RECORD VERSION

STATEMENT BY

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Chairman Graham, Ranking Member Gillibrand, and distinguished members of the subcommittee, thank you for this opportunity to provide Army Medicine's perspective on defense health care reform and to discuss our efforts to improve Army Medicine. Army Medicine's clear objective remains to enable the readiness of our Army. We do so by ensuring our Soldiers, past and present, and their Families receive the care they need while continuing to improve access and quality of health care for all beneficiaries.

No other health care organization could have accomplished what Army Medicine has done since 2001. For the past 14 years we have supported an All-Volunteer force fighting the wars in Iraq and Afghanistan, responded to natural disasters across the globe, and deployed to other contingencies such as the US Government response to the Ebola outbreak in West Africa. While caring for Soldiers and their Families we continued to embrace our retirees and veterans and ensured their pressing healthcare needs were met; even at the height of the wars.

But we do not rest on our laurels and today we must address the need for healthcare reform to ensure we maintain the lessons learned over the past 14 years and prepare for tomorrow's conflicts while continuing to provide a sustainable healthcare benefit to all who have earned it. We owe it to our Soldiers and their Families to ensure any changes to the military health benefit honor their sacrifices and preserve the long-term viability of the All-Volunteer Force.

Readiness

The global security environment continues to degrade and to place high demands on the United States Army. The Army must be prepared to confront near-peer competitors abroad, defend the Homeland, and respond to a wide range of crises, ranging from peacekeeping to disaster relief and humanitarian assistance. Throughout last year, the Army committed approximately 190,000 Soldiers to over 140 countries and to homeland defense to advance our national security interests.

The Army derives its power from the collective strength of its Soldiers. Our Soldiers are our primary weapon systems and ensuring they remain medically ready, trained, and prepared to deploy is our number one priority. Therefore, Army Medicine has a two-fold readiness mission. We must ensure Soldiers are medically ready to

deploy while maintaining medical forces, complete with trained personnel and equipment, to deploy and support our Nation's Army.

During the past 14 years of combat operations, our trained and ready medical providers contributed to a survivability rate of 92%, the highest in the history of warfare, despite the increasing severity of battle injuries. These advances in combat casualty care resulted from our integrated system of health that spans the continuum of care from the battlefield to our inpatient hospitals in the United States.

However, it would be a mistake to focus exclusively on sustainment of combat trauma, surgery and burn capabilities. Our experience shows that the Army must maintain a broad range of medical capabilities to support the full range of military requirements. From 2001 to 2015, only 16% of those evacuated from Iraq and 21% of those evacuated from Afghanistan were injured in battle. The remaining Service members were evacuated for disease or non-battle injuries. Similarly, greater than 95% of those that received care and remained in theater were treated for disease and non-battle injuries rather than combat injuries.

The 2014 deployment of over 2,500 personnel to support Operation United Assistance in Liberia demonstrated the value of non-trauma related medical specialties and the importance of force health protection in deployed environments where a major threat to our Soldiers is infectious disease rather than armed combatants. The geographically endemic medical risks to our forces in support of the rebalance to Asia and continued operations in Africa point to the continued need to remain ready to utilize the entire spectrum of Army medicine in the execution of all manner of military contingency operations.

Our medical centers, hospitals and clinics are our health and readiness platforms. They ensure we maintain trained and ready medical personnel. Our large medical centers serve as specialized training centers for our medical teams to provide care and clinical research for complex battle injury and illness. Our medical centers are complemented by a variety of military treatment facility types, from ambulatory clinics to community hospitals, to ensure our medical force is capable of providing primary and routine specialty care in the myriad of settings and conditions faced around the world.

These facilities must be capable of providing a broad range of patients with a wide variety of illnesses and injuries.

Our medical centers also serve as platforms for our Army Graduate Medical Education (GME) programs that are critical to develop trained and ready medical personnel. GME programs are vital to our ability to recruit and retain highly skilled medical providers. Army GME is the largest GME platform in the DoD and supplies more than 90% of all staff Medical Corps (MC) Officers for the Army. Our GME programs have nearly 1,500 trainees in 149 programs across 10 Army Health and Readiness platforms. Civilian GME programs do not have the capacity to absorb our interns, residents, and fellows. Our GME programs continue to lead the nation in training. The first time board certification pass rate of 95% across Army GME exceeds the 87% national rate. Agile GME program management assures ongoing alignment of training slots with deployment and readiness requirements.

Reducing our beneficiary population to only active-duty will result in an inability to sustain our GME programs due to lack of teaching cases and exposure to the wide breadth of disease within each specialty necessary to support any residency training program. Of the current 1.34 million beneficiaries enrolled to Army Medicine, 66% are non-Active Duty Service Members (ADSMs). Excluding behavioral healthcare, 80% of our total inpatient workload and 70% of our high-acuity inpatient workload is for Family members, Retirees and other non-ADSMs. Additionally, non-ADSMs comprise 50% of total outpatient care, and 53% of our general surgery cases. The active duty population at most Army installations, comprised mostly of healthy young adults, is insufficient to maintain an inpatient hospital. Therefore, nearly all of our 22 inpatient MTFs would need to transition to outpatient clinics. Even at the largest Army installations, the case mix presented by a young, relatively healthy active duty population would be insufficient to maintain the medical skills of our providers.

Beyond trained physicians, our deployable Combat Support Hospitals and Forward Surgical Teams require trained allied health professionals, nurses, OR techs, lab techs, and other specialties that operate as teams and maintain their skills in our MTFs. The loss of inpatient capability would pose significant risk to the maintenance of

their skills and directly impact the readiness of our operating force medical units. Training, once lost, cannot be replaced.

The Army recognizes the need to maintain the skills learned over 14 years of war to ensure these capabilities do not atrophy, while also ensuring that we maintain the full scope of medical capabilities needed to be flexible and adaptable to all future globally integrated operations. In conjunction with my fellow Service Surgeons General and the Joint Staff Surgeon, my staff is working to identify, define, categorize and prioritize the medical capabilities required to support future conflicts and contingencies. Readiness measures will be developed and reported in systems of record, such as the Digital Training Management System (DTMS) and the Defense Readiness Reporting System-Army (DRRS-A).

Health Benefit Reform

TRICARE is an excellent benefit tailored to support our beneficiaries and their unique needs and situations. However, most agree that change is necessary to ensure the long-term sustainability of the program and to improve performance. I support the TRICARE reforms proposed in the FY17 President's Budget.

Reforms should inspire beneficiaries to return back to our direct care system and military run medical facilities. I believe the best place for them to receive care is in our military treatment facilities where we understand their needs, can manage and document their care, ensure quality, and can ensure their readiness.

Reforms should incentivize health and healthy lifestyles. This is key to long-term cost control.

We must ensure our beneficiaries have access to high quality, safe healthcare in our MTFs and in the TRICARE network. To this end, we must increase transparency and exchange of data between both healthcare systems.

Reforms must not increase the financial burden on Active Duty Soldiers or Active Duty Family Members. Any increased financial burden on retirees must be modest and not inhibit them seeking necessary medical care in our facilities.

Reform also provides the opportunity to identify and close gaps in the benefit. In some cases legislation established benefits for active duty but excluded similar benefits

for Retirees or Family Members. In other cases, civilian insurance programs now provide benefit coverage for new or emerging technologies and treatment modalities not yet covered by TRICARE. TRICARE should be one of the most comprehensive health plans in the country and exceed all benchmarks under the Affordable Care Act. Our beneficiaries deserve nothing less.

Improving Access

Improving access to care remains a priority for Army Medicine. Specifically, our beneficiaries expect better acute care access. While we have made significant improvements in access, 21% improved since 2014, we are still not meeting our beneficiaries' expectations. Therefore, I have directed actions to radically improve access to primary care in our MTFs. I have established a goal of creating 260,000 (4%) more primary care visits above the 6.1 million visits we provided in FY15 and 119,000 (1.5%) more specialty care visits above the 7.9 million we visits provide in FY15.

We are standardizing processes across our enterprise to continue to drive improvement with access. Last year, Army Medicine instituted a first call resolution policy to ensure all enrolled beneficiaries receive a direct care appointment or network authorization on their first call. In addition, Army Medicine implemented a simplified appointing policy to reduce the types of primary care appointments from 12 to 5, with the vast majority of these being 24 hour acute appointments and future or follow-up appointments.

Army Medicine continues to expand our off-installation healthcare program by placing Community Based Medical Homes (CBMH) in communities surrounding our military installations closer to where our beneficiaries live and work. Today over 10% of our enrolled beneficiaries receive their primary care in a CBMH, many of which have extended hours and offer behavioral health, physical therapy, and prescription refill services. We currently have 20 CBMHs supporting 13 installations. In FY16, we will open three (3) more CBMHs at 3 installations and in FY17, we will open two (2) more CBMHs and our first open access acute care clinic in San Antonio.

To further improve access for routine care and specialty care, I have directed my staff to evaluate the feasibility of opening appointments beyond the current six-week

template to six (6) months or more. This will allow beneficiaries to depart at the conclusion of their appointment with follow-ups booked in advance without the need to call back in the future. Additionally, we are also conducting a comprehensive assessment across our installations to determine where expansion of clinic hours or establishment of Urgent Care Clinics is necessary.

We are partnering with the Navy, Air Force, Defense Health Agency, VA and other institutions to improve access as well. In San Antonio the Army will lease and outfit a CBMH that the Air Force will staff and run. We are also hiring civilian physical therapist and technicians to work in Air Force facilities. In Puget Sound the Army is hiring medical providers to work in Navy facilities. The Army is providing analytics and finance & accounting support to the National Capital Region Medical Directorate under the Defense Health Agency. We are providing staffing and analytic support to the enhanced Multi-Service Markets.

Army Medicine will continue to seek opportunities to leverage technology to enhance access for our beneficiaries. In FY15, Army Telehealth (TH) provided over 40,000 provider-patient encounters and provider-to-provider consultations across 18 time zones in 30 specialties over 30 countries and territories including the operational environment.

In FY16, Army Medicine will initiate a pilot to utilize TH to assist with overused Emergency Departments (ED). This pilot will utilize primary care physicians from Fort Gordon to treat patients with low acuity at Fort Campbell. This will allow the ED physicians to concentrate their efforts on patients with higher acuity and should drive down ED wait times.

The true promise of TH lies in the potential to reach patients in their homes. On February 3, 2016, the Assistant Secretary of Defense for Health Affairs signed a memorandum authorizing TH to a patient's home. We are leaning forward to develop implementation guidance to execute expansion of TH to the home.

Improving Quality and Safety

Since 1775, Army Medicine has been a reliable capability for our Nation, our Army and all those entrusted to our care. Army Medicine, in 2012, began working to

implement the tenets of the “High Reliability Organization” (HRO) to continue to evolve our understanding of patient safety. In 2015, we established the Deputy Chief of Staff for Quality and Safety to align all quality, patient safety, and organizational environmental and equipment safety elements within the same directorate. This alignment provides a synergistic environment to take advantage of analysis of problem areas and best practices across the full spectrum of quality and safety from within the command and in consultation with external experts and leaders.

Army Medicine is collaborating with The Joint Commission to pilot an assessment to gauge the HRO maturity of four Army MTFs. The team completed three assessments in 2015, and one in January 2016.

Army Medicine is increasing its participation in the American College of Surgeons' National Surgical Quality Improvement Program (NSQIP) to reduce surgical complications, improve outcomes, and improve patient satisfaction. Currently, nine (9) Army MTFs participate in NSQIP. By the end of 2016, all 22 Army MTFs with surgical services will participate in NSQIP. In 2015, Dwight D. Eisenhower Army Medical Center at Fort Gordon, GA was recognized by the American College of Surgeons as a top NSQIP performer and deemed “Meritorious” with regard to their composite quality score.

To drive further improvement, MEDCOM will design, develop and implement a Quality and Safety Center to more effectively use patient safety data, improve sharing of lessons learned across the MEDCOM, and increase transparency and availability of quality and safety information available to our leaders, staff, and beneficiaries. This center will be established in coordination with the Army Combat Readiness Center and will leverage many of the successful practices incorporated by the CRC.

Improving Performance

Since 2010, Army Medicine has maintained relatively stable enrollment of 1.4 million beneficiaries despite significant budget and personnel turbulence. As we improve access, quality, and safety, Army Medicine is also improving performance to maximize value. From FY11 to FY15, our operations and maintenance budget decreased from $7.6 billion to $7.0 billion. After reaching a high of over 43,648 civilian

personnel in January 2013, MEDCOM lost 5,140 civilian personnel due to the furlough and hiring freeze in 2013 and 2014. MEDCOM civilian end strength has slowly risen back to our authorized civilian end strength of 40,583 that we require for mission accomplishment. DoD imposed constraints on the number of staff we can employ is a limitation to our capacity and, therefore, to our ability to improve access.

Army Medicine is driving performance improvement at the MTF through the use of an innovative financial incentive model and performance based resourcing called the Integrated Resourcing and Incentive System (IRIS). IRIS aligns resources, funding and incentives to enhance MTF value production and adjusts resources based on actual performance compared to MTF business plans. IRIS financially rewards high-performance and incorporates quality measures through financial incentives to the facility for achievement in Evidence Based Practice standards, data quality, patient satisfaction, and continuity of enrollee primary care encounters.

Streamlining Structure

Army Medicine continues to evaluate its headquarters structure to ensure it is properly sized and aligned to support the Army. In Fall 2013, the AMEDD Futures Task Force was established to review the MEDCOM headquarters structure and provide recommendations on how to best balance and align the headquarters structure. The Task Force recommended a flattened and more integrated structure that is geographically aligned to support the Army. The Secretary of the Army approved this reorganization on 27 April 15 and MEDCOM initiated its transformation on 8 July 2015.

By the end of the two year implementation in FY17, the MEDCOM will transform from 20 to 14 subordinate Command HQs. This 30% reduction of headquarters will reduce our administrative overhead structure to less than 4.2% of MEDCOM's total requirements and authorizations. We will transform from fifteen functional regional command HQs to four multi-disciplinary Regional Health Commands (RHCs) by merging regional headquarters for public health and dental into the RHCs to create a single point of accountability for Health Readiness that is strategically aligned with the Army's operational force headquarters and units. Finally, we will transition the

headquarters for the Public Health Command, Warrior Transition Command, and Dental Command to elevate and integrate them into key staff on the MEDCOM headquarters.

Simultaneously, a work group was established to review the executive leadership within our MTFs. The results of this study led to an executive leadership model borrowed from the US Navy, the AMEDD Health Executive Leadership Organization Structure (HELOS), which was approved for implementation on 12 Jun 15. The model standardizes the leadership structure for medical centers, large hospitals, small hospitals, and clinics. It provides increased leadership opportunities at the deputy level and enhances oversight of quality, safety, the patient experience, staff development, and productivity within all MTFs. The new leadership positions will provide additional opportunities to groom future hospital and medical center commanders. The endstate will be more experienced leaders who are more accountable.

Conclusion

Army Medicine is one of the finest health care systems in the world. As the military health care reform discussion continues we must remain focused on maintaining readiness while continuing to improve the health of all those entrusted to our care. While our system has proven very successful over the last 14 years of supporting the Warfighter, we need to continue to improve and evolve it to meet the changing needs of our Nation's Army. No other health organization is required to provide, nor is capable of providing, the full spectrum of care from point of injury or illness on a battlefield through rehabilitative care while continuing to maintain high quality care in garrison environments for its beneficiaries. There is more we can do to improve readiness, enhance the benefit and ensure fiscal sustainability within our existing authorities. We remain fully committed to work with Congress, DoD, and all those entrusted to our care to improve our system.

I want to thank my partners in the DoD, the VA, my colleagues here on the panel and the Congress for your continued support.