

S. HRG. 110-198

**CARE, LIVING CONDITIONS, AND ADMINISTRATION
OF OUTPATIENTS AT WALTER REED ARMY
MEDICAL CENTER**

HEARING

BEFORE THE

COMMITTEE ON ARMED SERVICES

UNITED STATES SENATE

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

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MARCH 6, 2007
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CARE, LIVING CONDITIONS, AND ADMINISTRATION OF OUTPATIENTS AT WALTER REED ARMY MEDICAL CENTER

TUESDAY, MARCH 6, 2007

U.S. SENATE,
COMMITTEE ON ARMED SERVICES,
Washington, DC.

The committee met, pursuant to notice, at 9:34 a.m. in room SD-106, Dirksen Senate Office Building, Senator Carl Levin (chairman) presiding.

Committee members present: Senators Levin, Kennedy, Lieberman, Reed, Akaka, Bill Nelson, E. Benjamin Nelson, Bayh, Clinton, Pryor, Webb, McCaskill, McCain, Warner, Inhofe, Sessions, Collins, Ensign, Chambliss, Graham, Dole, Cornyn, Thune, and Martinez.

Committee staff members present: Richard D. DeBobes, staff director; Leah C. Brewer, nominations and hearings clerk; and Gary J. Howard, systems administrator.

Majority staff members present: Jonathan D. Clark, counsel; Gabriella Eisen, professional staff member; Gerald J. Leeling, counsel; and Michael J. McCord, professional staff member.

Minority staff members present: Michael V. Kostiw, Republican staff director; David M. Morriss, minority counsel; Lucian L. Niemeyer, professional staff member; Diana G. Tabler, professional staff member; and Richard F. Walsh, minority counsel.

Staff assistants present: David G. Collins, Kevin A. Cronin, and Jessica L. Kingston.

Committee members' assistants present: Frederick M. Downey, assistant to Senator Lieberman; Elizabeth King, assistant to Senator Reed; Darcie Tokioka, assistant to Senator Akaka; Benjamin Rinaker, assistant to Senator Ben Nelson; Andrew Shapiro, assistant to Senator Clinton; Lauren Henry, assistant to Senator Pryor; Jason D. Rauch, assistant to Senator McCaskill; Richard H. Fontaine, Jr., assistant to Senator McCain; Sandra Luff, assistant to Senator Warner; D'Arcy Grisier, assistant to Senator Ensign; Bridges Sinyard and Clyde A. Taylor IV, assistants to Senator Chambliss; and Adam G. Brake, assistant to Senator Graham.

OPENING STATEMENT OF SENATOR CARL LEVIN, CHAIRMAN

Chairman LEVIN. Good morning, everybody. This committee meets this morning to address reports of substandard living conditions, poor outpatient care, and bureaucratic roadblocks and delays for injured soldiers at Walter Reed Army Medical Center. We wel-

come our witnesses here today: Dr. David S.C. Chu, Under Secretary of Defense for Personnel and Readiness; Dr. William Winkenwerder, Assistant Secretary of Defense for Health Affairs; General Peter Schoomaker, Chief of Staff of the Army; and Lieutenant General Kevin Kiley, Surgeon General of the Army.

This committee is determined to understand what went wrong at Walter Reed Army Medical Center and what we need to do to make sure it does not happen again there, or anywhere else. Our Nation has a moral obligation to provide quality health care to the men and women who put on our Nation's uniform and are injured and wounded fighting our Nation's wars. This obligation extends from the point of injury through evacuation from the battlefield, to first class medical facilities in the United States, and ends only when the wounds are healed. Where the wounds will never heal, we have an obligation to provide quality care throughout the lifetime of the veteran. I am sad to say that we are not meeting this obligation, although it is an obligation which all Americans accept and insist be met to the fullest.

Today's hearing is about another example of the lack of planning for a war that was premised on the assumption that combat operations would be swift, casualties would be minimal, and that we would be welcomed as liberators instead of being attacked by the people we liberated.

I am proud of the fact that our military doctors, nurses, and medics have provided outstanding medical care to those who were wounded. Many servicemembers who would have died in earlier conflicts survived in Iraq and Afghanistan because of the advances in battlefield medical care, and the skill and bravery of our combat medical teams. Seriously injured troops are rapidly evacuated to world-class medical facilities like Walter Reed and Bethesda, where they continue to receive state-of-the-art care as inpatients.

It is when they leave inpatient status that the system has failed them. A recent series of Washington Post articles described deplorable living conditions, failure to account for, and bungled administrative processing of injured troops in outpatient status at the Walter Reed Army Medical Center. New reports indicate that these problems are not confined to Walter Reed. They exist elsewhere in the military and Department of Veterans Affairs (VA) medical systems. Washington Post reporters Dana Priest and Anne Hull are to be commended for bringing this tragic situation to light.

The Army now has acted to move soldiers out of a worn, aging facility that should never have been used to house wounded soldiers. These heroes deserve far better than that. They all volunteered for service in our military forces, with great hopes and dreams for their futures. Now they are faced with the daunting task of figuring out how to live with lifetime disability, a condition they incurred in service to our Nation.

It appears that the Army, especially the leadership at Walter Reed, was slow to recognize the need to increase the number of caseworkers and experienced noncommissioned officers (NCOs) to keep pace with the increased number of outpatients under their care. These NCOs and case managers are critical for assisting injured soldiers in making and keeping medical appointments, for accounting for and tracking of these soldiers during rehabilitation

and recuperation, and assisting them as they process through the disability evaluation system.

The Army is now hiring more case managers and bringing in additional NCOs to help these injured soldiers and their families navigate the health care system, and to ensure that these soldiers have a decent quality-of-life while they continue to recover from their injuries. The Army is also establishing a new command structure at Walter Reed that will be focused on taking care of wounded soldiers in an outpatient status. Good leadership should have taken those steps long ago, without prompting by a series of embarrassing news articles.

Senior officers are being held accountable for failures of leadership that led to these conditions. Unlike his predecessor, who fired only those who disagreed with him, Secretary of Defense Robert Gates has moved quickly to remove senior officials when he lost confidence in them because their actions did not measure up. Our soldiers will benefit as a result of Secretary Gates's decisive action to insist on accountability.

While the Army appears to be taking the necessary steps to repair and evacuate substandard buildings and hire additional staff to assist wounded soldiers, the more daunting task is to change an overly complex, bureaucratic, adversarial system used to evaluate and rate disabilities of injured servicemembers, and we are going to hear more about that this morning.

Last Friday, four colleagues and I visited Walter Reed and talked with a number of these wounded soldiers and their families. By and large, they had praise for the inpatient health care that they received and, despite our personal observation of substandard living conditions for the outpatients, they did not complain. What they were most concerned about is the military's disability evaluation system. Many of these soldiers have extremely complex injuries that take many operations and a long time to heal. For some this process takes more than a year. Once they get to the point where their doctors tell them that further medical care will not improve their condition and it is determined that they are not fit for duty, most of these wounded soldiers just want to go home and get on with their lives.

It is at this point in their treatment that they encounter the Department of Defense (DOD) disability evaluation system. This system places these soldiers in the position of having to fight for a disability rating that entitles them to medical treatment. After all they have been through, these injured soldiers should not feel that they have to fight for what we as a Nation have a moral obligation to provide.

One soldier with whom I talked had been injured by an improvised explosive device (IED) blast while on his second tour of duty in Iraq. He is continuing to receive care for his injuries in an outpatient status. He understands that he is no longer physically fit for military duty because of the seriousness of his injuries. He told me that he is "scared to death" that the physical disability evaluation system will rate his disability at less than 30 percent and therefore he would not receive a medical retirement, although he is going to be discharged, and that he would be "put on the street,"

in his words, without the ability to take care of his family and their medical needs, including his four children.

How can we as a Nation ask our young men and women to serve, and when they are wounded while serving put them in a position where they are scared to death that we will not take proper care of them and their families? Surely we must change such a system.

The problems are not over for these disabled veterans when they leave the military. After a servicemember is medically discharged or separated, he or she can apply for disability compensation and health care through the VA. The VA conducts its own assessment of the degree of disability of the veteran. Although the VA and DOD use the same standard for evaluating disabilities, their disability ratings often vary significantly and in most cases the VA disability rating is higher than the military disability rating. Unfortunately, only the military disability rating counts when determining whether the member is medically retired with family health care benefits or medically discharged with no benefits for his or her family, and that is extremely frustrating and confusing for our wounded servicemembers and their families, who then have to fight the system to get the best rating that they can.

I commend Secretary Gates for quickly recognizing that we are falling short in our obligation to our wounded servicemembers and, in a unique statement that he made of gratitude to the reporters who broke the story, said that he was very disappointed that we did not identify it ourselves. He added very accurately that our servicemembers “battled our foreign enemies; they should not have to battle an American bureaucracy.”

Senator Akaka, the chairman of the Committee on Veterans Affairs, and I and our ranking members, Senator McCain and Senator Craig, are determined that our committees will work together to improve the care of our veterans throughout their continuum of care. We will hold a joint hearing of our two committees in the near future to identify the remedies to the problems that our wounded soldiers are facing.

The American people are deeply angry about the shortfalls in care. The war in Iraq has divided our Nation, but the cause of supporting our troops unites us. We will do everything we possibly can do, not as Democrats or Republicans, but as grateful Americans, to care for those who have served our Nation with such honor and distinction.

Senator McCain.

STATEMENT OF SENATOR JOHN McCAIN

Senator McCAIN. Mr. Chairman, I want to thank you for calling this very important hearing. The revelations over the past week have been distressing to the Nation. I am dismayed this ever occurred. It was a failure in the most basic tenets of command responsibility, to take care of our troops.

This is even more troubling because we have reason to believe that the Army learned from the headlines of poor conditions, inadequate medical treatment, and bureaucratic delays for the wounded at Fort Stewart 3 years ago. You will recall that Acting Secretary of the Army Les Brownlee immediately visited Fort Stewart and initiated remedial action within the Army. By 2004, hundreds of

additional medical and administrative personnel had been mobilized and new regional centers established throughout the country to accommodate soldiers in medical holdover status.

In 2006, my colleague, Senator Graham, then chairman of the Subcommittee on Personnel, sought assurance from two of our witnesses today, Doctors Chu and Winkenwerder, that our Government was doing everything possible to ensure that wounded, once they get off the battlefield with the best medicine known in the history of warfare, do not fall through the cracks. Today I hope we will hear from Dr. Chu and Dr. Winkenwerder where we have failed.

Our Nation is blessed with a magnificent team of military and civilian doctors and nurses who care for our wounded. I think it is very important that we recognize and support their efforts. At the same time, we must demand accountability for the failure to take appropriate actions and move aggressively to take corrective action.

Senior Army leaders were defensive in the face of these revelations at Walter Reed, and were quick to lay blame for these failures on NCOs. Frankly, I find that appalling.

To the soldiers who spoke out and their families, you have our gratitude for your service and your courage. We should also be grateful to the Washington Post reporters who brought this to our attention.

Mr. Chairman, there are more questions to be answered. Is Walter Reed just the tip of the iceberg? How many other Building 18s are in the Army, the Navy, the Marine Corps, and the Air Force? What improvement projects at Walter Reed had a higher priority than basic life and safety improvements for wounded soldiers? What complaints were received by the Army and DOD inspectors general relative to conditions at Walter Reed, and what actions were taken? How did the base realignment and closure (BRAC) impact the decisions leaders in the Army and at Walter Reed made with regard to outpatient facilities?

We also have a responsibility to ensure that there is a future for our wounded that is better than the past. If legislation is necessary, we will pursue it. Systems and institutions must change. We utilize 21st century medical technology to save lives at a rate far greater than at any time in our Nation's history, yet Cold War processes to determine compensation and the ability to continue to serve. There have to be better ways to address the medical and disability evaluation systems for those who cannot continue on Active Duty due to their disabling conditions.

The Army leadership must continue to do what it has just begun, bring more resources to bear on helping wounded warriors and their families. They deserve nothing less.

Secretary Gates has introduced welcome change to the DOD. It is my sincere hope that through his leadership we will build on the quality and strength in our system today, but we must make right the wrongs that our wounded have endured in what has occurred and ensure accountability at all levels, all levels.

There is no more important responsibility than to act on our moral obligation as a Nation to those who are willing to give their blood for its freedom. Let us be guided by the words of President George Washington in 1789, who said: "The willingness with which

our young people are likely to serve in any war, no matter how justified, shall be directly proportional as to how they perceive that veterans of earlier wars were treated and appreciated by their country.”

Thank you, Mr. Chairman.

Chairman LEVIN. Thank you, Senator McCain.

Secretary Chu.

**STATEMENT OF HON. DAVID S.C. CHU, UNDER SECRETARY OF
DEFENSE FOR PERSONNEL AND READINESS**

Dr. CHU. My colleagues and I have prepared statements that I hope you would accept for the record.

Chairman LEVIN. We will.

Dr. CHU. Thank you, sir.

Mr. Chairman and Senator McCain, I am deeply chagrined by the events that bring us to this hearing this morning.

We set high standards for personnel actions in the DOD, and as you have celebrated in the quality of clinical care, starting on the battlefield and coming all the way back to our inpatient facilities here in the United States. Thanks to that care, as you reported, the United States enjoys the lowest disease and non-battle injury rate in the history of military actions by this Republic, and the highest rate of survival by the wounded that we have ever achieved. Indeed, the overall TRICARE health program enjoys high positive ratings from its beneficiaries and those have led Congress to add additional groups to the coverage under that program.

Where we have fallen short in administration, in billeting, in the processing of disability evaluation claims, I want to apologize this morning on behalf of DOD to the individuals concerned and to the American public. We need to maintain the same high standards in these areas that we have achieved in others.

If I may, Mr. Chairman, I would like to defer to my colleagues to testify to the medical issues and then return to the long-term issue at the conclusion of their opening statements that you have raised, and that is the disability evaluation system. You and Senator McCain have both spoken to this important subject. I think General Schoomaker would be next.

[The prepared statement of Dr. Chu follows:]

PREPARED STATEMENT BY HON. DAVID S.C. CHU

Mr. Chairman and distinguished members of this committee, thank you for this opportunity to discuss care for injured servicemembers and the administrative processes for restoration to duty or separation from military service.

We provide extraordinary medical services, on the battlefield, in transport to facilities outside of the theater, and in clinical centers here in the United States. With the advent of operations in Afghanistan and Iraq, our medical care systems mounted an enormously effective trauma treatment response. More of those suffering traumatic injuries were saved; in years past they might have succumbed to their wounds instead.

I will defer to Dr. Winkenwerder’s discussion of the specifics of medical care, but I wish to underscore that I share his distress with the significant administrative problems at Walter Reed. On behalf of the Department, I apologize to the servicemembers and to the American public.

We did not meet our standards as we should. The various review panels now being organized will help establish what occurred and the adequacy of remedial actions. Permit me to turn to the other issues of interest to the committee, starting with the Department’s disability system.

DEPARTMENT OF DEFENSE DISABILITY SYSTEM

The Right Paradigm

Does this Nation have the right paradigm in place military disability compensation? We have diverse approaches in the public sector to problems that have much in common. Social Security's disability payments, the Department of Labor, Workmen's Compensation, the Department of Veterans Affairs' (VA) and the Department of Defense's (DOD) disability evaluation system (DES) are carried out in different ways, against different standards, to achieve different ends. Perhaps foreseeing this issue, Congress in 2003 directed the establishment of the VA Disability Benefits Commission. Its report is expected October 2007, and it may help us understand how to achieve unity of effort and purpose.

Department of Defense Disability Evaluation System

The citizens of the United States have a long and proud history of compensating servicemembers whose opportunity to complete a military career has been cut short as the result of injuries or illnesses incurred in the line of duty. Congress mandated the development of a system of rating military disabilities in 1917 and over time that system has been further refined to the benefit of servicemembers and their families. The Career Compensation Act of 1949 formalized the code the military departments utilize today. In addition to DOD disability compensation, former servicemembers may be eligible for disability compensation benefits through the VA. A key difference between the DOD and VA disability systems is that the Services only award disability ratings for medical conditions that make the individual unfit for continued military service, whereas the VA may rate any change in health status that can be linked to the time the member was in Service regardless of whether it was disabling enough to preclude continued service. Military disability ratings are fixed upon final disposition, while VA ratings can increase over time when the condition worsens.

Now, as in the past, the DOD remains committed to providing a comprehensive, fair, and timely medical and administrative processing system to evaluate our injured or ill servicemembers' fitness for continued service using the DES. The overarching legislative guidance for the DOD DES is set forth in statute in chapter 61 of title 10 of the U.S.C. Since the inception of chapter 61 in 1949, the Department has provided additional policy guidance. Ultimately, Secretaries of the military departments have exercised this title 10 authority consistent with their roles and missions. However, the Department does mandate military department DES include four elements: medical/physical evaluation, appellate review, counseling, and final disposition.

Title 10 mandates that each servicemember determined to be unfit be afforded the right to a full and fair personal appearance and hearing. To ensure due process, Department policy requires Secretaries concerned to utilize a series of medical and administrative boards.

The evaluation process begins with the medical evaluation board (MEB). The MEB is typically generated by a physician when a servicemember has an unresolved medical condition or injury which precludes him or her from being classified as fit for full duty. The MEB documents the medical diagnosis(es), course of treatment, prognosis and any duty limitations of the servicemember. The MEB process serves to protect the health of the servicemember. But it may be the basis for referral to the physical evaluation board (PEB) process if the MEB calls into question the individual's fitness for continued military service. The PEB is a performance-based process composed of two board types referred to as informal and formal PEBs. Formal PEBs typically consist of three board members but board composition and membership is established by the individual Service Secretaries. The PEBs review a variety of medical evidence and performance information to adjudicate the impact of the servicemember's medical condition his ability to reasonably perform the duties of his or her office, grade, rank, or rating. The informal board is a record review process without representation whereas the formal board provides a personal appearance opportunity with legal representation. If the servicemember's case proceeds to a formal hearing, he or she is encouraged to utilize legal assistance, provided by the Service or retained by the servicemember at personal expense. The formal hearing is a non-adversarial proceeding designed to ensure fairness, equity, and due process.

Physical Evaluation Board Adjudication

On the basis of a preponderance of the evidence, the PEB determines whether the individual is fit or unfit (i.e., does not meet medical retention standards) for continued military service with one of four possible disposition recommendations: return to duty, separate from the Service, placement on the temporary disability retired

list, or permanent disability retirement. As a product of the PEB process and according to title 10, servicemembers found unfit for continued military service will be awarded a disability rating percentage, for the military unfitting condition, in accordance with the rating guidance established in the VA Schedule for Rating Disabilities. This disability rating determines entitlement to separation or retirement benefits.

Timely Disability Evaluation System Adjudication

The Department's DES timeliness standards were established in 1996 based on a 1992 DOD Inspector General recommendation. When a physician initiates a MEB, the processing time should normally not exceed 30 days from the date the MEB report is dictated to the date it is received by the PEB. Upon receipt of the MEB or physical examination report by the PEB, the processing time to the date of the determination of the final reviewing authority as prescribed by the Secretary of the Military Department should normally be no more than 40 days. One can easily see that the timeliness of the adjudication of each DES case is dependent upon a myriad of factors, e.g. the severity of the injury, the recovery process, administrative documentation, and due process concerns.

According to the military departments, the average adjudication period for MEB/PEB cases is now longer because the cases are more complicated as a result of the types of injuries servicemembers are sustaining in current combat operations. In 2004, in order to mitigate this formal board phenomenon, the Army Physical Disability Agency established a mobile PEB to augment its capacity to conduct formal boards at their three fixed PEB sites. This has helped the Army accommodate its increased case load. Reserve component servicemembers' cases occasionally take longer because private practitioners are involved in documenting the cases. The Army reports that its overall timeliness rates are above the DOD goal; this is attributed to the complexity of injuries and the challenges in collating case files for Reserve component soldiers.

It may be difficult for the individual servicemember to differentiate between the medical inpatient/outpatient recovery phase and the administrative MEB/PEB processes. This creates the impression of long processing times caused by MEBs/PEBs when, actually, the servicemembers could still be receiving medical and convalescing care for their injuries.

Let me also emphasize that during this process of health care, convalescent care, rehabilitation, and MEB/PEB review, servicemembers are in receipt of full pay and allowances. The system is designed not to rush a decision. I assure you our servicemembers' best interests are at the heart of the system. But we need to communicate better the purposeful and deliberate intent of the DES to our servicemembers and their families.

Update on the Government Accountability Office findings

The 2006 Government Accountability Office (GAO) report, "Military Disability System: Improved Oversight Needed to Ensure Consistent and Timely Outcomes for Reserve and Active Duty Servicemembers" concluded that disability ratings are consistent between Active and Reserve components. The report could not determine if dispositions were consistent, and lacking data on preexisting conditions, it called for stronger oversight. In response, the Department revitalized its Disability Advisory Council (DAC) so that it plays an active and strengthened role in molding Department DES policy.

Revitalization Efforts

In a self-policing effort, the Military Departments' Personnel Chiefs and Surgeons General recommended we charge the DAC with updating the set of DOD directives/instructions that promulgate disability policies. The Department has also tasked this group with strengthening oversight processes and making recommendations on program effectiveness measures. The Department has established working groups, under the Disability Advisory Council, consisting of senior human resource and medical subject matter experts from the military departments and OSD agencies to address the GAO recommendations on training, oversight and consistency of application. We anticipate revised DOD instructions will be completed in May 2007.

In addition to our DOD-level initiatives, the military departments are also continually reviewing their processes to make them more effective. For example, Army leadership recently established a Physical DES Transformation Initiative which integrates multiple major commands and the VA. This combined effort targets improving process efficiency and timeliness in areas such as: MEB and PEB processes, automation of disability data, counseling and training, and transition assistance. Additionally, in November 2006, the Army directed an internal Inspector General review of its DES process. I understand that the report is due out this fall.

QUALITY-OF-LIFE PROGRAMS FOR SEVERELY INJURED

Military Severely Injured Center

The Department is committed to providing the assistance and support required to meet the challenges that confront our severely injured and wounded servicemembers and their families during the difficult time of transition. Each Service has programs to serve severely wounded from the war: the Army Wounded Warrior Program (AW2), the Navy Safe Harbor program, the Air Force Helping Airmen Recover Together (Palace HART) program, and the Marine4Life (M4L) Injured Support Program. DOD's Military Severely Injured Center augments the support provided by the Services. It reaches beyond the DOD to coordinate with other agencies, to the nonprofit world, and to corporate America. It serves as a fusion point for four Federal agencies—DOD, the VA, the Department of Homeland Security's Transportation Security Administration (TSA), and the Department of Labor.

Federal Partners

The Military Severely Injured (MSI) Center unites Federal agencies through a common mission: to assist the severely injured and their families.

- The VA Office of Seamless Transition has a full-time liaison assigned to the center to address VA benefits issues ranging from expediting claims, facilitating VA ratings, connecting servicemembers to local VA offices, and coordinating the transition between the Military and the VA systems.
- The Department of Labor has assigned three liaisons from its REALifelines program which offers personalized employment assistance to injured servicemembers to find careers in the field and geographic area of their choice. REALifelines works closely with the VA's Vocational Rehabilitation program to ensure servicemembers have the skills, training, and education required to pursue their desired career field.
- The Department of Homeland Security's TSA has a transportation specialist assigned to the center to facilitate travel of severely injured members and their families through our Nation's airports. The Center's TSA liaison coordinates with local airport TSA officials to ensure that each member is assisted throughout the airport and given a facilitated (or private) security screening that takes into account the member's individual injuries.

Nonprofit Coordination

The MSI Center has coordinated with over 40 nonprofit organizations, all of which have a mission is to assist injured servicemembers and their families. These nonprofits offer assistance in a number of areas from financial to employment to transportation to goods and services. Many are national organizations, but some are local, serving Service men and women in a specific region or at a specific Military Treatment Facility. Some of the many organizations that are providing assistance are the Wounded Warrior Project, the Injured Marine Semper Pari Fund, the Veterans of Foreign Wars, the American Legion, Disabled American Veterans, the Coalition to Salute America's Heroes, and, of course, the Service Relief Societies. There are hundreds of other non-profits who offer assistance to military families in general that are part of the America Supports You network (www.americasupportsyou.mil).

Operation Warfighter

DOD sponsors Operation Warfighter (OWF), a temporary assignment or internship program for servicemembers who are convalescing at military treatment facilities in the National Capital Region. This program is designed to provide recuperating servicemembers with meaningful activity outside of the hospital environment that assists in their wellness and offers a formal means of transition back to the military or civilian workforce. The program's goal is to match servicemembers with opportunities that consider their interests and utilize both their military and non-military skills, thereby creating productive assignments that are beneficial to the recuperation of the servicemember and their views of the future. Servicemembers must be medically cleared to participate in OWF, and work schedules need to be flexible and considerate of the candidate's medical appointments. Under no circumstance will any OWF assignment interfere with a servicemember's medical treatment or adversely affect the well-being and recuperation of OWF participants.

In 2006, 140 participants were successfully placed in OWF. Through this program, these servicemembers were able to build their resumes, explore employment interests, develop job skills, and gain valuable Federal Government work experience to help prepare them for the future. The 80 Federal agencies and sub-components acting as employers in the program were able to benefit from the considerable talent and dedication of these recuperating servicemembers. Approximately 20 permanent

job placements resulted from OWF assignments upon the servicemember's medical retirement and separation from military service.

The core of OWF is not about employment, however; placing servicemembers in supportive work settings that positively assist their recuperation is the underlying purpose of the program.

Heroes to Hometowns

The American public's strong support for our troops shows especially in their willingness to help servicemembers who are severely injured in the war and their ever-supportive families, as they transition from the hospital environment and return to civilian life. Heroes to Hometowns' focus is on reintegration back home, with networks established at the national and State levels to better identify the extraordinary needs of returning families before they return home. They work with local communities to coordinate government and nongovernment resources necessary for long-term success.

The Department has partnered with the National Guard Bureau and the American Legion, and most recently the National Association of State Directors of Veterans Affairs, to tap into their national, state, and local support systems to provide essential links to government, corporate, and nonprofit resources at all levels and to garner community support. Support has included help with paying the bills, adapting homes, finding jobs, arranging welcome home celebrations, help working through bureaucracy, holiday dinners, entertainment options, mentoring, and very importantly, coordinated hometown support. Currently, Heroes to Hometowns assistance has been provided to 156 families in 37 States and 2 territories.

Many private and nonprofit organizations have set their primary mission to support severely injured veterans. The Sentinels of Freedom in San Ramon, California, for example, recruits qualifying severely injured to their community with "scholarships" that include free housing for 4 years, an adaptive vehicle, a career enhancing job, educational opportunities, and comprehensive community mentoring. Through a coordinated effort among local governments, corporations, businesses, nonprofits, and the general public, six scholarships have already been provided in the San Ramon Valley and plans are to expand the program nationwide.

Paralympics

The ability of injured servicemembers to engage in recreational activities is a very important component of recovery. We continue to work with the United States Paralympics Committee and other organizations so that our severely injured have opportunities to participate in adaptive sports programs, whether those are skiing, running, hiking, horseback riding, rafting, or kayaking. We are also mindful of the need to ensure installation morale, welfare, and recreation (MWR) fitness and sports programs can accommodate the recreational needs of our severely injured servicemembers. At congressional request, we are studying current capabilities of MWR programs to provide access and accommodate eligible disabled personnel.

The United States Olympic Committee Paralympics organization is also coordinating with key Military Treatment Facilities to see how severely injured sports and recreational opportunities can be expanded and incorporated into all aspects of the recovery, rehabilitation, and reintegration process. The Department is coordinating with other organizations such as the Armed Forces Recreation Society to provide similar opportunities to severely injured veterans on the municipal and local levels, even possibly partnering with colleges and universities to take advantage of those facilities and recreational programs.

THE WAY AHEAD

Earlier I requested the DOD Inspector General (IG) perform an independent review, evaluating our policies and processes for injured Operations Enduring Freedom/Iraqi Freedom servicemembers. The objective is to ensure they are provided effective, transparent, and expeditious access to health care and other benefits when identified for separation or retirement due to their injuries. I expect to receive the IG report by July 2007.

In compliance with the National Defense Authorization Act for Fiscal Year 2005, the Joint Medical Readiness Oversight Committee (JMROC) was established to improve medical readiness throughout the DOD and enhance servicemember health status tracking before, during, and after military operations. The JMROC oversees medical readiness issues by using a Comprehensive Medical Readiness Plan. Initially consisting of the 22 actions required by the National Defense Authorization Act for Fiscal Year 2005, the Department is expanding that list to include readiness initiatives emanating from the National Defense Authorization Acts for Fiscal Years

2006 and 2007. I believe the JMROC can assist the Department in implementing improvements to support our injured servicemembers.

As the various reviews reach their conclusions, I hope that we can reach a national consensus on the integration of Federal disability systems affecting our Nation's veterans and how they can be improved. I look forward to working with you to develop the best way to provide for the men and women who stepped forward to defend this Nation and were injured in its service.

Chairman LEVIN. General Schoomaker.

STATEMENT OF GEN PETER J. SCHOOMAKER, USA, CHIEF OF STAFF, UNITED STATES ARMY

General SCHOOMAKER. Mr. Chairman and distinguished members of the committee, I cannot tell you how disappointed and how absolutely angry I am to have to sit before you today and to stand accountable for what has occurred in the United States Army. I agree with your statement and the statement of the ranking member. I think that the military health care system, particularly the Army, one I am very familiar with, is full of the most professional, most caring medical professionals in the world, and I hope that we make sure that as we address the shortcomings here that we recognize the heroic work that is taking place by all of the men and women who are taking care of our wounded warriors and their families throughout this process.

Now, we have discovered shortcomings that were brought to our attention by the media. We should have known about these things ourselves and we are finding out why we did not. But I will tell you that I accept full responsibility and accountability for these shortcomings because I am the senior uniformed officer in the Army, just like I accept responsibility for everything that happens in the Army and fails to happen. That is the tradition of military service and accountability, and I stand before you accountable for what has occurred.

I will tell you that we all run in a bureaucratic morass. Life every day in this system is like running in hip boots in a swamp. It sucks the energy out of you every day, and not just in the medical system, but in everything else that we do. I hope that as we take a look at this that we look broadly at the kinds of things that we can do to bring all of this into the 21st century, because that is the challenge that I believe we all face and I believe it is a national security issue.

I would like to describe very quickly the things that we have done and are doing immediately to rectify and bring into standards and tolerance the situation that we find not only at Walter Reed, but across the United States Army system. First of all, we put a new leader in command at Walter Reed, Major General Eric Schoomaker. He took command last Friday and was on the ground within hours of taking charge. His deputy commander will be announced. He is being selected as I speak, and will be announced this week. He will be a combat arms brigadier general that will work for Major General Schoomaker and will assist in making sure that the proper care is being taken in an administrative and military way for our soldiers.

The Wounded Warrior Transition Brigade commander and command sergeant major, both combat arms soldiers-leaders, have been selected and are on the ground, and are taking charge of ac-

countability for health and welfare issues. The new brigade structure that we have approved out there is being manned.

A one-stop soldier and family assistance center has been established at Walter Reed and this brings together in one place the case managers, family coordinators, personnel and finance experts, Army Wounded Warrior Program representatives, Red Cross, Army community services, Army emergency relief, and VA representatives.

Additionally, we are establishing a hot line from across the Army directly into the Army operations center, which means that anybody can call in on a toll-free number and report directly into our operations center problems that they are having within the system so that the leadership will have direct access and immediate knowledge of what is occurring.

We have launched a tiger team of medical installation professionals to our major medical treatment facilities Army-wide to assess the outpatient care and to report back to the Army leadership within 30 days. We will launch a similar team early next week to assess outpatient care at our eight community-based health care organizations, which are locations where our Reserve component soldiers are given the opportunity to recover and rehabilitate closer to their families and their homes.

The Vice Chief of Staff of the Army will host a video teleconference this Friday with hospital commanders of those treatment facilities with major outpatient populations to get an assessment of their programs and need for resources.

All wounded soldiers, save those on leave or that are departing within the next few days, have been moved to Building 14, which was renovated in July 2005, on the Walter Reed campus. This will put all wounded soldiers on the Walter Reed compound. State-of-the-art Internet capability computers, television, and phones are being added to each room in Building 14 and those same accessories will be provided to all wounded soldiers out there.

We are pursuing a patient advocate, an ombudsman, program at Walter Reed and other major installations for soldiers. Additionally, for the soldiers we have a central issue point for uniforms for all wounded soldiers, centralized distribution system for all donated goods, have made improvements to the dining facility so that wounded soldiers can more easily access it, and are ensuring that awards that have been earned are expeditiously presented and as rapidly as possible.

There are many other things that we are doing outside Walter Reed specifically and for the purposes of brevity I will stop here. Again I want to recount that I stand accountable for what has occurred in the Army and all of our energy is going into make sure that the proper actions are being taken to correct it.

Thank you very much.

[The prepared statement of General Schoomaker follows:]

PREPARED STATEMENT BY GEN PETER J. SCHOOMAKER, USA

Mr. Chairman, Senator McCain, and distinguished members of the committee, thank you for this opportunity to discuss the outpatient care of our Nation's wounded warriors at Walter Reed Army Medical Center, and throughout our Army. Every leader in our force is committed to ensuring that Army health care for America's soldiers is the best this Nation can provide. From the battlefield through a soldier's

return home, our priority is the expedient delivery of compassionate and comprehensive world class medical care.

I am here today as the Chief of Staff of the U.S. Army. I can tell you, I have never been prouder than I am today to serve with our incredible soldiers, who motivate me every day and who remain the focus of everything we do as an Army.

As Americans, we treasure the members of our All-Volunteer Force who have raised their right hand to say, "America, in your time of need, send me. I will serve." We instinctively understand that in return for their service and sacrifice, especially in a time of war and demanding operational tempo, we owe them a quality of care that is at least equal to the quality of service they have provided to us.

I have visited Army medical facilities around the world, and I have met with soldiers, staff, and patients in Iraq and Afghanistan; at Landstuhl, Germany; at installations across the United States, to include Walter Reed and Brooke Army Medical Centers. Without exception, the people I encounter inevitably remind me that the United States is a special Nation, blessed with incredible sons and daughters who are willing to serve. From the wounded soldiers I meet, whose bodies have been hurt, but whose spirits remain strong, to loved ones whose tender attention and tireless dedication are easing our warriors' path to recovery, to the medical staff who have devoted themselves to fulfilling the promise of our Army's Warrior Ethos that we will never leave a fallen soldier; I have witnessed unparalleled strength, resilience, and generosity, and I am humbled by their bravery. Even if all of our facilities were the best in the world, and every process, policy, and system were streamlined perfectly, our soldiers and families would still deserve better. Without a doubt, they deserve better than we have been providing to date.

Today we have 248,000 soldiers deployed in more than 80 countries around the world. When injured or wounded, every one of those soldiers begins a journey through our medical treatment facilities with the top-notch care delivered by Army medics, surgeons, nurses, and civilians in the forward operating facilities. There, our soldiers receive extraordinary acute care that has drastically lowered our died-of-wounds rate, and is regularly cited as being without peer.

But it is after the incredible lifesaving work has been done, and the recovery process begins, that our soldiers are subjected to medical processes that can be difficult to negotiate and manage. Due to a patchwork of regulations, policies, and rules—many of which need updating—soldiers and staff alike are faced with the confusing and frequently demoralizing task of sifting through too much information and too many interdependent decisions. To compound this challenge, we have not optimally managed Army human and capital resources to assist wounded soldiers and their families. Some of our counselors and case managers are overworked and have not received enough training yet. At times, we do not adequately communicate necessary information. We must make better progress in improving our administrative processes. Some of our medical holding units are not manned to the proper level and some of our leaders have failed to ensure accountability, discipline, and the well-being of our wounded soldiers. We need to improve our maintenance of some of our facilities. Most of these issues we can repair ourselves, and we are working aggressively to do so. Some others may require your support and assistance to resolve.

We have identified and fixed a number of problems, but there is still much to do. The Army has launched a wide-ranging and aggressive action plan to address current shortfalls, both at Walter Reed and across our Army. We are committed to rapidly fixing these problems, and are focusing our efforts in four key areas: soldier welfare, infrastructure, medical administrative processing, and information dissemination.

At Walter Reed, we have made significant progress in repairing and improving conditions at Building 18. We have also accelerated improvements to the medical hold organizations and medical processes and are expediting the identification and implementation of ways to improve the Physical Disability Evaluation System across the force.

We are reorganizing the Walter Reed medical hold unit by establishing a wounded warrior transition brigade, creating an additional medical hold company, and increasing its permanent party personnel to ensure we have the right numbers of leaders with the right skills to properly take care of our outpatient wounded soldiers and their families. We have selected a command-experienced, promotable lieutenant colonel and command sergeant major who will lead this organization. We are assigning more platoon sergeants who possess greater tactical leadership experience and are re-establishing the Walter Reed Garrison Command Sergeant Major position to provide the right level of skilled, caring leadership our wounded soldiers and their families deserve.

To assist with outpatient care and reduce the delays in the medical and physical evaluation process, we are adding more personnel, improving their training, and ad-

justing our medical and administrative processes. We are expediting the reassignment and hiring of an additional 34 case managers and 10 physical evaluation board liaison officers to handle the increased patient load at Walter Reed. We have improved the physical, administrative, and medical transition of patients between the hospital and the medical-hold task force, and have implemented a revamped clinic appointment system for our outpatient wounded warriors. Additionally, a complete review of the medical and physical evaluation process is underway.

Addressing the emotional, physical, and administrative challenges our wounded warriors and their families face is a major area of emphasis. In addition to the improvements to our outpatient care and administrative processes, we have assigned Army officers to meet and escort the families of our wounded warriors from local airports to Walter Reed. To assist with their needs at Walter Reed, we are creating a streamlined "one-stop shop" Soldier and Family Assistance Center, have hired additional bilingual staff, and have increased counselor availability at the Mologne House. Finally, the Army has implemented the U.S. Army Wounded Warrior Program, which provides long-term support of our seriously wounded soldiers to help them be self-sufficient, contributing members of their communities.

Let me conclude by reiterating that Army Medical care is the best in the world. Each day selfless, dedicated Army doctors, nurses, and support staff perform miracles to save lives and limbs, and provide the best possible care for our wounded warriors and their families. We will do what is right for our soldiers and their families. They can be assured that the Army leadership is committed and dedicated to ensuring that their quality of life and the quality of their medical care is equal to the quality of their service and sacrifice.

On behalf of the nearly 1,000,000 soldiers that comprise our Army—and our wounded warriors and their families in particular—I appreciate the committee's concern for these critical issues, and for Congress' continuing support of soldiers and their families. Army Strong!

Chairman LEVIN. Thank you very much, General Schoomaker.

Now, Secretary Chu, who did you plan on speaking next?

Dr. CHU. Dr. Winkenwerder, next General Kiley, then I will come back on the disability evaluation system issue.

Chairman LEVIN. Dr. Winkenwerder, thank you.

Secretary Winkenwerder.

**STATEMENT OF WILLIAM WINKENWERDER, JR., M.D.,
ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS**

Dr. WINKENWERDER. Yes, sir, Mr. Chairman. Mr. Chairman, distinguished members of this committee, thank you for the opportunity to be here today to talk about the serious concerns that have been raised with regard to housing conditions and inappropriate bureaucratic delays and hurdles for our servicemembers at Walter Reed and for others that might be caught up in a similar circumstance elsewhere.

Our wounded servicemembers and their families expect and they deserve quality housing and family member support, along with well-coordinated services. In the case of the incidents at Walter Reed, we failed them. Today I welcome the chance to talk about these issues and what DOD is doing to move forward.

As you have just heard, corrective action plans in the Army and DOD are already initiated, but they will take the following approach. First, the top priority is on finding and fixing problems. Where policy or process or administrative change is required, DOD will do it.

Second, we welcome public scrutiny, even when it is critical and it is painful to hear. Problems cannot be solved and the people cannot be properly served if issues are not brought to light, and this process is doing that. I think all of us here endorse the statements of Secretary Gates. He has made it clear that defensiveness and ex-

planations are not the route to getting things done. Standing up, making things happen to meet the needs of our servicemembers and their families is our only responsibility right now.

I would assess the problems before us as follows. There are the physical facility issues we have heard about, there is a process of disability determinations, and then there is the process of care coordination. I will not speak about the substandard housing because, as you have just heard, the Army has already begun to correct that problem. Obviously, a wider review is needed across all Services and I think that is already underway.

With respect to disability determinations, let me just say that the servicemembers deserve fair, consistent, and timely determinations. Complex procedures must be streamlined or they have to be removed. The system must not be adversarial. I think you made an excellent point. It should not be adversarial, and the system has just got to improve.

Likewise, coordination of services. There must be a higher ratio of case managers to wounded servicemembers to ensure personalized care, better support, communication with families, and simpler processes. No servicemember should ever have to work through a maze or a gauntlet, or be on his or her own to figure things out. That is just unacceptable.

Let me address one thing, importantly, and make this clear. The problems cited in the press reports are not the result of unavailable or insufficient resources, nor are they in any way related to the BRAC decisions to close the Walter Reed campus as part of the planned consolidation with the National Naval Medical Center in Bethesda. I know there is a concern about that and we will be happy to answer questions during this hearing about that.

Significant resources have always been available and we continue to invest at Walter Reed for whatever is needed. For example, there were some, I might note, who questioned the decision in 2005 to fund \$10 million to construct a new Walter Reed amputee center. Yet we proceeded with this, and the new center will open in a few months. That was absolutely the right decision. We will not allow the plans for the new medical center to interfere with ongoing issues of care or needed improvements.

Secretary Gates's decision to establish an independent review group to evaluate and make recommendations on this matter will be very beneficial in my judgment. The group is highly qualified, it is a bipartisan team of former Congressmen, line, medical, and enlisted leaders. They have already begun their work.

Let me just say this. The entire Department has been informed of the review group's charter. Group members can go to any installation, talk to any personnel, and review any policy to get the information and answers they need. They will have the Department's full support.

DOD will be driven for results in its actions in the weeks ahead, engaged, action-oriented, and focused on making real and permanent improvements. Findings and actions will be shared with the public, the people we serve, the servicemembers, their families, military leaders, Congress, the Secretary of Defense, and the President. They all deserve to know that the job is getting done.

We have attacked problems in the past, solved them, and come out stronger as a result, and we can do that again. We have established, as Dr. Chu has noted, new standards in virtually every category of wartime medicine and also, I might add, in other areas of everyday medicine in America. The quality of our medical care for our servicemembers is excellent. There is no question about that.

But with regard to these issues, which are quality-of-life—and in my judgment they are equally important as quality of care, equally important—we have not met our own standards. In the current reports on Walter Reed, the trust that has been earned through our great achievements has been damaged. We have to re-earn that trust and that is our job.

Let me just say one final thing in closing and that is that as we all work together on these issues, maintaining the morale of those who care for our warriors and maintaining the confidence of our entire military in this system is critically important. It is important that people believe that they are going to get the care that they need, no matter if it is on the battlefield, in the hospital, after the hospital, or when they are in the VA. I just urge that we are sensitive and careful about that concern of keeping up our morale.

I look forward to working together with you, Mr. Chairman, and with leaders within the Services and DOD in the remaining weeks of my tenure in this important effort. I am grateful, really grateful, to have had the opportunity to have worked with the selfless and committed professionals and patriots who care for and support our Nation's heroes. These heroes deserve our very best.

Thank you, Mr. Chairman.

[The prepared statement of Dr. Winkenwerder follows:]

PREPARED STATEMENT BY HON. WILLIAM WINKENWERDER, JR., MD, MBA

Mr. Chairman, distinguished members of this committee, thank you for the opportunity to discuss the Military Health System, and in particular to address the concerns raised in recent news media reports regarding treatment of servicemembers at Walter Reed Army Medical Center.

Our wounded servicemembers and their families deserve coordinated professional health care services—both clinical and administrative—together with quality housing and family member support. In the case of the incidents cited at Walter Reed, the Department did not meet our patients' expectations, and we did not meet our own expectations.

I want to address the events associated with the media reports and internal findings regarding substandard housing for some of the servicemembers receiving outpatient, long-term rehabilitative care, and the administrative delays and hassles associated with the military's disability process.

I would first like to outline the principles that underlie the Department's approach in addressing this problem.

- We welcome public scrutiny, even when it is critical. Perhaps especially when it is critical. In this case, the Department accepts the fundamental premise of the reports by the Washington Post that unacceptable conditions existed at Walter Reed for some of our servicemembers.
- Where change is required, the Department will make it. The focus will be on understanding and fixing the problems using a systems approach. As Secretary Gates has stated, persons who allowed these conditions to persist will be held accountable. Yet, several of the issues identified cut across organizational boundaries, and our greatest attention will be to introduce change to the processes by which we support our servicemembers and families.
- Our military health system is a unique, national asset. It must be preserved. As we engage on this issue using the skills and talents of our people to solve the problems, we must act carefully to preserve the morale and trust of our dedicated caregivers.

CONTEXT WITHIN THE LARGER MILITARY HEALTH SYSTEM: MEDICAL SUPPORT TO
SERVICEMEMBERS

We serve over 2.2 million members in the Active, Reserve, and Guard components, to include over 251,000 servicemembers deployed overseas, and another 7 million families, and retirees. Over 9 million Americans are entrusted to our care—and in both battlefield medicine and traditional health care delivery here at home, we are excelling in our mission. Based on data, measures, and independent assessments by health care organizations around the country, the performance of our military medical personnel on the battlefield and in our medical facilities in the United States has been extraordinary. We have established new standards in virtually every major category of wartime medicine, and many areas of peacetime medicine:

- **Lowest Disease, Non Battle Injury Rate.** A testament to our medical readiness and preparedness, our preventive medicine approaches and our occupational health capabilities, we are successfully addressing the single largest contributor to loss of forces—disease.
- **Lowest Death to Wounded Ratio.** Our agility in reaching wounded servicemembers, and capability in treating them, has altered our perspective on what constitutes timeliness in lifesaving care from the “golden hour” to the “platinum 15 minutes.” We are saving servicemembers with grievous wounds that were likely not survivable even 10 years ago.
- **Reduced Time to Evacuation.** We now expedite the evacuation of servicemembers following forward-deployed surgery to stateside definitive care using airborne intensive care units and the latest technology, we have been able to move wounded servicemembers from the battlefield to hospitals in the United States in as little as 48 hours.
- **Our medical professionals have provided high quality medical care, and indicators of quality compare very favorably with national benchmarks.** The Department of Defense (DOD) Patient Safety Program is a national model, and efforts to reduce and eliminate medical errors have achieved ground breaking results.

We are also ensuring our servicemembers are assessed before deployments, upon return and then again 90–180 days after deployment. These health assessments provide a comprehensive picture of the fitness of our forces, and highlight areas where intervention is indicated. For example, we’ve learned that servicemembers do not always recognize or voice health concerns at the time they return from deployment. By checking with them 3 to 6 months later, we’ve found that about half of them report physical concerns, such as back or joint pain, and a third of them have mental health concerns. As of January 31, 2007, 212,498 servicemembers have completed a post-deployment health reassessment with 31 percent of these individuals receiving at least one referral for additional evaluation.

We have introduced an Individual Medical Readiness measure that provides commanders with a picture of the medical readiness of their soldier, sailor, airman, and marine down to the individual level.

We have worked closely with our partners in the Department of Veterans’ Affairs (VA), in our shared commitment to provide our servicemembers a seamless transition from the military health system to the VA. DOD implemented a policy entitled “Expediting Veterans Benefits to Members with Serious Injuries and Illness,” which provides guidance on the collection and transmission of critical data elements for servicemembers involved in a medical or physical evaluation board. DOD began electronically transmitting pertinent data to the VA in October 2005 and continues to provide monthly updates, allowing the VA to better project future workload and resource needs. Receiving this data directly from DOD before these servicemembers separate eliminates potential delays in developing a claim for benefits by ensuring that VA has all the necessary information to award all appropriate benefits and services at the earliest possible time.

Here in the United States, our beneficiaries continue to give the TRICARE program high marks in satisfaction. Military health system beneficiaries’ overall satisfaction with medical care in the outpatient and inpatient settings compares very favorably against national civilian benchmarks. The quality of our medical care is further attested to by such organizations as the Joint Commission on Accreditation of Healthcare Organizations that has recognized the excellence in our medical treatment facilities with ratings well above civilian averages.

Internationally, our medical forces have deployed with great speed, skill, and compassion. Their accomplishments in responding to international disasters has furthered our national security objectives; allowed us to constructively engage with a number of foreign nations; and saved civilian lives throughout the world.

Operating on the global stage, our medics—from the youngest technicians to the most experienced neurosurgeons—have performed in an exemplary manner in service to this country. We will make the necessary changes to our policies and processes, while remaining mindful of the skills, dedication, and courage of our medical forces.

IDENTIFYING THE WAY FORWARD

The set of issues addressed recently in the Washington Post deserve our immediate and focused attention. The Army and the Department have taken swift action to improve existing conditions, and enhance services provided at Walter Reed, and identify areas meriting further study and improvement. Army leadership initiated immediate steps to control security, improve access, and complete repairs at identified facilities and sought to hold accountable those personnel responsible to provide for the health and welfare of our Nation's heroes.

Most recently, Secretary Gates commissioned an independent review group (IRG) on March 1, 2007, to evaluate and make recommendations on this matter. The IRG shall conduct its work and report its findings to the Secretary of the Army, the Secretary of the Navy, and the Assistant Secretary of Defense for Health Affairs no later than April 16, 2007. The report will include:

- Findings of an assessment of current procedures involved in the rehabilitative care, administrative processes, and quality of life for injured and ill members, including analysis of what these heroes and their families consider essential for a high quality experience during recovery, rehabilitation, and transition.
- Alternatives and recommendations, as appropriate to correct deficiencies and prevent them from occurring in the future.

The Department will be relentless in its actions—engaged, action-oriented and focused on making measurable improvements. Goals will be clear and milestones will be established. We will regularly inform the people we serve—the soldiers, the families, military leaders, Congress, the Secretary, and President—on our progress. Findings and actions will be shared with the public.

We know that this approach works. It has been successfully employed in attacking other issues over the past—the development and implementation of pre- and post-deployment health assessments; clinical guidelines for psychiatric care; the development of stringent health information security measures and reporting processes; and the electronic collection of deployment health data.

AN ASSESSMENT OF THE ISSUES

There are a number of disturbing elements to the conditions at Walter Reed, yet I am confident that each of these items is fixable with sustained leadership and oversight. The Department, with the assistance of the Secretary's IRG, will come forward with revised approaches to addressing the more complex personnel and medical issues. I would categorize and assess the problems before us as follows:

Physical Facility Issues

In the case of substandard housing, the Army has been able to quickly implement a corrective action plan. Some of those actions have already occurred with facility repair and improvements. Clearly, other facility improvements may require more comprehensive repairs that may take longer. I am confident the Army and the Navy are taking steps to ensure that any needed improvements will be made.

Process of Disability Determinations

The critical first step in assessing this process will be to identify the desired outcome. We know that there are expectations that both the servicemember and the Department want:

- Full rehabilitation of the servicemember to the greatest degree medically possible;
- A fair and consistent adjudication of disability; and
- A timely adjudication of disability requests—neither hurried nor slowed due to bureaucratic processes.

The fundamental problems did not result from a lack of available resources. The main effort here must be focused on the processes being analyzed and assessed for their value and alternatives. The processes must be redrawn with the outcomes we have in mind, with as much simplicity and timeliness as possible.

Process of Care Coordination

Again, the quality of medical care delivered to our servicemembers is exceptional. This assertion is supported by independent review. Yet, the process of coordinating

delivery of care to servicemembers in long-term outpatient, residential rehabilitation needs attention. The Army will assess, and my office will review, the proper ratio of case managers to wounded servicemembers. The administrative and information systems in place to properly manage workload in support of the soldiers will also be assessed.

The planned consolidation of health services and facilities in the National Capital Region will enable the Department to best address the changing nature of inpatient and outpatient health care requirements, specifically the unique health needs of our wounded servicemembers and the needs of our population in this community. The BRAC decision also preserves a precious national asset by sustaining a high quality, world-class military medical center with a robust graduate medical education program in the Nation's Capital. The plan is to open this facility by 2011. In the interim, we will not deprive Walter Reed of resources to function as the premier medical center it is. In fact, in 2005 we funded \$10 million in capital improvements at Walter Reed's Amputee Center—recognizing the immediate needs of our warrior population. We are proud of that investment in capacity and technology. We simply will not allow the plans for a new medical center to interfere with the ongoing facility improvements needed in the current hospital.

The Legacy of Military Medicine

Sustaining a medically ready military force and providing world-class health services for those injured and wounded in combat remains our primary mission.

In the current spate of news reports on Walter Reed, the trust that we have earned through our other many medical achievements has been damaged. Everyone's efforts will be focused on repairing and re-earning that trust.

Our civilian and military leaders have remained steadfast in both their support of what we have accomplished, and their belief that these matters can be fixed. U.S. military medicine and our medical personnel are a national asset, representing a readiness capability that does not exist anywhere else, and—if allowed to dwindle—could not be easily reconstituted. We must preserve this asset.

As the problems that lie at the intersection of personnel issues with health care delivery are addressed, it is our shared responsibility to focus on the specific problems, and not the people who have done so much to improve the health of our military servicemembers. We are blessed with a rich cadre of dedicated, hard-working, skilled professionals. I have complete confidence that they will rise to the occasion again, as they have done in the past, learn from what went wrong, and build an even stronger, more responsive system for all.

After more than 5½ years of service as the Assistant Secretary of Defense for Health Affairs, I look forward to working together with you and with the leaders within the Services and DOD in the remaining weeks of my tenure to begin this effort at rebuilding this important part of our system that needs attention. I remain grateful for the opportunity to have worked with such selfless servants that comprise the military health system.

Chairman LEVIN. Thank you, Secretary Winkenwerder.

General Kiley, you are next, and then we will go back to Dr. Chu.

**STATEMENT OF LTG KEVIN C. KILEY, USA, SURGEON
GENERAL, UNITED STATES ARMY**

General KILEY. Thank you, Mr. Chairman, distinguished members of the committee. I am Lieutenant General Kevin Kiley, the Army Surgeon General, Commander of U.S. Army Medical Command (MEDCOM), and I am accountable for health care in the U.S. Army MEDCOM. A commander's first responsibility is the health and welfare of his soldiers. A physician's first responsibility is the health and welfare of his patients. As we have seen in the last couple weeks, we have failed to meet our own standards at Walter Reed. For that I am both personally and professionally sorry and I offer my apologies to the soldiers and families, the civilian and military leadership of the Army and DOD, and to the American people.

It is also clear that this complex, bureaucratic, administrative medical evaluation board (MEB), physical evaluation board (PEB)

process is in need of urgent simplification and I am dedicated to doing whatever in my power and authority to make positive change to this process. Simply put, I am in command. I am accountable, and I share in the failures, and I also accept the responsibility and the challenges for rapid corrective action.

As General Schoomaker has already outlined, the living conditions and welfare of soldiers, the responsiveness of our leaders and enhanced support services for our families are in evolution and in place as we speak. We are also beginning to put into effect long-term change to help with some of the bureaucratic medical evaluation processes that are impacting on our soldiers.

We have addressed the living conditions at Walter Reed. General Bob Wilson and my team are out, as the chief has alluded to, inspecting other installations to assure we do not have these similar issues at other installations. But we do have human problems, too, human systems problems, and that is about soldiers and families. American soldiers go to war with the confidence that if they are injured they can come back through a system that will care for them every step of the way, to include in particular Walter Reed Army Medical Center, and in fact, to date, that record has been outstanding.

They say a soldier will not take an objective out of sight of a medic, and by extension Walter Reed, both inpatient and outpatient care, is an extension of our trust with our combat soldiers, and nothing can be allowed to shake that confidence. Secretary Gates has made it very clear that he expects decisive action. He and our soldiers will get it.

As we have heard, the disability compensation and transition system is complex, confusing, and frustrating. It is further compounded by the exceedingly complex nature of the injuries that our young men and women are suffering, and the Army MEDCOM has been working with the Army to begin changing it to make it more responsive to soldiers and to reduce the confrontational and adversarial form that it presently has.

We are making the adjustments at Walter Reed. As we have announced, we are increasing staff to improve ratios and communications. But we really need to reinvent this entire process and we are in the process of doing that now. We want to take care of our soldiers fully, giving them time to heal and then carefully documenting their conditions to give them best outcomes through the disability process.

Our Army's medical professionals have earned a tremendous reputation during this war and this is a result of three factors: first, the dedicated, talented, caring professionals at our facilities, to include and in particular Walter Reed, and across the rest of the military system, many of whom have already served in Iraq and Afghanistan.

Second is the application of cutting edge technology to save lives on the battlefield and return them home safely.

Third and equally important has been the exceptionally strong support of Congress and the American people in this effort.

It is regrettable that you and the American people have had to learn these issues at Walter Reed through the Washington Post. That is something we should have known, I should have known,

and we should have been working on it immediately. But the light has been shed on this and, to be clear, having made those mistakes, we are taking immediate action and establishing future actions to correct it and prevent it from happening again.

I am committed to fixing it. I am personally committed to regaining the trust and confidence that our soldiers everywhere, and I, and the American people have had in Army medicine.

I appreciate the opportunity to speak to the committee today. Mr. Chairman, I look forward to answering your questions.

[The prepared statement of General Kiley follows:]

PREPARED STATEMENT BY LTG KEVIN C. KILEY, USA

Mr. Chairman, Senator McCain, and distinguished members of the subcommittee, thank you for the opportunity to discuss recent media reports about the living conditions, accountability procedures, medical care, and administrative processing of soldier-patients receiving recuperative or rehabilitative care at Walter Reed Army Medical Center (WRAMC) as outpatients. The leadership and staff of WRAMC are committed to providing world-class care for our wounded warriors and we are all upset by the problems detailed in the Washington Post series.

Let me begin by informing you that in the past 2 weeks I have directed three separate investigations into various problems raised by the Washington Post articles. First, prior to the articles being published, I asked the U.S. Army Criminal Investigation Division to open an investigation into allegations of improper conduct by Dr. Michael Wagner, the former Director of WRAMC's Medical and Family Assistance Center (MEDFAC). The Washington Post published these allegations on Tuesday, 21 February 2007. In addition, I directed two more investigations. The second investigation will look specifically at the execution of command responsibility by the WRAMC Medical Center Brigade and the WRAMC Garrison Command to ensure safe, healthy living conditions for our recovering Warriors. The final investigation will look into WRAMC's internal Medical Evaluation Board (MEB)/Physical Evaluation Board (PEB) processing. The intent of these investigations is to uncover systemic breakdowns in our processes and to improve our system of care for wounded warriors. Once these investigations are complete, we will report back to you on our findings and our actions.

Since 2002, WRAMC has provided highly personalized health care by treating more than 6,000 soldiers from Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). Nearly 2,000 of these soldiers suffered battle injuries, more than 1,650 of whom started their care at WRAMC as inpatients—receiving life-saving medical treatments, needed surgeries and physical therapy then progressed to outpatient status living near the hospital. A team of 4,200 medical professionals treat these wounded warriors and dedicate their lives and hearts to helping our soldiers. On average, more than 200 family members also join them to help with recovery, provide emotional support, and offer a strong hand or a warm hug to carry them through difficult days.

The requirement to assign soldiers to Medical Holding Units (MHU) is dictated by internal Department of Defense (DOD) regulations. The Army policy for assigning soldiers to MHUs is intended to support the needs of the individual soldier and his/her family. Soldiers with long-term debilitating conditions such as spinal cord and brain injuries or terminal cancer fall into this category and require intensive medical and administrative management only available at the MHU. In certain circumstances a soldier may be assigned to a MHU while undergoing outpatient treatment when the Military Treatment Facility Commander determines that continuous treatment is required and that the soldier cannot be managed by his or her unit, i.e., is unable to perform even limited duty at the unit.

Army military treatment facilities have two types of MHU. Active component soldiers whose medical condition prevents them from performing even limited duty within their unit are assigned to a medical hold company. Each Army hospital with inpatient capability is authorized a medical hold company. Generally speaking, a majority of soldiers assigned to medical hold companies have medical conditions that will eventually lead to separation from Service or medical retirement. Since 2003, Reserve component soldiers who cannot deploy, are evacuated back to the U.S. during their units' deployment, or return home with a medical condition are assigned to a medical holdover company. At WRAMC, both companies are organized under the Medical Center Brigade, which also has command responsibility for permanent party and students assigned or attached to WRAMC.

The current conflict is the longest in U.S. history fought by volunteers since the Revolution. Two dozen soldiers arrive each week and remain on the campus an average of 297 days for active duty, and 317 days for Reserve and National Guard. Often the very first thing they ask when they are able to speak is “when can I get back to my guys?”

The rehabilitation process at Walter Reed is also unique in its focus to restore these wounded soldiers not just to a functioning level in society, but to return them to the high level of athletic performance they had before they were wounded for continued service in the U.S. military if possible. This is the stated goal of the WRAMC program, as well as the newer program at the Center for the Intrepid which was modeled after the Walter Reed successes.

The amputee population deserves special note as an example of these initiatives. There have been a total of 552 soldier members who have suffered major limb amputation in the war. Of these, 432 of the patients were cared for at WRAMC: 394 servicemembers from OIF (68 with multiple amputations) and 38 servicemembers from OEF (6 with multiple amputations). There have been 35 amputee patients with major limb loss who were found fit for duty (17 that are Continuation on Active Duty/Continuation on Active Reserve and 18 remaining to complete the Medical Board process). Five of the 17 soldiers have returned to serve on the front lines in Central Command. All of the soldiers were monitored and supported by medical hold or medical holdover companies during their rehabilitation at Walter Reed.

It is important to note that, with the exception of burn patients, WRAMC cares for most of the critically injured soldiers. Our Brooke Army Medical Center and its new state-of-the-art rehabilitation center, cares for many critically injured soldiers with units or home of record in the southwest. The complexity of the injuries and illnesses suffered by these soldiers often results in a recovery period that is longer and more challenging than those cared for at most other DOD facilities. This places significant stress on the soldier-patient, their families, and the staff providing care. The media reports about inadequate living conditions brought to light frustrations with billeting and the administrative processes necessary to return these warriors to duty or to expeditiously and compassionately transition them to civilian life. I would like to address three problem areas reported in the Washington Post series: Living conditions in Building 18; accountability management of outpatient-soldiers; and, administrative processing of MEBs and PEBs.

BILLETING ISSUES AND LIVING CONDITIONS IN BUILDING 18

As soldiers are discharged from inpatient status, many need to remain at WRAMC for continued care. Historically, the combination of permanent party soldier barracks, off-post lodging, and three Fisher Houses have been sufficient to meet the normal demand for billeting soldiers assigned to the MHU at WRAMC. Beginning in 2003, the population of Active and Reserve component soldiers assigned to WRAMC's MHU increased from 100–120 before the war to a high of 874 in the summer of 2005. To accommodate this increase in outpatient-soldiers, WRAMC made use of all 199 rooms in the Mologne House—a nonappropriated fund hotel on the installation opened in 1996; 86 rooms in 2 buildings operated by the Mologne House; 30 rooms in 3 Fisher Houses; and, 15 contract hotel rooms in the Silver Spring Hilton. With the exception of Building 18, all of these facilities have had extensive renovations performed over the last 10 years and have amenities similar to many modern hotels.

In the summer of 2005, WRAMC began housing the healthiest of the outpatient-soldiers in Building 18—a former civilian hotel across the street from the main WRAMC campus. Building 18 was constructed in 1969 and leased periodically by WRAMC until the government acquired the building in 1984. Between 2001 and 2005, more than \$400,000 in renovations were made to Building 18. In 2005, a \$269,000 renovation project made various improvements in all 54 rooms to include replacing carpeting and vinyl flooring. Additional upgrades to the central day room included a donation of a pool table and the command purchase of couches and a large flat screen TV.

The healthiest of our outpatient-soldiers are assigned rooms in Building 18 after careful screening by the chain of command, case managers, and treating physicians. Patients who have trouble walking distances, have post-traumatic stress disorder, or have traumatic brain injuries are not allowed to live in Building 18.

Building 18 has 54 rooms. Whenever a new soldier was assigned a room, the building manager directed the soldier and his/her supervisor to identify any deficiencies or damage in the room and initiates work orders to repair identified problems. Additionally, residents and their chain of command may submit work orders through the building manager at any time. This entire process is being reassessed

to ensure proper accountability. Since February 2006, more than 200 repairs were completed on rooms in Building 18, repairs continue to be made, and a rapid renovation is planned.

In spite of efforts to maintain Building 18, the building will require extensive repairs if it is going to continue to remain in service. Upon reading the Washington Post articles, I personally inspected Building 18. As noted in the article, the elevator and security gate to the parking garage are not operational. Twenty-six rooms had one or more deficiencies which require repair. Two of these rooms had mold growth on walls. Thirty outstanding workorders have been prioritized and our Base Operations contractor has already completed a number of repairs. We are also working closely with U.S. Army Installation Management Command, the Army Corps of Engineers, and our health facility planners to replace the roof and renovate each room.

There are currently no signs of rodents or cockroaches in any rooms. In October 2006, the hospital started an aggressive campaign to deal with a mice infestation after complaints from soldiers. Preventive medicine specialists inspected the building and found rooms with exposed food that attracted vermin. Removing the food sources and increased oversight by the chain of command has since brought this problem under control, although such problems require vigilant monitoring, which is ongoing.

ACCOUNTABILITY AND INFORMATION FLOW TO OUTPATIENT-SOLDIERS

As of 16 February 2007 WRAMC had a total of 652 Active and Reserve component soldiers assigned or attached to two MHUs. Currently there are 450 Active component soldiers assigned or attached to WRAMC's Medical Center Brigade. There are 202 Reserve component soldiers assigned or attached. Platoon sergeants and care managers are key to accounting for, tracking, and assisting soldiers as they rehabilitate, recuperate, and process through the disability evaluation system. Prior to January 2006, WRAMC only had a single medical-hold company to provide command and control, and accountability for all of those soldiers. Since January 2006, the hospital created new organizational structures to decrease the soldier-to-platoon sergeant and soldier-to-case manager ratio from 1 staff member for every 125 soldiers, to 1 platoon sergeant and 1 case manager for approximately 30 soldiers.

Platoon sergeants and case managers attend staff training every Thursday. The training consists of various topics ranging from resource availability to soldier services. Weekly Thursday training is supplemented with a platoon sergeant/case manager orientation program. Departing platoon sergeants work along side their replacement for approximately 1 week. Reserve component case managers attend a 1-week training program at Fort Sam Houston Texas for an overview of the Medical Holdover Program, MEB/PEB process, customer service training and the duties of a case manager. Upon arrival at WRAMC, these case managers undergo a month-long preceptor program. Once hired by WRAMC, these case managers undergo a 1-week training program to address organizational structure, MEB/PEB process, case manager roles and responsibilities, use of data systems, administrative documentation, convalescent leave and available resources in the hospital and on the installation, as well as expectations and standards. There is also a weekly clinical meeting held with physician advisory board and case managers for chart reviews and recommendation for the MEB process. Where ever possible we are working to streamline and merge platoon sergeant and case manager training to make it identical for all new personnel such as incorporating the preceptor concept for both Medical Hold and Medical Holdover units. We will also enhance the weekly training to introduce topics that are not only important to the platoon sergeant and case manager but address recurring issues/concerns raised by soldiers and family members.

We are conducting a 100-percent review of the discharge planning and handoff process to ensure the transition from inpatient to outpatient is seamless and patients understand the next step in their recovery. This discharge will now include a battle handoff to a platoon sergeant. We are also in the process of hiring additional case managers and will submit plans to increase other critical positions in the Medical Center Brigade, which will reduce the current staff to outpatient ratio to more manageable levels, allowing more personalized service to the recovering soldier and family member in making appointments, completing necessary paperwork, and navigating the complex disability evaluation systems.

The MEDFAC will collocate functions performed by Human Resources Command, Finance, and Casualty Assistance into the MEDFAC allowing service in one location. In the near term, WRAMC will expand the staff to support the family members and relocate the operations to a more centralized 3,000 square feet space in the hospital providing an improved environment for the families to obtain assistance.

The Medical Center Brigade recently established a Soldier and Family Member Liaison Cell to receive feedback from soldiers and family members. A recent survey of soldiers and family members in January 2007 indicated that less than 3 percent of the outpatient-soldier population voiced complaints about administrative processes. The command will continue to enhance the structure of the soldier and family member liaison cell. We have requested three family life consultants from the Family Support Branch of the Community and Family Support Center, Installation Management Command to expand the resources available to identify areas of interest as well as provide counseling support to soldiers and family members. We also will expand the current survey feedback process to include an intake survey for soldiers and family members, a monthly town hall meeting and survey for ongoing issues, and an outtake survey upon the departure of soldiers and family members. This feedback will be reviewed by the WRAMC Commander and other key leaders.

The Mologne House has approximately 30 personnel on staff that speak Spanish. These personnel work in all departments and a number of them are in management positions. These personnel have been assisting the Spanish speaking soldiers and their families since the hotel opened. The Mologne House is taking steps to ensure the desk has a Spanish speaking staff member on call 24 hours a day to assist those in need of translation services.

Patients arrive at WRAMC by aero-medical evacuation flights three times a week—Tuesday, Friday, and Sunday. Additionally, some patients arrive at WRAMC on commercial flights for medical care. Family members may arrive with the soldier or through their own travel itinerary. Soldiers and family members who arrive on medical evacuation flights are met by an integrated team of clinical staff, MEDFAC, Red Cross, Patient Administration, Unit Liaison Noncommissioned Officers, and Medical Center Brigade representatives. Inpatients are triaged for further evaluation and disposition. Outpatients remain on the ambulance bus and are sent to the Mologne House with a representative from the Medical Center Brigade for billeting. Family members are met by MEDFAC and Red Cross and are escorted to the Mologne House for lodging.

Currently, there are 51 global war on terrorism inpatient casualties. Our census ranges between 30 and 50 depending on the volume of air evacuations (high of 359 in July 2003 to low since OIF began of 64 in November 2005). Roughly half of the patients come as inpatients, and half as outpatients. Outpatients are processed through the Medical Center Brigade for accountability and billeting when they arrive. Inpatients are accounted for by the hospital's patient administration office. We believe as many as one in five patients may be at risk to miss some of the administrative in processing at the Medical Center Brigade when they are discharged from the hospital, because of the timing of their discharge, their underlying medical condition, or miscommunication. I have directed a complete review of the discharge planning and the development of a new handoff process between the hospital and the Medical Center Brigade. This will include the development of a "Global War on Terrorism Discharge Validation Inventory" that will be completed by the attending physician, discharging nurse, discharging pharmacist, social worker, brigade staff, and hospital patient administration. The checklist will be validated by the Nursing Supervisor, Attending Physician, Deputy Commander for Clinical Services (DCCS) or Deputy Commander for Nursing.

Each soldier receives a handbook upon assignment or attachment to Med Hold or Med Holdover. The Med Hold handbook is provided to soldiers when they are assigned or attached by their respective platoon sergeant. Newly arriving family members receive a Hero Handbook as well as a newcomer's orientation binder. Family members attend a weekly new arrival meeting, and a weekly townhall meeting where information is exchanged to answer questions or discuss ideas. PEB Liaison Officers (LOs) conduct monthly training sessions on the MEB/PEB process for soldiers and family members. A Case Management booklet with frequently asked questions is also provided to soldiers.

ADMINISTRATIVE PROCESSING OF MEBS AND PEBS

The MEB/PEB process is designed with two goals in mind: (1) to ensure the Army has a medically fit and ready force; and (2) to protect the rights of soldiers who may not be deemed medically fit for continued service. This process was designed to support a volunteer Army with routine health occurrences and it is essentially a paper process. We can and will improve this process in order to ensure that it can support a wartime Army experiencing large numbers of serious casualties.

The average Reserve component soldier assigned to Medical Holdover at WRAMC has been with us for approximately 289 days. We know from past experience they will be with us, on average, for 317 days from the time they are assigned to the

Medical Holdover Company. The primary reason for this lengthy stay is the requirement that each soldier be allowed to achieve “optimal medical benefit”—in other words, heal to the point that further medical care will not improve the soldier’s condition. All humans heal at different rates and this accounts for the longest part of the process.

Once the treating provider determines the soldier has reached the point of optimal medical benefit the provider will initiate an MEB. This is a thorough documentation of all medical conditions incurred or aggravated by military service, and ultimately concludes with a determination of whether the soldier meets medical fitness standards for retention. If the treating provider and the hospital’s DCCS agree the soldier does not meet medical fitness standards, the case is referred to the PEB.

The PEB is managed by U.S. Army Human Resources Command and is comprised of a board of officers, including physicians, who review each MEB. The role of the PEB is to evaluate each medical condition, determine if the soldier can be retained in service, and, if not retainable, assign a disability percentage to each condition. The total disability percentage assigned determines the amount of military compensation received upon separation. It is important to note that the MEB/PEB process has no bearing on disability ratings assigned by the Department of Veterans Affairs (VA), but thorough and complete documentation of medical conditions is essential for expeditious review by the PEB and will also aid the soldier in completing VA documentation requirements.

The Washington Post articles provide anecdotal experiences of soldiers and families who have had medical records and other paperwork lost during the MEB/PEB process. All medical records at WRAMC are generated electronically. However, paper copies must be printed since the PEB cannot access the electronic medical record used by DOD hospitals.

There are currently 376 active MEB/PEB cases being processed by the WRAMC PEB LOs. The average time from initiation of a permanent profile to the PEB is 156 days. The MEB is processed through the PEB and Physical Disability Agency for an average of 52 days (including the 15 percent of cases returned to the hospital for further information). Thus, the total time from permanent profile to final disability rating is currently 208 days. At present, WRAMC has 12 trained PEB LO counselors. We are hiring an additional 10 counselors and 4 MEB review physicians to expedite the medical board process. It takes at least 3 months to train a PEB LO counselor and these employees are the main interface between the soldier and the MEB/PEB system. As you might imagine, PEB LO counselors need to have excellent interpersonal and communication skills to perform well in a system that can be very stressful for the soldier, family, and counselor.

In closing, let me again emphasize my appreciation for your continued support of WRAMC and Army medicine. The failures highlighted in the Washington Post articles are not due to a lack of funding or support from Congress, the administration, or the DOD. Nor are they indicative of the standards I have set for my command. Walter Reed represents a legacy of excellence in patient care, medical research, and medical education. I can assure you that the quality of medical care and the compassion of our staff continue to uphold Walter Reed’s legacy. But it is also evident that we must improve our facilities, accountability, and administrative processes to ensure these systems meet the high standards of excellence that our men and women in uniform so richly deserve. Thank you again for your concern regarding this series of articles.

Chairman LEVIN. General Kiley, thank you very much.

Back to you, Dr. Chu.

Dr. CHU. Sir, thank you. Let me underscore at the outset a point that General Schoomaker made, and that is we recognize that to deal properly with these cases we need several echelons of support in DOD. That is the reason a year ago we established the Military Severely Injured Center as a backstop to the Services’ programs. It has a 1-800 number which any family or any servicemember can call 24 hours a day, 7 days a week. It is the place in which we try to bring together the Services and the several government agencies that deal with these issues—Department of Labor, Transportation Security Agency, and the VA. It has been one of the elements we have used to ensure there are VA representatives in our major clinical centers.

It has been our agent in helping establish the Heroes to Hometowns program, in which we partner with local organizations, with the American Legion, with the State VA apparatus, to ensure that when the service person returns home there is a sponsor, there is the kind of support the country properly expects.

I want to thank Congress for its actions in support of these multi-echelon efforts. As one example, in your National Defense Authorization Act for Fiscal Year 2007 you granted the authority we sought to allow us to award to the service person the equipment that we provide them on Active Duty under our computer electronics accommodations program.

But you raised, Mr. Chairman and Senator McCain as well, I think the fundamental issue that I hope this debate will allow us to address. That is the adequacy, the structure, the nature of the Nation's disability programs for injured servicemembers. As you appreciate, we have a variety of different programs that support these members, the principal ones being those in the DOD, but also, as you cited, the VA and the Social Security Administration. These proceed from different statutory authorities. They have somewhat different purposes and, as you have noted, they reach somewhat different conclusions about individual cases.

It is not surprising to us that individuals in the system find it frustrating and difficult to navigate. I believe the ultimate question here is whether the country has the right paradigm or whether we should try to bring these programs together. That is the question ahead of us; answering that question I believe we will benefit from the several review groups that have been appointed, both those constituted within the last several days and those appointed earlier.

As you recall, sir, Congress mandated there be a commission on veterans disability benefits. It is scheduled to report in October of this year with its findings and we have been supporting its deliberations.

Within the existing system, DOD has begun revitalizing how we deal with these issues. We are in the process of revising the instructions that apply to the program as it stands today, the program that we administer, and the Services are addressing their issues, because these programs are run by each military department on a decentralized basis, I would point particularly to the Army's transformation initiative in this regard.

I am confident, with the energy, the attention, the interest that is being paid to these programs, with your support for necessary statutory changes, that we can replicate for disability and disability evaluation the same success for the Nation that we have already achieved in our clinical services.

I thank you, sir, and look forward to your questions.

Chairman LEVIN. Thank you, Secretary Chu.

There has been a statement submitted for the record by the Veterans for America and that statement will be made part of the record.

[The information referred to follows:]



March 5, 2007

Chairman Levin, Senator McCain, Members of the Committee:

Thank you for the opportunity to submit a statement for this hearing.

The recent uproar over the treatment of returning service members at Walter Reed is not simply an issue of dilapidated physical facilities, mice and mold, or inadequacies with one hospital. The issue is much larger. Specifically, there is a systematic failure in both Department of Defense (DoD) and Department of Veterans' Affairs (VA) programs designed to address the medical and overall readjustment needs of war veterans. As one example, there appears to be no plan to gather robust consistent data and then closely monitor the 1.5 million deployed Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) service members as they return to duty or reintegrate into civilian society. As a result, we do not have an adequate understanding of the unique needs specific to our newest generation of veterans.

The controversy around Walter Reed reminds Veterans for America of the squalid conditions of the hospitals and the inadequacy of care for the returning service members more than 36 years ago. This topic was on the cover of the May 22, 1970 issue of *Life* magazine, which was the second-highest selling issue in the magazine's history.

Today, the same story is being repeated for a new generation of war veterans. The recent scandals were noticed by many when the *Washington Post* gave the issue national attention, but the alarm bell first rang in a 2003 series by Mark Benjamin, then with United Press International, for which I helped to provide key information.

With Benjamin's reporting, along with that of others, providing ample evidence of a broken, failing system, I am surprised that the nation has not expressed its outrage before now. That said, I am pleased that the Congress has begun to execute its oversight authority on this critical issue.

On March 5, 2007, the *Washington Post* reporters who published the series on the Walter Reed situation stated that they were flooded with e-mails, calls, and faxes from service members and veterans recounting similar experiences in military and veterans' hospitals across the country. It was clear to these reporters that the system has failed.

Veterans for America has also been dealing with tremendous numbers of service members, veterans, and their families reaching out to our organization for help. Too often we have encountered unresponsive agencies. We have been painfully aware of the distress that exists amongst service members and the need to address it. The situation requires immediate remedies, and the effort required will need commitment and

leadership from the upper echelons of our government – starting with you, our elected representatives.

The face of the American soldier has changed since Vietnam. The average age of the service members then was just over 19 years old. Today's military is much older. The average age of an active-duty soldier is twenty seven years. The Reserve and Guard soldier is even older: averaging thirty three years.

More than 155,000 women have served in Iraq and Afghanistan. Among their ranks are more than 16,000 single mothers. More than half of those deployed are married, and three out of every five deployed service members have family responsibilities (i.e., a spouse and/or children)

Recently the American Psychological Association released an excellent report stating that no serious study has yet been undertaken to define what these new factors mean in terms of the needs of returning service members and their families.

We are all too familiar with the failure to recognize the unique needs of each generation of veterans. For instance, it was not until a decade after the height of the Vietnam War that the Veterans Administration undertook the first study of Vietnam veterans. Years later the National Vietnam Veterans' Readjustment Study was commissioned. Post-traumatic stress disorder was not recognized as a mental health problem until 1980. We can only guess at the number of veterans whose lives were destroyed because no one understood their needs. In short, we failed an entire generation of veterans.

What's happening today is new chapter in an old book. We have yet to begin to recognize the true needs of the current generation and create programs and services appropriate to their war-related problems.

- What have multiple deployments meant?
- What are the implications of traumatic brain injury being the signature injury of this war?
- What are the effects of so many being constantly exposed to a high degree of violence?
- What does it mean to have the unprecedented survival rates of casualties?

These questions – and many more – need answering.

VFA is especially concerned that service members and veterans are not being provided the mental healthcare they need. There are a number of pressing issues:

- A dramatic rise in less than honorable discharges, and subsequent loss of VA healthcare and benefits,
- Overuse of “personality disorders” to discharge veterans (e.g., use of chapters 5-13, 5-17, 14-12),
- Rise in disciplinary problems related to alcohol and drug use, domestic violence, risk-taking behavior, motor vehicle violations, and other war-related reintegration issues,

- Inadequate staffing in mental health, Medical Evaluation Board-Physical Evaluation Board (MEB-PEB) case work, social work, family care and “seamless transition” programs into the VA network,
- Absence of consistently prompt mental health referrals as part of Post-Deployment Health Assessment process, and
- Absence of Alcohol and Substance Abuse Programs (ASAP) at all military bases.

To address these problems, VFA urges members of the Senate to consider co-sponsoring S. 117, the Lane Evans Veterans Health and Benefits Improvement Act of 2007 which:

- **Requires face-to-face medical exams.** DoD currently requires service members to answer a limited questionnaire to determine if they need to be referred for treatment. Soldiers are typically rushing to return home after a deployment and do not necessarily give these questions sufficient thought. DoD should instead conduct mandatory in-person physical and mental health exams with every service member 30 to 90 days after deployment.
- **Extends VA Mental Health Care.** Currently, the VA holds a two-year window to allow newly returning veterans to obtain free health care. Unfortunately, it can take many years for symptoms of PTSD and other mental health problems to manifest themselves. S. 117 provides a five-year window for veterans to receive a free assessment of mental health medical needs by the VA.
- **Defines the Global War On Terror (GWOT).** To accurately determine healthcare and benefit eligibility for returning service members, the GWOT needs to be explicitly defined in statute. Currently, the Secretary of Defense is not allowing some soldiers serving in GWOT territories to receive combat-related medical benefits.
- **Establishes a GWOT registry to track health care data.** Collect aggregate data on GWOT service members and veterans to monitor their healthcare and benefit use. The data will help lead to better budget forecasting and avoid shortfalls. A similar effort was undertaken after the Gulf War.
- **Requires equal transition services for Guardsmen and Reservists.** A 2005 GAO report found that demobilization for guardsmen and reservists is accelerated and these units receive insufficient transition assistance.
- **Requires Secure Electronic Records.** DoD should provide a full, secure electronic copy of all medical records at the time of discharge.

Again, Veterans for America appreciates the opportunity to submit a statement for this hearing. We reaffirm our desire to work with Congress and the relevant agencies in trying to address these critical needs. It will require a review of the basic social contract between our nation and those sent to war. Who is it that serves when the country goes to war? What do we owe these service members, before, during, and after deployment?

These are core value issues for the American society to decide. Those principles and values within our society must be clear to guide the necessary overhaul of how America responds to its service members.

Sincerely,

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Chairman LEVIN. Senator Pryor, I believe, has to chair a committee hearing and he wants to make a unanimous consent request.

Senator Pryor.

Senator PRYOR. I do have a statement for the record that I would just ask be entered into the record. Also I have a letter from a soldier from Arkansas who spent in and out about 2 years in Walter Reed after being injured in Iraq. Mr. Chairman, I just ask that be submitted for the record, and I want to thank you and Senator McCain for your leadership on this issue.

Chairman LEVIN. Thank you, and they will be made part of the record.

Senator PRYOR. Thank you.

[The prepared statement of Senator Pryor follows:]

PREPARED STATEMENT BY SENATOR MARK L. PRYOR

I would like to start by apologizing to our service men and women and their families—not just those who have suffered due to the conditions at Walter Reed, but all of our veterans and servicemembers across the country. This is unacceptable, period. It will be remedied, and remedied soon. That is why I joined my colleague, Senator Obama, in co-sponsoring the Dignity for Wounded Warriors Act. This legislation is an important first step, and I encourage this committee to mark it up and the full Senate to pass it soon.

When I read the Washington Post series, I couldn't help but think that we've failed our brave service men and women. Like my colleagues and most Americans, I was outraged and surprised to learn of the unacceptable conditions in Building 18 of the Walter Reed Army Medical Center. I've visited Walter Reed many times, even as recently as last month, and was never informed of the poor condition of Building 18. I didn't even know of the existence of Building 18. I guess I know why Building 18 was left off of my tour.

What kind of message are we sending to these young soldiers and their families when the hospital or medical facility has holes in the ceiling and black mold growing on the walls? These men and women have sacrificed so much to keep this nation safe and free. We owe it to them and their families to provide the very best medical care and treatment that this country has to offer. I refuse to believe that this is the best we can do.

As the President proposes to send another 21,500 brave American service men and women to serve overseas in Iraq and thousands of others prepare to serve our country elsewhere around the world, the condition of our medical facilities is even more crucial. We need to implement change quickly—not just at Walter Reed but at any and all of our Department of Veterans Affairs (VA) facilities that are in need of upgrades or repairs, in addition to our battlefield facilities. Although I've been to the VA facilities in Arkansas many times, after hearing the revelations about Walter Reed, I plan to visit again at the next available opportunity to ensure that I have the full picture of the facilities' strengths and shortcomings.

I am somewhat heartened to see that the Army is taking some responsibility for the failures at Walter Reed. Defense Secretary Gates has expressed his commitment to resolving this issue, and several officers with direct oversight of Walter Reed have either resigned or been fired. I would like everyone to know that I intend on holding Secretary Gates to his word, and I took forward to working with my colleagues to provide active oversight to ensure that this never happens again. I know my colleagues are as anxious as I am to move forward and find solutions to ensure that our overburdened VA system is able to care for all of our veterans—those just returning home and those who served us in previous military conflicts.

I want to thank the chairman and ranking member for holding this very important hearing. I want to thank our witnesses for being here. I know that you'll be asked some tough questions, but hopefully we can get to the bottom of this to make sure our service men and women get the best medical care our government can provide.

Letter from a constituent who spent roughly 2 years at Walter Reed Army Medical Facility.

“My overall medical care was good, I was happy with my doctors except by the time I would get use to them they would have to transfer out and I would get a new one in, I would have to go through everything all over again with them. I was very satisfied with my physical therapist Bob Barr, he was great, he went above and beyond to help me and my wife.

I don't feel there was enough support overall for the families or council for them, they were going through some horrible things along with the soldiers and there just wasn't anything going on to help them. My wife was with me almost 7 months helping me with my therapy and my overall emotional state at the time, we were with out her pay check and was running out of money, we were told to go to the family assistance center and they could help us, we talked to one of the workers there and he made me feel like we were having to beg for charity, I was upset over they way the Sgt was acting towards us so we left without their assistance.

I didn't feel the conditions inside the hospital were very sanitary, my floor in my room was dirty and the bathrooms had mold on the walls and floors were dirty.

When I finally was discharged to go to outpatient I was told to report to med hold, I was in a wheel chair at the time and had a hard time getting into the med hold building, it wasn't wheelchair friendly, my wife had to push me most everywhere we went and it was hard getting into most of the buildings. Once I found where I was suppose to go I found out they lost my paperwork and the Sgt that was in charge at the time was very rude, she informed me that she just came back from Kuwait after spending 3 months and that I was just a Spc and yes I had some traumatic injuries but I wasn't high on the priority list. I was furious by this point that a soldier that risk his life could be talked to in that manner. I went back to the hospital to find out who was a higher authority and I found Steve Springer who was assigned to me, he had personally sent my paper work to med hold. They lost my paper work a total of 3 times before I could get released to come home. It was hell trying to get out of there and back home. Pam left to come home in December 04, I had to be back at Walter Reed the first of Jan 05, I was moved to the Malone house and roomed with another soldier, my room was not handicap friendly, the shower was a regular stand up shower and to shower I have to take my prosthetic off so it made it hard for me. At this point I wasn't doing anything (no therapy) I started drinking out of bordom, there wasn't anything else to do, it got so bad that it seemed like I was drinking all the time, the stress of them holding me there for absolute no reason was causing alot of problems in my marriage, making me very depressed. I kept going to med hold and the med board trying to get them to see that it was costing them money to have me there when they needed the extra bed for other soldiers that needed to be there and that I could recoup better at home with my family.

This drug on for 5 months for no reason at all, like I said I wasn't doing anything but taking up space. I tried to get senior officials at the hospital to listen to me about the

things that were going on with the med hold process and keeping soldiers there that should have been home but they didn't want to listen to me. Finally Paul Wolfowitz's assistant helped me get through the red tape and got me home, tempers started getting a little worn and when I finally was retired out the Colonel that was in charge at that time personally gave me a hug and told me he hoped not to see me again. I didn't feel there was enough communication for the soldiers of where to go and what to do once they were released from inpatient to outpatient status. My wife, son and I were fortunate enough to stay at the Fisher house while they were there, Vivian Wilson was wonderful in making sure we were ok. We learned alot of information through the Fisher house and I felt we were at an advantage over the soldiers that were in other housing because the speakers that came to the Fisher house didn't go else where to inform. The first month Pam was there she had to stay at the Malonge house and it really made it rough because everything cost her out of pocket, all her food, washing and most the time the washers there were broken. There were Rats the size of a small dog running around the old buildings. Many times we would be going to the hospital while I was doing therapy, we would meet a soldier that didn't have family with them to help, struggling to wheel themselves up the hills to go back to the Malone house from the hospital, my wife would offer to help them. I felt there should have been some assistance for these guy's, there were shuttles but they only ran every 45 min's.

It would not have been too much to ask for someone to assist in pushing these guy's where they needed to go.

I know of others stories that have happened to soldiers while at Walter Reed that were not good experiences, problems with the same thing's such as med hold and the family assistance center because the mother or wife took off work to be there for their family member and could not get help with there bills at home. I will say without mentioning the name of the soldier, he had a bad experience at med hold with the same Sgt that I had problems with, her mouth just kept on, this guy lost his arm and he just got his prosthetic and was learning to use the hand, he had a hand full of papers and while in her office dropped them the Sgt smarted off "what do you need to do grow a new hand", needless to say he was furious.

Stuff like that went on alot while I was there. I'm not saying my whole experience there was terrible but it was just messed up.

When the med hold finally got straightened out I found out that I didn't even belong in the office where the smart mouthed Sgt was attached, that was for active duty, I was to report into National guard med hold, the officers there were much more helpful but it still took a long time to be discharged.

I hope this helps. If I can do anything else don't hesitate to call me.

Thanks,
Spc. Henry A Phillips"

Letter from a constituent detailing his experience at an active duty facility.

“Dear Senator Pryor:

I write this not that my case can be investigated, but that problems for other soldiers can be avoided and hopefully eliminated. I retired (Army Senior NCO) in October 1995, but I had an experience at Brooke Army Medical Center in San Antonio that I would like to share with you. I apologize for the lengthiness of this missive.

On June 24, 1994, I was scheduled for surgery for a hip fusion to be done. As I was on my way to the restroom before surgery, a brown mouse ran across the floor in front of me. I believe I was on the fourth floor. It took them about a week to get my body cast put on. One morning, I was taken to the cast room supposedly to have this down, and was left laying completely unattended for around four hours. I did get in a nice nap. My doctor, then a Major Arrington, was furious and jumped all over the people who had left me lying there unattended. I was taken back to my bed to wait a few more days to wait some more. For about 2 days, I had no appetite. I don't know whether the nurses charted that, and I don't remember being asked about it by the doctor. Now, while I was in the hospital, I received a shot of Heparin abdominally every evening. I had told them I had a history of post surgical blood clots, but when I was discharged a few days later, I was not given any medicine or instructions to avoid their occurrence. On my second night home, I awoke around 0200 with chest pain and difficulty breathing. My wife called an ambulance and though he didn't tell me, the paramedic knew I had a pulmonary embolism and thought I was going to die on the way to the hospital. After I arrived I was given a V/Q scan (may God spare you from ever experiencing that) and not one, but several blood clots showed up throughout both my lungs. Our family doctor showed up around daylight and advised my wife (Anita) to call my family b/c he did not think I would live another day. I was sent to what was then North Little Rock Baptist Memorial Medical Center, where a fine pulmonologist named Dr. Craig installed a Greenfield filter in my pulmonary artery. None of this would have been necessary if the staff at BAMC had simply done their jobs. I spent about a month in the Conway Hospital simply trying to survive. When Dr. Arrington called me and asked me why I had not come back for my followup appointment with him, I explained all this to him and told him I had been kind of busy just trying to stay alive. He did not have a whole lot to say in reply.

I sincerely hope they are being much more conscientious with our troops returning from Iraq and Afghanistan.

Once again, I apologize for being so lengthy. Thank you for listening.”

Chairman LEVIN. We will have an 8-minute first round.

When we visited Building 18 last week we were told that there were too few NCOs to take care of the assignment of the medical needs of the outpatient soldiers under their supervision and to do other things that needed to be done that they were required to do, including the health and welfare inspection of soldiers' rooms. We also learned when we visited Walter Reed last week that there was a backlog in work orders for the maintenance and repair in Building 18.

General Schoemaker, let me ask you, who in the chain of command should have been aware that there were no inspections going

on of soldiers' rooms and that there was a backlog in the work orders for maintenance and repair?

General SCHOOMAKER. At Walter Reed, the commander of Walter Reed is the ultimate authority there that should have known that. He is supported by a chain of command that supervise the soldiers on a day-to-day basis and he is supported by a garrison command whose job it is to manage the maintenance, et cetera, out there. So he had in my view adequate assistance on the ground out there, and in the exercise of commandership and leadership out there should have known this.

So should the Army have known it, though. I will tell you, I went through Building 18. Never even heard of it before. I went through it myself. There is nothing out there we could not have corrected with the proper attention, and we should never have had that problem.

Chairman LEVIN. General Kiley, were you aware of those two specific shortfalls, that they were not being conducted, the inspections of the soldiers' room, and that there was a backlog of workorders for maintenance of Building 18? Were you aware of those?

General KILEY. No, sir, I was not.

Chairman LEVIN. All right.

Dr. Winkenwerder, were you aware of those two shortfalls?

Dr. WINKENWERDER. No, sir, I was not.

Chairman LEVIN. Should you have been?

Dr. WINKENWERDER. Yes.

Chairman LEVIN. General, should you have been?

General KILEY. Certainly if the Walter Reed commander was having any difficulty executing the repairs of those I should have been aware of that. If General Weightman felt that I needed to know that, I should have been aware of it. But I am still accountable as his next higher commander.

Chairman LEVIN. General Kiley, General Weightman testified yesterday before the House that, "We had a system that probably was accurate about 80 percent of the time" as to the handing off of inpatients to outpatient care. That was the figure he used. About 20 percent of the time, he said, we did not do a good handoff of those patients from inpatient to outpatient. Would you agree with that percentage?

General KILEY. Sir, based on what he told me, yes, sir, because I would believe him.

Chairman LEVIN. Were you aware of it at the time?

General KILEY. No, sir.

Chairman LEVIN. Should you have been aware of it?

General KILEY. Yes, sir, as the commander I should be aware of that, particularly if it is an issue for General Weightman, to bring more resources to bear.

Chairman LEVIN. General Kiley, veterans advocates, lawyers, and servicemembers say that the Army is shortchanging our troops on the disability retirement ratings and they point to the fact that the same soldiers are more often being given higher disability percentages by the VA than they are by DOD, and this is particularly true, but not limited to, post-traumatic stress disorder (PTSD) and traumatic brain injuries (TBI).

Would you agree that we have been shortchanging troops in that area, those two areas particularly?

General KILEY. Senator, I have said on multiple occasions that the emergence of PTSD and the emergence of particularly mild TBI is a very complex process that we are only now in the last year or 2 beginning to realize how to diagnose and treat. I would agree that it is very difficult for the disability system of DOD to recognize the nuances, if I can use that term. It is very clear to me in talking to soldiers even as recently as last week that the present disability system recognizes something as fundamental as a missing limb, but does not appreciate or take into account the whole man theory, that the PTSD this soldier may have, or TBI, may be as significant or more significant for their future.

So I agree that we have an issue there and I think we need to take that on.

Chairman LEVIN. In that respect, our failure to take those problems into account, would you say we have been shortchanging some soldiers?

General KILEY. Yes, sir, I think we have.

Chairman LEVIN. We are going to take every step we can possibly change to correct that, working with you folks, because it is a huge issue.

General, do you want to add a quick word there?

General SCHOOMAKER. Sir, I do, if you do not mind. One of the things I learned and I did not know before is, of course there are two different laws, and I am not trying to—just for clarity. The military system operates under a different law than the VA system does, and I was very surprised to see that where a soldier would be rated, say, at 40 percent in the military system that the VA may rate that very same soldier at 70 percent.

This kind of problem is fundamental to people's understanding and trust and confidence in the system, and it is very difficult to explain.

Chairman LEVIN. It is not only difficult to explain, it is unexplainable, it is inexplicable, and it is unacceptable, and that is one of the reasons why these two committees are going to be meeting together. We are going to try to end that separation, that difference, the crack that exists between the DOD and the VA.

There was a recent article that was written about PTSD by Mark Bowell. He quotes Lieutenant Colonel Dr. Charles Engell, who is the Director of Deployment Health Clinical Center at Walter Reed, as saying that military doctors are reluctant to diagnose soldiers with PTSD because it would, "stigmatize the person or bring harm to their careers."

General Kiley, should military doctors be reluctant to diagnose soldiers with PTSD to avoid stigmatizing them?

General KILEY. Mr. Chairman, I do not believe they should be reluctant to, but I think that is absolutely the reality. As part of the mental health task force that Congress has directed and that I am co-chairing, we have visited Army, Navy, Air Force, and Marine bases around the world. It is very clear that our soldiers, sailors, airmen, and marines are very concerned about being diagnosed with PTSD as it relates to security clearances, as it relates to a perception among their peers and their superiors that they are

somehow inadequate or not capable of being soldiers and leaders. I think it is one of the great challenges in military medicine and in the Nation to move past that.

Chairman LEVIN. But should doctors be reluctant?

General KILEY. What I believe happens is that the individual soldiers are reluctant to talk to doctors about it and the doctors know they are reluctant and so they attempt to deal with it. There is a difference between helping soldiers—but I do not think they should be reluctant. I think if a soldier has a diagnosis of PTSD it should be documented.

Chairman LEVIN. There was a National Public Radio story about Fort Carson, Colorado, where it was alleged that there was a failure to provide adequate treatment for soldiers suffering from PTSD and other service-connected mental health problems. Are you, Dr. Winkenwerder, aware of that story? I think you have looked into allegations; I believe you have now undertaken an investigation at Fort Carson. What have you found there?

Dr. WINKENWERDER. Mr. Chairman, I did learn about that and I learned about it during the interview. I had not been aware that there were problems. I was disturbed to hear about the individual cases because, as I heard about them, they had merit in my judgment. It appeared to me that people had been potentially improperly discharged or discharged without the proper medical diagnosis, and it appeared that there might have been some instances of retribution or just not the right behavior.

I have worked very hard over the last 4 to 5 years to send the signal and to work with all of our leaders, both medical and non-medical, to destigmatize mental health issues and to make caring for mental health part of the routine of what we do.

Chairman LEVIN. We have a long way to go.

Dr. WINKENWERDER. Yes, we do.

Chairman LEVIN. One final question has to do with the funding. The fiscal year 2008 budget request actually has less funding requested for the sustainment of defense facilities, defense health facilities, than the fiscal year 2007 budget. The fiscal year 2007 budget has \$341 million. The fiscal year 2008 budget request has \$335 million. Now, sustainment is the funding that is used to maintain buildings at their current level of quality. This is the fixing of roofs, air conditioning, the kind of things that they are doing at Building 18, and this includes preventative maintenance.

One hundred percent funding simply means you are doing enough maintenance to keep your facilities at the same quality as last year to prevent deterioration. This is 87 percent request of this year's funding. How does the administration, Dr. Chu, possibly justify requesting 13 percent less than is needed to sustain our medical facilities at this year's level?

Dr. CHU. I think, Mr. Chairman, when you come to the budget figures you have to take into account not only the base budget, but also what is in any supplemental request.

Chairman LEVIN. You are saying there is a supplemental request in this area, sustainment of medical buildings?

Dr. CHU. I think, if I may, sir, to get the full picture we have to look at what was spent this year in 2007 and where that is going to be, also what was spent in 2006, as well as what is planned for

2008 to understand the condition of the actual facilities. Obviously, it is our intent to request what is necessary to keep those facilities in a good condition and where they are inadequate to make sure they come up to the right standard.

Chairman LEVIN. But your budget request does not keep the dollars even at last year's level. I am just telling you that.

Dr. WINKENWERDER. I will be glad to help answer this. The figures I have are that in 2006.

Chairman LEVIN. There was a hurricane issue in 2006. That is why I left it out. There was a big issue about hurricane damage to one particular facility. So start in 2007: \$341 million for sustainment; the request for 2008, \$335 million. That is a reduction. By your own figures, if you look at the bottom line, it was 96 percent in 2007 of the level needed to maintain it at the previous year's level; 87 percent; and in 2009 goes down to 77 percent. How do you justify budget requests that are that reduced?

Dr. WINKENWERDER. Sir, we will take a look at that. I just would note for you that, not just in 2006 but 2005, the sustainment and modernization budget for the entire military health system was at 150 percent and 172 percent of the requirement. There is no reluctance to provide whatever is needed. There is just not an issue there, I can assure you about that.

Chairman LEVIN. Well, the numbers do present an issue. You will have to take a look at that.

Dr. WINKENWERDER. We will look at them.

Chairman LEVIN. Thank you.

Dr. WINKENWERDER. That should not be an issue.

Chairman LEVIN. It should not be.

Dr. WINKENWERDER. Yes, sir.

[Additional information provided for the record follows:]

The fiscal year 2008 budget request of \$335 million for the sustainment of Defense Health Program (DHP) facilities is \$7 million less than the fiscal year 2007 budget of \$342 million. This reduction results from a detailed scrub of programs within each of the Budget Activity Groups (BAGs). As a result, there was realignment of programs and the associated funding among several of the BAGs; one such realignment resulted in an overall decrease to sustainment funding between fiscal year 2007 and fiscal year 2008. The primary decrease was attributable to the realignment of funding to the In-house Care BAG for patient appointing, a patient related cost.

The fiscal year 2006 budget request of \$324 million for sustainment of DHP facilities was \$18 million less than the fiscal year 2007 budget of \$342 million. As a result of funding that became available during the year, total fiscal year 2006 expenditures for sustainment of facilities equaled \$512 million. Funding may become available during fiscal year 2007 to perform additional facility sustainment requirements (see table below).

Facilities Sustainment Model (FSM)

	Fiscal Year		
	2006	2007	2008
	Actual	Estimate	Estimate
FSM Requirement	\$ 351,385	\$ 356,302	\$ 387,890
Budgeted	323,859	341,937	334,858
Funded	512,072	341,937	334,858
Funded to FSM Rate	145.7%	96.0%	87.0%

Chairman LEVIN. Senator McCain.

Senator MCCAIN. Thank you very much, Mr. Chairman.

I would like to note the presence today of members of our veterans service organizations, the Veterans of Foreign Wars, American Legion, and others, who are with us, who I have had the honor of working with for the last 25 years. I think there is no one more capable of providing us the advice and counsel on these issues than our veterans organizations, who themselves have served. So I am glad to have them here with us.

Chairman LEVIN. Thank you, Senator McCain, for pointing that out, and I know you do that on behalf of the whole committee. We join you in that.

Senator MCCAIN. General Schoomaker, do you think that the Washington Post articles fairly characterize the problems at Walter Reed?

General SCHOOMAKER. I believe they did, especially in regards to the frustration of the soldiers. I think Building 18 became a metaphor for a bigger problem, and that is the frustration that we have been discussing and the bureaucracy, and the inexplicable rules and the bureaucracy that surrounds it. So in that regard I would say yes.

Senator MCCAIN. So how do you evaluate Lieutenant General Kiley's responsibility for the problems at Building 18 and the lack of resources assigned to medical hold personnel?

General SCHOOMAKER. General Kiley is the Surgeon General of the Army and he is the principal, he is dual-hatted. He is both the medical command commander—he commands the entire medical command across the whole United States Army, as well as being the principal medical adviser to the chief of staff of the Army and the Secretary of the Army. So from the standpoint of knowing something specifically that had not been brought to his attention in a single barracks someplace, I would say that is a stretch.

However, the system should elevate the kinds of things that require resources and they get fixed. I will say that what is inexplicable is that we, for 3 years, have been putting hundreds of millions of dollars into substandard barracks. I have been in the Army for almost 4 decades. We have never funded barracks, housing, and things the way they should be funded, either in terms of numbers or in terms of maintenance. It has always been a stretch.

We tried to correct that in the last 3 years by making some major shifts. You can find years where we are funding maintenance at less than 50 percent of what was required. That is not unknown to people. So to have—with all of the energy that we put into trying to fix this problem Army-wide, it is a surprise to me that we would have any reluctance to get Building 18 fixed. So what I am telling you is that the commander on the ground there clearly should have had it fixed and been accountable for it. We should have known about it if it was a problem.

Senator MCCAIN. I appreciate that, General. But already there are stories, there are complaints about conditions at Fort Lewis, Fort Dix, Fort Knox, Fort Bragg, and Fort Irwin according to published stories today. What credence do you give those complaints?

General SCHOOMAKER. We are going to check, and we are going to find out, and we will correct those that we have.

Senator MCCAIN. So it is not just a Building 18, maybe?

General SCHOOMAKER. Maybe not, that is correct. Again, I want to reemphasize something, that this has been a challenge for decades. We have short-shifted maintenance because we had to carry readiness accounts, we had to train, we have had to repair equipment. That has always been a challenge.

Senator MCCAIN. General, with all due respect, I know of no time in the 24 years that I have been a Member of Congress that the DOD has come over and asked for funding for this kind of needs for the military it has ever been turned down. So I understand your statement and I think there may be something to it, but every time there has ever been a request that has to do with personnel matters in 24 years that I have been in Congress we have always not only granted those funds, but we have tried to exceed them.

So maybe there is something wrong in the system that has caused, maybe at Secretary Chu's level and Secretary Winkenwerder's level, that we have not funded these facilities, because it certainly is not a reluctance on the part of Congress and the American people.

General SCHOOMAKER. Sir, I certainly was not saying that that was the problem. I was stating the facts, that in my entire experience this has always been a challenge and I think we all know that. So it is not an excuse, either. It is just a fact. So I only bring it up because with the emphasis that we have put on trying to rectify this and improve the quality-of-life of our soldiers and their families that there is really no excuse for this kind of thing not to have surfaced and been rectified.

Senator MCCAIN. Again I would assert that these kinds of problems are viewed as unacceptable by everyone, and they exist, apparently they exist in other bases around the Nation as well.

General Kiley, I want to read you a quote from the Washington Post on February 23, 2007, where you conducted a tour by the press in Building 18. "In the next room there is a little water drop in the ceiling. You can get a nice shot of it," Kiley joked." According to the report, there was water dripping into a wastebasket in the game room used by recovering soldiers in Building 18.

If that quote is accurate, what does that say about your attitude to this problem, General?

General KILEY. Sir, I do not believe that quote is accurate. It was in room 416. It was in a double, a two-room suite on the fourth floor of that building. I had been in that room earlier in the day and had talked to the sergeant who lived in there about the leak. They had offered to move him out and he was okay with it. He was getting ready to leave the area.

I was attempting to provide full disclosure to the press about what we had found in terms of our walkthrough. I was not joking about anything. This is very serious. It had rained a little bit earlier in the afternoon before the press corps get in there. We went up, I walked into the room and one of the reporters asked me to point out the drop. So I put my finger up at the drop and it disappeared and we waited for another drop. But there was nothing humorous. We were not in the process of making jokes about this process.

Senator MCCAIN. Dr. Winkenwerder, beginning last year your office initiated a so-called "efficiency wedge," which is a deduction

from the service medical budgets. Both the Army and Navy Surgeons General have indicated that these reductions are unexecutable. What is the value of the efficiency wedge reductions across the Army, Navy, and the Air Force between 2007 and 2009?

Dr. WINKENWERDER. I do not have that figure right in front of me, but it is several hundreds of millions of dollars over that span of time.

[Additional information provided for the record follows:]

The table below provides details of the reduction to the Services' budgets for the period fiscal years 2007–2009 as a result of the efficiency wedge:

[In millions of dollars]

	Fiscal Year			
	2006	2007	2008	2009
Army:				
DHP O&M	4,970.6	4,635.8	4,867.5	4,963.9
DHP Procurement	66.0	73.8	78.8	73.0
DHP RDT&E	354.0	222.5	5.0	5.0
Medical Milpers	2,114.2	2,232.2	2,141.4	2,190.0
Total	7,504.8	7,164.4	7,092.7	7,231.9
MTF Efficiencies	29.8	82.1	142.3	227.3
Percent of Total	0.4	1.1	2.0	3.0
Navy:				
DHP O&M	2,877.9	2,862.4	2,657.3	2,737.0
DHP Procurement	61.5	53.2	50.8	52.7
DHP RDT&E	46.9	29.8	23.8	24.3
Medical Milpers	2,435.8	2,431.6	2,420.5	2,400.6
Total	5,422.1	5,377.0	5,152.3	5,214.6
MTF Efficiencies	30.6	84.4	146.5	234.2
Percent of Total	0.6	1.5	2.8	4.3
Air Force:				
DHP O&M	2,506.0	2,477.6	2,377.8	2,528.6
DHP Procurement	104.5	66.2	63.0	52.2
DHP RDT&E	54.2	19.0	22.0	22.5
Medical Milpers	2,810.9	2,717.9	2,812.9	2,828.4
Total	5,475.6	5,280.6	5,275.7	5,431.7
MTF Efficiencies	33.6	92.5	197.5	323.7
Percent of Total	0.6	1.7	3.6	5.6

[In millions of dollars]

	Fiscal Year		
	2007	2008	2009
Army	-\$82.1	-\$142.3	-\$227.3
Navy	-\$84.4	-\$146.5	-\$234.2
Air Force	-\$92.5	-\$197.5	-\$323.7
Defense Health Program Total	-\$259.0	-\$486.3	-\$785.2

Senator MCCAIN. What was your rationale in imposing a tax on medical operating budgets of hundreds of millions of dollars in time of war?

Dr. WINKENWERDER. This was part of a long-term budget plan that had been developed about 3 years ago in conjunction with the then surgeons general, and the vice chiefs, and the leaders from all of the Services about what was believed to be more efficient, effective delivery of health care that could take place as part of that. Some of that led into some of the BRAC decisions, for example, with closing small community hospitals so that we could, in turn, use care that would be out in our network that would be equally, if in some cases better, received by our beneficiaries, but would be a dollar savings to the DOD.

We are charged with trying to do the right thing in terms of managing the budget. I think you raise a very good question that I think that needs to be reevaluated in the context of everything that we are dealing with right now.

Senator MCCAIN. If a plan was developed 3 years ago, I would have hoped you would not wait until this hearing to evaluate it, given the level of conflict that we are in throughout the world today in Afghanistan and Iraq.

Dr. WINKENWERDER. We do evaluate things each year. So it is not like we make a decision and forget about it. But I take your point and we will be doing that.

Senator MCCAIN. I hope you will inform this committee as to what the needs are, because clearly any proposal to reduce spending, as the chairman just pointed out, given the level of casualties that we are receiving, is also hard to fathom.

Dr. WINKENWERDER. I will. I would, Senator, if I might, note that our aggregate budget—Congress has been very supportive. One of my goals coming on board 5½ years ago was to ensure that we never ended up in a position where, frankly, DOD and the military health system had been before, where we were coming to Congress year after year, falling short, needing supplemental funds and we had to fight, frankly, to ensure that the out growth projections were accurate based on what the increased cost of health care is.

So our budget has more than doubled. It was about \$18 billion in 2001. It is approximately \$40 billion today. So we are spending a lot more money, but we need to spend money to make sure that we get the job done right.

Senator MCCAIN. Mr. Chairman, I want to thank you for the additional hearings we are going to hold with the Veterans Affairs Committee, because one of the major policy issues that needs to be addressed by Congress is this disconnect, which you have already talked about and is being discussed, between our VA care, treatment, hospitalization, et cetera, and those who are on Active Duty.

It seems that the experts I have talked to believe that there needs to be a seamless transition here and clearly that is not taking place and is a cause of a lot of the very significant difficulties, the manifestations of which we are exploring today.

I thank you, Mr. Chairman, for holding these hearings and the future ones we will hold with the Veterans Affairs Committee.

Chairman LEVIN. Thank you, Senator McCain.

Senator Lieberman.

Senator LIEBERMAN. Thanks. Mr. Chairman, I thank you and Senator McCain as well for what you are doing here.

General Schoomaker, you made a comment that I think ought to resonate and ring through our brains and hearts and souls as we go on with our response to the Washington Post series on Walter Reed, which is that what was happening in Building 18 really is a metaphor for a lot else that is wrong with the system. I think you are right. It is a metaphor, it is a wakeup call.

I think what is important is to focus on the fact that the element of the story that infuriated most of us, embarrassed us most—the rodents on the floor, the mold on the walls, which none of us want our veterans, particularly those injured, to have to cope with, those problems can be resolved rapidly. They have been resolved. The mold has been taken away, the rodents have been eliminated. But what remains both in the DOD and I think increasingly we will find in the VA is a system that simply shortchanges those who have served us, both because of the bureaucratic red tape that is part of it—I thought, General, as you approach the conclusion of your great career of service to our country, your statement earlier about the red tape that surrounds so much of what you try to do to protect our national security—I think you used the metaphor there of feeling like you were going constantly through a swamp—is something that also ought to ring bells in a lot more that we do and that is done within the Pentagon.

But let me come back to it. The mold on the walls, the rodents on the floor, they are taken care of. But what remains is a system in the DOD and the VA particularly, I think, that is too bureaucratic, and that in that bureaucratic red tape frustrates and in some sense insults the veterans because of what it puts them and their families through.

But also I believe as I have gotten into this deeper and deeper that what we all have to come to conclude—let me just speak for myself; I conclude—we have not made a national commitment to our veterans in this war on treatment, including particularly Iraq and Afghanistan, commensurate, as great as the service and sacrifice that we are asking them every day to give.

We have simply got to close that gap between what we are asking them to do for us on the battlefield and what we as a Nation are doing for them when they come home. The fact is, and the other thing that we ought not to let the mold and the rodents conceal, is that the battlefield medical care, the acute care they are getting, and the care that they are getting as inpatients, so much of which is going on at Walter Reed and Bethesda, is the best in the world. But in a lot of other ways, in the outpatient services and in the red tape about disability, we are really failing them.

That is where I echo what has been said. I think Senator Levin and Senator McCain are doing something very important in bringing us together with our colleagues on the Veterans Affairs Committee. There are hundreds of thousands of claims for disability that are pending today in the VA. They are waiting 6 months to as long as 2 years. It is just shocking and unacceptable.

Whatever it takes—and I think it is going to take some money in addition to reorganization—we have to resolve to end that gap and take care of our veterans in some way approaching the way they have taken care of us.

General Kiley, you indicated in response to earlier questions that there were some things going on that you did not know in your role as Army Surgeon General. I want to ask you what your conclusion is about why you did not know them and what you are going to do now to correct that situation so you will know anything that is wrong with the system henceforth?

General KILEY. Senator, if you are referring to this complex bureaucratic process of the MEB and PEB process, I think I probably should have known more, and what is going on at Walter Reed in terms of the frustration of the staffs and the patients is probably mirrored to some extent in most of our other facilities, as I hear commanders talk to us about these issues. I think it is amplified a little at Walter Reed because of the sheer numbers. There are a lot of soldiers at Walter Reed that are going through that process.

We clearly need to take a look at everything from what we call quick fixes that we could suggest to the Department of the Army that we eliminate as part of the 22 different forms. We need to reenergize, I need to reenergize, commanders to understand that they have all the resources they need. They can hire all the case managers and doctors, not just at Walter Reed, but across MEDCOM, to get these conditions corrected if they are there.

I think we still need to recognize that soldiers still need time to heal and that in that healing process there is consultation and time. So I am always faced with the challenges as the commander of MEDCOM through my commanders. We want to give soldiers enough time without delaying it, and some feel that their processing is being delayed. As we try to expedite that care, soldiers feel we are rushing them out of the system, that we are not giving them time to heal. It is a very tight rope that the commanders, the attending physicians, the case managers across MEDCOM have to walk.

We talk to them at commanders conferences. I talk to the senior leaders on video-teleconferences (VTCs), if not weekly, monthly about these kinds of issues. When there are special issues or problems associated, for example, with deployment or redeployment of major combat units into installations, we keep an eye on the med holdover and med hold soldiers. So there is a lot going on.

Senator LIEBERMAN. General, let me ask you this personal question. From 2002 to 2004 you were the commander of the Walter Reed Army Medical Center.

General KILEY. Yes, sir.

Senator LIEBERMAN. I do not know, I presume you do not know, whether the conditions at Building 18 during that period of time were what they were when the Washington Post did the investigation. But presumably the red tape problems that a lot of the soldiers are finding did exist. As you look back, do you hold yourself accountable for the development of some of the shortcomings or do you hold others under you accountable?

General KILEY. I hold myself accountable. As I relinquished command in 2004, the number of soldiers on the post was increasing. We were filling up all the rooms in the Mologne House. We had just begun the case manager process. I think we still had, if I remember correctly, patients serving as platoon sergeants, and we

were starting to hear that was not fair to the sergeants and it was not fair to the rest of the soldiers.

I probably could have, and should have, taken action earlier, trying to learn lessons from that installation and the other installations in my North Atlantic Region, to include Forts Dix, Drum, Knox, Attaberry, and McCoy. We were out looking at this all the time, attempting to improve it, never wanting for resources, but sometimes difficult in execution.

General SCHOOMAKER. Senator Lieberman, if I could add something here.

Senator LIEBERMAN. Yes, sir.

General SCHOOMAKER. Building 18 I have now learned has gone through—it went through a renovation in 2001. It went through another renovation in 2005. But there is a metaphor within the metaphor here. We fixed the mold, we fixed the things that you talked about, but the roof is not fixed. If you do not fix the roof, these things are going to be back if that is the problem.

Senator LIEBERMAN. Right.

General SCHOOMAKER. It really is a metaphor for a much bigger challenge that we have. I will tell you: How much energy have all of us here spent on the VA, MILCON, BRAC bill this year? We are 6 months into the fiscal year and we do not have a bill.

Senator LIEBERMAN. Right.

General SCHOOMAKER. We spent a lot of energy, and we are about \$2 billion short on the BRAC, on the deal which is going to be—this is not pointing fingers. Last year we worked—we did not get our first funding until December 30, a quarter into the fiscal year. We did not get our other increment until the end of June, only 90 days left. So we are running through this swamp, spending our energy in a huge way at the senior level, and that energy could be so much better spent trying to be more effective leaders and managers down there. But that is just the reality. That is the bureaucracy.

Senator LIEBERMAN. It is a point well-taken.

My time is up. I do not want to ask a question, but I just want to ask you to please think about something, whether we ought to go back and take a second look at the BRAC recommendation to close the Walter Reed Army Medical Center. It just seems to me that when we know there is going to be an increasing demand from veterans for services, medical services, to close this facility that has some state-of-the-art services, I am not sure it makes sense.

It may be that you want to concentrate certain medical services there to veterans, not just in the Army, or soldiers not just in the Army, but across the four Services and to concentrate some more in Bethesda. I am having second thoughts about the wisdom of that.

General SCHOOMAKER. First of all, the BRAC thing is way above my pay grade, but I will say is that we need that hospital at Fort Belvoir, because that is where the center has moved. The transportation system supports it. We need to get better medical care for the broader community.

Second, we need to improve Bethesda and get the Uniformed Health Services University, get the research center and everything set up.

Third, I have concerns as we go through this long war about taking down capacity that may be needed. So I am not suggesting opening BRAC or anything else, but I think we ought to be very, very careful about disconnecting certain things with the realities that we face today.

Senator LIEBERMAN. I totally agree with you and that is why I think we ought to take a second look at that decision about Walter Reed.

Mr. Chairman, I have gone over my time.

Chairman LEVIN. Secretary Winkenwerder did want to comment, apparently, on that.

Dr. WINKENWERDER. Yes, I would like to comment on that as well. I do think it is the right decision to bring these two great facilities together. We will be stronger. Military health care will be stronger. We will be more joint.

Chairman LEVIN. If we do what?

Dr. WINKENWERDER. Bring these two institutions, Walter Reed and Bethesda, to the new Walter Reed National Military Medical Center.

Chairman LEVIN. To the Walter Reed?

Dr. WINKENWERDER. The new, the new Walter Reed; move forward with the BRAC recommendations.

For all the reasons that are talked about, there is the opportunity to get all of our great expertise in one place with our medical school, the research, and the National Institutes of Health is right across the street with the great research programs there. There is an opportunity to invest a large sum of money. We are talking approximately \$2 billion that is to be spent on state-of-the-art facilities.

The people are the key and the people obviously are not going away. The programs are not going away. It is the facility at that location that I think is the right thing.

Now, having said that, I totally agree with you that we all need to be absolutely careful, scrutiny to the highest degree, to make sure that nothing falls through the crack, nothing is left undone, until the day that that move occurs. We absolutely have to continue everything just as if Walter Reed were going to continue for another 15 years until that move occurs.

So that is my view. I know that there will be other discussions on it.

Chairman LEVIN. Thank you.

Senator Warner.

Senator WARNER. Thank you, Mr. Chairman.

Mr. Chairman, I have to reflect that in the 29 years that you and I have been together on this committee, as I approached this hearing this morning it was with a feeling of great distress. This is one of the most distressing situations that we have ever seen in the time that we have been here together. I commend you and Senator McCain and others at the forthrightness with which this committee is going to address it.

I think as we listen to the accountability unhesitatingly coming forward from this group of witnesses we should also examine our own oversight process and to see how a situation of this magnitude in many ways was not brought to our attention. Of course, our

oversight is performed not only through the hearings and the witnesses, but from constituent inquiries, and when I visited Walter Reed, which was just the Friday following the disclosure of the very valuable investigative report in the Washington Post. I was present when Secretary Gates came out and spoke at Walter Reed about this situation and his first steps that he took, and I commend him for the expeditious manner in which he stepped up to accept his share of responsibility as we deal with this question.

But I want to bring to the attention of our witnesses again the value of constituents contacting us. When I was out there I visited with a staff sergeant—I will withhold his name, although if necessary I will make it disclosed—and his commander out there, a colonel, full colonel, who dealt with this issue.

My first question goes to General Schoomaker. I have had the privilege of being associated with the military for many years and the limited contribution I may have made came up through the Reserve side of our military. I have always been concerned about the differential treatment between the Reserves and the regulars. In the context of the problem we have here today, constituent inquiries on this issue bring this question to mind.

I go back to the famous slogan that the Army had for many years, "An Army of One." What did that mean, General? I interpret it as meaning that Reserves and regulars are to be treated as one. Is that correct?

General SCHOOMAKER. That would—sir, really we talk about a total Army.

Senator WARNER. Total Army.

General SCHOOMAKER. I think you know that throughout my entire tenure I have made that one of my highest priorities.

Senator WARNER. No question about it.

General SCHOOMAKER. Made this one Army. I will tell you that I believe that we are on the path to do that.

Senator WARNER. I want to say as you begin to draw to a close your distinguished career, as you say, of 40 years, it has been a privilege to work with you. You are a man not only of proven combat courage, but a man of enormous compassion for your soldiers of all ranks and their families, and I know this situation you find very distressing. As a matter of fact, when you greeted me here at the dais this morning I think those were the words that you used.

But let us go back to that "Army of One," because part of the oversight performed by this committee was in the context of our National Defense Authorization Act of Fiscal Year 2006, and in it we directed the Government Accountability Office (GAO) to review the results of the military disability and evaluation system, the very thing that is before us today. That report when it was released said as follows: "GAO's analysis of the military disability benefit decisions for soldiers who were determined to be unfit for duty were less definitive, but suggests that the Army reservists were less likely to receive permanent disability retirement or lump sum disability severance pay than their Active Duty counterparts."

It is interesting. Just yesterday I was visited by a member of the Veterans of Foreign Wars (VFW) here in Washington for the conference, as Senator McCain mentioned, and there is another means

by which members of this committee receive valuable information to work on our legislative and oversight responsibilities.

But let us go and address that, because this sergeant whom I visited on Friday, February 23—it was the afternoon of the press conference by the Secretary of Defense. As I mentioned, he stepped up and accepted his accountability; very prompt and decisive direction in that conference. But this sergeant brought that up, and he had with him a full colonel who was in charge of the cadre of soldiers in the Reserve and the Guard, and he confirmed what this sergeant had said.

If you look back on this extraordinary chapter of military history here in regard to Afghanistan and Iraq, we have relied upon the Guard and Reserve to a greater extent than ever in I suppose the contemporary history of our military.

So can you, General, talk to the question of the credibility of these comments with regard to different treatment between the Reserve and the Guard? A wound is a wound whether it is borne by a guardsman, reservist, or a regular Army soldier.

General SCHOOMAKER. Sir, first of all, I agree with you. In fact, I do not think our system at the medical—the doctors do not differentiate. I certainly do not when I go around and visit these patients. Now, the realities are as they go back out through the system there are other challenges. Whereas an Active component member comes from an installation that has a support base that is coherent and cohesive in a certain sense many of our Reserve component members go back out into smaller communities and the Guard Bureau and the Army Reserve Command have other systems to help make up for that.

But one of the points is, is there a difference in the disability ratings, et cetera, and I would be glad to provide for the record some figures here that I got out of our personnel and medical command that shows that in fact the Reserve component soldiers have gotten a higher percent—in 2005–2006, actually received a higher percentage of permanently retired and temporary disability retirement list ratings than the Active component did.

I think it indicates that Reserve component soldiers are not being disadvantaged in terms of how they are being evaluated.

Senator WARNER. Yet the GAO seemed to have found that there was a disparity.

General SCHOOMAKER. We will provide the figures.

[The information referred to follows:]

U.S. Army Medical command does not discriminate among patients based on component. The only factor considered in scheduling appointments or the administrative processing of soldiers is the clinical requirements of the patient as determined by the treating health care providers. A review of scheduling information for clinics at Walter Reed Army Medical Center and across U.S. Army Medical Command indicates no differences between Active and Reserve component soldiers in access or timeliness of appointments.

Senator WARNER. All right. Let us ask the Surgeon General. Incidentally, on my visit on February 23 following Secretary Gates' press conference you and I met. You took me through Building 18 and I think we discussed that issue, and what was your observation as to any disparity of treatment between the Reserve and the regular?

General KILEY. Senator, in the 4 years from Walter Reed to my command of MEDCOM there clearly has been a concern among Reserve and National Guard soldiers that they perceive that they are not getting timely enough care quickly enough, and consistently our message to commanders, to clinicians, is not only are they to get the same access, but because of some of the uniqueness, unique administrative requirements for Reserve and National Guard soldiers as they work their way through the process of the MEB-PEB, I have asked commanders to move Reserve and National Guard to the front.

Senator WARNER. My time is coming to a conclusion.

General KILEY. Yes, sir.

Senator WARNER. I would like to have you join with the Chief of Staff of the Army in reporting to this committee.

General KILEY. Yes, sir.

Senator WARNER. I would like to return to the issue of this BRAC issue. I have been looking into it. Indeed, following a hearing in the House there were similar representations by the Subcommittee of the Appropriations on Defense. Indeed, General Cody said the following: "I think we need to take a look at and address whether we should sanctuary Walter Reed during this long war." I think he meant by "sanctuary" put it in some holding status, which would require going in and amending—only by law could we do it—the BRAC process.

I urge that we, if we wish to look at that, certainly we should, but on the other hand it seems to me, Mr. Chairman and Senator McCain, it would be incumbent on this committee perhaps to reach a recommendation that we should begin to expedite the funding profile to do the augmentation at Bethesda and to begin to break ground and proceed with the new hospital. Is it to be called Walter Reed, the follow-on? Fine.

Dr. WINKENWERDER. Yes, sir.

Senator WARNER. Which is at Fort Belvoir. Now, I am going to address those questions, but I think those who want to try and reinvigorate Walter Reed should look at the volume of expenditures required. Did you not mention that to me on Friday, General Kiley, your estimate of the amount of MILCON that would be required to put Walter Reed back into a situation where it is a front-line military facility?

General KILEY. Sir, I think it is a front-line military facility. But there is a master plan that at its maximum called for multiple hundreds of millions of dollars for renovation projects, yes, sir.

Senator WARNER. So we have to balance that. Thank you. When I used the word "front-line" I meant to put it in condition so that it can continue to do the work.

By the way, the medical attention received by individuals in the course of this very tragic dispute has not been questioned. I think that should be made clear for the record.

All right. I do hope that we look at the BRAC in the context of moving ahead, keeping the BRAC decision with the new facility.

Chairman LEVIN. Thank you, Senator Warner.

By the way, General, you have used the term twice now, "PEB" and "MEB". I think we know what they are, but for the record you should state.

General KILEY. "MEB" is the Medical Evaluation Board and "PEB" is the "Physical Evaluation Board."

Chairman LEVIN. The MEB comes first and then the PEB?

General KILEY. Correct, Senator.

Chairman LEVIN. Thank you.

I am glad I asked that question. I do not know if Senator Bill Nelson is happy, but Senator Reed is next.

Senator REED. Thank you, Mr. Chairman.

Thank you, gentlemen. Dr. Chu, there are two icebergs that are looming as the administration steams ahead. One is the adequacy of the DOD medical system itself, the hospitals, the capacity, the human capacity, doctors, et cetera; and the other one is the capacity of the VA to handle all these young Americans, probably for 50 years. Specifically, you mentioned the coordination, but do you have a sense right now which you communicate to the VA where these people are going, their costs over time? Because this is not a transitory issue.

Are you providing the kind of coordination or do you have the authority to coordinate so that you can assure these young people right now that, not just through their military service and their first few years in the VA, but for 50 years that they are going to be cared for with the same level of concern we have all expressed here tonight, or today rather?

Dr. CHU. Senator, thank you. That is I think a significant issue. We believe that the procedures and processes in place will sustain these veterans over the long-term. We meet regularly with our VA counterparts. We have constituted, in addition to a health executive council that Bill Winkenwerder co-chairs with Dr. Kussman, his VA counterpart, a benefits executive council, and the VA deputy secretary and I co-chair a joint executive council that meets quarterly to confront exactly these issues.

Do we have all the authority we need? I am not confident that that is the case, although I would like to wait for several reviews that are ongoing, including one that I have asked our own inspector general (IG) to do. Let me just point to one of the same issues, which is as long as they are on Active Duty there are certain things they cannot get from title 38, the VA statute. We may want to come back to Congress and ask to allow an overlap here.

A similar issue, for example, with support for the families of injured veterans. This is not so much the long-term. This is more the short-term. We can, under statutes this committee has granted, provide support to families to visit the bedside and so on and so forth. VA does not have, as I understand it, similar authorities. So one transition issue is, back to Senator Levin's question, when they move from us to the VA there is under American law a different set of rules of the game.

We can ameliorate that with voluntary organizations, support from America at large, and we do mobilize that. Again, it is premature for me to make a recommendation at this stage, but I do hope within a few months we will come to the conclusion, what do we need to do, perhaps less on the long-term, more on the, as Senator Levin pointed, short-term transition issue from DOD to VA.

Senator REED. How many billions of dollars do you estimate it will cost just at this point to care for these young people over the course of their lives?

Dr. CHU. I do not have an estimate at the top of my head, sir.

Senator REED. Will you get that estimate?

Dr. CHU. I would be delighted to work on one, yes, sir.

[The information referred to follows:]

This question addresses lifetime costs of caring for Iraq/Afghanistan veterans, the biggest piece of which will be Department of Veterans Affairs (VA) costs. Since we do not possess VA cost data, we respectfully defer to the VA on this question.

Senator REED. Let me ask another question. For years now many members of this committee and other colleagues have called for the increase of the Army's end strength, and until a few months ago the administration rejected in a serious way those proposals. My understanding is that during that period of time the Army was trying to constitute maneuver brigades by taking people out of overhead. Did that overhead include either the medical system by not adding additional positions or by taking people away from the medical detachments and the medical service corps elements?

Dr. CHU. I do not believe so, sir. I will let Dr. Winkenwerder and General Schoomaker speak to the specifics of Army medical manning. It is the case that the Army has converted some military billets to civilian status within its system, although its conversions are generally more modest than those of the other military departments because it started with a higher civilian content than the others. But I believe the staffing is stable or possibly growing, sir.

Senator REED. I will ask General Schoomaker. But what prompts the question is that before the conflict in Iraq and Afghanistan the inpatient population of Walter Reed I am told was roughly about 100 people. It swelled in 2005 to 874. They now have 674. Average patient stay is 45 days. Outpatient stay is 300 days. Yet I do not think there is any concomitant increase in the number of people in the medical hold detachment and in those nonclinical areas.

General, as we talked about this issue before, the Army was desperately trying to pull people out of TRADOC and other places. If not directly contributing to this problem, was there the implicit notion that you could not ask for more people to go up and staff a medical detachment at Walter Reed?

General SCHOOMAKER. The answer, sir, is no, I do not think that there is any connection between the two. I think that we were successful in growing the operational portion of the Army through some moves. We are constantly looking at it because we are concerned about what institutional risks we take. We have been aggressive on the military to civilian change. But we have also mobilized a great many medical professionals, reservists, and we have looked at joint solutions.

I will give you a good example. Landstuhl largely has been staffed by Reserve component soldiers over there. Today—in fact, I think it took place when I was there at Christmas time. They had just turned over. We have about 300 to 350 naval medical personnel now that are staffing Landstuhl. So there have been joint solutions to this. There have been Reserve component solutions. Quite frankly, in our structure we have actually grown medical capacity for the battlefield on that in terms of our structure.

Senator REED. General Kiley?

General KILEY. Sir, I agree with the Chief. We have watched that military-to-civilian conversion very carefully in MEDCOM. It is spread across all our facilities, not just at Walter Reed. The risk that we take at a place like Walter Reed is where for other medical services and capabilities we can contract or hire civilians, you cannot put civilians in as platoon sergeants and company commanders.

Where we failed is in not asking the Army for help, which is now what we are doing, bringing in soldiers from the line Army to stand up this task force. So that in that respect I failed in terms of realizing the potential impact on that.

Senator REED. I think that is an accurate after-the-fact evaluation, because I think obviously, we recognize there has been a failure there. Interestingly enough, and I will not dispute your analysis, General Schoomaker, but so many times when we find a problem the solution seems to be, well, put more people there, where before the problem was discovered obviously we did not have enough people.

Just one final area of concern and that is the culture of the organization. Most major medical organizations I know are not run by doctors any longer. They are run by Masters of Business Administration (MBAs). Yet in the military system it seems all these major facilities are run by physicians, who have great clinical training, great care, great compassion. Are we going to look seriously at a new model of running institutions like this, doctor, secretary?

Dr. WINKENWERDER. That is a great question and I welcome that. Just for the benefit of your background—I spent most of my—I am a physician, trained, an internist. I also trained in business and have a business degree, and fortunate enough to have worked with some great health care organizations in the private sector.

One thing I will say just is this is the toughest organization. I totally echo General Schoomaker's remarks. We are a very complex, very large organization, tremendous management challenge. One of the things I see a need for—and we have talked about this, but again this may take legislative change or regulation change—is a need for strong civilian administrative capability in these locations. All of the military treatment facilities are managed through the Services.

One of the issues we face is turnover of people, changes of command and leadership. Our people work hard. They are wonderful people, committed and talented managers. I think if I am to compare from my private sector experience, we have some great managers. But I think we would be well-served to have, if you will, some leadership that is administrative that provides some continuity, so that things do not fall through the gaps and that we can make sure we get it right.

Senator REED. Thank you, Mr. Chairman.

Chairman LEVIN. Thank you, Senator Reed.

Senator Inhofe.

Senator INHOFE. Thank you, Mr. Chairman.

First of all, I thank both Secretary Chu and General Schoomaker for beginning your remarks complimenting the people who are offering care at our various institutions. I have been to all of them and you have, too. But I think when you look at some of the statis-

tics, World War II, 30 percent of those who were injured died. In Vietnam it was 24 percent. Now it is 9 percent. A lot of that is due to better equipment, I understand that, but also better treatment.

What I get, whether it is Landstuhl or Walter Reed, in making my visits I hear from the troops who are injured and their first concern is—they are very complimentary on the treatment they are getting and the first thing they want to do is get back to their unit. So I am glad that we are all recognizing that. There is a lot of people watching us now that are thinking it is the quality of treatment in areas where it is not.

I do want to get to the PEB and the MEB thing. I think that is very important. Each one of us up here has cases where we have been called by veterans. I have one where a soldier had lost his leg actually to cancer, but it was diagnosed as an aggressive cancer and he did qualify. Then when that paperwork reached Washington they rediagnosed it and decided it was a slower growing cancer and he was not qualified. We corrected that problem. But I thought that was an isolated case until I have been hearing some of the testimonials in conjunction with this hearing.

Now, General Schoomaker, I cannot figure this out, but when you look at the GAO report, unless I misread it, it talks about the Marines, the Air Force, and the Army. Thirty percent of the cases before the Marine PEB have been granted permanent disability, 24 percent of the Air Force, and only 4 percent of the Army. I have to ask what could be the reason for that?

General SCHOOMAKER. Sir, I have asked the same question. I cannot figure it out either. Some people have said, we are talking about in many cases a younger population that does not have the years of service and therefore there is a different deal. But I am not satisfied that we know the answer. In fact, General Kiley and I were having this conversation. So I think we owe you an answer and we will probably have to do it for the record, but it does not make sense.

[The information referred to follows:]

The 4 percent figure and disparity with other Services comes from a quote on February 25, 2007, in The Washington Post Magazine: "The Defense Department reports that the Army, which handles more than half of the military's disability cases, put less than 4 percent of the 10,460 active duty soldiers and reservists it evaluated last year on permanent disability retirement and less than 15 percent on the temporary list. (Temporary retirees undergo periodic reassessments of their condition for as much as 5 years before a final decision.) By comparison, the Navy (including the Marine Corps) retired about 35 percent of its injured, temporarily or permanently, and the Air Force about 24 percent the Defense Department says." Although not stated in the article, these Department of Defense figures are only from fiscal year 2006.

Approximately 19 percent (4 percent + 15 percent mentioned above) is the appropriate Army disability retirement figure to compare to Navy and Air Force. Further refinement of the Army disability retirements: fiscal year 2006—18.70 percent; fiscal year 2007 through February 28, 2007—21.36 percent.

Senator INHOFE. That is fine for the record, but I was wondering. I was an Army guy myself and I always look out and see the differences in treatment, and I want to make sure that is not the case. I would not want the Army to be out of step with the other Services.

Now, Senator Lieberman said that Walter Reed is kind of a metaphor or a wakeup call for other institutions and, General Kiley,

you talked about directing three investigations. One of those investigations was the MEB and PEB insofar as Walter Reed is concerned. Now, are you also taking into consideration looking into all the other institutions as well?

General KILEY. Senator, we are doing an in-depth analysis of how the medical board process works inside Walter Reed, so that we can streamline it, iterative-reiterative process of looking at how the doctors and the soldiers—that is one.

The second process is this team that I have sent out with Bob Wilson and the professionals who are looking across all the installations for communications, infrastructure, bureaucracy issues, to make sure we do not have duplication. Then I have a series of investigations going on, one by CID and two what we call AR-15-60s.

Senator INHOFE. I see, okay. The GAO, in the same report, reported that the PEB caseload grew from 7,200 cases in 2001 to 13,700 in 2005. The number of soldiers waiting to go through the process across the country averages 5,000 cases.

I am not saying this critically, but I know that the Army particularly, and other Services too to a lesser degree, during the draw-down of the 1990s—I can remember going to the floor many times and talking about we are going to come back and pay for a lot of this, because it was a reality at that time. Now, if funding is the problem we really need to know it. Mr. Secretary, you mentioned I think—maybe I misunderstood you, but you did not think it was. You think you have had all the resources you need. When you said that, I did not quite agree with it, because it appears to me that funding is a problem.

We all know what we went through recently. General Cody, who I thought was originally going to be on this panel, his concern at one time, it looked like we were not going to be able to pay reenlistment bonuses, we were not going to pay widows benefits, and things that would really be a disaster unless we have the proper funding. Then of course they pulled \$3.1 billion out of the BRAC account, which is I think really a disaster and it needs to come back in, not at the expense of something else, because there is no fat left out there. It cannot come out of modernization, it cannot come out of Future Combat System, it cannot come out of the RPM accounts, or whatever they call those accounts now.

But I seem to think this is a problem. I would like to have you, each one of you, address this, because I think we are looking at a funding problem. Here is a quote that I have from General Cody. He said: “Our counselors and case managers are overworked. They do not receive enough training. Our medical holding units are not manned at the proper level.”

Do you have any comments?

General SCHOOMAKER. Sir, that is precisely what we are fixing.

Senator INHOFE. You cannot fix it without adequate resources and money.

General SCHOOMAKER. That is correct, and so I want to address that. One of the things that I think I have to say here, because I think maybe we are overlooking it, and that is even before the war we had thousands of people that were going through the MEB-PEB process. Every soldier, regardless of whether they are injured

in battle, whether they are injured in training, whether they are injured through whatever, deserves exactly the same treatment.

I looked at some figures the other day. Seven of the soldiers at Building 18 that were living in there, were battle-injured soldiers. The others were not battle-injured soldiers that were living there. So there is a baseline of soldiers that have always been in this system. Part of our problem is that as we go through the budget deliberations and get in these arguments everybody talks about how much more money we have today than we had before. The issue—we have always had too little money. I have testified here too much about the underfunding of the United States Army historically.

This is about how much we should have and how much the Nation can afford to do. So we need to take a look at it in a direction that says this is the standard for these soldiers, regardless of whether battle-injured, non-battle-injured, whether they are sick, cancer like your constituent, et cetera, and we need to fund this correctly. We need to make sure the pay systems interact, that the VA–DOD health system interacts.

This country can do this. But you cannot do it when our energy is not being spent on doing it and we are arguing over stuff that we should not have to argue over. I say this because I do believe we have to put it in perspective.

The last thing I would like to say is we all have constituents. My constituents are soldiers and their families, and when I have gone around, everywhere I have gone they have complimented the health care providers in our system. If we are guilty of one thing, it is we have been drinking our own bath water about how well we have been treating everybody. Everybody is giving us thumbs up on it, and we have overlooked something that we should not have overlooked. Digging down inside the bureaucracy, and there is this category of soldiers that we owe exactly the same kind of care to, and we have just let them down.

I just needed to get that out and make sure that we do not run down a rabbit hole here, because we still have this big context and this future, not only the long war, but the future volunteer force, must be resourced properly.

Senator INHOFE. That is why I asked the question. This is a good forum to bring it out, and I knew you would and I appreciate it very much.

By the way, when Senator Warner talked about you will be before long going into retirement, you have already been there, and you have come back and answered the call for service. I want to tell you how much I appreciate the service.

My time has expired. Just I only want to ask, Mr. Chairman, the Building 14 that you mentioned that you are moving some of this to, what is in that building now? Is somebody else going to have to be kicked out in order to utilize that?

General KILEY. Sir, there were permanent party soldiers that were in there. They had empty rooms. We moved some of the soldiers from Building 14 into some very nice apartments.

Senator INHOFE. So it was more of a barracks operation?

General KILEY. Yes, sir. Building 14 is a barracks. It is an exceptionally outstanding, just renovated, \$25 million barracks at Walter Reed. There are individual rooms for soldiers. That is where those

soldiers from Building 18 are now sitting, are now housed. They are living there now.

Senator INHOFE. Thank you very much.

Thank you, Mr. Chairman.

Chairman LEVIN. Thank you, Senator Inhofe.

Senator Bill Nelson.

Senator BILL NELSON. General, you said unfortunately we have let them down. I am going to point out another area where it appears that we have let them down and I would like to know what you can do about it. One of the most serious injuries that we are seeing in Iraq is TBI and it is often caused by the explosions coming out of those IEDs. There are four TBI centers in this country. They are set up under the VA hospitals. Medical experts tell us if there are any delays in the initiation of the comprehensive rehabilitation for those soldiers who suffer the brain injuries then they are going to have a long-term problem of long-term recovery. In other words, the delays in treatment lessen the chances of recovery for our soldiers.

Now, this was of concern last summer to the VA's IG and he wrote a comprehensive report on this. He pointed out—and I am just going to read from the report—that he found that “Groups differed substantially with respect to the median length of time from injury to initiation of comprehensive TBI rehabilitation.” He pointed out that in model systems the delay was only 2.1 weeks and in the VA it was 6.1 weeks.

Now, the IG also found out that remaining on Active Duty—this is where you come in—was a barrier to soldiers receiving more timely rehabilitative care from a veterans facility. He further pointed out—I am quoting here from the IG report: “We identified one soldier on duty at a military post who had had little constructive activity for several months while she waited to be discharged. Another patient”—I am still quoting “still on Active Duty spent 4 months without rehabilitation after the lead center staff had told them to go on and get that soldier taken care of.” At that veteran's medical facility he was told he would not be eligible for care until he was retired or discharged.

Further, in talking with some of these soldiers the IG found that 40 percent of them said that they felt uncertain about whether they were receiving quality care. This is the TBI. Seventeen percent said they lacked the money to pay for the medical services and rehab and 8 percent said they were receiving no medical care.

Beyond that report, I have received complaints and one of the complaints just received a day or so ago, now that this Building 18 issue has raised the visibility. Familiar with a particular brain injury facility, decried the conditions, and I quote, as “horrible.”

So we have two issues here with regard to you. Where there are Active Duty soldiers on a VA facility receiving care, that is good if the facility is not “horrible.” So there has to be some interagency cooperation between you to see that our soldiers are being taken care of. Or, number two, of processing those soldiers faster so that they are not a ping-pong ball, being referred to the VA facility, which has happened in the case of some of these four brain injury centers in this country, then to be bounced back by saying, we can-

not take care of you in this VA facility because you have not been processed out of the military.

Now, that is just, as we have heard the word used over and over here, inexcusable. So what can you do and what have you already done to ensure that the rehabilitation and the lifelong care for these brain injured soldiers are initiated quickly and without regard to Active Duty status, where they get delayed as that one soldier was in this IG report for 4 months or they get to be a ping-pong ball because they have not been outprocessed by the military?

General SCHOOMAKER. Sir, Kevin will handle this, but let me just say something. Everything you describe there is totally—number one, it is unacceptable. But number two, it is all feasible; there is no argument that that occurs. There are people that have experienced TBI, kinds of concussive events that do not end up with any shrapnel holes in them or bullet holes and they continue with duty, and many of them—and I think you would have to agree—do not even know they had this injury until later. It is like a boxer, a football player, a bull rider and everybody else who gets knocked in the head. Sometimes this stuff is—so that is one thing.

You have the situation where we are rapidly evacuating people through the system and they get the very best of care and the medical process works perfectly. I have been to one of those four hospitals, the one in Tampa, the Polytrauma Rehabilitation Center down there, VA center, which is an extraordinary facility, and everybody wants people to get that kind of care.

So what I guess is part of the problem we have here is the fact that every one of these is an individual story, that is what I am trying to say.

Senator BILL NELSON. Of course the IG was not addressing that. The IG was addressing the deficiencies.

General SCHOOMAKER. Yes.

Senator BILL NELSON. That is the question, what are you going to do about the deficiencies?

General SCHOOMAKER. The problem is that the solutions have to—as we try to solve these challenges, we have to solve them understanding that there are so many individual kinds of solutions that will be required.

Senator BILL NELSON. I do not doubt that. But a soldier should not be a ping-pong ball—

General SCHOOMAKER. He should not.

Senator BILL NELSON.—needing that rehabilitative care for a brain injury, and saying we cannot treat you because you are still on Active Duty status.

General SCHOOMAKER. That is right. All I am trying to say—I am not trying to defend the system. I am saying as we move to solve it how we start to solve it is going to have a lot to do with where we end up. If we do not understand that this is a very complex thing and approach it with its complexity, we will miss the boat and come up with some generic cookie cutter solution that is going to disadvantage people.

Senator BILL NELSON. What is the solution? That is what I am asking.

Dr. CHU. Senator, if I may, it is exactly—

Senator BILL NELSON. I want to hear General Kiley and then I will come to you, Secretary Chu.

General KILEY. Senator, I agree with you completely in all these comments, and I recognized this last summer as a major issue that had not been addressed. I thought we were doing fairly well with amputee work. The mental health task force was coming to closure. I asked one of my senior medical leaders to establish a task force to look at every piece of TBI, from research to ongoing diagnosis to therapy to follow to long-term follow-up.

Over 2 years ago or at least a year and a half ago, I put Active Duty ombudsmen into the four VA Polytrauma centers in an effort to coordinate the same kind of care soldiers coming to Walter Reed and Brook get at Tampa, Minnesota, Palo Alto, and Richmond. I was in Iraq in January and the senior medical leadership in Iraq informed me that they have established a TBI protocol over there for the practitioners.

I think we are just recognizing the depth and extent of the challenges associated with these very mild but extremely important conditions. As the Chief has said—in fact, Senator, we got into a discussion about, frankly, should a TBI qualify for a Purple Heart. I mean, there are some criteria for that. This is the level of intense interest the medical community has in this.

The capability to take care of an Active Duty soldier in the VA should be transparent to the soldier. Refer back to my comments about the complexity and the frustrations associated with taking care of soldiers. That is something that we will have to work out between the two Departments, I agree with you. Some soldiers do not want to be retired, feel like they are forced into retirement simply so they can get this health care. We have to fix that.

Senator BILL NELSON. It ought to be transparent. But there is an IG report from June of last year that says it is not.

General KILEY. Yes, sir.

Senator BILL NELSON. So what are we going to do, Secretary Chu?

Dr. CHU. We already did something and therefore I am puzzled by the IG's finding. I am not familiar with this report. I will look into it, obviously.

[The information referred to follows:]

In general, the Department of Veterans Affairs (VA) requires proof of separation to care for servicemembers, unless they are acting in the role of supplemental care provider. Supplemental care is a system to pay for care for Active Duty servicemembers when local military health care is not available. VA medical centers are often providers under the supplemental care system. In the case described in the VA Inspector General report, it appears that the patient should have received services through supplemental care either at the local VA or through another local provider, if these services were required and the servicemember was at home for convalescence after discharge from a VA Lead Center.

There appeared to be some confusion on the part of the Lead Center staff, who apparently told the servicemember to go directly to the local VA medical center for care. In fact, the military medical treatment facility responsible for case managing (from the military viewpoint) the care at the Lead Center should have made arrangements for his local VA medical center to supply that care under the supplemental care program, and should have made arrangements for a coordinated transition of that care (from supplemental care to VA authorized care) upon return home and upon separation from service.

The confusion in this case needs to be addressed, and we will do so as part of our larger effort to simplify and streamline current processes.

Dr. CHU. Exactly for this reason, several years ago, after great effort by Dr. Winkenwerder and company, we signed an agreement with the VA that we would treat each other's patients on a standard reimbursement schedule. So I do not understand how a patient was "refused" because they were still Active Duty. We will look into it, try to understand why that occurred. It should not have happened, bottom line.

Chairman LEVIN. Thank you.

Thank you very much, Senator Nelson.

Senator COLLINS.

Senator COLLINS. Thank you.

General Schoomaker, I received a letter from a mother in Portland, Maine, whose son was injured in Iraq. I want to read to you part of this letter because it is so disturbing to me because it suggests that the problems we are facing with military health care go far beyond one facility at Walter Reed. This mother writes about the horrors that her son David faced while trying to recover over the past few months. She says:

"The recently published Washington Post articles on Walter Reed detail conditions and treatment that are appalling. I can assure you that the issues were virtually the same at Fort Hood, Texas, where my son was stationed. I can also assure you that the public is just starting to become aware of the problems and anger is building.

"David had nothing but great things to say about the doctors and nurses and med-evac flight crew that transported him to Germany. His complaints stem largely from an Army bureaucracy culturally unprepared to handle the wounded and sick, an Army so desperate for manpower that many NCOs are poorly suited for authority and commissioned officers are fearful of being removed from career tracks if they try and change the system. It is also a system that wastes money daily while charging wounded soldiers for the most basic of needs."

This is a disturbing indictment because it suggests that we are facing far greater problems than just the physical conditions at Walter Reed or even the battles that soldiers are having trying to get disability payments. What is your reaction to what I just read you?

General SCHOOMAKER. I am disappointed that that was the experience, and I think that as we go down looking comprehensively through the thing we ought to be seeking out these kinds of anecdotes and find out what is the root cause of it.

I will tell you that the Army has undergone more change in the last 4 or 5 years than it has in over a quarter of a century. The fact of the matter is while we are fighting a war we are radically changing not only the culture, but the organization and the doctrine and everything else that we are doing. So I would tell you that change is very much part of our culture right now.

But nevertheless, these kinds of anecdotes are extraordinarily disappointing. They should be pursued. We should find out what the problem is and make sure that they are not perpetuated for more people.

Senator COLLINS. I guess what troubles me is this mother's conclusion that there is an Army bureaucracy culturally unprepared to handle wounded and sick soldiers. That suggests that we need to do way more than remove molds or repair a roof. I wonder if we should take a look at the entire way that we are delivering health care in the VA system and in our military system. I am not sure that that is the answer, but I was thinking this morning about the fact that the GI bill is unanimously acclaimed. It has been very successful. It essentially gives a voucher to a retired soldier to pursue his education. That contrasts with the VA system and the military system we have. We are trying to do better with community-based clinics, but I still have World War II elderly veterans traveling 5 hours to get to the one VA hospital in Maine.

Should we take a look at our VA and military health care system and consider a whole different approach of delivering services?

General SCHOOMAKER. Ma'am, I think that—and I will just give you my opinion, but I want to throw a caution out here. The military health care system in this country is the best in the world. There is no other country in the world that has it. Every one of our allies are looking at us and are—"jealous" is not the right word; or "desirous"—but they really like what they see.

For instance, my British counterpart. The British have no corresponding system. They have military wings in civilian hospitals. They are very critical of what they are going through by going to commercial initiatives on these kinds of things, and they have virtually no follow-up in the manner that we are talking about right here.

So with all our warts, we better be careful that we do not really damage what is an extraordinary system that has problems. We need to correct the problems.

Dr. WINKENWERDER. If I might add as well, Senator.

Senator COLLINS. Yes, doctor.

Dr. WINKENWERDER. I would echo General Schoomaker's remarks. There are so many areas in which the system broadly is working very, very well. The TRICARE health plan is one of the top-rated plans. We know that, consistent increased satisfaction. Things work. Battlefield medicine works. Acute care works. Out-patient care across the board tends to work well.

But the issue, if I can hone it in to where I think, to answer your question where is the problem or problems, it is those who have been injured and wounded after their acute care in this phase, the seam, the transition, and the disability determination process and the coordination, at that point, which is critical because those individuals deserve our very best. That is where our focus should be, I believe, because so many other things are working well.

The other thing I would say is that we have great capacity in this TRICARE network. We have the ability for any of our Active Duty and our retirees to see over 240,000 physicians across the United States, that network, in nearly every civilian hospital.

So there is a lot of capacity in this system. I am not sure we have used it properly between that and the jointness. We have not talked today about using Air Force, using Navy when Army is overstressed, and that has happened in the theater. The Blalad facility

is staffed by the Air Force, so we have to think better about how to manage those resources.

Senator COLLINS. We do. But there is clearly a problem. These are not isolated stories or anecdotes. There is a pattern here of very good care on the battlefield and inpatient and then it seems to fall apart after that. I think we have to remember that these in many cases are soldiers who are going to have life-long problems as a result of the injuries. So the aftercare is as important.

General Kiley, I want to bring up a comment that you are reported to have said at the House hearing yesterday because I really found it disturbing, assuming you were quoted correctly. You were asked why you were unaware of the living conditions across the street from your own home and according to the paper you replied: "I don't do barrack inspections at Walter Reed."

I must say that I found that to be a stunning and troubling response. The maxim of the military has always been that you get what you inspect, not what you expect. I realize that you personally do not go and do barracks inspections, but you are responsible for ensuring that they—or you were responsible for ensuring that they do get done. I just would like to hear further from you because it struck me as such a disclaiming of responsibility that it was enormously troubling.

General KILEY. I am sorry if I misled anyone in that hearing. It was not my intent to somehow shed responsibility for that. What I was attempting to explain, and I did not do a very good job of it, was that, consistent with the chain of command, there are company commanders and first sergeants, colonels and a general on the post whose primary responsibility is to inspect barracks. I would inspect barracks. I have inspected barracks. I understand that is part of command responsibility and accountability. Just as we have talked earlier, barracks inspection, the health and wellness of soldiers is critically important.

I only meant by the comment, because it was pointed out that I live right across the street and somehow that I should have been inspecting, it was not that I would not inspect it if someone came to me, particularly General Weightman, and said, you need to go see these, or if somehow talking to a soldier it came to my attention that there were mold or rats or problems in the barracks. I would have been right over there looking at it. I certainly would have alerted the chain of command that I was going to look at it.

I do apologize if I misled you or misled anybody on that. I simply was attempting to articulate the concept of the chain of command and authority in the sense that commanders have responsibilities. In this case I obviously did not check enough on what was going on at Walter Reed. But I do inspect barracks. I have inspected barracks. I inspect hospitals. I visit hospitals and walk through hospitals. I visit new medical facilities that we are building as part of our Army transformation.

Senator COLLINS. Thank you.

Chairman LEVIN. Thank you very much, Senator Collins.

Senator Ben Nelson has very generously agreed to switch places with Senator McCaskill, so that the order now on this side will be Senators McCaskill, Clinton, and then Ben Nelson.

Senator McCaskill.

Senator MCCASKILL. Thank you, Mr. Chairman, and thank you, Senator Nelson, very much.

General Kiley, you just referenced, in response to Senator Collins's questions, about the chain of command. But you are in fact responsible for the culture of command within the MEDCOM of the United States Army, is that not correct?

General KILEY. Yes, ma'am.

Senator MCCASKILL. I am here today to try to—and what I am going to say is going to make probably some uncomfortable and it is going to be awkward, but I think it has to be said about your command of the MEDCOM unit. I would like to speak on behalf of a sergeant from Missouri who is at Walter Reed. He has been there since he lost both of his legs on the battlefield 10 months ago. I had the opportunity to meet him when I went to Walter Reed and spent 3 hours last week.

I have tried to communicate with him since then. At 8 o'clock last night he sent me an e-mail and I would like to read what this sergeant said:

“General Kiley had the opportunity during his time as Walter Reed commander to identify and begin correcting the issues that were evident. Rather than addressing those issues, General Kiley simply swept them under the rug. General Kiley received more avenues to dispose of the issues once he was appointed as the Army Surgeon General. However, rather than addressing the problems he was more aware of than anyone, he continued to downplay and minimize the issues.

“We as injured veterans and those family members who depend on military medical facilities deserve nothing less than the resignation of General Kiley.”

The question becomes, General, what did you know and when did you know it? In late spring 2003, the Veterans for America had a meeting with you and outlined their concerns about what was going on at Walter Reed. Specifically, they talked about people in barracks are drinking themselves to death and people who are sharing drugs and people not getting the care they need.

February 17, 2005, you sat in on a congressional hearing where the following testimony was given: “Soldiers go months without pay, nowhere to live, their medical appointments cancelled. The result is massive stress and mental pain, causing further harm. It would be very easy to correct the situation if the command element supported it. The command staff at Walter Reed needs to show their care.”

This was testimony by Sergeant First Class John Allen, who was wounded in Afghanistan, who said “Walter Reed has a dysfunctional system.”

On December 20, 2006, a board that you co-chair, the DOD Mental Health Task Force, once again you heard testimony concerning the systemic problems of outpatient care at Walter Reed.

The problems of the bureaucracy have been referenced in your testimony today. In fact, the entire panel has referenced the problems of bureaucracy. General Kiley, you are a professional, not a bureaucrat. My question to you is, do you have the authority as the

commander of the MEDCOM in the United States Army? Do you not have the authority to fix the bureaucracy?

General KILEY. In terms of your question about fixing the bureaucracy of med holdover, yes, I do have the authority to fix communications and infrastructure. As it relates to the member of the MEB process inside Army regulations and particularly the PEB process, its adversarial role and the resulting sense of despair among soldiers, I individually do not have authority to change that, but I am bound to work with the rest of the Department of the Army, particularly the personnel community, to fix that.

We recognized some of that in the summer of 2003 and held a task force, a summit, with the Army personnel community and the Adjutant General to begin to address some of the issues that we were seeing in spring 2003 after our ground operations in Iraq began.

I have listened to Mr. Robinson's brief as part of the Mental Health Task Force brief in terms of his presentation along with members of his organization. I do not remember meeting him in 2003, but we were aware of and became aware through my own counselors and my own chain of command whom I met with, if not weekly, twice a month, to address issues of med holdover when I was the hospital commander at Walter Reed.

Clearly, some of these challenges are complex. They are buried in Army regulations. They are buried in DOD Instructions. Again, I reference the complexity, the injuries we were seeing, and the growing number of them. It was a source of frustration for me as the Walter Reed commander that it seemed every day we had new issues that we had to address. We were anticipating as best we could. But the staff worked hard. We paid very close attention to the soldiers' needs. We instituted soldier lounges where the soldiers could sit and watch games, et cetera.

I do not think I was passive in command at Walter Reed. But obviously, as the commander of MEDCOM we sit here today because of my failure to anticipate and correct these things before they happen.

Senator MCCASKILL. I am just concerned that General Weightman was relieved and the Secretary of the Army was relieved, and it appears to me that you are in fact the commander that was in the position to know the most and be in the position to do the most about it. In fact, in your testimony I am concerned, General, because on page 8 it is almost like you still continue to try to diminish the severity of this problem and the fact that it is systemic and that there is so much work that needs to be done.

You say: "Soldiers and family members in January"—this is your testimony today. "Soldiers and family members in January 2007 indicated that less than 3 percent of the outpatient soldier population voiced complaints about the administrative process." It would be hard to walk through outpatient at Walter Reed and talk to soldiers and not confront a complaint in terms of the bureaucracy and the problems. The fact that you want to point out that there were only 3 percent, is that not more a reflection—you do not really believe that only 3 percent of the outpatients had complaints, do you?

General KILEY. I think that was General Weightman's testimony, Senator, not mine. But what that came from—

Senator MCCASKILL. This is your statement that I just read you provided to the committee today.

General KILEY. Yes, ma'am. In the discussions, I was referencing the discussions yesterday. What we did in response to our concerns about families and the issues with families was to begin surveys of soldiers as to what their issues and concerns were. We have not gotten back all the surveys. We continue to do surveys.

There is another way to pulse the system to see if we can find issues and problems. My understanding as I sit here today was that the ratings on the case managers were very good, the ratings for the doctors were very good, but we had a whole list of issues that soldiers had about the bureaucracy, sometimes inpatient, often outpatient.

Senator MCCASKILL. On the sergeant that I have been visiting with who, as I said, is a double amputee, he indicated also problems with the electronics system, and I want to briefly bring that up. As he says, on any computer in the world he can bring up his enlistment contract, all of his award recommendations and commendations, even his counseling statements and evaluation that he received during his time in the military. This can be sent ahead of a soldier that is permanent change of station (PCS)'ing, somebody who is changing their station—for people who do not understand—their permanent station, so the receiving unit knows the caliber of the soldier they are receiving.

Why cannot that same technology be used to expedite the MEB-PEB process? Why is that not a problem that has been identified by your command and fixed while you have been in charge of this part of the Army?

General KILEY. I do believe that that is one of the things that we want to look at through our iterative analysis of the medical board process, is how can we better computerize this program and pass it to the PEB. I agree with you. Why we cannot do that, I do not know the answer why we do not have that in place now.

Senator MCCASKILL. Ultimately, the culture of command is incredibly important here. It is incredibly important in terms of how people feel about complaining and whether they think their complaints are going to go anywhere. I must respectfully say, General Kiley, I think that belongs at your doorstep.

Thank you very much, Mr. Chairman.

Chairman LEVIN. Thank you, Senator McCaskill.

Senator Chambliss.

Senator CHAMBLISS. Thank you very much, Mr. Chairman.

General Schoomaker, as you wind down your career I want to join the sentiments of everybody up here. Thanks for your service to our country.

There is another General Schoomaker who is going to be coming to Walter Reed as our new commander there. General Eric Schoomaker happens to be somebody that I know very well, having served at Eisenhower Medical Center at Fort Gordon. He is a good soldier, a good outstanding physician, a good administrator, and I have every confidence that he is going to be able to address the situation at Walter Reed as we move forward.

Gentlemen, a failure on the battlefield brings disastrous results. Here we are seeing a failure off the battlefield that brought about

disastrous results that none of us are happy about, obviously, including you. This is not the first time this has happened. In 2003, we had a very similar situation that took place in Fort Stewart, Georgia, with our Iraq Walter Reed veterans as the Guard and Reserve soldiers in the medical holdover unit were waiting months for follow-up treatment and the facilities and the living conditions which those men and women were put in were horrible.

At the time, although we were horrified at how our heroes were being treated, the Army was very responsive and implemented immediate changes at Fort Stewart. In fact, the Army staff and the Pentagon assured us, and I quote: "What we learned from this incident is going to help the Army when we have other major units returning from Operation Iraqi Freedom."

Given this response, the Army's recognition of the problem, and the commitment from the Army at its highest levels, and even the implementation of new policy from then-Acting Secretary of the Army Les Brownlee, I have to wonder what the Army actually did learn and take away from the situation at Fort Stewart. Basically, it concerns me greatly and it should concern all of you that we have seen this problem before and apparently we did not learn enough from it to stay ahead of the issue.

In relation to the issues that came up in Fort Stewart in 2003, can you share what were the lessons learned there and how and who were they shared with, and who were the take-aways communicated to, and what changes were actually implemented? Dr. Chu, let us start with you.

Dr. CHU. Let me start with an issue General Schoomaker has already addressed, which is the adequacy of our housing facilities for our personnel. I think one of the important issues at Fort Stewart was that with the mobilization of significant numbers of Reserve personnel, the higher training needs for this conflict, we needed more and better housing facilities.

The Department had already embarked on a course of action to improve those facilities before the Fort Stewart concerns were raised. That was one of the hallmarks of his initial decisions as President, the President's decision to direct the Department to do so. We have put substantial money into it, but I am with General Schoomaker. It is not a problem, unfortunately, and I think this is ultimately the source of the Building 18 immediate issue, that can be rectified overnight. There is a limit to how fast you can do this.

We have made enormous progress in both family housing and barracks housing. We have been spending a billion dollars a year or so on barracks housing in the Department during the course of this administration. Have we caught up in all areas? No, sir. Are we committed to catching up in all these areas? Yes, sir. But it is a major challenge to take the Department, which had not invested, I regret to say, in earlier decades in the housing stock the way it should have, to get to the right place.

Now, in the short run—and one of the earlier questions dealt with this. In the short run, it has been complicated by the commotion over—Senator Inhofe raised this question—the MILCON appropriation for fiscal 2007. I am very hopeful we can get that straightened out because that is indicative of how we do fall short. As one of the other questions emphasized, when we do not get the

funding you cannot execute. So it is important to keep that funding train, the BRAC funding train, on track, if not, as Senator Warner suggested, accelerating somewhat.

I think the major lesson, one of the major lessons that came out of Fort Stewart, was this question of the adequacy of our billeting for our troops across the board. We did not have enough for the expanded operations today. We have put money into that. It does take time. It was not all done in 1 year and there are still issues to be addressed.

Senator CHAMBLISS. Anybody else care to comment?

General SCHOOMAKER. Sir, I will comment because the Fort Stewart situation was one of the first things that confronted me when I was brought back into the Army. It was one of the first challenges I had. I went down there and visited. The lessons learned from Fort Stewart were many. There were over 600 soldiers down there in the Fort Stewart deal. The reality is is that was a mobilization issue. Very few of those soldiers had deployed and been injured. In fact, I think something like 14, or less than 20 anyway.

Nevertheless, we have a responsibility once bringing soldiers on Active Duty to correct and to return them corrected. So it is a different issue in many respects, yet the same issue in terms of the administration—the housing, the chain of command, the administration of medicine and the MEB/PEB process and all the rest of it. What we largely learned was to mobilize soldiers and prepare them with their pre-mobilization training, medical readiness, et cetera, before we mobilize them and brought them on Active Duty. That was one of the big lessons.

We obviously learned a lesson in chain of command. We learned a lesson in having adequate housing and capacity, et cetera. The problem that we are dealing with here on the back side of this is an additive problem, and that is many of these soldiers that we are now dealing with have very serious war wounds, multiple wounds, all of the issues we have heard on TBI and PTSD, and all the rest of that. That complicates it enormously as this process arbitrates it. So it magnifies way over what Fort Stewart was the challenge that faces us here to do right by these soldiers.

Nothing I have said is an excuse. It is that this is by far a more complex problem that we are facing here than Fort Stewart was. So Fort Stewart did not have all of the answers to the dilemma that we face today. No excuse for either one of them.

Senator CHAMBLISS. General Kiley, in your testimony you talk about the fact that between 2001 and 2005 more than \$400,000 in renovations were made to this Building 18. In 2005 \$269,000 in renovations were made. Who made the decision to spend that money on Building 18?

General KILEY. Sir, I believe my predecessor at Walter Reed made a decision in 2001 to do some renovation. While I was the commander, the numbers that I remember—I was reminded that we put \$40,000 into the building for new carpets and curtains.

Then in 2005, I believe General Farmer made the decision to do a major renovation at the \$260,000.

Senator CHAMBLISS. During the process of your making the decision to spend money on this building, did you go in that building?

General KILEY. No, sir.

Senator CHAMBLISS. Did you know what you were spending the money on at the time?

General KILEY. Yes, sir. That was not a patient billet in my command. It was a standard barracks. The commander came to me and said: Look, we could use a little bit of help in Building 18; I have some student detachment soldiers over there and I would like some money to replace the carpets and the curtains. I do not remember the specific conversation, but I approved the money.

In retrospect, would it have been good to go over and take a look? Certainly. Certainly, now with what we have seen, I erred in not doing that. But I trusted my colonel commander and the garrison commander that that is what it needed.

Senator CHAMBLISS. Who made the decision to convert this into a building to house patients?

General KILEY. Sir, it is my understanding that General Farmer made the decision to do that, because of the load of soldiers that he was having to care for.

Senator CHAMBLISS. Is it standard operating procedure to make a decision like that without examining the building? Is that part of the bureaucracy issue that we are talking about?

General KILEY. No, sir, I do not believe that is true. I honestly do not know whether General Farmer examined that building before he made the decision with his chain of command. I certainly think that part of our error and certainly my error in counseling my commanders, I clearly failed in this regard, is in anywhere that we are putting patients, soldier patients, despite the fact that we have worked very hard on that from day 1 at Fort Stewart until a couple of weeks ago when the papers revealed our shortfalls, that patient care and patient billeting areas should have the highest priority.

That was part of the problem we found with Building 18, and I failed in that regard.

Senator CHAMBLISS. Thank you, Mr. Chairman.

Chairman LEVIN. Senator Clinton is next. There is a vote on. We are going to work right through this vote. Senator Clinton, when your time is up will you recognize the next Senator in order. You will be given that list. I will try to get back here in about 10 minutes. If no one is here, could you just recess it until one of us returns.

Senator CLINTON. Yes, sir.

Chairman LEVIN. Thank you.

Senator CLINTON. Obviously we are here today because we are all distressed by the problems that are facing our wounded soldiers. I think we all agree that these men and women are the best we have and they deserve a lot better from our government and our country.

I have tried to focus in on the needs and treatment of our wounded and sick soldiers, and over the last 2 years I was disturbed by reports about pay problems that wounded soldiers were confronting and had an amendment accepted in the last year's DOD authorization bill. My office was recently briefed on the result of a study that I commissioned in that amendment, an audit that found that 24

percent of wounded soldiers requiring inpatient care had underpayments. That is, they were not paid on time.

The Army I know is working to fix the problem, but the number is still too high. Now we have learned that wounded soldiers are living in substandard conditions, trapped in bureaucratic red tape. This is just the latest incident. If all we were here to talk about would be the problems in Building 18 and the other problems that have emerged, not only at Walter Reed but other of our facilities, that would be disturbing enough. But there is a pattern here that somehow we are just not focused on what needs to be done to help these young men and women.

I am deeply concerned that the problems they are confronting could be, frankly, overlooked again if we just focus on who made what decision to put in new carpeting in Building 18 and what else needs to be done. This is a systemic problem.

When I was out at Walter Reed on Friday I had an opportunity to visit with a number of our wounded and sick soldiers from New York, as well as seeing Building 18 for myself. One of the common denominators of the complaints I heard remains the disjointed and unfair MEB/PEB process, the untrained and overworked PEB liaison officers, the various stops along the process, the lack of legal counsel during appeals, the prolonged period either to start or complete the process.

We have already heard about the disconnect between the VA schedule for rating disabilities that does not adequately address the current nature of wounds like TBI and PTSD and amputations and hearing loss and diseases. In the audience is Steve Robinson. He and I worked together a couple of years ago in trying to get a pre- and post-deployment physical exam done so that we could actually tell what was the condition of a soldier before being deployed and the condition of that soldier when he returned. One of the things we could not get through was a mental exam assessment before someone was deployed.

We are now hearing that people who are reporting with TBI and PTSD are being told it was a preexisting condition. If the proposal that I had made and that others had lobbied before had been accepted we might have a baseline to figure out what actually happened to these young men and women during their deployments.

The problem that I heard over and over again is a perception that Walter Reed was concerned with releasing soldiers from Active Duty at a greatly reduced disability benefit level, as quickly as possible, a lump sum solution, cheaper than a lifetime of financial retirement care.

I have a number of soldiers whose specific cases I would like to present to you and to get your response to. A specialist from Grand Island, New York, appealing his PEB disability benefit rating of 20 percent, has chronic pain conditions and without medical retirement will not qualify for lifetime insurance. The pain condition is debilitating. He does not believe that is being taken into consideration.

Here is the dilemma he faces today. He has been offered a new treatment, but if he accepts the new medical treatment he loses his opportunity to appeal. If he proceeds with his appeal, he loses his opportunity for the new medical treatment. There is just something

wrong with that kind of Hobson's choice to present to this young specialist.

A major from Manhattan. He was injured in Operation Enduring Freedom in 2001, but stayed on Active Duty, deferred treatment until finally he could not, and now he has been at Walter Reed for 26 months. He did not feel he was being well taken care of at Walter Reed, so he sought treatment at Bethesda, where he was able to appeal the Walter Reed prognosis and receive the surgery his injury required.

He began the MEB process in December 2006, but has not been able to meet with his liaison officer because she cancelled his first four appointments and now is too busy to meet with him. He is trying to get legal assistance. His requests have gone unanswered.

Finally, a staff sergeant from the Bronx, also appealing a PEB disability percentage, because he believes that the case mis-evaluated his pain and did not give him a high enough return. When he met with me, he denied himself his medication so that he could meet with me and feel like he was in full control of his faculties, and it was totally evident to me that he was suffering from pain on an ongoing basis.

So it is really important that we take on this MEB and PEB process. But again, I think we have to do more to try to clean up the system now. I know we have to approach the longer term problems, but it does strike me as totally unacceptable that, according to press reports, there are three lawyers and one paralegal to handle a 750-case caseload to deal with these PEB appeals.

General Schoomaker, we have over 4,000 Judge Advocate General (JAG) lawyers in the Active, Reserve, and National Guard of the Army. Can we please get some help to try to clean up this backlog and get people some legal assistance as they are trying to go through this process?

General SCHOOMAKER. We are going to gang-tackle that out there. I am not familiar with the numbers you just said.

General KILEY. I agree with the Senator that we have to get this stuff fixed. I agree with the Chief; we are going to take that on. This is my reference earlier. There are things or actions we can take—more JAG officers, more caseworkers. I do think that the first case, the young soldier with the 20 percent disability, Senator, does not rise to the 30 percent which is the medical retirement. Frankly, it is not the fault of the doctors or the case managers and it is not the fault of the people in the PEB who are just being stingy with the dollars. It is more based on what our regulations and our policies have in place.

To me, even if it is a temporary medical retirement until the soldier heals up more, I think we should be much more aggressive in recognizing that. The VA is very quick to recognize the whole man or woman and reimburse at a much higher rate. But as we have said earlier, that does not get you the medical retirement, it does not get you the care for your children and your spouse. There is clearly a financial impact over the long haul to the Department and to both Departments in terms of that. But I think it is the right thing to do.

The individual obstacles about getting appointments, et cetera, we are taking that on right now, as the Chief has said.

Senator CLINTON. Obviously we need, as General Schoomaker often does very memorably say, to gang-tackle this problem and let us try to get it on a faster track. Obviously, we have systemic problems.

I just want to end with two additional points because I am going to have to recess and go vote. Or maybe, Senator Dole, can you go next?

Senator DOLE. Yes.

Senator CLINTON. Let me just conclude by saying, number one, I am deeply concerned about the impact that the BRAC Commission order had on Walter Reed. It was I believe demoralizing. I do not know that we can put an exact frame around what did not happen because people were either of the opinion that they were going out of business in a few years anyway or they were pulled off of caring for patients and dealing with the important issues right in front of them because they were involved in planning for the eventual end of Walter Reed. I really hope—and I told Secretary Gates this—you got to take a look at this. I do not have an answer for it, but I think it has undermined an already fragile system.

Finally, these independent contractors. It is a problem. Our government is outsourcing important services to people who we are not accountable for. This idea that yet again Halliburton, and it raises its head by being a former Halliburton official who got a contract to do in-house maintenance at Walter Reed—I tell you, folks, this has to end. Somebody has to be responsible, and all this contracting out of the important work that we are doing and then we try to turn around and find out who in the chain of command is responsible. Well, let us start by making it clear that we are just not going to turn over important jobs to people that we are not directly responsible for.

So with that, I am going to have to run to vote. But I am going to leave it in the good hands of my friend and colleague, Senator Dole. I want to commend your husband, Senator Dole. Former Senator Dole and Secretary Shalala are going to be heading up this commission and I think the President has made a very good choice of the two to do that.

Senator DOLE. Thank you very much. I agree with what you just said.

Gentlemen, we know that Walter Reed has a reputation for providing world class care for our wounded soldiers. Doctors, nurses, and other medical personnel at Walter Reed provide extraordinary care to the servicemembers at this facility. It is this excellent reputation that makes these recent revelations all the more appalling. I have to believe that a profound failure of leadership at many levels is responsible for these deplorable conditions.

Everyone from the top down, from the people overseeing Walter Reed to the nurses aides, must above all else think first of the patient. If that concern is compromised, even the best facility in the world can quickly become cold and inhospitable, potentially undermining the quality of care.

This committee has the responsibility to our servicemembers and to their loved ones to thoroughly examine what has happened at Walter Reed and to ensure that every mistake is corrected and

every wrong is made right, so that our Nation's heroes are always treated with the dignity and care they so richly deserve.

General Schoomaker, let me ask you, how do we go about selecting our senior leaders to command at institutions such as Walter Reed? Have we been doing something wrong? Are there ways in which the selection process can be improved?

General SCHOOMAKER. I think the ways in which leaders are grown and developed is very complex. There is actually training and education, et cetera, that goes into all that. But there is also statutory board processes that select people for promotion under the law. When you get to positions, commander positions, we have boards of officers that sit and look at people's credentials. Obviously, in the case of medical credentials, the Surgeon General is involved in that, and we select people based upon not only their specialty, but based on the responsibilities, the broader commandership, leadership, and demonstrated performance previously.

It is one of the most important responsibilities we have. We call it growing the bench. We selected a new commander at Walter Reed who happens to be my brother.

Senator DOLE. Right.

General SCHOOMAKER. You need to know that I recused myself from that process, rightfully so, and allowed the proper people to look at who was best out of who was available.

By the way, everybody was available out there. This was not just who is closest and we can grab by the shirt sleeve, but taking a look across the whole inventory of people that could help solve this problem. In this case, Major General Eric Schoomaker ended up being the one that surfaced, which I agree was a very good choice.

So I tell you, I think leader development is one of the most important responsibilities we have. You can see what happens when we have a failure in these systems and why it is so important that we reinforce the chain of command and hold people accountable and do the things we have to do. These are very, very complex commands we are talking about.

Senator DOLE. General Schoomaker, General Matthew Ridgway in his history of the Korean War observed that there is never a shortage of physical courage on the battlefield, but that there is often an absence of moral courage when and where it is needed most. I cannot help but conclude that we confront a similar situation today.

Do you believe that we are observing an instance of leaders failing to speak up because they believe they must operate within a fixed top-line budget?

General SCHOOMAKER. No, I do not. I believe that obviously that is a factor, but I believe in this case there is just a failure in performing their duties and to ask the right questions, look in the right places, and to take the right kinds of action based on what they saw. I think that is what this is.

I also think it is an extraordinarily complex system that they are having to deal with. If you think about what the commander at Walter Reed has to deal with, it is not just the administration of this very complex process we are talking about, but he is running a small city. He is concerned with the health and welfare of all the people that are there, the scheduling and the patients and all of

the things that go on, the physical security and maintenance—very, very complex.

So the financial aspect is an important factor, but there is no reason, there was no financial impediment to do what was right here. We, as I said upfront, have been spending hundreds of millions of dollars correcting inadequate barracks, inadequate conditions in all of the rest across the Army, and we certainly should have not had them at Walter Reed.

Senator DOLE. Thank you.

Mr. Chairman, I understand I am going to miss the vote if I do not leave immediately, so thank you very much.

Chairman LEVIN. Thank you, Senator Dole.

Senator Ben Nelson. Again, our thanks to you, Senator Nelson, for your accommodation.

Senator BEN NELSON. Thank you. Thank you, Mr. Chairman. I want to thank the panelists for being here today as well.

General Kiley, to be in charge of a hospital, in many cases it is the person who has an MBA or a hospital administrator's experience or management experience that is used as a base for determination of somebody who would be qualified to run a hospital. This is not pejorative. It is just an inquiry. Do you have an experience like that, an education in hospital administration, or any particular qualifications other than your rank, which I am not going to challenge?

General KILEY. I do not have an MBA in hospital administration, Senator. My experience in a series of positions inside the Army medical department over the last 20 years, really longer, both as a practicing physician and as a senior executive inside the Fort Bragg Medical Center, and then as a hospital commander at Landstuhl from 1994 to 1997 I would say or characterize prepared me for further assignments, to include command at Walter Reed and the North Atlantic Regional Command.

We have a system, as the Chief has referenced, of leader development inside the Army medical department. It is not just doctors that command hospitals. We have had, we have nurses commanding, medical service corps, medical specialist corps. We have had a nurse, Major General Pollock, commanding at Tripler, and Brigadier General Rubenstein commanded Landstuhl as a medical service corps officer. We are seeing a nurse command Landstuhl.

I am very comfortable that the system leader develops our officers of all corps. Now, dentists do not command hospitals because they command dental, and the veterinarians do not command because they command veterinarians.

There is one small point that is not a small point, and I think General Schoomaker referenced this, that unlike the civilian community, a hospital commander is more than just a manager or leader; he is a commander or she is a commander. There is part of understanding what command is about, accountability for command, executing the mission, completing the mission, being held accountable morally, physically, ethically for your performance. Not that they do not do that in the civilian, but there is real authority vested in commanders that I do not know that there is necessarily a counterpart in the civilian. That is also part of the career development and the leader development inside the Army medical de-

partment. We certainly have courses—CGSC that we now have, it is called. It has changed its name. We have the War College. We have courses in medical administration. We do have officers who have gotten advanced degrees in hospital administration. We have the Baylor program which graduates classes every year.

Senator BEN NELSON. Do you think that having some specific education, specific experience in information technology might have led to finding a solution to the problems of the bureaucracy and particularly the paperwork? I have heard of 22 forms that had to be filled out with 8 different commands, to the point where a staff sergeant, after moving to outpatient status, had appointments for 2 weeks and nothing. “I thought, should they not contact me? I did not understand the paperwork. I would start calling phone numbers, asking if I had appointments. I finally ran across someone who said: I am your case manager; where have you been?”

That is a combination of a lack of coordination of the care command and the garrison command, as well as the paperwork. Would information technology help in that area?

General KILEY. Yes, sir, it would. We have evolved an electronic medical record inside not only the Army medical department, but the entire MHS, that we call ALTA. It is not complete yet. There are parts and pieces of it, as they say, that still need to be developed. It is a very big and complex, privacy protected program that is worldwide. That is part of the solution.

Moving the MEB and PEB process to a totally paperless process would improve it. But if we still have 22 forms that have to be filled out electronically, that is still 22 forms that need to be filled out.

Senator BEN NELSON. Or fill out one and transfer it to 20 different locations.

General KILEY. Yes, sir, but it is about 20 different forms with potentially 20 different pieces of information on it. It is very cumbersome, and we want to challenge the complexity of that.

Senator BEN NELSON. Secretary Chu, I have the American Legion coming in today, the VFW coming in today, the Nebraska Veterans Home Administrators coming in today, and the VFW coming in tomorrow. What should I tell them?

Dr. CHU. I think you should tell them that we are committed to correcting the shortcomings here, we are committed to looking at the fundamentals of the system, and that we are and we will get on top of the issues that have been raised.

Senator BEN NELSON. Can I tell them that we are going to work toward seamless care and seamless transfer from Active Duty status to the veterans care, so that we do not have people stranded somewhere in between or trying to choose which one works better for them?

Dr. CHU. Absolutely. We have made, I think as you are aware, significant progress on that score in the last several years. We have a system now which alerts the VA, particularly when someone is going to go on the temporary disability retirement list, that this patient is coming so they can begin the reception process and so that there is not a seam in the process.

We have sent several million records electronically to the VA in the last several years so that they have that evidentiary base. A

much stronger relationship I would argue, sir, between the two agencies now than there was 5 or 6 years ago.

Senator BEN NELSON. As much as we commend, and I think we should commend, the inpatient care, the acute care facilities, and the care that the soldiers get is outstanding and second to none, and the care that is provided by the caregivers, whether it is the physicians or the nurses or the other personnel and staff, is outstanding. But it does break down, as we have talked, about outpatients. It is not just the outpatients that have been there on the campus or across the street from Walter Reed. People get stranded when they are sent home.

I met with, a little over a year ago, a soldier, a wounded soldier in Nebraska who was sent home with floating ribs and the kind of care that was going to require somebody who had—a bone surgeon, it was going to have to have something in the orthopedics. The follow-on care was so inadequate that when I met with that patient and her parents that they had not been able to get calls back, they had not been able to get referred to a physician in Nebraska in the middle part of the State, 200 miles from Offutt with the hospital and care that might be available there.

I just picked up the phone and called the nurse at Walter Reed who was assigned to this patient. This nurse was apparently very overworked and asked me why I was butting in. I got to thinking, if a United States Senator has trouble trying to cut through the bureaucracy, why would you not expect the average family might have a very serious problem cutting through that follow-on care, that aftercare, when somebody is sent home to convalesce, as you said, General Kiley, the healing process.

Well, this healing process I think was interrupted by the lack of follow-on care. Fortunately, by the end of that day we were able to get an orthopedic physician assigned to that patient, that hero, that wounded soldier, who was otherwise unable to get it done.

We are going to have to do a great deal more to make sure that the follow-on care, the aftercare, because there is a stranding that can go on once they are that far away from Walter Reed or from wherever the facility is.

So I guess, Dr. Chu, can I tell them that we are going to do a better job for follow-on care and follow-up care and to make sure that the aftercare that they get is first rate just like the acute care that they get at the hospital?

Dr. CHU. Yes, sir. If I could reiterate, that is one of the reasons we created this military severely injured center, as a backstop to the service programs. We recognize that people may not get satisfaction at the first level. We need another level of intervention. So to that individual now or in the future who has those issues, if he or she is not satisfied with what was done, that telephone number is there 24 hours a day with a masters degree level person who is trained to intervene in the bureaucracy, figure out what is the issue, and get it resolved and provide a warm handoff to another person for the resolution of that problem.

So I invite those who feel that—and I think that is part of the issue here. There are going to be individuals who are not satisfied with the first level response. If they are not satisfied, that backstop

is there and that safeguard is there to try to make sure we do not have these situations.

Senator BEN NELSON. That might help avoiding the situation that I had with the near-Nurse Ratchett situation. Thank you.

Dr. WINKENWERDER. Senator, if I might also say, that just should not be the experience that someone should have. I happen to believe—

Senator BEN NELSON. I did not think I should have been treated that way, but I was not the patient.

Dr. WINKENWERDER. Absolutely. Not you or the soldier. It just should not happen.

I think that from where I look at this across the entire system, people need to understand, we take care of across the entire system 110,000 patient visits a day. This is a very large system. This is not a large number of people that we are talking about who have these issues and concerns. We ought to be able to have case managers who could follow these individuals and ratios so that we ensure that everybody gets touched and helped when they need to.

I would just add one other thing that we have done that I think is making a difference. It is the 4- to 6-month post-deployment health reassessment process that started 2 years ago. Everybody, not just when they come back, but 4 to 6 months down the line—and this is when many problems do occur, not necessarily for everybody—but we reach out, and it is a requirement. Every single person is supposed to have that, that touch and evaluation, not just a questionnaire; personal, professional evaluation: How are you doing? How is your family doing? What do you need?

So that hopefully is another step to reach out to people.

Senator BEN NELSON. We sure know more than we knew before. Thank you.

Chairman LEVIN. Thank you, Senator Nelson.

Senator Webb.

Senator WEBB. Thank you, Mr. Chairman.

I believe that, gentlemen, the opinions of this committee have been pretty forcefully stated today. I am going to resist the temptation to pile on in a lot of anecdotal ways here. I would like to thank the chairman, first of all, for committing to further hearings, particularly with the Veterans Committee. I am also on that committee. I think it is probably the best way to address some of these overlapping issues.

Dr. Chu, always good to see you. I have been privileged to work with Dr. Chu for more than 20 years, 4 years inside the Pentagon on a daily basis. We were sort of fellow data dinks and I know how hard it is to scrub some of these numbers.

I approach this issue from two different perspectives, one as a lifetime recipient of military medicine. I grew up in the military. I was very fortunate to be the recipient of a great deal of compassionate care while I was on Active Duty, after I was wounded, when I was recuperating, and I have been able to use the system since then because I was medically retired from the Marine Corps following that experience.

I also have worked on these issues as a committee counsel on the Veterans Committee when we were looking at a number of these issues nearly 30 years ago, some of them. Particularly, one com-

ment, Mr. Chairman, with respect to the questions about the military evaluation of PTSD. I served as counsel for a good percentage of those hearings when we were attempting to fully understand PTSD back in the late 70s. One of the challenges with PTSD is that it does not always manifest itself when you are on Active Duty. It is a very difficult thing, I think, for military medicine to get its arms around.

What we were seeing when we were looking at the data—and we went back to all war eras when we were looking at PTSD—is that in many cases it will not manifest itself until typically 8 to 10 years after someone goes through the experience, and then again more than 20 years after someone goes through the experience. So this is an area that in my view should be a principal focus of the VA with correlation with DOD.

With respect to BRAC, just having listened to some of these hearings, one of the things that I have observed over my lifetime is the continuing consolidation of medical facilities. It is difficult to recruit physicians. It is difficult to keep them on Active Duty. When I was on Active Duty, we had a full-up hospital in Quantico. I was treated there. We had medical facilities down here at 23rd and Constitution Avenue that I used when I was in the Marine Corps. They are gone.

So when we talk about eliminating yet another facility, even though I take the point with respect to the consolidation of research information and the ability to have the National Institutes of Health (NIH) across the street and all the rest of that, I am very concerned whenever we start eliminating military medical facilities, given not only the people on Active Duty, but also the retiree population that frequently is served by military medicine.

But I also look at this and cannot help but look at this issue with the perspective of someone who spent a good bit of time in command and also civilian responsibilities. Uniquely in the military, there are the responsibilities and the obligations of command. One of those responsibilities is to show up and to supervise any facility that is under one's jurisdiction. When I would visit ships when I was Secretary of the Navy, the first thing I would do would be to go down to the engineering spaces down in the boiler rooms, and one of the first questions I would ask them was: When is the last time the commanding officer visited you down here in the boiler rooms, where the 1,200-pound steam boilers were going? That was a pretty good indicator, I think, of command, of command responsibility and the attention that command was paying.

To borrow another metaphor here, General, this is sort of the boiler room. This is the boiler room of Walter Reed. People needed to be showing up and talking to the troops and asking them how they were doing.

What I have been seeing from the veterans side and also from the military side on these issues is that we seem to be at a clear breakdown at the point of transition, with DOD on the one side in a number of these problems, how you process these people after they have been given undoubtedly some of the finest medical care in the world, how we process them, evaluate them, either return them to duty or get them into the veterans network.

Also on the VA side, we have a 400,000-case backlog in the VA in terms of evaluating people's claims. These transitional programs go beyond medical. They go to disability evaluation. Dr. Chu, I want to ask you a question about this in a minute. They also go to such areas as how we are rewarding service, which is one of the reasons that I introduced a good GI Bill, a World War II type GI Bill, for these people who have served since September 11, which seems to be resisted in some cases because potentially of the cost. Well, how do you evaluate the price of service and how do you evaluate the value of service?

What I am seeing here in many cases is an indication of where leadership is putting its priorities, civilian and military. We know we have to put priority on the battlefield. But we need a greater expression from this administration and from military leaders about these kinds of priorities, the sorts of things that we are focusing on.

I have a question—and again, Dr. Chu, you and I love data. This is a March 20, 2006, GAO report on the military disability system. It has been around for a year. Its title was “Improved Oversight Needed to Ensure Consistent and Timely Outcomes for Reserve and Active Duty Servicemembers,” and it goes through the evaluations of individuals and how their disability claims were processed.

One of the things that jumps out at me—I am not going to ask you to answer this in detail today, but it is just a real point of curiosity. It is on page 50 of this report, where it gives the statistics for disability evaluations from 2001 through 2005. On the face of it, it is an Active Duty versus Reserve component evaluation. But here is the thing that jumps out at me, and it goes along the line of questioning here about perhaps pushing these people out of the system, or maybe it is just the inability to collect the right kind of data.

What it shows here is that on the Active Duty side there were in 2001 6,378 total people evaluated, in 2002 6,632 people evaluated. By 2005, with the war going on, there were only 6,465 people evaluated. That just seems implausible to me when you consider the casualty flow from these operations from woundeds and also from people who were injured but not wounded.

I would greatly appreciate a clarification of this data before we can jump into trying to figure out where solutions might be needed.

Dr. CHU. Delighted to.

Senator WEBB. Good. Thank you very much.

Thank you, Mr. Chairman.

Chairman LEVIN. Thank you, Senator Webb. You are looking for that for the record?

Senator WEBB. Yes, I would appreciate a response for the record. We can provide you with a follow-up letter with the data on it.

[The information referred to follows:]

The data on page 50 of the Government Accountability Office report is incorrect. The Department asked the Army to verify their data, and the Army provided corrected data for disability dispositions, as shown below. These revised data show an increase in the number of soldiers in the Disability Evaluation System (DES), especially for the years 2004 and 2005. In 2006, there were 7,665 Active component soldiers in the DES, which is a significant drop from 2005, but is still significantly higher than in 2001. For the Reserve component, the increase was significant across

the last 5 years, from 567 in 2001 to a high of 4,213 in 2004, and with 2,784 in 2006.

UPDATED NUMBERS FROM THE ARMY

March 5, 2007

Case Count by Calendar Year	Physical Disability Case Processing System Total
Active component:	
2001	6,557
2002	6,907
2003	6,094
2004	8,277
2005	9,297
2006	7,665
Reserve component:	
2001	567
2002	773
2003	1,624
2004	4,213
2005	3,221
2006	2,784

Chairman LEVIN. That would be great.

Senator WEBB. Thank you, Mr. Chairman.

Chairman LEVIN. Thank you so much.

Senator Kennedy.

Senator KENNEDY. Thank you, Mr. Chairman. I think all of us are grateful to you for having these hearings and, as others mentioned, enormously troubled by all of this situation.

Let me just mention—I know you have heard these stories before, but just in my own State of Massachusetts we have story after story of the soldiers who are wounded: Bilad, Iraq, November 2003, changing a tire on an Army helicopter, accident resulted in the loss of both arms; working with the USO, our office facilitated the soldier's family's travel to Washington, DC, so they could visit at Walter Reed. Then the family contacted us because it appears that the soldier was falling through the cracks. He received adequate care at Walter Reed, then experienced difficulty receiving care at a VA facility because the discharge paperwork was delayed. Ultimately, because of administrative problems he needed assistance in receiving his annuity pay, as well as receiving care at the Brockton VA hospital.

We have instance after instance of that type of thing, which we must avoid.

But let me come back to the central issue, and it is not unrelated to what Senator Webb has mentioned. A month ago the DOD reorganized the way it releases the casualty figures from Iraq and Afghanistan. On January 29, the Department's Web page listed a total of more than 47,000 non-mortal casualties. The next day, on the same Web page the category of non-mortal casualties had been replaced by one titled "Total Medical Air Transported," and the figure was slightly more than 31,000.

This new figure excludes more than 16,000 wounded or injured servicemen and women whose conditions were deemed not serious enough for evacuation. On the Department's press resources Web

site, only those who are wounded in action are mentioned, about 23,000 troops. So we have these figures. These differences are both confusing and raise questions that we hope that you can answer. They have implications in both the short- and long-term about care of our troops, about allocations of resources, about what the needs are when you have these kinds of disparities.

Dr. Winkenwerder, why has the DOD suddenly felt the need to cut in half the number of soldiers who needed the care?

Dr. WINKENWERDER. Senator, thank you for that question. There was confusion. I think we within the Department created that confusion unnecessarily. Let me assure you and others that there is no intent other than to accurately and properly inform everybody of what casualty figures are and what they are not, just to be absolutely candid about this.

What had arisen was the term—it gets to the term “casualty.” The individuals that were being moved from the theater for the last 3 or 4 years for whatever reason—and early on there were quite a number of people because there was not medical care there—that might have been moved for a routine exam, a female exam, whatever, these were not casualties. These were just people moved for routine care. That is called medical air transports.

People had taken that information, I think because we had expressed it improperly, and had concluded that these were war injuries or war wounds, and they were not. So it was just an effort to clarify that. We should not have misled people in the way that we did in the first place. So that is what it is, that is what it was. The figures are what they are, and it would be crazy, absolutely insane, to try and imply that the figures are any different than what they are. That is it, that is the answer.

Senator KENNEDY. Thank you, but how—what were your—did you have the estimates of what you thought were going to be the casualties? Did you make the estimates now of what you thought were going to be the casualties, say for March of this year? Did you make those estimates a year ago or a number of months ago, so that you would know whether there is going to be the allocations of personnel and the allocations of resources and the training of different personnel and trying to anticipate that? Are these, the numbers that we have now, the same as those? Are they different? How are they different?

Dr. WINKENWERDER. The casualty estimates, going back to even the beginning of the conflict, are generated by, and any projections of those and therefore what sort of medical resources in theater do we need, are made by the Joint Staff. They are really military estimates. We review them and assist it with ensuring that the right level of medical care was in theater.

As things have progressed, obviously, over the last 3, now 4 years, we observe and track, and I know General Kiley and the other surgeons general and the other service leaders are tracking the casualty flow to ensure that all the resources not only are there in theater, but when people get back. That is how it is done, and so there is a constant look at it.

Senator KENNEDY. Dr. Chu, did the career professionals in DOD estimate the number of military personnel who would need health care services as a result of service in Iraq and Afghanistan?

Dr. CHU. The Department has conducted a thoroughgoing analysis of what the size of its capacity needs to be for all our contingencies, including the ongoing challenges in Iraq and Afghanistan. Based on that, we have sized the present and future medical establishment.

I also want to note the Department has transformed—this is an extraordinary achievement by the medical community—how we deal with war casualties. Our prior model, as you are aware, was to try to take forward the care apparatus. That is bulky, it does not necessarily get the best clinical care for the complex wounds we are seeing today. The transformation in these two conflicts, Afghanistan and Iraq, is that the role of the forward medical community is to stabilize the patient, to act as a safeguard against any surge in casualties, but that our objective is to bring the casualties back to the United States, where we can concentrate the best clinical talent on their recovery, their recuperation.

That is the great achievement in the last several years. It is an enormous tribute to the skill of the medical personnel in theater, to the skill of medical personnel who are manning this in-transit system. As you have seen in the press reports, people are accurately reporting that they have gone from the battlefield to Walter Reed or Bethesda, often in 36, 48 hours, and they are the better for it.

It allows us, among other benefits besides the sheer medical benefit of the transformation, to bring the family to the bedside in a way that the previous model did not. Really quite an extraordinary change in how we do business.

Senator KENNEDY. Secretary, no one is complaining about that. We are full of admiration for that service. It is heroic efforts, every single day, the people. That is not our issue that we are talking about here. We are talking about an entirely different situation, what is happening to these individuals over their experience of their lives.

I mentioned—I will give you another. Here is soldier number two, a paraplegic, served two tours in Iraq and Afghanistan, due to injuries sustained in combat ended up at Walter Reed, transferred to West Roxbury VA facility, did not have specific problems with the care, but once transferred to the VA facility the Army, specifically Walter Reed, lost track of him, resulting in lack of pay for the soldier and his family.

Our office was contacted to help out in October. We talked to Walter Reed. The paperwork was incomplete, leaving him in a troubling grey area where he is not on Active Duty, not officially discharged. This is the situation that is repeated, where people are being left out and effectively dropped.

Another patient received psychiatric treatment at Walter Reed, had been at Walter Reed for 21 months. He came to our office, he was getting transferred to a VA hospital. Once he got transferred to the facility, his family was told that he was being discharged because he was technically still Active Duty and his discharge documents were waiting on signatures. Due to the fact that he was no longer at Walter Reed, yet not a veteran, he was unable to receive any kind of benefits.

This is instance after instance. I am not going to take the time, but that is the great gap that we are seeing, and that is both in treatment and in care and attention and focus. As was mentioned, I think, earlier during the course of the hearing, getting an advocate, the advocate that is going to speak and follow for the individuals, is something which is enormously valuable and very helpful in the health care system in any event, and is something that we certainly ought to consider with regards to the veterans.

I thank the chair.

Chairman LEVIN. Thank you, Senator Kennedy.

Senator Sessions.

Senator SESSIONS. Thank you, Mr. Chairman.

As is so often the case, I had another hearing, but I have benefited from what we have heard today. I believe Secretary Gates has an awesome responsibility and he has ultimate responsibility for everything in DOD. I think he has shown courage and leadership and he has insisted on strict accountability, and I am sure that some might feel that that power may not have been wielded perfectly, but I believe he wielded it effectively and I think it has helped us begin to emphasize the need to reevaluate what is going on in the health care of our soldiers.

The care that they receive I agree with Senator Lieberman should be commensurate with the risks we have asked them to undertake for us. We have asked them to give everything they have to execute our policies. Therefore we should do everything we can to make sure that their health and safety are taken care of, particularly if they are injured while serving their country. I think we all understand that, but obviously we have not met the high standards that we would like to meet.

One article I believe in the Christian Science Monitor of recent days noted that a Colonel Garibaldi had warned that, "Patient care services are at a risk of mission failure," due to a privatization effort that had left the hospital short-staffed. General Kiley, could you give us your insight into that troubling comment?

General KILEY. Yes, sir. That is part of the A-76 study that actually started when I was in command at Walter Reed, following the law and the requirements of the Army to identify capabilities on the installation. In this case, it was the garrison operations, the personnel actions, the Director of Public Works.

Senator SESSIONS. Explain the garrisons for those who are listening.

General KILEY. A garrison is the command that is responsible for essentially running the town or city. So every one of our installations has a commanding officer accountable to the senior mission commander and to General Wilson, except for Walter Reed because it is a separate installation to date.

Senator SESSIONS. Are those uniformed personnel?

General KILEY. Yes, sir.

General SCHOOMAKER. City manager is what it is.

General KILEY. Yes, sir, city manager.

In this case, the MEDCOM had Walter Reed, Fort Dietrich, and Fort Sam Houston and had undergone an A-76 at Fort Sam Houston and was directed to undergo an A-76 analysis, which would require the government employees to compete against the contractor.

They began that process. In the process of appeals and re-appeals, Colonel Garibaldi realized that he was at risk to dip below a functional capability to manage the city, not necessarily for clinical—

Senator SESSIONS. It is one thing to have an A-76 study about privatization for cutting the grass at a military base. It is another thing when you are dealing with entrusting the health care of our soldiers. Is that correct?

General KILEY. The health care was not part of that A-76. It was just the installation support, to include maintenance.

Senator SESSIONS. But that is why that is relevant to maintenance at the facility.

General KILEY. Yes, sir, and particularly to Building 18. That same capability was at risk and that was part of Colonel Garibaldi's challenge.

He sent that memorandum up through General Weightman, to my resource manager with a series of requests. We analyzed that and concurred that he needed support and resources and provided those to him. His challenge was that because of the nature of the pending shift to the contractor, there were people that were not interested in coming to work for a couple of months and that made him struggle a little bit in completing the mission because of the lack of personnel to complete the mission.

Senator SESSIONS. I think it indicates that we have had some knowledge of our danger earlier. I do believe that perhaps all of us in Congress could have done a better job of maintaining oversight. I just must say that. We have had oversight over prison treatments. We have had half a dozen hearings on Guantanamo and how we are treating the terrorists. Perhaps we should have had some hearings on how to treat our own soldiers, or maybe a lot more hearings on it.

Tell me about this deal of this situation in which a soldier who has been severely injured, they need a good bit of reconstructive surgery, and then they are eligible to go back home, or perhaps when do they go back and receive care where their families may be, and when do they stay here, and are we confident we are making the right decisions about that?

General KILEY. Yes, sir. We have two populations. We have the Active Duty population med hold. We have Reserve and National Guard in the med holdover. I believe it was in 2004 we began a program called the Community-Based Health Care Organization (CBHCO), where we recognized—and some of this came out of our experiences at Fort Stewart—that we had soldiers who had injuries, combat injuries, and were going to require long-term, not low level, but not high risk health care, physical therapy, occupational therapy, care they could receive in their communities where they lived. They simply asked the question: Why can I not go home and see a doctor or a therapist in my hometown, and then I will remain on Active Duty while I do that, under the control of a CBHCO command and control?

So we established that. We have been running that for a couple of years. We presently have about 1,300 soldiers around the Nation at home getting their health care. At some point as they heal up, they either become fit to be released from Active Duty, or if they

need an MEB/PEB we begin to do that. We have done that for the last couple years.

Senator SESSIONS. How would you evaluate the success of that program?

General KILEY. In general, I think that program has been very successful.

Senator SESSIONS. Now, is that the problem we are dealing with?

General KILEY. No, sir.

Senator SESSIONS. What is the difference in that?

General KILEY. The difference is that many of the soldiers that are at Walter Reed—and by the way, Walter Reed has almost by an order of magnitude got a larger number of soldiers in outpatient status around Walter Reed than most of the rest of my medical facilities, although I have sent the teams to them.

These soldiers have very complex, very complex multi-system injuries—we heard a soldier last week—with PTSD, and TBI, and orthopedic injuries, sometimes amputations, and the need to develop prosthesis, sometimes multiple prosthesis, sometimes requirements for sequential surgeries over time.

Senator SESSIONS. I am aware of that.

General KILEY. We and often the soldiers would like to stay at Walter Reed and get their care done and then reach a final decision, maximum therapeutic care, and make a decision about return to duty. Some of them would like to come back to duty even with amputations and prosthesis. Some are ready to be medically boarded and discharged.

So we make a decision almost on a case-by-case basis, or we should be, that says, you should stay here, I want to stay here. If we have soldiers that would like to go, for example, from Walter Reed to Brook Army Medical Center because they are from Texas or from San Antonio or Fort Lewis, we will make arrangements to transfer them there.

Senator SESSIONS. My time has expired. I would note that there is an article, op-ed I guess, in the New York Times by retired General Paul Eaton that said “Soldiers have long joked”—I guess, Dr. Winkenwerder, I will ask you this—“long joked, ‘If you are really sick or injured, Army medical care is okay. But if you are hurting only a little, especially if it is not visible, you are in big trouble.’”

General Eaton goes on in a critical piece here, he does go on to say, “The American soldier still receives the best trauma care in the world, especially at Walter Reed. The problem there has been with deplorable outpatient care management. The system, the military health system, is seriously undermanned and underfinanced for the number of casualties coming home.”

Let me ask you to comment on those remarks.

Dr. WINKENWERDER. I do not know how familiar General Eaton is with things that have been done in the last 4, 5, or 6 years, the advances, not just in battlefield care, which he alludes to and does not have a concern about. Just based on the evaluations that we do, from the clinical quality and the satisfaction across the system, would not support his conclusion about that.

Senator SESSIONS. Is that on the question of money or the question of—

Dr. WINKENWERDER. On the question of whether people get and are satisfied with their care as outpatients or for everyday kinds of care. In fact, the survey work—and again, our goal is to have no bias. That is why we benchmark to the private sector, and that is where I spent my career, so I have some sense of this—is that the satisfaction is very good with everyday routine care. The issues that we have been talking about now I think are for the special population of people who have the—it is outpatient care, but it is the long-term rehabilitation population, not someone who is coming in for cold or flu or for a sprained ankle.

That may have been the case—and General Schoomaker or others can comment—historically within the Army, but I think there have been dramatic improvements in satisfaction, and we have very good data that can show that. Are we satisfied? No, we are never satisfied. We can always be better, and I think that is the culture, that is the idea that we need to embrace: Never satisfied, always get better, always compete to get better.

General SCHOOMAKER. Sir, if I could add something. I do not mean—this is not meant to be flippant, but I said earlier this is not about comparing to other things. This is about what is right and what should be expected and what the standard should be for these soldiers. If you look at the Gallup Poll in 2005 and 2006, health maintenance organizations in this country were at the bottom of everything on the list, and I would not measure military medicine against civilian medicine in any form or fashion. Our soldiers and their families deserve far better commitment than the standard that is out there in the civilian thing.

I personally object to the business attitude about all of this. This is a bigger commitment than that. So I am not lecturing you, but I want to go back to this business about what the right price for things are. You cannot put a price on what these young men and women are doing and the responsibility we have for them for the rest of their lives.

I was just looking at the figures. Just of the Army, 31,581 soldiers were evacuated out of the area of responsibility (AOR), just Army, since October 7, 2001, and those figures are good as of March 3 of this year. So it is very new information. Seventy-two percent of those evacuated are outpatients. That is 22,738.

This is what our difficulty is here. The 8,843 that are inpatients are getting the finest care in the world. But we have to bring this standard to the people in the outpatient business. We cannot compare it to business and to civilian kind of stuff and all these people because it is not respected out there on the civilian side, according to the Gallup Poll. I do not know because I do not go out there.

I will tell you, just of the 31,581 people that have been evacuated out of the AOR—these are the people who have been evacuated now, not the ones who have been returned to duty—4,000 of them are battle-injured, and 8,843 are non-battle injuries. Over twice the non-battle injuries than battle injuries, and 18,633 are disease. So 59 percent of all those evacuated were disease, 28 percent non-battle injury; 13 percent were battle injuries.

I guess what I have been trying to say throughout this testimony here is this is another layer on top of a system that is already dealing with a baseline of families and soldiers and all the rest of it

here. Much more complex. So again, I am sorry to sound pedantic here, but I do feel passionately about this Nation's responsibility, not only to resource our soldiers, sailors, airmen, marines, and everybody else that is serving this country when they are well and how we put them into battle, but we damn sure ought to be doing better than we are doing on those that have been injured or diseased or hurt while we are doing it.

So I hope our baseline is against what should be and could be, not about some kind of what is happening out there in small town America.

Senator SESSIONS. Thank you, General Schoomaker, for your magnificent service to your country. I have to tell you, I understand your brother has many of the qualities of integrity and commitment that you do and I am confident that he will make progress for us.

General SCHOOMAKER. Thank you, sir.

Chairman LEVIN. Thank you, Senator Sessions.

Senator Akaka.

Senator AKAKA. Thank you very much, Mr. Chairman.

Let me welcome Secretary Chu, Dr. Winkenwerder, General Schoomaker, and General Kiley to the Senate committee this morning and tell you, General Schoomaker, you were right on target in what you just said about our commitment, and the commitment is with you as well as us here in the Senate to give the best to our troops as they continue to serve us.

We are here to look at the problems with patient treatment at Walter Reed and our effort here is to find out what it is all about, what we are dealing with, and to try to find solutions to do that. For that reason, I really am grateful for your responses today.

One of the things that the chairman mentioned—and I want to thank the chairman for this hearing—was that the Veterans Affairs Committee and the Armed Services Committee should work together on this and to meet together in a joint hearing as well. We have talked about it and I do look forward to that happening, Mr. Chairman, and all for the effort of trying to find solutions to the problems that we are facing. We can do no less than the best that we can.

One of the concerns that I have had, and I have mentioned this before, has been about BRAC and what impact that BRAC has had on all of this. We all know that in 2005 the BRAC Commission did name Walter Reed as a facility that would be closed by 2010, in a 10-year period. I just would like to have a comment from Dr. Chu and Dr. Winkenwerder about what they feel about that, the decision that was made by the BRAC Commission, and whether that has had an effect on what is happening now?

Dr. CHU. Let me speak to the decision and allow General Schoomaker and General Kiley to speak to any effects at Walter Reed as a campus. It is a decision the Department supports. We think it will further advance the cause of military medicine because we bring these two great institutions together on a single campus with the revamped state-of-the-art facilities they ought to have to meet the standard General Schoomaker just outlined.

Both buildings, both institutions, need their physical plant refurbished. Walter Reed is the more urgent, the current Walter Reed

building is the more urgent of the two, but eventually Bethesda needs the same thing. The Bethesda location that was selected by the commission we think has great advantages because it is also the campus for the Uniformed Services University of Health Sciences and, as you appreciate, right across Wisconsin Avenue is NIH.

So we have charged the President of the Uniformed Services University with improving the partnership with NIH as a prelude to what we hope will really be a truly extraordinary national asset.

I want to emphasize one of the important additional elements in the BRAC decision and that is the call to increase our capacity at Fort Belvoir. If you look at where our people live in this region, they are mostly south, west, however you want to call it, of the Potomac River. So therefore it is very important that we have a better primary care capacity at the principal inpatient location in the region, that is Fort Belvoir. So a very important piece of this is Fort Belvoir and what it will give in terms of primary care capacity.

Dr. Winkenwerder, would you like to add something?

Dr. WINKENWERDER. I just agree with everything you have said. I would also just add to that that our message coming certainly from my office is we have a critical mission. It continues right until the day of that transition. We have continued to invest in the Walter Reed campus. There is a new amputee center that a decision was made about in 2005, \$10 million. It is going up. It will be completed later this year. If there are more issues or more needs, we continue to invest.

We cannot underfund, and we will not underfund, and have not underfunded what is going on today and that has to continue. That will be what takes place. Maybe from the other, day-to-day aspect, I do not know if, General Kiley, you would want to comment from your vantage point.

General KILEY. Just two quick comments. I made a comment earlier. After the Washington Post article was released, I was asked the question, did BRAC cause this. My answer was no from the basis of my position as the MEDCOM commander, in that I was not making any funding decisions nor was I restricting any funding to Walter Reed because of the BRAC. The intent was to maintain Walter Reed as robustly as we could and with all the resources that they needed.

Subsequent to that, in my discussions with General Weightman, it is clear that, even though I went out probably a couple months ago with the Navy Surgeon General to reassure the professional staff at Walter Reed that the new National Military Medical Center at Bethesda would carry on all the great traditions at Walter Reed, there is clearly still a psychological impact on the organization. I do not believe it impacts on the health care of the soldiers, but it has some second and third order effects downrange in terms of recruiting and retention that I am not real sure what that impact is.

So from a financial perspective, from an operational, OPTEMPO perspective, it did not impact and should not have impacted. But culturally and emotionally, I am not sure how much it impacted on Walter Reed.

Then of course, the analysis of the soldiers and the soldier flow is still something that we need to take a look at.

Senator AKAKA. Thank you for that. I have worried about that and I am grateful for your responses.

One of the problems that we think has affected what has happened has been the budget for treatment. You just mentioned, General Kiley, that this did not happen as far as Walter Reed is concerned. But the Boston Globe reported yesterday that the Pentagon is concerned that the cost of health care could erode our military readiness and that is very important to us.

Dr. Winkenwerder, you are quoted in the article as saying "Without relief, spending for health care will divert critical funds needed for warfighters, their readiness, and their critical equipment." The focus on the article is on the impact of health care on military readiness and therefore it is very critical that we deal with that. I am concerned about whether or not budgetary constraints are forcing our military to take tough measures to address rising health care costs and whether these measures are a contributor to the systemic problems as we are finding at Walter Reed.

Dr. WINKENWERDER. Thank you, Senator. That is an excellent question and I am glad to address it. The issue is that we do have a growing cost challenge for health care broadly. But I would like to put into perspective where most of those dollars go. Over 60 percent of our entire budget goes for retiree health care, not for today's Active Duty and their families. It is that retiree portion within which we have experienced the greatest cost growth.

So I do not believe we have had any issues to date that have affected necessary investments in the direct provision of health care at Walter Reed or other institutions or anything that we are doing today. My concern was as I look forward and look out that there has to be pressure, growing pressure, with these costs and it has created and will create more pressure in the future for the entire DOD. So there is a challenge out there that we have to address and recognize and deal with.

I would invite Dr. Chu or General Schoomaker to comment as well.

General SCHOOMAKER. I am a retiree and I am about to be released from Active Duty and to be one again. I just remind you that the retirees we are talking about fought World War II, they fought Korea, they fought Vietnam, they fought the global war on terror, and they have earned this. We are about to have in my view, as has already been alluded to, a growing population from the global war on terror and the long war as we go of many very seriously injured young men and women that are going to become older men and women with these very serious injuries and all the complicating factors. I think that if it is not a problem today, it will be a problem, and that what we ought to be doing is anticipating it.

It is no surprise to anybody here because I have been saying it a long time: This Nation spends too little on defense, and part of defense, a big part of defense, are the people that volunteer to man our formations. So I have heard it back on some other committees what I have said before: We ought to be spending 5 percent at least of gross domestic product (GDP) on defense. We ought to be taking

care of people, who are our most valuable asset. We ought to be putting the very best equipment on these people when we ask them to go in harm's way, and we ought to take care of them after they perform their service. That is where I stand and I am at odds with lots of people that think they are managing some kind of checkbook and that some how our priorities ought to be in other areas. I just disagree with them.

Senator AKAKA. Thank you, General Schoomaker. You are right on target.

Thank you, Mr. Chairman. My time has expired.

Chairman LEVIN. Thank you, Senator Akaka.

Senator Thune.

Senator THUNE. Thank you, Mr. Chairman.

I appreciate that last comment. I also agree. In World War II we were spending a third of our GDP on military. Korea and Vietnam, it dropped down in the 10, 15 percent range, and then Cold War, post-Cold War period, continued to drop, and it is about 3.8 percent of our GDP today. We are at war, we are in a war.

I think that these are all symptoms of a bigger problem. That is that we are not putting enough into making sure that when we fight wars we are able to fight and win, but second that when we have people coming home from those fights that we are taking the appropriate care of them.

I have been to Walter Reed Hospital on five different occasions visiting with soldiers. I have been to Landstuhl in Germany, and I think in every case when I have been there and I have visited with people who have been treated there, particularly in the inpatient setting, there is a high level of satisfaction with the quality of care. At least that has been my observation in visiting, interacting with soldiers who have been injured.

It does seem that this is a function more of a very different type of war and one where we are having a lot more injuries. Fortunately, people are living because of the body armor, but it creates a very different strain on the military health care system.

But I guess I have a question with regard to outpatients. Perhaps, General Kiley, you can answer this. There have been, I am told, nearly 4,000 outpatients that are currently in the military's medical holding or medical holdover companies which oversee the wounded. What is the average length of time a wounded soldier spends in a medical hold or holdover status and are we keeping soldiers in that status longer than is necessary?

General KILEY. Sir, I would have to take the—I do not know the answer to the average stay across the entire MEDCOM. I can report that back to the committee. I think the answer to “are we keeping them too long” clearly identifies one of the challenges we have, because we have soldiers that want to get on with the process of going through the MEB and the PEB, working their way through that bureaucracy, and we have other soldiers who are concerned that all of their concerns will not be diagnosed and properly cared for. So we have this tension between how long is too long.

[The information referred to follows:]

The average length of stay in medical holdover for Reserve component soldiers is 172 days when they remain at a Military Treatment Facility. The average length of stay in Community-Based Health Care Organizations (CBHCO) is 291 days. The

average length of stay for Active component soldiers in medical hold status at Army hospitals is 176 days. The average time in medical hold begins when the treating physician initiates the Medical Evaluation Board and ends with final disposition by the U.S. Army Physical Disability Agency.

It is important to note that the medical hold (Active component soldiers) does not include time spent healing after injury or illness. Most Active component soldiers remain assigned to and working within their units during this phase. Duty limitations for medical hold soldiers are specified in temporary profiles issued by the treating health care provider. Medical holdover and CBHCO averages stay includes healing or rehabilitation time.

General KILEY. I hear occasionally allegations or concerns that soldiers, they are rushing us out the door, they are rushing us out the door. So we continually give guidance to the commanders all the way down to the CBCHOs and to the hospital commanders who oversee the medical board piece of this that, you have to take the time to examine all the issues that soldiers have and properly take care of them.

Where we are at risk and where we are going to redouble our efforts so as not to delay the processing of soldiers is in that area where we are down to one or two conditions, as an example, and we have one or two more consultations and then we can begin to type up the summaries and do the 22 pages of paperwork and there are delays. A clinic appointment is cancelled or it takes another couple of weeks to get a test. Those are case-by-case, but they start to mount when you have 4,000 individuals in med hold and med holdover.

We need to go back and take a look at that, and I think part of that has to do with again the complexity of the conditions, requiring multiple consultations instead of a single one. Part of it has to do with making sure that we have the ancillary support staffs that we need, properly proportioned to the numbers of soldiers, so that we can in exactly the right timing work them through this very bureaucratic process.

Senator THUNE. Secretary Chu, in the National Defense Authorization Bill last year there was some report language that directed the Department to look at—in fact, the language says, “The conferees continue to learn of instances in which returning members of the Armed Forces have been delayed in receiving needed health, mental health, and rehabilitative services both in military hospitals and in medical holdover status. The conferees believe that a wounded, injured, or ill soldier, airman, or marine deserves the highest priority for care. Should sufficient resources in the military hospital system not be available, civilian resources must be made available without delay.”

There was a requirement in here that there be a tracking of these wounded soldiers as they come back and that you prepare a report regarding that. I am curious to know what the status of that report is.

But second, is this a capacity problem and do we need, particularly in this outpatient setting, where we have a lot of these injuries, to be referring more to a civilian resource if that is necessary? That was the last observation of the conference committee last year in the National Defense Authorization Bill. What is the status of the report?

Dr. CHU. The report should be to you within the next couple of months. We have begun working on the issues that the conference report language raised.

On the capacity issue, broadly I think the answer is no, there is not a capacity issue. That is not to say that we should not advantage ourselves of the best care in the country for the particular conditions the person might have. So I do not want to rule out the use of the civil sector. Indeed, you see an example of our partnership with the non-DOD sector in using the VA's four major polytrauma centers for TBI. We recognize this is not going to be something that every facility can offer.

It does raise, and I think General Kiley has touched on this already, a tension for our people. They often do want to go home and that was the purpose of the Army's CBHCO effort. We must recognize sometimes that there will not be quite the same level of care in some communities for the tertiary type situations as there might be at a major medical center, and that is a choice the individual has to make.

But we are committed to devoting the resources necessary to get these people well. I do think a place that we may yet put additional resources—and this is an evidentiary matter, although the Army has already put a good deal of resources in this effort—is in the staffing for case management. It may be that, as several members have noted, it is the importance of the advocate for the patient that will bring the bureaucratic process together in a way that is more effective, especially for someone who is trying to understand where is he or she going with his life, what is the future going to look like here.

But the bottom line, I would argue, is I do not think we have an important capacity issue per se.

Senator THUNE. I want to commend you for acting quickly and decisively with respect to the Building 18 issue. I do think that these men and women who serve our country are heroes and they deserve the best of care, whether that is in the inpatient or outpatient setting.

The other thing we are going to be dealing with at the VA, if you look at the statistics from Vietnam or Korea, there were three injured soldiers per one dying soldier. World War II it was two injured per one dying. In this current conflict it is 16 injured for 1 dying, which I think points to down the road as these soldiers get on with life they are going to have ongoing medical needs that are going to put additional strains and stresses on the VA, and I think that is something that we have to be prepared to deal with as well, and it is a cost of war.

But these people who serve our country are heroes and they deserve the very best of care, and I appreciate the fact that you responded quickly and are trying to shore up some of the shortcomings that we have in the system today, and particularly with regard to the outpatient setting. So thank you for your testimony and I am sure this will not be the last time that we discuss this issue, but clearly this committee wants to act quickly as well and make sure that we are doing everything we can to see that you are resourced to deal with these problems and challenges. Thank you.

Thank you, Mr. Chairman.

Chairman LEVIN. Thank you, Senator Thune.
Senator Graham.

Senator GRAHAM. Thank you, Mr. Chairman.

Chairman LEVIN. Excuse me for interrupting you, Senator Graham. But if you are the last Senator to have an opportunity this round, we will not be able to go to a second round, given the hour, and I just want to announce that. But the record will be kept open for questions.

Senator GRAHAM. I am sure they will want to stay and hear my questions, but I do appreciate your letting everyone know that. If I could go I would, but I have to actually ask them.

General Kiley, should you resign?

General KILEY. Sir, that is a difficult question to answer. I certainly serve at the pleasure of the senior leadership of the Department and would respect their decisions. I am accountable for what happened at Walter Reed, as I am accountable for Landstuhl and accountable for Brook and the Center for the Intrepid, for the quality of the doctors and nurses that go to the combat zone.

If I could step away from myself, I think at this time, with us still at war, we have had some changes in the leadership already in the MEDCOM. I still think I have the right skill sets and the right experience to fix these problems. But as I said, I stand ready for decisions.

Senator GRAHAM. It seems to me that Building 18 is one part of the problem, obviously, and the system problems are large and complicated. Mr. Chairman, we need a whole hearing about retiree health care in the DOD and what we can do to get a grip on it. Because you are going back into retirement, General Schoomaker; do you believe that you were promised as part of your contract lifetime health care in retirement free, without any shared responsibility?

General SCHOOMAKER. No, because it is not free.

Senator GRAHAM. Well, it is not. There are copayments, and we have to figure out what is fair to the retirees.

General SCHOOMAKER. Sir, I do believe that there is an expectation that that was very much a part of the compensation for service, because as you know we are not compensated in fiscal terms.

Senator GRAHAM. Do you have a problem with a retiree having to make a copay for TRICARE services or a premium payment?

General SCHOOMAKER. No, I do not, because we do now.

Senator GRAHAM. That is right, and we need to look at that system over time and see what is fair. I want to work with everyone on this panel to do it.

But about the building itself, could you provide us, General Kiley, the names of the first sergeants—and I do not speak Army, so I do not know what organizational—I know one thing, that people in the Army complain a lot less than they do in the Air Force. I cannot imagine people in the Air Force not complaining about this building, and apparently no one complained. Is that true? No one that lived in that building ever complained to anybody?

General KILEY. Sir, I think Specialist Duncan yesterday in his testimony clearly stated he not only complained to his leadership at Building 18, he made his concerns known to Sergeant Lester, who is the NCO in charge.

But sir, that whole thing, if I may, is still under an official investigation, and I can certainly provide for the record the names of the individuals.

Senator GRAHAM. I do not want you to provide—I would like with the chairman to work on a list of people who are responsible for that building at every level of command for as long a period of time it was in a state of disrepair, so that eventually at an appropriate time we could talk with them. I would like to know how a building could be in that state of disrepair that long and it not percolate up.

How long do you think the building was in a state of disrepair that would be unacceptable? Do we know the time period in question?

General KILEY. Sir, as I understand it the building underwent a \$260,000 renovation, to include paint and repairs of exactly the kinds of things that were addressed in the article. That happened in 2005. I cannot tell you at what point Room 205 started having mold behind the wallpaper. I think it is an old building. I think it has had a series of continuing repair jobs. I think there is a humidity issue in this building, I am told.

But I think it has had renovations. People have attempted to pay attention to it. Clearly what changed the calculus was that we were putting patients in there, and there is no excuse to have soldiers in moldy rooms like that. But I think our sense of urgency was not heightened at that point and we should have been more aggressive.

Senator GRAHAM. Right. I guess what I am trying to find out is, when we start assessing who is responsible I would like to know who was closest to the problem, and we can go up to the President if we want to, but I do believe in the military that command responsibility is a shared obligation, and if I am a commander I do expect my subordinate commanders to be out there doing their job and I want to look at the whole, how did Building 18 get to become Building 18. I think it would be helpful for us to know that.

General KILEY. Yes, sir.

General SCHOOMAKER. Sir, let me, if I could add to it. I agree with that track. I think that is exactly the right way to go. But just for clarity sake, every room in Building 18—and I know you have been through it—was not moldy.

Senator GRAHAM. No, I have not been through it, and that is what I need to learn.

General SCHOOMAKER. There is a leak, the roof leaks on the east side of that building on the fourth floor. There is a humidity issue there. It has been through several renovations. There are many rooms—and I talked to soldiers over there—they are perfectly happy with the rooms, they are dry, they are clean. They have their TVs in there. They are doing some stuff. But it is not the standard for the whole building that we should expect to have soldiers in.

Senator GRAHAM. The only reason I mention each room by room is that what we have in this war is a capacity problem. We are looking at every building we can get our hands on and we are throwing as much duct tape as we can, and what you see in the health care area you see in other areas of military. We are asking

a lot. Nobody anticipated this war lasting this long, causing this many casualties, and we are playing catch-up.

General SCHOOMAKER. Sir, there is another issue here, and this is what we are investigating, going down through the chain of command. But we had empty rooms in Building 14 on the campus over there, which is a state-of-the-art one-plus-one, standard wonderful place. We had Building 18 that was not full. Only two-thirds of the rooms or something like that were being utilized. There were rooms that were open there and some of the rooms that were in the worst shape, obviously, were not being occupied.

Senator GRAHAM. What we need to take from this whole exercise is that our military is under stress at every stage. Abu Ghraib was about people not being trained to do a job and being asked to do a job they were not trained about, a prison that had 200 or 300 people in it that wound up with 6,000. We have to get ahead of some of these problems.

So what I want to learn from this is how did each room go bad and for how long and why no one caught it. But look at the bigger picture: What do you need? Is this a management problem or is this a resource problem? Is Building 18 a result of bad management or just we are having to take every resource, no matter how delapidated, and put it into play?

General SCHOOMAKER. Sir, my quick look at it, it is a leadership problem, it was a management problem, and it was also a resource problem in that the A-76 thing that went on for 6 years went from 300 maintainers to 60 maintainers on the installation and therefore ended up with some of these issues.

So it is all of the above and it is not acceptable, and we are going to hold everyone accountable for it.

Senator GRAHAM. Including us here in Congress. I will say that. You do not have to.

But now let us talk about very quickly what happens to a person who is injured in Iraq, and you are taken out of the line because your injuries are so substantial that you have to come back. Dr. Chu, the first thing that happens to that injured soldier is a determination as to whether or not they can ever go back to Active Duty; is that correct?

Dr. CHU. Yes, sir, that is the first bureaucratic step in that regard. But of course, our first priority is getting the soldier well.

Senator GRAHAM. No, I understand that. I am talking about now we are past the health care.

Dr. CHU. Once it is decided that the individual may not—and I underscore the word, “may not”—meet retention standards because of physical issues, then the so-called medical board is held, MEB. A narrative summary is dictated that describes the case, describes the situation.

Senator GRAHAM. How long does that normally take?

Dr. CHU. It can take a long time.

Senator GRAHAM. I know my time is up, Mr. Chairman. I am just trying to walk through this very quickly.

Dr. CHU. Our standard is 30 days. It is not a standard Walter Reed was meeting, although that is understandable given the complexity of the conditions.

It then passes to the PEB, which decides on disposition of the case. First there is an informal board, essentially based upon the documents, and if the soldier is agreeable to the finding of that informal board that is the end of the process. If, however, the soldier wishes to continue, there is a formal board. The soldier can be represented at that board. Again, if the soldier is not comfortable with the conclusion the soldier may appeal, so there is appellate review.

Our standard is 40 days for that whole board process. The Army on average meets that standard, although not typical at Walter Reed, I should admit. The majority of the Army's cases stay within the 40-day limit, although the distribution does spill outside that limit.

I should emphasize that the cases that go to the PEB, if I remember the Army's numbers correctly, about 20 percent or so the soldier is returned to duty. So this is not a black and white situation.

Senator GRAHAM. And the 80 percent do not?

Dr. CHU. And 80 percent do not.

Senator GRAHAM. They have to go to the VA and start all over again, basically, do they not?

Dr. CHU. No. We have changed that process. If we anticipate that you are going to be on the temporary disability retirement list, we notify the VA right away that Smith is coming and we start opening a case file at the VA, so that when the individual arrives under the VA's aegis the VA is better prepared to deal with him or her. So for the most seriously injured this is handled differently from a more routine situation in that regard.

As General Schoomaker just said earlier this morning or today, we have all sorts of cases in this physical evaluation system peace or war.

Senator GRAHAM. Thank you.

Chairman LEVIN. Thank you, Senator Graham.

Senator Graham has suggested that we get the names of the people directly in charge of the maintenance and repair at Building 18 and that we would then talk directly to those people. We do not need them to be stated publicly here, but for the record if you will get us their names, Senator Graham's staff, our committee staff, will work together to interview those people to get the kind of picture which Senator Graham has talked about.

If you also for the record—there will be other questions—tell us what the role of privatization either has been or will be in this process. There is some privatizing going on. Is that going to create even more uncertainty, confusion, and possible gaps? The record will be kept open until tomorrow afternoon for additional questions for all of you.

[The information referred to follows:]

Walter Reed began an A-76 competition for Base Operations in 2000, which reached initial decision in September 2004. The final decision report was submitted to Congress on June 5, 2006. Proposed congressional actions called into question whether Congress would allow fiscal year 2007 funds to be used for performance of this contract. These proposed congressional actions caused the medical command to delay the contract award and start of the 90-day transition to full contractor performance until November 2006. iAP Worldwide Services (iAP) began full performance of the contract on February 4, 2007.

In 2004, a Residential Communities Initiative to privatize family housing took effect. A total utility privatization effort began prior to the Base Realignment and Clo-

sure (BRAC) 2005 announcement, but this effort was stopped following the BRAC recommendations.

An Enhanced Use Lease (EUL) privatization contract was planned in May 2004 for Building 40, which had been empty for over 4 years at that point. The EUL on Building 40 did not have any personnel impact, because the building was empty. The effective date of BRAC was estimated to be over 6 years from the time it was announced in 2005.

The Department of the Army provided to the committee the names of individuals who filled key leadership positions at Walter Reed Army Medical Center with responsibility for oversight of maintenance and repair at Building 18:

Brigade Commander	
COL Ron Hamilton	July 2006–present
COL Rosaline Cadarelli	2004–2006
COL Dorene Hurt	2002–2004
Brigade Command Sergeant Major	
CSM Monshi Ramdass	July 2006–March 2007
CSM George Sosa	2004–2006
CSM Santiago	2002–2004
Med Hold Company Commander	
CPT Aaron Braxton II	2006–2007
MAJ Carzell Middleton	2004–2006
CPT Matthew Bowles	2002–2004
MED Hold First Sergeant	
ISG Donald Walker	2005–2007
SFC Warren-Clark	2004–2005
ISG Andrew Patterson	2002–2004
Med Holdover Company Commander	
CPT Arthur Jenkins	2007–2007
CPT Sheri Swandal	2006–2007
MAJ Carzell Middleton	2004–2006
CPT Matthew Bowles	2002–2004
Med Holdover First Sergeant	
ISG Angello Gordon	2007–2007
ISG John Zelch	2006–2007
SFC Carol Warren-Clark	2004–2005
ISG Andrew Patterson	2002–2004
Student Company Commander (occupied Bldg #18 in 02–04)	
CPT Tonia Ashton	2002–2004
Garrison Commanders	
COL Bruce Haselden	July 2007–present
COL Peter Garibaldi	2005–2007
COL Jeffrey Davies	2003–2005
COL Randy Treiber	2001–2003

Chairman LEVIN. We thank you again for your testimony and we will stand adjourned.

[Questions for the record with answers supplied follow:]

QUESTIONS SUBMITTED BY SENATOR DANIEL K. AKAKA

COMMAND PRESSURE

1. Senator AKAKA. General Schoomaker, a report in the Army Times states that some of the Walter Reed patients thought they were being punished with morning inspections and being made to clean their rooms as retribution for the Washington Post article. Moreover, patients were told that they could only talk to media after getting permission from the chain of command, if they were going to be interviewed on government property. They were further told that they could go down the street to a coffee shop, if they did not want to seek permission to speak with the media first. From the outside world, this would seem like the Walter Reed leadership is applying pressure on the patients to prevent them from talking to the media.

These are very serious allegations. It's my understanding that in General Kiley's testimony before the House National Security Subcommittee on Monday, March 5, he stated that you had discussed the allegations from the Army Times article with the brigade commander, Colonel Hamilton, and that his sense was that the troops were not being pressured to keep quiet. Is that correct?

General SCHOOMAKER. Lieutenant General Kiley and Major General Eric Schoomaker both discussed the allegations in the Army Times with Colonel Hamilton. An investigation of the allegations has not been completed. Colonel Hamilton did hold a formation during which he reemphasized his open-door policy and encouraged soldiers to bring their problems and concerns to the chain of command so the command could address those issues. The chain of command exists to help soldiers with problems such as those uncovered by the Washington Post, and commanders should be available and approachable so soldiers can bring problems to the command's attention without fear of retribution or reprisal. Additionally, the Army has established the Wounded Soldier and Family Hotline, to connect callers directly with staff in the Army Operations Center. These issues will be briefed weekly to the Army leadership.

2. Senator AKAKA. General Schoomaker, I cannot help but notice that there is a significant disparity between the allegations made in the Army Times and the results of General Kiley's discussion with Colonel Hamilton. Did you or any of your staff discuss these allegations with the troops themselves in order to understand what is causing these perceptions by the patients at Walter Reed?

General SCHOOMAKER. The Army leadership has frequent personal contact with soldiers, patients, families, and others expressing concern about medical care and leadership concerns, among other issues. My staff reviews those complaints, forwards them to the appropriate Army command for investigation, and provides a response to the soldier/patient. However, these specific allegations were not raised in my discussions. I am confident that the Commander at Walter Reed Army Medical Center will conduct a thorough review of the allegations and is very sensitive to the perception created by the article. If additional information comes out that substantiates the allegations in the articles we will take appropriate action.

3. Senator AKAKA. General Schoomaker, has it been your policy for you or your staff to discuss complaints of this nature from patients directly with the patients?

General SCHOOMAKER. Yes. The Army leadership has frequent personal contact with soldiers, patients, families, and others expressing concern about medical care and leadership concerns, among other issues. My staff reviews those complaints, forwards them to the appropriate Army command for investigation, and provides a response to the soldier/patient.

CONTRACTOR OVERSIGHT

4. Senator AKAKA. General Schoomaker, how did the Walter Reed command ensure that renovations conducted on Building 18 since 2001 were conducted correctly? What oversight of the contractor was conducted?

General SCHOOMAKER. The current contractor took over responsibility of performing maintenance on Building 18 on February 4, 2007. All previous renovations to Building 18 were the responsibility of the Government. Currently all work performed by the contractor is inspected in accordance with the Quality Assurance Surveillance Plan by the Continuing Government Organization before it is accepted.

5. Senator AKAKA. General Schoomaker, how was the contractor selected to perform the work, and what type of contract was awarded?

General SCHOOMAKER. The contractor was selected based on a public/private competition in accordance with Office of Management and Budget Circular A-76. As the private sector contractor chosen to compete against the government bid, the private sector contractor was selected based on a competitive formal source selection process conducted in accordance with the Federal Acquisition Regulation, Part 15, Negotiated Procurements. Part 15 procedures are designed to foster an impartial and comprehensive evaluation of offerers' proposals, leading to selection of the proposal representing the best value to the government. The resulting contract was a 1-year cost-plus award fee contract, with four 1-year option periods.

6. Senator AKAKA. General Schoomaker, did the contractor have a record of performance on government contracts? If so, how had they previously performed?

General SCHOOMAKER. The Government performed an extensive check of past performance prior to award. The evaluation process included checking references provided by the contractor, checking Department of Defense (DODI-wide performance databases, and performing three on-site evaluations at the following DOD facilities where the contractor was performing the work: Forts Gordon and Polk, and Jacksonville Naval Air Station. All findings were positive. The contractor had extensive facility operations experience at several locations where the government contract administrative staff gave the contractor overall excellent ratings.

DETERMINING SERVICE CONNECTED DISABILITIES

7. Senator AKAKA. General Schoomaker, as chairman of the Veterans' Affairs Committee, and as chairman of the Armed Services Committee's Subcommittee on Readiness and Management Support, I find myself looking at the issue of determining disability for wounded or injured servicemembers from two different perspectives.

Please explain why it seems that DOD uses a different standard for determining service connected disabilities than the VA. After all, we are talking about one servicemember with one set of medical problems.

General SCHOOMAKER. The DOD is required to use the statutory standards found in chapter 61, U.S.C. Specifically, title 10, U.S.C. 1201 indicates servicemembers can be compensated for impairments incurred or aggravated while entitled to basic pay. This has been interpreted by past Comptrollers General opinions to be the "date or onset of a disease or occurrence of the injury." The VA is bound by title 38, U.S.C. 105 and definitions found at title 38, U.S.C. 101. The VA defines "service-connected" as any injury or disease incurred or aggravated during active military service determined to have been in line of duty.

There appears to be little difference in how the VA and DOD define eligibility for disability compensation. However, the Services can compensate for non-service incurred or aggravated impairments when the servicemember has over 8 years of Active Duty (10 U.S.C. 1207a), while the VA cannot, and the VA has statutory presumptions regarding when certain diseases are presumed service-connected where the Services do not. There might also be some disparities as the result of different views of the evidence by individual reviewers.

8. Senator AKAKA. General Schoomaker, to follow-up, I understand that there is a big difference between the percentage of retired disability that separating Operation Iraqi Freedom and Operation Enduring Freedom servicemembers have received from DOD versus what they later received from the VA. Please explain how this can happen. Also, please provide statistics on the numbers of percentages of retired disabilities awarded by DOD versus the VA. Please break out the statistics to show Active, Guard, and Reserve Forces separately.

General SCHOOMAKER. The VA rates every service-incurred condition, whereas the Army rates only those conditions that make a soldier unfit for further duty. Although there may be specific conditions the VA rates higher than the Army, the Army does not have visibility on VA ratings. The Veterans Disability Benefit Commission results should provide that information.

Fewer than 15 percent of Army soldiers are separated or retired through the Army's disability system with combat-related injuries. The vast majority of soldiers wounded in action are returned to duty—a testament to our great medical care. From the beginning of October 2001 to 1 April 2007, the Army placed 18.48 percent on disability retirement; Active component 17.97 percent; U.S. Army Reserve 18.97 percent; and National Guard 20.80 percent.

BUDGET CONCERNS

9. Senator AKAKA. Secretary Chu, Dr. Winkenwerder, and General Schoomaker, at the hearing on Tuesday, March 6, I raised a question regarding an article in the Boston Globe. Specifically, the Boston Globe reported on Monday, March 5, that the Pentagon is concerned that the cost of health care could erode our military readiness. Dr. Winkenwerder is quoted in the article as saying, "Without relief, spending for health care will . . . divert critical funds needed for warfighters, their readiness, and for critical equipment." I raised my concern about whether or not budgetary constraints are forcing our military to take tough measures to address rising health care costs, and whether these measures are a contributor to the systemic problems we are finding at Walter Reed. I was assured by you all that it was not.

I note that several times during the hearing, you all stated your belief that budgetary issues were not the cause, or part of the cause, for the problems at Walter Reed. However, at the same time, General Schoomaker repeated his statement that

the Army has been historically underfunded. We heard during the hearing that the problems at Walter Reed are systemic and have been occurring throughout the military medical system for quite some time.

How can you be sure that the military medical community is not feeling pressure to keep costs down, potentially contributing to the problems at Walter Reed?

Dr. CHU and Dr. WINKENWERDER. We do not believe available resources were the cause for the facility issues at Walter Reed. In the Defense Health Program, the Military Health System leadership (including the medical department senior leaders) collaboratively determines the programmed budgets. As with any appropriation, emerging requirements during a fiscal year can exceed available funding. However, since fiscal year 2001, we have been able to restore enough funds during our mid-year review budget adjustments to meet, and in some years exceed, projected annual requirements in the areas of facility sustainment, restoration, and modernization. The ultimate uses of those funds are at the discretion of the individual Services' medical departments.

General SCHOOMAKER. The U.S. Army Medical Command (MEDCOM), like the entire Military Health System, is under pressure to keep costs down but budgetary constraints were not the root cause of all the problems that have surfaced at Walter Reed Army Medical Center. The Assistant Secretary of Defense for Health Affairs (ASD(HA)) has funded our immediate requirements as we have identified them. Historically, MEDCOM begins the fiscal year with sufficient resources as identified in our President's budget request. Any additional military health service unprogrammed requirements or higher execution of programmed needs compete for funding at mid-year. Routinely, by year's end, the AD(HA) funds all reasonable requirements to support the global war on terrorism and other high priority requirements.

10. Senator AKAKA. Secretary Chu, Dr. Winkenwerder, and General Schoomaker, what budgetary guidance have you given the Army medical community? Have they been given everything they have requested in each year's Army budget dating back to fiscal year 2001?

Dr. CHU and Dr. WINKENWERDER. The medical community (including Army) begins the budget process by making adjustments to the previous year's Defense Health Program President's Budget. This base line amount is then adjusted for programmatic changes, such as new or discontinued missions, planned military to civilian conversions, savings assumptions associated with cost reduction initiatives, changes in managed care support contracts, and other similar items. This revised amount is then inflated at standard DOD rates to establish the next year's budget proposal.

As with all Federal agencies, proposals can exceed funding availability within the top line budget guidance provided for the Defense Health Program by DOD leadership. When this occurs, the Military Health System leadership (including medical department senior leaders) collaboratively decides what areas of the budget risk may be taken without harming patient care.

Actual budgets, of course, are determined by Congress. In execution, the mid-year budget review reallocates funds to areas of need. Since fiscal year 2001, we have used this review to ensure we meet or exceed projected requirements for medical facilities sustainment and modernization.

General SCHOOMAKER. The Army received adequate Defense Health Care Program funding by year's end to accomplish our core missions. However, we start a typical fiscal year with an inadequate budget and compete for additional resources from the TRICARE Management Activity throughout the year. This resource uncertainty precludes a stable business environment and creates inefficiencies.

11. Senator AKAKA. Secretary Chu, Dr. Winkenwerder, and General Schoomaker, if these problems at Walter Reed Army Medical Center were not a result of lack of funding, then what do you believe is the root cause? Is it due to a lack of judgment?

Dr. CHU and Dr. WINKENWERDER. The DOD Review Group and the other reviews by the Army will assist the Department in understanding the root causes of the issues at Walter Reed. It would be premature to speculate before their reports are rendered.

I would respectfully point out, however, that while there are many factors involved, it would not be fair to conclude that the A-76 competition had a destabilizing effect on Walter Reed. Although the Army should have proceeded with its public-private competition in a more timely manner, Army data does not show a precipitous drop in the number of employees providing base operating support during the competition. In fact, I understand the number of employees remained rel-

actively constant during the competition and up through May 2006 when congressional actions delayed the formal award of the contract and the transition to contract performance. In the final analysis, competitive sourcing allowed the Army to reach a sound management decision for the efficient and effective performance of maintenance at Walter Reed. Under the Army's supervision, the contractor will be required to meet the same quality standards, at a minimum, as would have been applied to the in-house team. The contract will save resources—estimated at more than \$32 million over 5 years, which is \$17 million more than would be realized if the work were retained in-house that can be applied to other Service needs.

General SCHOOMAKER. I want to emphasize that the quality of medical care provided to our soldiers at Walter Reed is absolutely superb. There are problems with billeting and administrative processes for medical hold and medical holdover soldiers and we are fixing those problems. Several factors contributed to the infrastructure problems at Walter Reed Army Medical Center. First, a prolonged A-76 competition had the effect of attriting the garrison workforce that maintained the infrastructure. The BRAC decision resulted in infrastructure and capital improvement projects being down-scoped or cancelled, along with enhanced use lease projects for Building 18 and the old Walter Reed Army Institute of Research Building to be placed in abeyance. In general, the aged infrastructure at Walter Reed requires intensive maintenance. The war resulted in a significant increase in medical hold/holdover outpatients, stretching the ability to serve and support this population.

[Whereupon, at 1:36 p.m., the committee adjourned.]

