domestically.

   The Fiscal Year 2017 NDAA directed the Secretary of Defense to establish a Joint Trauma System within DHA, establish a Joint Trauma Education and Training Directorate that will include a personnel management plan for certain wartime medical specialties, and establish high-performance military-civilian integrated health delivery systems in collaboration with the Service Departments. In the context of the current combat support agency model, DHA will be able to negotiate military-civilian partnership agreements in regional markets at the enterprise level on behalf of the Services, as well as conduct research and incorporate the resulting standards of care within the enterprise.

However, this framework and the integration of trauma standards to meet combat readiness requirements is occurring outside of the Services' medical departments. While the Surgeons General rightfully retain the ability to determine their operational readiness requirements and whether their respective Services will be included in DHA's trauma integration efforts, this model ironically blurs the lines of responsibility about the extent to which the DHA owns readiness.

4. Decoupling the MTFs from the Services. Although MTFs are not the sole source of training, they are and have been an important link in the readiness and deployment pipeline controlled by each Surgeon General. In the context of how the integrated healthcare delivery system relates to Service-specific operational medicine, this realignment presents a concern with the extent to which DHA is responsible for readiness, and it decentralizes management decisions.

5. Separating Research Programs from the Services: The Fiscal Year 2019 NDAA built on DHA's research integration authority and directed the transfer of the Army Medical Research and Materiel Command, among other medical research and public health programs across the Services, into a new Research and Development Directorate at the DHA. While DHA should have a role in streamlining and coordinating research activities, ensuring that efforts are not unnecessarily duplicated, there are also reasons to keep Service-specific research, and research tied directly to combat readiness, within the Military Departments.

We must be able to learn from the recent health crisis as well as listen to those who have been operating on the ground throughout this MHS transition overall to adjust course when necessary. Through their experiences, we know that reforms are needed to ensure we have a ready medical force, a medically ready force, and high-quality beneficiary care.

In the recent past, this Committee has reaffirmed its commitment to reforming the MHS and pressing forward with the efforts to fully establish the DHA. Certainly, the MHS transformation is an evolution that is both necessary and overdue, and that transformation need not be halted completely. In fact, making changes while the agency is changing may well prove to be the more prudent course of action rather than waiting for a final product that is knowingly flawed in order to then go back to fix those problems we know about now.

As the Committee looks develops the policies that will ensure DoD continues to operate a beneficial healthcare integrated delivery network with no adverse effects on readiness, I urge the Committee to reconsider the overarching structure of the MHS and DHA's role within it, incorporating lessons learned thus far in the transformation process and from COVID-19.

Moving Podiatrists to the United States Medical Corps

Under current law, doctors of podiatric medicine (D.P.M.) are only allowed to serve in the United States Medical Service Corps, where officers serve within the areas of Administrative Health Services, Medical Allied Sciences, Preventive Medicine Sciences, Behavioral Health Sciences, Pharmacy, Optometry, Podiatry, Aeromedical Evacuation, or Health Services Maintenance Technicians. However, officers in the MSC are only allowed to deploy if they apply for and are granted a special waiver.

Doctors of medicine (M.D.) and doctors of osteopathic medicine (D.O.), on the other hand, serve in the Medical Corps, which is a non-combat specialty branch whose officers are assigned to military medical facilities, deployable combat units, or to military medical research and development units. Physicians in the Medical Corps are considered fully deployable.

Physicians and surgeons in the Medical Corps may have greater opportunities available to them compared to their Medical Service Corps counterparts, specifically because those in the Medical Corps are more readily deployable. Because of this misalignment, podiatrists are at a disadvantage compared to their M.D. and D.O. peers for advancement within the Services, even if they have more years in service and more experience in practicing medicine and surgery.

Podiatric education, training, and practice have evolved considerably over the past four decades. Podiatrists now complete four years of graduate medical education at one of nine colleges of podiatric medicine. Doctors of podiatric medicine receive basic and clinical science education that is comparable to medical doctors; podiatric residency curriculum is also comparable to M.D. and D.O. residency training and a minimum of three years for civilian podiatrists. All of the Services also require a three-year surgical residency.

The present-day podiatric surgeon is trained in all aspects of surgical principles, patient admissions, performing history and physicals, and taking emergency call. The military faces a tremendous shortage of surgeons, and podiatrists have even served as chief of surgery in the military in theater. Their careers track along the lines of their M.D. and D.O. counterparts in the civilian world and in the Department of Veterans Affairs. As such, I urge the Committee to consider updating the law to move doctors of podiatric medicine from the Medical Service Corps to the Medical Corps.

I appreciate the Committee's consideration of these two issues and look forward to working with my colleagues on the Committee in support of our warfighters and their families.

Sincerely,

Brad Wenstrup
Member of Congress