

STATEMENT BY
LIEUTENANT GENERAL RONALD R. BLANCK
THE ARMY SURGEON GENERAL
ON HEALTH CARE IN THE UNITED STATES ARMY

Mr. Chairman and members of the Committee, I am Lieutenant General Ronald R. Blanck, The Army Surgeon General. It is a privilege for me to address this committee. I am particularly pleased to do so here – in this setting with the other two Service Surgeons General. As this committee knows, we have and continue to work more and more closely together along with the Assistant Secretary of Defense for Health Affairs. I am very gratified to say that, in no small part, the success of today's Army Medical Department is built on this continued relationship of inter-service cooperation and collaboration.

Today I would like to provide you with a picture of the Army Medical Department. I will provide this picture in the context of the three Army imperatives: shaping the force, preparing the force, and responding to the needs of our Army and the nation. Through this picture you will see an Army Medical Department fully integrated not only on any future field of battle, but in garrison as well, taking care of all our soldiers, retired and active, and their family members. At the conclusion of my testimony, I believe you will agree that today's Army Medical Department is more flexible and better prepared to meet all our diverse missions than ever before. I thank you for your continued support of our efforts to provide the finest quality of medical support to America's Army.

Current Status of the Army Medical Department. The Army Medical Department continues to respond with creativity and energy to the challenges of health care in a rapidly changing environment. Even as we reduce our numbers, we are deploying all over the world more than we have in recent years. These deployments are not only for combat support, but also for humanitarian assistance, stability and support operations. Medical personnel are finding that on these missions they are typically providing preventive medicine expertise, disease and environmental surveillance. All the while, we must maintain day-to-day health care for soldiers, retired soldiers and their families.

The Army leadership has articulated three imperatives as we prepare to meet the challenges of the 21st Century. We in the medical department have aligned ourselves with the rest of the Army to shape our forces to meet the needs of a changing world; we must also prepare our forces by staffing, equipping and training them to successfully complete all missions they may be called upon to perform; and we must respond to the needs of the Army and the Nation.

The primary mission of the Army Medical Department continues to be support of the Army in the field, whether that means dealing with military threats, peacekeeping or humanitarian relief. Let's look at the Army Medical Department's current priorities, as they relate to these imperatives:

SHAPE

We are continuing to refine our organizational structure in order to perform our mission in the most efficient and effective manner. In 1998, the Army Medical Department celebrated 25 years as a distinct Major Command for health care units. Health Services Command was activated on April 1, 1973. Before then, the leadership chain for medical units was fragmented, with hospitals under the authority of individual installation commanders.

The organization has been an undeniable success. Refinements were added through the years, including expansion and redesignation as Medical Command in 1993. Most recently, Medical Command Headquarters merged with the Office of The Surgeon General in 1997 to create one staff under the authority and command of the Surgeon General dual hatted as the Medical Command Commander.

The great added value of this organization is integrating the peacetime and readiness roles of Army medicine into a total health-care system. Each component of the medical system is inextricably linked to all of the other components. This seamless organization produces significant economies and efficiencies, as demonstrated by the fact that we currently provide health care to our beneficiaries for significantly less than such care costs in the civilian marketplace.

Leadership Development Opportunity. As I testified last year, historically, senior leadership positions and commands within the Army Medical Department had been corps specific. As an example, officers of the Medical Corps have commanded Medical Treatment Facilities and non-deployed Table of Organization and Equipment - - TO&E -- medical

units have been commanded by Medical Service Corps officers. Dental Corps and Veterinary Corps Officers have commanded Dental and Veterinary units respectively. As a result, there have been few corps immaterial senior leadership or command opportunities for Army Medical Department officers. This policy has limited the Army Medical Department's ability to select the best-qualified officers for senior leadership positions.

In January 1997, the Secretary of the Army approved my request to change Army regulations, which had restricted command of Medical Treatment Facilities. In general, veterinary, dental, aviation, garrison and logistics commands will remain corps specific. Virtually all other commands are quickly becoming Army Medical Department corps immaterial. The implementation of corps immaterial commands within the Army Medical Department will be phased in over the next few years. The Fiscal Year 98 Department of the Army Command Selection List selection boards held in November 1997 for Lieutenant Colonel and January 1998 for Colonel was the first opportunity for Army Medical Department officers to compete for commands designated corps immaterial. Results of these boards yielded increased facility command opportunities for highly qualified Medical Service and Army Nurse Corps officers. These colonels will begin to assume their new duties this Spring and Summer. In addition, the Army Medical Department has identified and opened appropriate non-command senior leadership positions to the best-qualified officers of each Army Medical Department Corps.

Most noteworthy in this area, Major General Nancy Adams, Army Nurse Corps, was selected to be the Commander of Tripler Army Medical

Center and took command of that organization last summer. Brigadier General Marianne Mathewson-Chapman, Army Nurse Corps, was selected to be the Deputy Surgeon General/Special Assistant Army National Guard in the Office of the Surgeon General. Brigadier General Mack Hill, the Medical Service Corps Chief, recently assumed command of Madigan Army Medical Center and the Western Regional Medical Command. All are firsts for the Army Medical Department.

Reserve Component Integration. The Army depends heavily on its Reserve Component for medical support. About 70 percent of the Army's medical forces are in the Army Reserve and Army National Guard - representing approximately 273 medical units. Several efforts over the past several years have improved some aspects of reserve readiness. For example, Medical Command and U.S. Army Reserve Command signed a Memorandum of Understanding that allowed closer interaction and support between reserve and active duty assets. Medical Command has also established Regional Medical Commands that are responsible for active/reserve integration in their respective geographical areas. Additionally, for the first time we have captured and documented Reserve Component individual medical readiness requirements and are progressing to insure they are equally considered for appropriate funding.

Although these efforts have been successful in meeting their major objectives, we continue to have serious problems in other areas, most notably acute shortages of physicians and dentists in many reserve units. With a loss rate higher than our gains every year since Desert Storm, the current recruiting incentives are obviously not meeting the objectives of the force.

It is a very complex set of challenges but we have already begun working on the following partial remedies with increased emphasis with Recruiting Command on manpower needs; and individualized efforts to convince physicians and dentists leaving active duty to join reserve units.

Neither of these efforts alone will solve the problem, but if we do a good job in both areas, along with on-going restructuring, we can make significant inroads in eliminating the shortages.

Dental Officer Shortages. We continue to have concern regarding the recruitment and retention of dental officers in the Army Dental Corps. Our budgeted end strength for active duty dental officers is 1138, and on the September 30, 1998, we had 1013 in the Dental Corps, indicating that we are 11 percent under-strength. We have not been able to meet our accession goals for the past 14 years. Additionally, the Dental Corps is an aging force. As of September 30, 1998, there were 292 Dental Corps officers (29 percent of all Dental Corps officers) were retirement eligible (20 or more years of Active Federal Service) and an additional 55 Dental Corps officers will be retirement eligible within one year.

In response to this, Congress enacted a pay increase for both junior and senior officers, and an accession bonus and loan repayment program to enhance the recruiting of new officers. The National Defense Authorization Act of 1998 also provides for a Multiyear Retention Bonus for Dental Specialists.

We are working to maintain the number of Health Professions Scholarship Program scholarships in dentistry and to obtain funding for specialists under the Multiyear Retention Bonus. We will continue to work in this area and monitor its progress.

Physician Assistant Shortages. Since 1992, the number of Physician Assistants leaving the Army has exceeded the number of accessions. This has resulted in insufficient numbers of Army Physician Assistants, creating assignment challenges in prioritizing Physician Assistant placements. There are a number of reasons for this problem and we are looking at several potential solutions. The solutions range from loan repayment for Physician Assistant School and recruitment bonuses to expanding the Green to Gold program and increasing the number of Physician Assistant Training seats. This problem is receiving a great deal of attention and I am confident we will overcome this critical shortage.

Consolidate Regions. The Army Medical Department has begun to align its subordinate organizations in three ways. First, we are positioning ourselves around the deployable corps --XVIII Airborne Corps, III Corps and I Corps-- by focusing on the needs of each of the warfighting Commanders in Chief. Also, we are looking to align and link ourselves better with TRICARE lead agents. They are increasingly important organizations for coordinating health care throughout the Army, Navy and Air Force. And, to a certain extent, we're looking to align with the Public Health Service and the Department of Veteran's Affairs, in order to oversee managed care support contracts and sharing agreements.

We have begun that alignment process by consolidating the Southwest Regional Medical Command with the Great Plains Regional Medical Command last fall. The expanded Great Plains Regional Medical Command supports III Corps, and will focus on Southern Command. The Pacific Regional Medical Command and the Western Regional Medical Command have signed a Memorandum of Understanding defining their peacetime/wartime support of I Corps and Pacific Command, particularly with regard to crossed lines of authority in Alaska. The North Atlantic Regional Medical Command and the Southeast Regional Medical Command are developing a Memorandum of Understanding as to how they will both support 18th Airborne Corps and share resources. Southeast Regional Medical Command will focus on Central Command and North Atlantic Regional Medical Command will align with the Europe Regional Medical Command to focus on European Command. These alignments should clarify regional responsibility and facilitate and improve training and support relationships.

Integration of Field Units into Fixed Facilities. The Army must maintain a number of deployable, fully staffed, combat support hospitals to meet the early bed requirement for two nearly simultaneous Major Theater Wars. Other Combat Support Hospitals are given "Caretaker" status and must be able to rapidly deploy within 30 days to round out the required number of beds needed to support the Warfighting force. This helps maintain clinical skills and makes the best use of personnel to meet the daily demand for health care. Each Caretaker Hospital, with the staff working in the fixed facility, provides approximately \$24 million worth of health care per year to our beneficiaries. Reserve personnel will mobilize to staff the fixed hospital when its active personnel deploy with their

Caretaker Hospital and train with the hospital during their annual training period, providing even more cost savings. TRICARE support contracts also provide for increasing the level of care and number of providers available during times of war or full mobilization.

Medical Reengineering Initiative. The Medical Reengineering Initiative is the outcome of a process that examined the ten functional areas of Combat Health Support to ensure their relevance to future operations. It provides for a single, modular hospital and better command and control, with treatment teams and streamlined support elements. The Army Medical Department is an integral part of the Army, and as the Army reduces, so must its medical support. As a result of the Quadrennial Defense Review decision to reduce the Army from 495,000 to 480,000, the Medical Command will be reducing by about 800 military spaces. Some of this directed reduction will impact on health care providers and ancillary support. Although we are still assessing how best to execute our share of the Quadrennial Defense Review decrement, Medical Command intends to base its reduction on changes in workload and population served. Critical to this analysis will be the protection of Medical Command's core competency as a readiness focused health care enterprise.

Reinvention. The Army Medical Department's commitment to reinvention remains strong and enthusiastic. The U.S. Army Medical Command has been designated as a Reinvention Center and has committed itself to the principles of the National Partnership for Reinventing Government as well as the Total Army Quality initiatives. Examples of this Center's efforts include a patient centered dental care

delivery system, the use of innovative practice management to serve more patients, more efficient professional development training and the implementation of clinical practice guidelines to improve quality of patient care.

In addition to the Medical Command Reinvention Center, the Army Medical Department now has five Reinvention Laboratories as well as a Science & Technology Laboratory. These laboratories champion innovation, encouraging prudent risk taking, removing bureaucratic barriers, and linking authority, responsibility and accountability.

PREPARE

Readiness Training. A phased implementation of new standards to train all medical soldiers for combat support began October 1, 1998. These are not intended to revolutionize the substance of training, but rather to ensure wider understanding of requirements and greater consistency in implementation. The eight requirements are survival skills, weapons training (for selected personnel), collective training, competency-based orientation, Deployable Medical Systems training, job-specific medical training, job-specific readiness training and a briefing on Medical Force Doctrine.

Battlefield Evacuation. Clearing the battlefield continues to be one of my highest priorities. The platforms designed to evacuate our wounded from the battlefield have not kept pace with the modernized force and can no longer provide rapid battlefield evacuation. Studies conducted on injuries sustained in combat indicate that prompt treatment and evacuation

of the wounded on the battlefield significantly reduces the mortality rate. The use of nuclear, biological and chemical weapons on the battlefield could significantly delay this process and may require altering the mix of battlefield evacuation resources. To meet this prospective challenge, we are working to modernize three major evacuation platforms: the UH-60Q helicopter, the Armored Medical Evacuation Vehicle, and the Armored Medical Treatment Vehicle.

The UH-60Q is the number one near-term medical modernization issue for the Army Medical Department and is critical to early entry, mounted and dismounted forces. It improves the medical, navigation and communication capabilities of our current UH-60A aircraft. With the UH-60Q we significantly improve our capability to evacuate casualties from as far forward as the tactical situation permits; conduct combat search and rescue; transport medical material and teams on an emergency basis; and perform the shore-to-ship evacuation missions.

The UH-60Q program received partial funding in the current Program Objective Memorandum, with funding starting in 2002. Additionally, we have a coordinated effort with the Army aviation community to align the UH-60Q production with the UH-60 Service Life Extension Program. As a result, we will gain a better performing aircraft; have commonality across the utility fleet; and save Research, Development Test and Evaluation dollars.

The total requirement is 357 medevac aircraft - 192 to the active component and 165 to the reserves. Fielding priority is in the Department of the Army Master Priority List sequence. Current modernization funding projections for the UH-60Q complete the 117 aircraft requirement

identified in Total Army Analysis-05 for Force Package One by 2012 and the 75 aircraft in Force Package Two by 2016.

The Armored Medical Evacuation Vehicle supports ground evacuation of our wounded and is intended to replace the M113 Armored Ambulance for direct support to the heavy forces. It has the mobility, survivability and maintainability equivalent to the supported force, all traits lacking in the M113.

The Armored Medical Evacuation Vehicle is a component of the Armored Systems Force Modernization Plan currently being briefed to Congress by the Army staff. Development of the Armored Medical Evacuation Vehicle is funded from Fiscal Year 1999 to 2000, however procurement is unfunded. Fielding requirements for the active force and the enhanced Separate Brigades of the Army Reserve and National Guard are 819 vehicles.

The third leg in our battlefield evacuation triad is the Armored Medical Treatment Vehicle. The Armored Medical Treatment Vehicle is intended to replace the M577 Battalion Aid Station and is designed to provide a protected, trauma treatment workspace in direct support of our heavy forces. The Armored Medical Treatment Vehicle is a variant of the M4 Bradley and is 100% common with the Command and Control Vehicle. In addition to the medical workspace improvements, the Armored Medical Treatment Vehicle provides the mobility, survivability, situational awareness, and communications similar to the supported forces.

A prototype of the Armored Medical Treatment Vehicle performed superbly last spring during the Task Force XXI Advanced Warfighting Experiment at Fort Irwin, California. Although Armored Medical Treatment Vehicle development is essentially complete, procurement remains unfunded. Production, however, is possible whenever program funding is available. The procurement objective is 142 Armored Medical Treatment Vehicles for the Digital Corps and the Army Pre-positioned Stocks 3, 4, and 5.

These three platforms are more mobile, enhance survivability, and offer greater medical capabilities than the platforms they are designed to replace.

Special Medical Augmentation Response Teams (SMART). We have organized SMART Teams in our regional medical commands and major subordinate commands to give us a preset, ready-to-go capability to provide rapid assistance when civilian authorities need help due to a terrorist incident, accident or natural disaster. It is possible for us to have a few highly-trained specialists on site within a few hours, with skills in trauma/critical care, burn injuries, chemical/biological casualties, stress management, communications, telemedicine, preventive medicine, disease surveillance, veterinary care and health facility planning. When Korean Air Flight 801 crashed in Guam last August, Tripler Army Medical Center had a critical care team in the air within hours to assist the Navy hospital in Guam. Shortly thereafter, the Institute of Surgical Research at Brooke Army Medical Center had two teams of burn specialists flying to the site to provide care to casualties. The teams will give us the capability to get two-to-four highly skilled care providers to a remote site rapidly,

while larger support forces are mobilizing. These teams, primarily based in the Continental United States, are designed to quickly respond to regional needs, often civilian, and are not designed to replace field units.

Technology. We are enthusiastically incorporating advanced technology into the way we provide world-class care to our patients. Some of our initiatives are:

-- The Personal Information Carrier (PIC) or “digital dog tag”, which will carry medical and personal information on service members. Commercial-off-the-shelf candidates were tested last summer, and a model built to military specifications will be field tested this year.

-- A dry fibrin sealant bandage developed by the U.S. Army Medical Research and Materiel Command in conjunction with the American Red Cross. Made from the last two proteins in the human blood coagulation cascade, and freeze dried on absorbable packing. The bandage will set a clot within one minute. Research shows it can reduce blood loss by 50 to 85 percent. The Red Cross plans to conduct clinical tests and seek Food and Drug Administration licensure of the bandage within three years.

-- A high-tech litter with resuscitative and life-sustaining capabilities that allows field surgery and care en route during evacuation. The Life Support for Trauma and Transport prototype was approved by the U.S. Food and Drug Administration for human use last June. This approval allows further evaluation by Walter Reed Army Institute of Research, using volunteer research subjects and patients.

I would be remiss in discussing technology if I did not also mention our refurbished World Wide Web site for Army medicine. It has a new

look, easier navigation and more updated information. We plan to make full use of the site (<http://www.armymedicine.army.mil>) for rapid communication with the public. It regularly carries updates on my Top 20 priority issues, messages for our staff and copies of our Army Medical Department newspaper, as well as information about our organization, history and values.

Telemedicine is a technology to efficiently leverage healthcare delivery over long distance. The aims of this technology are to improve quality, improve access, enhance provider and patient satisfaction, and reduce cost. The technologies that it encompasses may include the personal computer with internet and email access, intranet access, store-and-forward technology, videoconferencing and digital exchange of various types of images. Most of Army Medical Department telemedicine is store-and-forward technology usually sent over the internet; this involves the capture of still images via digital camera attached to a personal computer. Tertiary care physicians can review the images and render a diagnosis and return the diagnosis back to the referring physician via the internet.

Last year the telemedicine projects from the six Regional Medical Commands were catalogued and can be reviewed at <http://www.tatrc.org/pages/projects/armyproj.html>. There are close to 54 projects being done in the Army Medical Department. The majority of projects are in the areas of radiology, dermatology, and psychiatry. At the North Atlantic Regional Medical Command, there are projects with teledermatology. Shortly, this will be deployed at Brooke, Madigan, Landstuhl, and Eisenhower Army Medical Centers. Telechocardiography,

which is digital radiographic examination of the heart, is starting between Fort Belvoir Army Community Hospital and Walter Reed Army Medical Center to provide echocardiogram support to the military beneficiaries. The Armed Forces Institute of Pathology continues to pioneer telepathology throughout the United States and to foreign countries. The Center for Total Access is doing home health telemedicine for the care of diabetic patients. The intent is to improve the compliance and control of the patients with diabetes and to prevent inpatient hospitalizations. In the Great Plains Region, active neuropsychology telemedicine sessions take place between Brooke Army Medical Center and Darnall Army Hospital at Fort Hood, both in Texas. In Europe, there are teledentistry programs at 37 sites. In the Pacific Regional Medical Command, there are a number of projects that deal with teleradiology from Korea and Japan to Tripler Army Medical Center, Hawaii. There is an internet tumor board to review patients from the remote Hawaiian islands with neoplasms and subspecialist in pathology, radiology, surgery, radiation oncology and hematology oncology render opinions on the best treatments for these patients. In addition, Tripler Army Medical Center has been active in the development of video-otoscopy (video inspection of the middle ear) for diagnosis of middle ear diseases in patients from remote sites, which will be important for early treatment and possible prevention of significant hearing loss.

The Advanced Medical Operations-Telemedicine Advanced Concepts Technology Demonstration is an effort to work with Pacific Command and the Joint service community to evaluate mature technologies for command and control and medical situational awareness. These issues include minimizing the medical footprint in the tactical area

of operation, minimizing the need to evacuate Disease Non-Battle Injury casualties, enhancing medical threat information accessibility, and providing deployable telemedicine capabilities. The Army Medical Department continues to excel in telemedicine and attempts to efficiently leverage the care of its beneficiaries over a wide geographic distance.

Soldier Medical Readiness. The Medical Protection System, a Medical Occupational Data System application, has been identified as the system to record, report and archive soldier and unit readiness. Implementation of the system is ongoing with anthrax immunization tracking being the first module to be completed.

Ambulatory Data System. This new automation system captures diagnosis and procedure information on outpatient visits. Capturing this more detailed clinical information is critical for decision making and to support our new costing methodology.

Clinical Pathway Implementation. Variation is the enemy of quality. Clinical practice guidelines and clinical pathways are road maps used to reduce unwanted variation and to maximize the quality of care rendered. The use of clinical practice guidelines, the adaptation of locally specific clinical pathways and the sharing of information will enable us to achieve our overall goals of improving clinical outcomes, conserving resources and improving patient satisfaction.

Initiatives from the National Quality Management Program have been incorporated into a database to identify indicators of patient care quality for each of our medical treatment facilities. These actions coupled

with the TRICARE Management Activity Reengineering efforts and the activities of the Department of Defense and the Veteran's Administration Practice Guideline Working Group are expected to facilitate this initiative.

The Military Health System in partnership with the Veteran's Administration began an aggressive effort, in early 1998, to implement practice guidelines throughout the system. Extensive efforts are ongoing to have guidelines in place to support informed clinical decision making for our providers and patients. Our Medical Treatment Facilities are now using 103 more clinical pathways than they were a year ago.

RESPOND

This last imperative is where the Army Medical Department differs somewhat from the Army's line units. We must not only respond to the call to battle in far-off lands, but also to the daily demand for high-quality, cost-efficient health care for soldiers, retirees and their family members.

Army medicine answered the call in 1998 as it has every year since the Continental Congress authorized a Hospital Department and Director General and Chief Surgeon of the Continental Army in 1775. The most dramatic example came in August when bombs exploded at American embassies in Kenya and Tanzania. Personnel from the U.S. Army Medical Research Unit-Kenya joined the medical effort within hours and provided support for rescue, treatment and recovery operations for five days. A forward surgical team and a combat stress company flew in from Germany to help, and 22 casualties were evacuated for treatment at Landstuhl Regional Medical Center in Germany, Walter Reed Army

Medical Center in Washington, DC and Brooke Army Medical Center in Texas.

A medical task force in Haiti not only supported units remaining there, but carried out frequent humanitarian missions to help the impoverished people of that island. Other medics on humanitarian training missions brought health care to people in Asia, Africa and Latin America, and helped the medical establishments of Eastern Europe modernize and adapt to post-Communist society.

In the U.S., we helped alleviate the affects of a winter ice storm at Fort Drum, New York, and of an April tornado that swept through Fort Stewart, Georgia. In August, Army National Guard medics helped people in Texas recover from floods after Tropical Storm Charley.

As we deal with current requirements for medical support, we also must prepare for developing threats. The Army is the executive agent for the Department of Defense program to immunize all U.S. military personnel against anthrax, one of the most dangerous biological weapons. This initiative poses tremendous challenges in logistics and record keeping. A million service members, many deployed around the world, must receive a series of six injections on the proper schedule over 18 months.

The program began in 1998 with military personnel in Southwest and Northeast Asia. It is a high priority to ensure this is done right and all indications are we are doing it right.

Perhaps the biggest challenge, to the implementation of this program, is overcoming misinformation that has linked the anthrax vaccine to well-publicized illnesses affecting some veterans of Operation Desert Storm. This Food and Drug Administration-licensed vaccine has been used safely and effectively for 27 years, primarily with veterinarians. Additionally, various scientific bodies, such as the Presidential Advisory Committee, have also found it to be safe. Educating service members, their families and the general public is essential and is an ongoing challenge.

Terrorism may be the greatest threat our nation faces in the near future. Small groups that could never stand up to the U.S. military in open battle can stage clandestine attacks against our citizens and our interests with relatively little danger to themselves. Thus, we can expect terrorism to become the strategy of choice for opponents of U.S. policies. The Sarin gas attack on Japanese commuters in 1995 revealed a new dimension to this form of threat. We have stepped up efforts to ensure we are ready to provide assistance to civilian authorities with such an incident.

Quality of healthcare. Army medical facilities exceed the civilian average score on surveys by the Joint Commission on Accreditation of Healthcare Organizations. We are particularly proud of Tripler Army Medical Center at Honolulu, Hawaii and Martin Army Community Hospital at Fort Benning, Georgia, who scored 100 and 99 out of 100 respectively and received accreditation with commendation in 1998. The 121st General Hospital in Korea received a score of 96 and commendation after its first ever Joint Commission on Accreditation of Healthcare Organizations survey. Munson Army Health Center at Fort Leavenworth,

Kansas, received a 98 and commendation in its first survey after downsizing from inpatient hospital to clinic; Noble Army Health Clinic at Fort McClellan, Alabama, scored a perfect 100 in its first survey after downsizing in 1996. The majority of our facilities surveyed in the last three years have scored over 90. Success is always due to outstanding people and the Army's medical people compare well to any health-care organization anywhere and I am proud of them.

TRICARE. In 1998 TRICARE, the Department of Defense's managed-care initiative, became fully operational in all CONUS regions. Implementation has been a challenging journey since the first TRICARE contract became operational in March 1995 at Madigan Army Medical Center, in the Northwest Region.

We want TRICARE Prime to be the number one choice of beneficiaries as their health-care system. To reach that goal, we must stress quality of care, ease of access and customer-focused service.

A study of the Northwest Region, where TRICARE is most mature, has shown increases in use of preventive care, obtaining care when needed and satisfaction in making an appointment. There has been a decrease in use of the emergency room as a walk-in clinic, keeping it free for true emergencies. Most beneficiaries surveyed reported they were satisfied with the quality of their care. This was accomplished without increased cost to the government.

We are forging closer relationships between the services and the TRICARE Lead Agents to ensure issues requiring immediate action are

handled without delay. And, as TRICARE continues to mature over the coming years, I am confident it will produce the desired benefits in terms of healthier military beneficiaries and lower costs for taxpayers.

Another highlight of 1998 was the demonstration of TRICARE Senior Prime (sometimes known as “Medicare subvention”), which began in selected locations throughout the Department of Defense. Army medical treatment facilities participating are at Madigan Army Medical Center, Tacoma, Washington; Brooke Army Medical Center, San Antonio, Texas; Fort Sill, Oklahoma; and Fort Carson, Colorado.

The purpose of this three-year program is to deliver accessible, high-quality care to people eligible for both Medicare and military medical benefits, without increasing the total Federal cost for either Medicare or the Department of Defense. The Department of Defense will continue to provide the level of care it has historically provided for these “dual-eligible” patients and Medicare will pay Department of Defense for care beyond that historical level.

Federal Employee’s Health Benefits Program demonstration, TRICARE Senior Supplementation, and the pharmacy benefit expansion target Medicare-eligible beneficiaries living outside Military Treatment Facility catchment areas. Of the eight sites identified, one Army site, Fort Knox, Kentucky, will participate in the Federal Employee’s Health Benefits Program test. Military Medicare eligibles will be able to join the Federal Employee’s Health Benefits Program during the Fall of 1999 open season.

These are all important steps toward meeting our obligation to take care of those who devoted a career to military service.

One way we are operating more efficiently is through closer cooperation with the Department of Veterans Affairs. The Army and Department of Veteran's Affairs are benefiting from more than 130 Resource Sharing Agreements, at least 35 Memoranda of Agreement or Understanding and nine Interagency Support Agreements. These various kinds of agreements have different administrative and funding details, but all involve using resources of both departments more efficiently to provide services for less cost.

In addition, many Department of Veterans Affairs facilities are participating as TRICARE providers. The Department of Veteran's Affairs is treating outpatients in community-based clinics at Fort Belvoir, Virginia, and Fort Leonard Wood, Missouri. Tripler Army Medical Center, Hawaii provides care for most veterans in the Pacific region. A Joint Venture there includes a renovated wing for administrative services, an ambulatory care center and a 60-bed "Center for Aging" facility. In Fiscal Year 1997, Department of Veteran's Affairs reimbursed Tripler \$9.5 million for its services. Department of Veteran's Affairs patients receive easier access to care, and both agencies benefit by expanded training and research opportunities. This is truly a "win-win" partnership.

We should see greater savings as we move into the era of enrollment-based capitation. With an accurate count of beneficiaries enrolled in TRICARE Prime through each facility, and with the ability of the Corporate Executive Information System to keep "score" of resources

expended, we can make better financial decisions. However, there is a bottom below which we cannot responsibly go. Our priorities must be to provide quality medical care, to keep faith with our service members and to invest in the future so the quality of our medical program will keep pace with advances in medical science.

As I mentioned previously, each of our medical treatment facilities displays the Military Health System “report card”. This compares the actual quality, access and satisfaction performance of that facility to published standards or to civilian norms. We exceed the standards in almost every area, though we seek continuous improvement, particularly in access. Our system must remain firmly rooted in the unique values of military medical service. The system must never be used to deny care, but rather to facilitate appropriate care in a proper setting.

Health Promotion and Preventive Medicine. Whether engaged in armed conflict, deployed in support of peacekeeping operations, participating in any operation other than war, or training in garrison, commanders are concerned about any potential threat to the mission. In particular, commanders are becoming increasingly concerned about the health threats their personnel face and the ways to prevent these threats. This concept, designated Force Health Protection has three basic tenets: provide a healthy and fit force, prevent diseases and non-battle injuries, and care for casualties.

The vision for Force Health Protection requires a robust public health surveillance capability to provide commanders the timely information needed to identify and neutralize the health threats to their

troops. The limited capability of the Department of Defense to address health concerns of veterans of the Gulf War (1990-1) with valid and timely data on force health and potentially hazardous exposures reinforces the need for comprehensive military medical surveillance.

Medical surveillance is defined as the timely, routine, and systematic collection and analysis of pertinent health information on a defined population and dissemination of this information to those who need to know. Comprehensive military medical surveillance is conducted to reduce or prevent illness and injury, and targeted to assist commanders and other decision-makers.

Comprehensive military medical surveillance is a Department of Defense capability to provide timely information (at the tactical, operational, and strategic levels) on a broad range of indicators of health in populations of interest unique to Department of Defense (active duty, civilian workforce, etc.).

Some of the major health indicators are population factors, including demographic risk factors (age, sex, and military occupation); potentially hazardous exposures (including workplace and deployment-related exposures); use of protective measures and equipment (immunizations, personal, protective equipment); personal risk factors (smoking, alcohol use, stress, pre and post deployment screening); health outcomes (injury, illness, sentinel health events); clinical screening (occupational "medical surveillance"); relevant data elements are integrated and analyzed in order to provide population based information at the corporate level to support policy decisions. A major product of this

effort is the construction of a series of related "accession through retirement" databases on the Department of Defense populations of interest.

One of our recent significant successes used distance-learning technology to educate military and civilian health care providers on the care for biological warfare casualties. Through satellite links, 17,319 medical professionals at more than 583 downlink sites in the U.S. and overseas were able to tap in to the expertise of the U.S. Army Medical Research Institute of Infectious Diseases in treating injuries from biological weapons. Cosponsored by the Centers for Disease Control and Prevention, the 12-hour course included information on the medical consequences of a bioterrorist attack and scenarios on defense against battlefield biological threats.

Our researchers are continuing to develop vaccines against a variety of diseases, both naturally occurring and those that may be employed as biological weapons. In addition to protecting soldiers, this work can make a great contribution to civilian health. An antitoxin developed by the U.S. Army Research Institute of Infectious Diseases saved the life of an Ohio infant suffering from botulism last January. U.S. Army Research Institute of Infectious Diseases arranged an overnight shipment of the antitoxin when their assistance was requested, and after administering the antitoxin, the baby girl began to show improvement within hours. The antitoxin is an Investigational New Drug developed to protect soldiers on the battlefield but clearly such research can be beneficial to civilians as well.

The world is constantly changing and as the Army and the Army Medical Department adapts to these changes, we will continue to focus on our core values and functions. We will maintain our position as a world class system capable of continuing Army Medicine's proud tradition of "Caring Beyond the Call of Duty." Mr. Chairman, thank you again for the opportunity to appear before the committee.