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FORCE HEALTH PROTECTION: LESSONS LEARNED AND APPLIED FROM THE FIRST GULF WAR

HEARING

BEFORE THE

SUBCOMMITTEE OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGTH CONGRESS

FIRST SESSION

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FORCE HEALTH PROTECTION: LESSONS LEARNED AND APPLIED FROM THE FIRST GULF WAR

WEDNESDAY, JULY 9, 2003

U.S. HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC

The subcommittee met, pursuant to notice, at 2:25 p.m., in room 334, Cannon House Office Building, Hon. Steve Buyer (chairman of the subcommittee) presiding.

Present: Representatives Buyer, Boozman, Hooley, and Evans.

OPENING STATEMENT OF CHAIRMAN BUYER

Mr. BUYER. The House Committee On Veterans' Affairs Subcommittee on Oversight and Investigations will come to order.

This hearing will examine the issue of force health protection—in particular, lessons learned and applied from the first Gulf War and the implementation of present law and DOD regulations.

I have a written and prepared statement that—I ask unanimous consent that not only my written statement but any others be submitted for the record.

Hearing no objection, it's so ordered.

[The prepared statement of Chairman Buyer appears on p. 51.]

Mr. BUYER. I come to this issue with a great deal of history over the last 11 years, and it is fascinating for me, even as a legislator. You come in, you do an assessment of a particular problem or concern, you pass a law, you hope that the law is implemented and followed by the guidelines of the intent.

We have a change of administration, and I have read your opening statement, sir, and you know, I find it interesting how you are going to tell me the purpose of what I had written.

I find that fascinating only in that you have got it so wrong, whoever wrote this.

So let me, on the basis of open disclosure, tell you about the motivation, the motive behind it, and then maybe we can understand how we proceed.

After the Gulf War we had so many soldiers then coming back with these unexplained illnesses, it was very challenging for everyone, not only for the VA—in particular, the service members and their families who are struggling, and the VA and the DOD at the time not willing to recognize that there was a problem.

So we went through many different hurdles.

This committee, at the time, under Sonny Montgomery, did a lot of good work, along with Lane Evans and Joe Kennedy, and at the time, I remember partnering with Joe Kennedy when we passed a bill for compensation for undiagnosed illnesses. It was pretty radical, but basically, we had done that because our compassion was real and we didn't want a repeat of Agent Orange to say, well, yes, I know you are sick, but we can't prove—we don't have the causal link, tough luck. And we didn't want to do that.

Then, in the mid-'90s, when I became chairman of the personnel committee on Armed Services, I had the benefit of being with the military health delivery system, dealing with military medical readiness issues, and then here sitting on this committee, dealing with the health issue. So I got to see the totality of the two systems and begin to work in them.

I am concerned about the standard in which the committee set in the language that this committee passed under the Kennedy-Buyer language, concerned only in that I don't want that to be the standard here on out into the future.

So in order for me to change that, I then turn to DOD, through directive language back in 1998, that there are certain things we want you to do, and for you to know and understand that we spent a lot of money to recruit a force—we always talk about recruiting and retention, there is another word in between recruiting and retention, it is called maintenance, maintaining the force—and part of that maintaining the force—yes, we buy those weapons systems and we focus on our training, but also, there is a piece of it called the health, the health of the soldier, because if we deploy a soldier that is not healthy, then we have really wasted our time and our assets and our investments.

So, you know, Congress here has put some hoops for you to jump through for a particular reason, and I wanted you to hear it from me.

So there are multiple purpose here. The multiple purposes is not what is stated in your statement. The multiple purpose here was on the military medical readiness, and the other issue is to establish that baseline, that once you establish the medical baseline, then we here in the Veterans' Affairs committee, when we become the receiver, then, of our new customer, that we know how to make competent decisions with regard to the medical health and, i.e., benefits.

Otherwise, we are going to continue to have this standard whereby the treasury is open, the presumption, the benefit of the doubt will always go with the soldier, and if they have an ailment or a sickness that they would have had anyway, we pay for it. And we want to get back to sound science. That is where I want to get us back to, and that baseline is pretty important.

So it is two-pronged. I think the GAO, when they did their assessments, understood that. So I congratulate them on their report.

I did not do that to chastise DOD. That is not the purpose. My purpose is so you can hear directly from me why I did what I did and have done over the years, and it is not just me. I have spoken with Chairman John McHugh, who took my place on Armed Services, and he even has concerns about what occurred with the 10th Mountain Division that he has in his own congressional district on

pre- and post-deployments, and you know, he even put some follow-up provisions and things that I had worked on in last year's defense bill. So I know this is a very positive statement.

Let me yield to the ranking member for any comments that she would like to make.

OPENING STATEMENT OF HON. DARLENE HOOLEY

Ms. HOOLEY. Thank you, Mr. Chairman.

I, too, am interested in what lessons we learned and how we have gone about dealing with those lessons we have learned from the past, and I think we have an incredible opportunity not only to send healthy service people from different parts of this country overseas but to also have a chance—if they come back with something like Agent Orange—to be able to take a long look at that and say here is the health when they left, here is what has happened to them when they have come back, why did some people in the same situation react negatively to this while others didn't?

So, I think you have an incredible learning situation, and I think that, many times, we forget those lessons. Well, I think this is a time that we need to make sure that we don't forget those lessons.

After Operation Desert Storm, we took steps to memorialize processes that would enhance force readiness, provide for better force protection, and establish an evidence-based system for assessing health care needs of re-deploying soldiers, sailors, airmen, and marines. These actions have broad sweeping benefits for all components of the total force and for veterans.

What we are asking for today is proof that meaningful actions are producing results. Rhetoric about how we are getting started, to plan, to share, to collect, to structure, is too late.

Lessons learned about the lack of medical and dental readiness of reservists following Operation Desert Storm were to have resulted in the improved monitoring and improved readiness of reservists for deployment.

While medical problems precluding deployment reportedly decreased, the percentage of reservists not meeting a dental health standard suitable for deployment, dental classification one or two, stayed at the same unimpressive level.

This means between one-fourth and one-fifth of our reserves could not be deployed when recalled because of bad dental health.

If projected to all reserve forces, this would mean about 200,000 members of the Guard and ready reserves who complete their annual training requirements are not deployable due to dental health concerns, and how does that impact defense planning?

On a brighter note, the quality of pre-deployment screening seems to have improved, resulting in fewer in-theater medical and dental-related problems for the troops.

DOD, after some delay, has implemented a more robust post-deployment screening system. Thank you for doing that. Medical information and data collected and reviewed against uniform jointly-established clinical practice guidelines should provide for a uniform approach to diagnosing common illnesses as well as ill-defined or unexplained illnesses. Long-term advantages may extend to active Reserve members and to veterans.

Aspects of the system are reported to be in place by DOD.

VA is now working with DOD to obtain information about recent combat veterans to facilitate its review, but it appears that this has not yet happened. GAO questions the consistency of the Army health and dental assessments. At today's hearing, we seek to better understand how well it is really working.

Mr. Chairman, with the recent growth in the number of hot spots worldwide with the potential for U.S. troop deployment, we can ill afford to allow force protection to be a partly completed effort. We should have verification that this is working as reported.

I yield back my time.

Mr. BUYER. Thank you. Mr. Boozman.

Mr. BOOZMAN. I really don't have a statement. I just want to thank you and the ranking member for holding this hearing.

Certainly, this is a very, very important subject, and I really look forward to the testimony.

Mr. BUYER. Thank you.

Before I yield for the opening, Ms. Embrey, help me here with my memory, but last year, you were in my office and we went over this stuff prior to deployments, didn't we? This is going to be fun. Thank you for coming. You are a brave woman.

Help me, also. At that time, we had discussions about the 10th Mountain Division and pre-deployment. Oh, yeah. Cool.

All right. Mr. Evans.

OPENING STATEMENT OF HON. LANE EVANS

Mr. EVANS. Thank you, Mr. Chairman.

We have troops deployed in the Persian Gulf once again. While Operation Iraqi Freedom ended in May, thousands of troops are still deployed in that region. Nine thousand troops remain in Afghanistan. Others may soon be sent to Liberia.

The DOD has had over 6 years to implement its medical tracking system. We are here to examine exactly what the DOD has done for our troops before and after deployment. What is being done to ensure that the troops on active duty and coming to the VA have the medical information necessary to prove service-connected illnesses?

Future progress is important, but verifying current progress is essential.

Before I yield back, I want to say that this is an important issue. I know the Chairman is also a member of the Armed Services Committee, as I am, and he has worked very hard with us to look into the possibility of DOD and VA sharing resources.

This could be one of the most important ones in which they should be vitally involved in, and I think that is why we are here today.

I yield back.

Mr. BUYER. Thank the ranking member.

Dr. Winkenwerder, you are now recognized.

STATEMENTS OF WILLIAM WINKENWERDER, JR., M.D., ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS, DIRECTOR, TRICARE MANAGEMENT ACTIVITY, DEPARTMENT OF DEFENSE ACCOMPANIED BY ELLEN P. EMBREY, DEPUTY ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS FOR FORCE HEALTH PROTECTION AND READINESS, DIRECTOR OF THE DEPLOYMENT HEALTH SUPPORT OFFICE, TRICARE MANAGEMENT ACTIVITY; MICHAEL E. KILPATRICK M.D., DEPUTY DIRECTOR, DEPLOYMENT HEALTH SUPPORT DIRECTORATE, OFFICE OF THE DEPUTY ASSISTANT SECRETARY OF DEFENSE FOR FORCE HEALTH PROTECTION AND READINESS; AND JONATHAN B. PERLIN, M.D., DEPUTY UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS ACCOMPANIED BY K. CRAIG HYAMS, M.D., M.P.H., CHIEF CONSULTANT FOR OCCUPATIONAL AND ENVIRONMENTAL HEALTH, DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF WILLIAM WINKENWERDER, JR.

Dr. WINKENWERDER. Thank you, Mr. Chairman, and it is a pleasure for me to be here today. I look forward to the discussion, and with your permission, I would like to submit my written testimony for the record and then provide the committee with a brief opening set of remarks.

Protecting the health of our military personnel is a paramount concern for the DOD and for my office. The department's force health protection strategy establishes a comprehensive approach to sustain the health of service members throughout their military career. We sustain their health with thorough medical examinations when service members enter the military, with periodic physical examinations, and with comprehensive medical care throughout their military service.

Service members are protected against numerous health threats through immunizations, health promotion programs, health protection training, such as safety training, including chem-bio protection and health threat counter-measures and physical and mental fitness programs. Thankfully, some of those measures that we had trained to protect ourselves in Operation Iraqi Freedom were not employed against real measures or real threats, as we did not face those.

Our deployment health program is an important element of our overall force health protection strategy. Since Congress established the requirement for deployment health assessments in 1997, which, by the way, I think was a very good idea, DOD has made continuous improvements in the implementation and management of all aspects of our deployment health program—pre-deployment, theater-based care, and our post-deployment process.

First, our pre-deployment process begins 30 days prior to deployment.

After large Reserve mobilizations following September 11th, DOD expanded this process to include Reserve component personnel activated for 30 days or more even if they were not being deployed overseas.

The deployment process includes a health assessment, a medical record review, a verification of a current serum sample collected

within the previous 12 months, a health care provider review to ensure deployment-specific medical counter-measures have been completed.

Blood serum samples are archived in the DOD serum repository, which currently houses 30 million frozen samples of more than 7 million service members.

We electronically archive each service member's pre- and post-deployment health assessment in the Defense Medical Surveillance System.

The Department of Defense has captured more than a million of these forms so far, and the completed documents are available to health care providers worldwide through our web-based program, TRICARE On-Line, which is a new capability that we just introduced in the last year or so.

During deployment, there is extensive medical and environmental surveillance. DOD routinely deploys preventive medicine and forward laboratory teams. Electronic daily and weekly disease and non-battle injury reporting were implemented for Operation Iraqi Freedom, and a system of electronic medical record-keeping was partially implemented in this operation.

During Operation Iraqi Freedom, combat stress teams were also deployed to address specific service member concerns, and I will come back and touch on that issue of combat stress, as that is an ongoing concern.

Our latest enhancements to the post-deployment health process introduced in April of this year added a requirement for health care providers to individually assess each service member, the introduction of a more comprehensive self-assessment, and a collection of blood samples within 30 days of return.

All health issues detected during this screening process must be addressed by health care providers using the post-deployment health clinical practice guideline used now throughout the DOD and the VA.

We are in the early stages of the re-deployment process. It is too early to establish definitive findings or conclusions, but we have established a rigorous quality assurance program, and we are actively monitoring compliance.

Although I want to be cautious with any results reporting thus far, the services have reported less than 10 percent of active-duty personnel and a slightly higher percentage of reservists have identified medical or dental problems or mental health or exposure health concerns—that is, less than 10 percent.

My office will continue to monitor service member health concerns through the comprehensive medical surveillance systems we have in place now.

We have demonstrated that we are committed to continuous improvement, and where shortfalls occur, we intend to quickly remedy these issues.

In addition to our medical efforts, the Under Secretary of Defense for Personnel and Readiness, David Chu, and his counterpart, Dr. McKay, have established a joint working group under the Health Executive Council that I co-chair with Dr. Roswell from the VA, a joint working group on mobilization and deployment account-

ability to address the issues of deployment, personnel, accountability, and locations.

Significant progress has been made, and this month, we will identify measures to further improve deployment accountability.

The Army, Navy, and Air Force will also identify the steps they are taking to improve the quality of location data. This initiative is essential for our own medical surveillance efforts.

Mr. Chairman, again, I thank you for inviting me here today, and I will be pleased to answer your questions.

[The prepared statement of Dr. Winkenwerder appears on p. 52.]

Mr. BUYER. Dr. Perlin.

STATEMENT OF JONATHAN B. PERLIN

Dr. PERLIN. Mr. Chairman, I am pleased to testify today on VA's role in the care of veterans of Operation Iraqi Freedom.

With me is Dr. Craig Hyams, VA's chief consultant for occupational environmental health.

I am also pleased to be here with my colleague, Dr. Winkenwerder, for it is through our agencies' collaboration that we will assure the best and most seamless health care for our service members, retirees, and veterans.

With your permission, I have submitted a formal statement for the record, and I would like to take this opportunity to highlight some key issues.

First, I am grateful for this opportunity to emphasize the VA is better prepared today than at any other time in its history to provide high-quality care to combat veterans. Since Operation Desert Shield and Desert Storm in 1991, a number of improvements have been made that allow us to meet the health care needs of those veterans.

VA has implemented a innovative new approach to health care known as the Veterans' Health Initiative. This program is designed to improve recognition and treatment of deployment health effects, better document veterans' military and exposure histories, improve patient care, and establish database for further study, and it continues to support the development of a lifelong medical record beginning with baseline health data at recruitment.

In 2002, VA established two war-related illness and injury centers to provide specialized health care for veterans from all combat and peace-keeping missions who suffer difficult-to-diagnose but disabling illnesses.

The centers also provide research into better treatments and diagnoses, develop educational materials and specialized health care programs to meet veterans' unique needs.

VA recently released a program announcement on deployment health research to expand VA's research portfolio on the long-term health effects of hazardous deployment. Up to $20 million will be spent on research to evaluate these deployment health hazards.

Operations Desert Shield and Desert Storm made clear to us the value of timely and reliable information about war-time health risks.

VA has developed two brochures that address main health concerns for military service in Afghanistan and Iraq. These brochures answer health-related questions that veterans, their families and

health-care providers may have about these hazardous deployments. They also describe VA's medical care developed to meet the health needs of those returning veterans.

VA recently published, in collaboration with the Department of Defense, a new brochure called "A Summary of VA Benefits for National Guard and Reservist Personnel." This brochure does an excellent job of summarizing the benefits available to these veterans upon return to civilian life. We are printing one million copies, and DOD is helping distribute these brochures to every Reserve center. I believe you have a copy of these submitted in a red binder, along, also, with our clinical practice guideline.

These health care databases allow us to evaluate the health care status and utilization of veterans every time they obtain care from VA. Newly developed clinical practice guidelines based on the best scientifically supported practices give health care providers the needed structure, clinical tools, and educational resources that allow them to diagnose and manage patients with deployment-related health concerns.

It is our goal that all veterans who come to VA will find that their doctors are well-informed about specific deployments and related health hazards.

VA is working with DOD to assure inter-agency coordination for all veteran and military deployment health issues.

As a result, the Deployment Health Work Group and the VA-DOD Health Executive Council was established in 2002. This work group has met repeatedly during the recent conflict in Iraq to coordinate government efforts such as the roster of deployed troops.

VA and DOD are closely collaborating to develop the capability to share medical information electronically. Recently, the VA-DOD Joint Executive Council and the Health Executive Council approved a plan that allows inter-operability between DOD and VA health information systems. Today, with the Federal Health Information Exchange, VA can receive health information from CHCS or any health records that DOD submits to the FHIE repository.

VA has actually worked with DOD to implement the standardized separation physical exam that thoroughly documents veterans' health status at the time of separation and meets the requirements of the physical examination needed by VA in connection with a claim for disability compensation.

To date, VA's experience with health care issues of veterans of Operation Iraqi Freedom has been limited.

We can say that 22 returning service personnel have been transferred to VA from DOD for specialized long-term health-care needs and rehabilitation for injuries such as spinal cord trauma, gun shot and grenade wounds, and other combat trauma.

Mr. Chairman, a veteran separating from military service and seeking health care today will have the benefit of VA's decade-long experience with Gulf War health issues. VA is working diligently with DOD to address all health-care issues of returning combat veterans and to add to the knowledge that we have gained since the end of Operations Desert Shield/Desert Storm.

That experience shows us the importance of improved medical record keeping system and environmental surveillance data in addressing the long-term needs of veterans.

For VA to provide the optimal health care and disability assistance after the current conflict with Iraq, we need a roster of veterans who served in designated combat zones and data from any predeployment, deployment, or post-deployment health evaluation and screening.

Mr. Chairman, I have had the opportunity to personally attend briefings and demonstrations of DOD's acute casualty care. I do want to praise the DOD for the sophisticated care that they provide to our troops in the battlefield.

We look forward to working with DOD to assure provision, also, of the highest-quality care to our Nation's veterans.

This concludes my statement. Dr. Hyams and I are pleased to respond to any questions that you or other members of the committee may have.

Thank you.

[The prepared statement of Dr. Perlin appears on p. 63.]

Mr. BUYER. Thank you very much.

Have you had an opportunity, both the VA and DOD, to review the GAO's testimony here today?

Dr. WINKENWERDER. I have not.

Mr. BUYER. You haven't? Can somebody please get a copy of it?

Ah, Ms. Embrey has, but the boss hasn't.

Why don't you just read the summary part there at the beginning? You see what their criticisms have been. Let me turn to the VA while you are looking at that.

Dr. Perlin, I was interested to read in your testimony that the VA is working with DOD in obtaining as much deployment health and exposure information as possible, including data on troop locations and data collected as part of pre- and post-deployment health screening.

At a meeting that Secretary Embrey attended that was in my office, along with Dr. Roswell and Secretary Ed Wyatt, Dr. Roswell, at that time, in November, expressed concerns—and maybe this has been worked out, so you need to let me know—about collection of the data, getting what they needed, and so, when I think about this, you know, the troop locations, how we are going to make the right and competent decisions—so, what data has been collected? When was this information collected? Where is this information archived? Who is responsible for evaluating the data?

Dr. PERLIN. Thank you, sir, for the question.

The Deployment Health Working Group has been a collaborative effort under the aegis of the Health Executive Council, involving staff in both DOD and VA, including Dr. Hyams and, I believe, Ms. Embrey. There has been a lot of fruitful interchange about the items that would be most relevant and most beneficial for the ongoing care of service personnel.

I would have to defer to Dr. Winkenwerder for any comments on what data are available.

Mr. BUYER. Are you satisfied with the data which you are presently getting, so you are able to make competent evaluations, Dr. Hyams?

Well, that is a long pause.

Dr. PERLIN. We have not received data yet, but the majority of personnel, ground troops, certainly remain deployed or on active duty.

For those individuals that have come over, we have their service records, but in terms of your original question, I would defer to my colleague at DOD.

Mr. BUYER. Dr. Kilpatrick and Ms. Embrey, in the testimony, it talked about the mental health evaluations and screenings, and you have got these teams, and obviously you have focused on Operation Iraqi Freedom, but you know, we didn't do so well with regard to Afghanistan and these special forces and these guys coming back and committing crimes against family and friends. It was pretty violent. It is pretty awful.

So, could you comment, with regard to these cases where we had special operations soldiers return, not handle family crises well, turn and kill a loved one and then kill themselves or they take their anger—they are trained assassins, and they actually assassinated, you know, their family.

So, can you comment to me on—with regard to these special forces and other soldiers who came back from Afghanistan, about these teams and the evaluations in the testimony that you are doing?

Ms. Embrey, this is your responsibility, isn't it?

Dr. WINKENWERDER. Well, it is ultimately mine, and let me, if I might, initiate an answer to that question and then turn to Ms. Embrey and Dr. Kilpatrick for a complete response. We want to provide as much information as possible.

That series of events shocked and saddened everybody, and most particularly the people there at Fort Bragg and their families and friends.

It was, without question, a reason to delve further, much further into the process that was in place at the time or was not in place at the time, to re-incorporate individuals back to their home life and their life on the base and to assess whether the appropriate things were being done.

We followed the actions of the Army Surgeon General's office and others and actually, obviously, strongly encouraged an aggressive response to that issue. They deployed a team of people to fully investigate the medical issues associated with that.

Mr. BUYER. My question was about—your testimony—you testified to this committee that combat stress teams were also deployed to assist with health risk communications and address specific service member concerns.

Dr. WINKENWERDER. That is right.

Mr. BUYER. That is in your written testimony. In your oral testimony, you excluded Afghanistan and only mentioned Operation Iraqi Freedom. Was that on purpose or was that by mistake?

Dr. WINKENWERDER. No.

Mr. BUYER. What are we to interpret from the written testimony versus your oral?

Dr. WINKENWERDER. We had combat stress teams in Iraq and, I believe, in Afghanistan, as well, and to my understanding, that is something that we had not done in the past.

It is certainly a step, we think, to help address early and identify early concerns. It would not necessarily always prevent every unfortunate——

Mr. BUYER. I understand that.

In regards to the special operations, would these commanders permit these types of evaluations to be done prior to post-deployment?

Dr. WINKENWERDER. I should hope so.

Mr. BUYER. Were they done in these cases in which murders had occurred?

Dr. WINKENWERDER. The process that we set into place in—with enhanced post-deployment evaluation only was introduced about 3 months ago. That includes questions that deal with mental status, specifically.

That process was not in place at the time those deployers came back from Afghanistan in the May-June time-frame of 2002.

So, it is hard to say whether the process that we now have in place might have——

Mr. BUYER. Ms. Embrey, you nodded your head yes, in the affirmative, when I asked the question. Do you have knowledge that Dr. Winkenwerder does not have?

Ms. EMBREY. At the time the Fort Bragg incidents occurred, we were very concerned about what processes were in place to preclude this from happening or why they slipped through the system, because there is a system in place.

I worked, specifically, directly with the Surgeon General of the Army, since it was an Army-specific issue, and worked, also, with another part of the OSD staff in personnel and readiness, the family support organization, to make sure that the chaplain community, the family support community, as well as the medical community, the psychologists, and the other kinds of support systems were out there, and to determine what happened that allowed these things to occur.

As Dr. Winkenwerder said, a team was formed specifically to go to Fort Bragg and deal not only with the families and the colleagues of those involved but also to the command and control structure.

Mr. BUYER. Would you do this for me? Would you please advise the committee as to whether or not these assessments were done in these particular cases, and if so, were they meant to be done in country, or were they going to wait to have them done here in the States?

Ms. EMBREY. Do you mean pre- and post-deployment assessments?

Mr. BUYER. Yes. I would like to know what happened.

Dr. WINKENWERDER. The information is there.

Mr. BUYER. I am sure it is.

Now that you have had an opportunity to do your assessments and we have had a lot of men and women who were in combat and have come back. Was it your goal that some of these assessment teams would be able to speak with them before they were redeployed to the States, or was this something you were going to wait till they got back to the States to do? What is your preference, in theater or continental United States.

Dr. WINKENWERDER. I think it is not either/or, and let me try to explain the role—the combat stress teams are in-theater teams—psychiatrists, psychologists, mental health technicians, social work, trained individuals.

They are there to deal with stress and behavior in theater.

In addition to that, the Army, in particular, has implemented a new program or enhancement to activities that it had been previously conducting to focus on the redeploying individual service member and his or her family to go through a checklist of questions that very much focus on stress and mental health and family relations and all of that.

There was actually an article, just came out, I think, in the last day or two, in the Christian Science Monitor, from Fort Stewart, Georgia. A very comprehensive, long, long report that describes this in detail.

I wish I had the article with me, but it describes a new process that the Army has put into place, and I think it is fair to say it was in response to those very unfortunate events a year ago.

Mr. BUYER. So, we have a present system—we conduct a survey and do a questionnaire. If they answer the questionnaire in a particular manner, then they have a referral.

Dr. WINKENWERDER. Yes.

Mr. BUYER. Then, over and above that present system, you have these special assessment teams. If you have a commander that says I have got these individuals who were involved in a particular fire-fight, they are not taking it very well, I want them to talk about it but they are not, they are holding it within, I am concerned about these particular soldiers, then the teams are brought in in that particular circumstance.

Dr. WINKENWERDER. Absolutely.

Mr. BUYER. All right. Ms. Hooley.

Ms. HOOLEY. Thank you.

I just want to do a follow-up to the question you just asked.

When you have people dealing with the stress teams, are there families—I mean if there are problems and they are being redeployed back to the United States, do we ever talk to the families about some of these problems? When do we do that?

Dr. WINKENWERDER. The answer is yes, and that is part of the Army program that has been instituted. It is meant to look at not just the service member but his or her family and to provide—to extend outreach to that family member or family members and, really, to assist the service member and his or her family to returning from what is often a very difficult experience.

Ms. HOOLEY. Is that targeted? I mean do you do——

Dr. WINKENWERDER. No, it is meant to be across the board, that is my understanding of it. We would be glad—I think it might be useful—to provide a description of the program and the details.

It is a program that is in place now, that has been introduced within the last 12 months.

Ms. HOOLEY. There are some questions that—because I am rather new to this committee—so excuse me for asking questions that maybe everybody knows, but when you deploy a reservist, National Guard, whatever, do they actually go through—are they given a physical before they are deployed?

Dr. WINKENWERDER. They would need to comply with the standard——

Ms. HOOLEY. Now, don't tell me they need to comply—just tell me, are they going to get a physical? The reason I ask is because when I talked to those reservists that were being deployed, I mean many of them said, they got 3 days' notice or 5 days' notice, and some of them were sent elsewhere in the United States before they were actually deployed overseas.

My question is do they fill out an assessment? Are they actually given a physical and a dental examination?

Dr. WINKENWERDER. They would get a health assessment.

Ms. HOOLEY. What does that mean?

Dr. WINKENWERDER. It is a self-administered questionnaire to be followed by an interaction with a medical provider who goes over that questionnaire and then makes a determination at that point——

Ms. HOOLEY. Do they have blood drawn at that point?

Dr. WINKENWERDER. They would if they had not had blood drawn within the prior 12 months.

There is a principle in play here, and that is knowing that one is healthy to deploy is best based on information not necessarily at one day or one point in time but within a window of a period of time, and that window is——

Ms. HOOLEY. So, if they have had a physical from their family physician within a year of deployment and they fill out a self-assessment, then they meet with a medical doctor——

Dr. WINKENWERDER. Or a nurse practitioner or a medical provider, a medical professional——

Ms. HOOLEY. Okay.

Dr. WINKENWERDER (continuing). Who would review that information that they have filled out on themselves, and there would be an assessment about whether further medical examinations or tests or other things would need to be performed.

Ms. HOOLEY. I have got medical records from my doctor. I may forget something to put down on my assessment.

Dr. WINKENWERDER. Right.

Ms. HOOLEY. So, is there ever a cross-check with their own physicians?

Dr. KILPATRICK. For those in the Reserve, they may well go to see their private physician in town, and that record will most likely not end up in their military health record.

What is looked at before they deploy is their military health record. The requirement for those under 40 is to have a physical examination done every 5 years. If that is not done within the previous 5 years of that deployment, it is done before they deploy.

Ms. HOOLEY. You said a year and then you just said 5 years. So, is it one year or 5 years?

Dr. KILPATRICK. The requirement for physical examination for those individuals under 40 is every 5 years, a periodic physical examination. They have to have an HIV test or a blood test done within 12 months prior to deployment.

Ms. HOOLEY. Okay. But the regular physical is only done every 5 years if they are under 40, and then what about dental?

Dr. KILPATRICK. Dental examinations are to be done on an annual basis. There is a check at the time of the deployment to see whether they are class one or two, if that assessment has been done within the previous year. If it has not been done, it has to be done at the time.

Ms. HOOLEY. So, even though they are given a few days before they are called up, if they haven't had those things done, they have to then get those taken care of, or do you take care of them?

Dr. KILPATRICK. Again, this is part of looking at the individual medical readiness of every man or woman in the military, be it Guard, Reserve, or active duty.

Ms. HOOLEY. When they come back, when do they have to have another physical exam or dental exam when they are returned back home?

Dr. KILPATRICK. When they return home, the requirement stays with what our periodic physical examination period is, and for those under 40 in the Reserves, it's every 5 years for periodic physical examination.

The post-deployment health assessment asks a whole series of questions or symptoms, and if the person has anything positive, then that health care provider at that face-to-face interaction makes the determination of whether other testing——

Ms. HOOLEY. So, is that self-assessment done afterwards?

Dr. KILPATRICK. It is within 30 days of coming back.

Ms. HOOLEY. Then they have to do a self-assessment.

Dr. KILPATRICK. That post-deployment health assessment is done either in theater or on coming home to station, and the blood test must be done within 30 days.

Dr. WINKENWERDER. Congressman, this is a process that was changed and enhanced in April to include a much more extensive set of questions that get into much greater detail about health and mental health issues, as well as possible exposures to a wide variety of agents, and that is the basis for further examinations, physical examinations or testing, and that is—I will say—the element of our overall process that is of most concern to me that we follow most diligently.

We have some preliminary information on this, and I might want to share that with you now, if it is okay, because the questions you have asked, as well as the chairman, sort of go to the issue as to whether we are deploying people who are healthy, and we have some indication that says that absolutely yes, we are.

In review of several thousands, tens of thousands of assessments that have been performed during this recent operation, only about 6 per 10,000 have had to be redeployed or sent home because of a health problem.

Ms. HOOLEY. When we talk about health, we are talking about mental health, physical health.

Dr. WINKENWERDER. Any kind of health problem—mental, physical.

Ms. HOOLEY. Dental.

Dr. WINKENWERDER. So, what that tells me is that—obviously, we expect people to be healthy.

We have a way of looking at their health status before they are deployed, but this method of checking suggests that we are, in fact,

sending people who are healthy to be deployed, not perfect, and I am sure there are some who have slipped through the cracks, but our process, we think, is working pretty well.

Ms. HOOLEY. I have a lot of questions, but I know my time is up.

If I may, Mr. Chair, one question for Mr. Perlin, Dr. Perlin, and that is—I notice the brochure, that you have two related illness/injury study centers.

Why are they both on the east coast? I mean we have a lot of people that live on the west coast. Why would you put two on the east coast? I am sorry, but it doesn't make any sense to me.

Dr. PERLIN. Your point is well taken. We are a national system, and we tend to think as a national system. They are both on the east coast. They were the most successful applicants for the request for proposals. When an announcement was made to try to recruit the best and provide the most timely capacity, these were the two that responded.

I would note that, in our commitment to research, the research proposals related to these war-related deployment illnesses really span research centers across the country, and one can imagine, with future requests for proposals, that might be more ecumenical in terms of that.

Ms. HOOLEY. I would recommend, in the future, when you do requests for proposals, that you ask for one, at least, on each coast, so that they are separated by more than a few hundred miles.

Thank you.

Dr. PERLIN. Thank you.

Mr. BUYER. Mr. Boozman, if you'll endure me for a second, I want to follow on this.

Ms. Hooley, you are right on the edge—and Dr. Kilpatrick, I wish you had made one more statement. With those individuals who are 40 years and over, yes, it is for 5 years, unless they are in an early deploying unit. If they are assigned an early deploying unit, then they are required to do that physical every 2 years. When the GAO went in and looked at seven particular units that were reservists, 68 percent of those individuals who were over 40 years of age that were required to get a biannual physical did not have one, correct?

Dr. KILPATRICK. That is correct.

Mr. BUYER. Now, sir, I asked you to take a look at the GAO—I know you didn't have a lot of time to look at that. Could you please—hold that. I apologize. I will do that on a second round. I just wanted to do that follow-up from Ms. Hooley.

Mr. Boozman?

Mr. BOOZMAN. Certainly at the end of the first Gulf War, we had all the problems with the Gulf War syndrome, and again, that is, to a large extent, why we are here today. How long did it take before those symptoms started showing up?

Dr. WINKENWERDER. My understanding is that it took months to, in many cases, years, before individuals began to complain of——

Mr. BOOZMAN. Okay. So, we are not really in the time-frame yet, and we don't know if we are going to have a similar occurrence this go-round.

Dr. WINKENWERDER. Well, I would say it is too early to have a complete understanding of the health effects of this deployment.

In the first place, there are many people that are deployed that have not rotated back. So, we only have preliminary information.

We do not have any suggestion that there have been exposures of either chemical or biological or other agents that would produce any long-term ill health effects.

Mr. BOOZMAN. If a person starts developing symptoms, say 6 months from now or whenever, what is the protocol? Will they go to a base doctor if they are a reservist? Will they go to the family practitioner in town?

Dr. WINKENWERDER. If they are an active duty military person, we would expect them to be seen in a DOD hospital or clinic.

There is a clinical practice guideline which guides the practitioner to quickly ask the question about deployment and the relationship or possible relationship of their symptoms to the deployment.

The same would apply if the person had been separated and was now eligible for VA benefits. They would employ the clinical practice guideline.

In the case of a reservist, the individual would, in all likelihood, would be utilizing his or her private physician or could use the VA.

Mr. BOOZMAN. It does seem like, again, we are trying to do two or three different things here, but one of them is that we are trying to get to the bottom, you know, of what has happened in the past and prevent it from happening in the future.

A big percentage of these guys are reservists, and so, if they go see their family practitioner that knows, you know, absolutely nothing about, you know, this particular thing—the other thing is if they do see their family practitioner, you mentioned earlier that those records won't go—you will never have those records, will you?

Dr. WINKENWERDER. Well, there is no question but that segment of care that is provided by tens, if not hundreds of thousands of physicians across the United States for that Reserve population is going to be more difficult to document and to have a complete information base on than those service members who are seen in DOD or VA.

It is a challenge. We reach out to the veteran community through a wide variety of approaches to make them aware that they may certainly come to the Veterans Administration to receive those services if there is any question that they have about a relationship between their health and their deployment.

Mr. BOOZMAN. The Centers for Disease Control, if certain things happen, then the physicians report back. It does seem like you could figure out some sort of system where, if they see Joe Blow, you know, that was involved—you know, it does seem like you could put out some sort of something so that those guys wouldn't fall through the cracks.

Dr. WINKENWERDER. Do we have information that is available, Ms. Embrey?

Ms. EMBREY. As part of the implementation guidance on the post-deployment assessment program, we specifically asked the services to establish specific guidance to the reservists coming off active duty, when they get their separation physical, when they get their DD-214, that they are also instructed as to how to gain access to our system or to the VA should they have any health concerns

related to their deployment. That is part of each service's implementation plan for the current operations, both Afghanistan and——

Mr. BOOZMAN. But people are busy, and they do tend to see, you know, the local folks. Is there a mechanism—if I were sick and I went to see my family practitioner internist and I said send my records over, I mean is there any mechanism for you to actually take those records? I mean do you want them?

Dr. KILPATRICK. Those records can be incorporated from health care provided in the civilian sector into the person's military record. That would then be the record that would go to the VA when they seek care at the VA.

We obviously have an issue with those reservists who are inactive. Their health records are kept at their drill site, and this is an issue that we and the VA have discussed as to how do we get those records to the VA from the drill site when the person shows up at the VA hospital and they are entitled to care.

So, this is a logistics area. If we were totally electronic, we wouldn't have that, but when we are still with paper, it is going to continue to be an issue that we need to address.

Mr. BOOZMAN. Thank you.

Mr. BUYER. Mr. Evans.

Mr. EVANS. Thank you, Mr. Chairman.

I find myself in the same quandary that our colleague from Oregon faces. I have got a lot of questions and don't really know where I should be leading these questions to, but you know, I guess my original analogy about the Fort Hood cases came out of a Washington Post story.

The reason I bring it up is that we are told by Dr. Perlin that combat veterans may have to wait to apply for access to health care and get their first appointment at a typical VA facility. My point is that people go into combat and they don't think that they are going to be actually themselves injured in combat.

Meanwhile, women get battered and abused throughout our history. Some people have suggested that we look at it from both points of view.

You are denying access to people who really need the health care. At the same time, you have to answer these questions that arise.

My question, I guess, is there is a new system in which neither party would be happy? With the Fort Hood story, you could say that these are veterans that deserve the treatment that they are going to get, but the story led me to other things, one being that we have an opportunity to do something about these problems, but we don't know what all these problems are.

To say seven soldiers were arrested for murdering their wives is horrible, but they do have rights. I don't condone what they have done, but one of the problems the Vietnam veterans had was, when they would be accused of being crazy, of being a malefactor. You know well, Mr. Chairman, that is still the image of Vietnam veterans to this day. I think we have got to be very careful when we get into these issues that, if we are talking about specific individuals, printing it in every newspaper of this country, that they have rights, too. Again, I do not condone what they may have done, but I understand that there were seven who allegedly engaged in these

activities, and I just think we have to be very careful, and you know, for that matter, these are war veterans.

There are seven soldiers during that time period, I am told, veterans who would have maybe done these horrendous acts on their own within the normal course, people who get into trouble, and you just have to be careful not to put people in this category.

We have got to be careful that we do do the things necessary to make sure that justice goes forward, but these are issues that I think I'm going to have to raise through written questions.

We have a response not only to these folks when they're in the forces, but when they get out. They don't have anyplace to go deal with their problems, not to the VA, at least, and I think it says something about our country. Unfortunately, that we don't have answers for these women, in particular, or maybe even the men, even, but it just seems to me that it is kind of effort that is going to be needed to get to the bottom of this. I know I have gone over my time, but I don't know if anyone would like to answer the question that I didn't ask or respond to those that I did ask.

I guess I will yield back.

Mr. BUYER. Actually, Mr. Evans, when I think of those individuals—and you are right, they got the headlines on the nightly news, I concur with the Secretary's remarks that, at Fort Bragg, they were pretty shocked that this had occurred. I notice by even some of the comments made by embedded reporters from this last war, that commanders had openly discussed combat and implications with their soldiers.

That is a little compliment to you, whoever got that to be done at Forces Command, because our soldiers are filled with all this macho and that, if they are not dealing with that combat stress very well, that somehow that is a weakness, and so, what these commanders wanted their soldiers to do was to talk about it.

You have just killed a human being. You can't keep that inside. It is okay. So, at the end of the day, after a fire-fight, they were okay to talk to each other about, All right, what did you just experience, how did you get through it, and they wanted them to openly discuss it, rather than for them to hold it from within.

So, when you look back—I hate to do this generationally, but as I look at your generation, as the sons of the World War II veterans, they kept a lot of it on the inside and instructed their sons to keep it on the inside. My father is a Korean War veteran, and in the first Gulf War, people really didn't talk about it, but we learned some lessons, and I think DOD, to do that to their commanders, is a good thing.

I like the fact that you have got these teams that are out there. We are not going to catch them all, and I think there is a good story to tell, Mr. Evans, of what DOD is trying to do, and maybe in the end, we, as the receiver of these patients—i.e., the VA—that if we can reduce some of the post-traumatic stress with regard to these veterans, it is good for our customer—i.e., the veteran, in particular.

So, I think, on the preventive side, I think that is pretty healthy.

So, I welcome the gentleman's comments.

Sir, you have had an opportunity to review, slightly, I suppose, the GAO has had some pretty strong criticisms.

Would you like to comment on any of them that you have had an opportunity to look at?

Dr. WINKENWERDER. I will be very brief. We can and should do better.

Mr. BUYER. Yes.

Dr. WINKENWERDER. The reservist community, I think, is one that poses particular challenges, and it is incumbent upon all of us at DOD, including those line unit commanders in the Reserve operations, as well as the health operations within each of the services, to ensure that the performance improves.

I will say that we have established a metric recently for all three services. It is a unified metric that relates to individual medical readiness, and it is a score card that looks at everything from dental readiness to appropriate immunizations to appropriate medical examinations and the like, and that is now being implemented across all three services and will be held out as a performance indicator for the military health system.

It is one of our three key performance indicators for the system.

Mr. BUYER. As I look and read, whether it is GAO's or even your testimony or the VA's, I mean I am consumed with a lot of emotion because there were a lot of things on a very multiple front. I also tried to be very proactive, and I put a lot of different systems in place so that we would not run into the problems of the past, and so, my emotion is charged.

I just want you to know it really is. It is charged. But there are some good things that you have done, too. I mean when we were trying to figure out—when the 38th engineers had blown up all of those chemicals and took us into the troop location units and then we also were dealing with the issues of where we actually put staging areas next to a refinery and, you know, all kinds of things that we did in the first Gulf War—so, we went into this one trying to be different.

So, there is a good story in your written testimony about these extensive operational assessments—excuse me—extensive environmental assessments of operationally selected staging areas and bay sites for both Operation Enduring Freedom and Operation Iraqi Freedom. Congratulations.

Dr. WINKENWERDER. Thank you.

Mr. BUYER. Thank you. You did that, okay?

Dr. WINKENWERDER. I will give credit to the Army, with the Center for Health Prevention and Preventive Medicine.

Mr. BUYER. That is a good thing.

On page 5, in the second paragraph of your written testimony, you discuss pre-deployment processing that is required within 30 days.

Excluded in that paragraph—you do not even mention dental.

Was that, in that paragraph, excluded for a reason?

Dr. WINKENWERDER. No, that was just an omission.

Mr. BUYER. All right. So, you would put dental in there.

Well, I feel a little better.

In 1992, in the GAO's testimony, about 33 percent of the brigade's personnel were found to have deployability problems because of dental conditions or incomplete dental records when they re-

ported to their mobilization stations, 33 percent, one-third of the force, and I remember what that was like from my own unit.

So, I said, you know what, that is another one I am going to take care of.

So, I went out there and used the taxpayers' money and, you know, created the dental insurance, and I mean I did all kinds of things, right? And then I go, well, how did we do?

Dr. WINKENWERDER. We made some impact.

Mr. BUYER. Yes? What was the impact?

Dr. WINKENWERDER. Well, the figures I have suggest figures that are in the range of the teens to low 20s.

Mr. BUYER. Twenty-two percent.

Dr. WINKENWERDER. Yes.

Mr. BUYER. So, I guess we have come down from 33 percent to 22 percent.

Dr. WINKENWERDER. That is not good enough. It is not good enough. I agree.

Mr. BUYER. Yes. It is not. You are right, it is going in the right direction, but to me, it is still a failure rate.

I just want you to know, from me, from all the things I have done—and I have spent a lot of my life working on the Hill on these particular issues to prepare that force—I can only do the systems. It is up to DOD to implement these things. And if you say, Steve, you are crazy, you shouldn't be doing this kind of stuff to us, just tell me. Tell me that you are overburdened with these unfunded requirements, okay?

I don't think so, but what I'm looking at here is the taxpayer, too, okay?

We spent a lot of money on that individual, and when you don't follow the procedures and they are then not deployable, shame on us.

Dr. WINKENWERDER. Yes.

Mr. BUYER. Would you concur with that?

Dr. WINKENWERDER. I would. I agree with you. Our people are our most important resource, our most important asset, however you want to label it, and you put your money where your mouth is, and I think that we have made significant strides. I am pleased with the progress in many areas.

The game is not over. There is more to do. There are lots of opportunities in other areas for us to further improve our development of a metric to ensure accountability, the requirement that I have established for a quality assurance system for conducting the pre- and post-deployment health assessments. Those ought to be done at or near 100 percent.

The opportunity, really, to further protect people with other types of immunizations or other medical preventive measures, the opportunity to look at not just disease but non-battle injury—I think you know, being in the military, there is the DNBI disease, non-battle injury rate, and our rates have come down wonderfully over the last three or four decades, but there are still a number of people who are injured.

Many of those injuries and accidents could be prevented.

We have lost lives because of accidents, and I am pleased to say that the Secretary of Defense, Secretary Rumsfeld himself, has es-

tablished this as a priority and has established that DOD safety council will be participating in this, because there is an opportunity to save lives and to prevent a lot of anguish and suffering just through improved procedures.

At the end of the day, many of these things rest in the hands of the commanders. The health teams—we are support, we can help, we do help, we can do better, but it is a commander's set of responsibilities.

Mr. BUYER. Forty-nine percent of early deploying reservists lacked a current dental examination. That is almost speechless. I am not even going to ask you to defend it, because I don't think you can.

Secretary Embrey, I don't mean to pick on you, but I am going to do this, because you were in the room, and we tried to get ahead of this one, okay?

Ms. EMBREY. So did we.

Mr. BUYER. You, at the time, were saying yes, I agree, we want to do this, because there are a lot of things we didn't do with regard to deployment to Afghanistan, and I don't want to put words in your mouth, but I left that meeting with an expectancy.

The expectancy was that there was some concern that Dr. Roswell had expressed with regard to data collection, okay? We need to get your answer on that question from earlier. So, hold on that and please respond.

What went wrong from our meeting? I had this expectancy that these things were going to happen, and as soon as the first units started going out of Indiana, immediately went down, and then I sent one of the committee staffers to go down to Fort Knox, and that stuff wasn't happening. So, help me out here as to why directives from somebody, from you or somebody up above, were not followed.

Ms. EMBREY. Well, I can't speak for the command and control structure of the services, but I do know that we left your meeting with a great deal of optimism. We spent an inordinate amount of time working with the surgeons and with the vice chiefs to communicate the importance of getting a good baseline before the folks that were deploying left, making sure that the pre- and post-deployment system was fully implemented according to procedures, that we captured that data, that once they were there, we had good medical record-keeping.

We instituted a brand new medical surveillance system capable of capturing electronic medical records. It wasn't totally effective in terms of its full implementation in OIF, but we do believe that there has been an emphasis on the part of the surgical community, the medical community in Operation Enduring Freedom to do a much, much better job of keeping good medical records on those who were there.

I can't say that things have gone wrong. I can't say that everybody implemented every encouragement to do the right thing, but I am not ready to indict the department yet that we haven't done a good job.

Mr. BUYER. I am.

Ms. EMBREY. Okay.

Mr. BUYER. I am.

I never got a 49 percent on a test, but I think if I did, my mama wouldn't be proud of me.

Ms. EMBREY. Are you speaking of the Reserve readiness?

Mr. BUYER. I am just using that as an example. I mean that GAO report is pretty tough.

Ms. EMBREY. Yes, but that report also was very shortly after our meeting, and it represented times before our meeting occurred.

Mr. BUYER. No. I mean they are going to be up here to testify, but this was in an April-May time-frame.

Ms. EMBREY. That is when the report came out, but the data is much, much earlier.

Mr. BUYER. We will find out in their testimony here in a second.

I thought their survey from that particular unit happened in the spring.

The GAO is back there. When did you survey the seven units?

Dr. KANOF. It was during the summer before the report came out.

Mr. BUYER. Thank you.

Ms. Embrey, you are correct.

So if they were to have done seven units in March, you are saying that the result would have been much different?

Ms. EMBREY. I don't know that, but I would certainly hope so.

I do have to tell you——

Mr. BUYER. Let me interrupt you.

Aren't you doing a follow-up for the Armed Services Committee?

Can you slide forward, please, identify yourself?

Dr. KANOF. I am Dr. Marjorie Kanof. I am the director of the health care unit at the GAO.

It is somewhat in the public document that the GAO is doing another report, not looking at the early deploying reservists but actually looking at the Army and the Air Force deployers, and the preliminary information that came out in the House Armed Service Committee is that, in fact, many of the soldiers and Air Force pilots have not had their pre-deployment and post-deployment physicals and that the information is not collected in a uniform spot and that the information is lacking some of the in-field treatment.

Mr. BUYER. So, may I read? "Ongoing reviews by GAO indicate that, while the services and the department have made efforts to meet the intent of the law, especially in the promulgation of policy, the department is not meeting the full requirement of the law and the military services are not effectively carrying out many of the department's policies. For example, the GAO has found that many of the service members are not getting pre- and post-deployment health assessments."

Did I read that correctly?

Dr. KANOF. Yes.

Dr. WINKENWERDER. I think, Congressman, if I am correct, that that was based on information that was collected about a year ago.

Mr. BUYER. Not this.

Dr. WINKENWERDER. We appreciate the work that the GAO has done. It gives us an indication—my perspective is it ought not be our way of knowing how we are doing, and that is why we have incorporated our own quality assurance.

Mr. BUYER. The GAO serve as the constructive critic.

Dr. WINKENWERDER. Right.

Mr. BUYER. They have a very unique function and they are very, very helpful to us.

I have one other question before I yield to Dr. Boozman.

Let me ask you this, Doctor. Board-certified internal medicine. I want you to define a word for me, okay? In an examination, okay, what is an examination?

Dr. WINKENWERDER. A medical examination.

Mr. BUYER. A medical examination.

Dr. WINKENWERDER. I think a medical examination is a collection of information to determine someone's health.

Mr. BUYER. Am I to infer from your answer that a questionnaire is a medical examination?

Dr. WINKENWERDER. A questionnaire could be. You have asked a precise question. I want to try to be as precise as I can. It could be a questionnaire and an interview that provides that information. That alone may not be sufficient, and therefore, an examination may, therefore, necessitate a physical examination and/or additional testing.

Mr. BUYER. Is a medical examination, written in form, considered a medical physical examination?

Dr. WINKENWERDER. I am sorry. Could you restate the question?

Mr. BUYER. Is a written questionnaire in form considered a physical—medical physical examination?

Dr. WINKENWERDER. It would not be considered a physical examination.

Mr. BUYER. Why?

Dr. WINKENWERDER. Well, because a physical examination in medical lexicon means a putting on of the hands, a physical examination, un-gowning of someone and examining their body.

Mr. BUYER. When Congress writes into law that we would like for there to be a physical exam, if DOD only uses a questionnaire, you would say that is insufficient.

Dr. WINKENWERDER. My understanding of the law is that it calls for a medical examination and not a physical examination.

Mr. BUYER. Oh, we are going to play semantics. I have got to change the law?

Dr. WINKENWERDER. Well, I do not know what the Congress intended when the law was passed.

Mr. BUYER. Well, see, I am not a doctor, okay? I can mess things up.

So, your interpretation is that you think now that a questionnaire is sufficient to satisfy the law on medical examination.

Dr. WINKENWERDER. A questionnaire and an interaction with a medical provider which then may, in turn, result in a physical examination and additional testing.

Let me just restate my original—a collection of information to properly assess someone's health. For a young, healthy person, a physical examination adds no value, and there are actually good studies to show that.

Mr. BUYER. All right.

Let me ask this question. What is a medical examination?

Dr. WINKENWERDER. A medical examination is a collection of medical information to make an accurate assessment of a person's health.

Mr. BUYER. I am inferring from that definition that it does not require hands-on physical contact with a patient.

Dr. WINKENWERDER. It may not, in certain circumstances, or as a general rule, I would say, for a young, healthy person, it would not necessitate a physical examination, because the physical examination does not tend to lend additional information that tells you anything about that person's health.

Mr. BUYER. All right. Thank you. Ms. Hooley.

Ms. HOOLEY. Thank you, Mr. Chairman.

I am going to follow up a little bit on this whole issue of medical exam, physical exam, hands-on.

When somebody is returning from war, if you do a questionnaire, how do you catch mental illness on a questionnaire? How do you catch an epidemiological illness on a questionnaire?

Dr. WINKENWERDER. The questionnaire is combined with a face-to-face encounter with a medical provider.

Ms. HOOLEY. Okay. Let us talk about before deployment, and then we'll talk about after, when they are coming back, returning.

For a lot of people, there is still a stigma about revealing that they may have some mental health problems. Many times, your own primary care physician would have no clue that you have some mental health problems.

So, if I fill out a questionnaire before I am going and I am under 40 and I have had a physical in the last 5 years and probably no reason to even see my primary care physician—you know, maybe I have had the flu or a cold or something.

So, I fill out a questionnaire and I talk to a medical provider, who could be anyone—I do not even know what levels there are, whether it is a nurse's aide or nurse; but I talk to a medical person.

How would they discover or know if I didn't tell them that I have some mental health problems?

Dr. WINKENWERDER. The questionnaire asks about mental health.

Ms. HOOLEY. Yes, but I am not going to admit anything on that questionnaire.

Dr. WINKENWERDER. Well, then one would not know, but that is the same circumstance that occurs every day when patients walk into their physician's office and the physician asks how are you doing, anything bothering you and so forth, as I have done many times with patients, and they don't tell you.

Ms. HOOLEY. Right.

Dr. WINKENWERDER. So, there is no way that I know of to get beyond that except the general encouragement and request of people to be forthcoming with anything that is bothering them from a mental standpoint.

Ms. HOOLEY. When they return from war, if you are doing a questionnaire again, how do you catch certain illnesses and how do you, again, catch mental illness?

Dr. WINKENWERDER. Well, the questionnaire is part of a process.

Let us take that group of individuals who are required to obtain periodic examinations, including assessments with questionnaires,

and physical examination and medical testings. There is a schedule that occurs, and we know that the vast majority of people are very likely, highly likely to be perfectly healthy. You are starting out really trying to find if there are people with health problems in the group, to find a very small percentage. A good way to do that is with a questionnaire and a face-to-face interaction between that person and a medical provider, a medical professional.

I would just say I know there has been concern about the issue of the semantics or distinguishing between medical examination and physical examination. I want to just re-emphasize, from my perspective, as a physician, as one who practiced medicine for many years, internal medicine, a physical examination, in my judgement, in the vast, vast majority of cases, does not add valuable information to make a determination about the health of a young, healthy cohort of people.

Ms. HOOLEY. Let me just follow up.

Mr. BUYER. A physical exam does not? Is that what you said?

Dr. WINKENWERDER. Does not generally add useful information to make a determination of the health of a large cohort of young, healthy people. If it were so, we would—as a matter of practice—be recommending that people began yearly physical exams in their 20s. We don't do that. We recommend an a every-5-year basis to come in for a physical examination.

Actually, the screening guidelines for the U.S. Preventive Health Services are a targeted set of activities that includes questionnaires and certain tests. It is very risk-dependent. If you are obese, then you would have certain tests. If you have a history of heart disease, you would have a certain test. The practice of medicine has gotten away from a physical laying on of hands as the best way to extract information about people's health except until they get, generally speaking, into their 50s.

Ms. HOOLEY. Let me just follow up, because I do understand that, as a group, generally people are healthier, have less problems when they are younger, just as a general statement, but you have elements of a system—the system described in subsection A went through the use of pre-deployment medical examinations and post-deployment medical examinations, including an assessment of mental health and the drawing of blood samples to accurately record the medical condition of members before the deployment and any changes in their mental conditions during the course of their deployment.

The post-deployment examination shall be conducted when the member is redeployed or otherwise leaves an area in which the system is in operation or as soon as possible afterwards.

So, from that, I have a couple of questions.

How do we do mental health assessment, and do we draw blood samples, and when you talk about as soon as possible, is there a time schedule for when they are deployed back to the United States, or redeployed? Is there a time-line of when they have that assessment, and in fact, what kind of a mental health assessment do they get? I guess that is the thing that I am very concerned about.

What kind of a mental health assessment do we do, both for deployment and re-deployment?

Dr. WINKENWERDER. I don't have the questionnaire in front of me, but I could actually provide the questions for you. Certainly, we could do it for the record.

There are a series of about four questions that relate to mental health issues and status.

Ms. HOOLEY. Then what is the time-line, because there isn't a specific time-line in here. What is the time-line in which an examination occurs after——

Dr. WINKENWERDER. Within 30 days.

Ms. HOOLEY. Within 30 days.

Dr. WINKENWERDER. Ideally, it would occur just before someone redeploys or as they are coming back into the United States.

Let me just touch on some of the questions that relate to mental health status.

We ask, did you see anyone wounded, killed, or dead during this deployment?

Were you engaged in direct combat where you discharged your weapon?

During this deployment, did you ever feel you were in great danger of being killed?

Are you currently interested in receiving help for a stress, emotional, alcohol, or family problem?

Over the last 2 weeks, how often have you been bothered by any or some of the following: little interest or pleasure in doing things, feeling down, depressed, hopeless, thought you'd be better off dead? These are kinds of feelings that people who are depressed might have.

Have you had an experience that was so frightening, horrible, or upsetting that, in the past month have you had nightmares, thought about when you did not want to, tried not to think about it, or went out of your way to avoid situations that reminded you, were constantly on guard, watchful, or easily disturbed, felt detached, etcetera, and then, finally, are you having thoughts or concerns that you may have serious conflicts with your spouse, family members, or close friends, that you might lose control and hurt somebody?

So, these are meant to get directly at people's mental health and risk for behavior that could be harmful to themselves or to others.

Then, of course, there are additional questions about——

Ms. HOOLEY. Okay. Is that used just——

Dr. WINKENWERDER. It is used with everybody.

Ms. HOOLEY. For both before they are deployed——

Dr. WINKENWERDER. Not before.

Ms. HOOLEY. After.

Dr. WINKENWERDER. After.

Ms. HOOLEY. When they are coming back.

Dr. WINKENWERDER. Yes.

Ms. HOOLEY. Okay.

Then, you have something that assesses their mental health before they're deployed?

Dr. WINKENWERDER. We have——

Ms. HOOLEY. You can just give me copies of that.

Dr. WINKENWERDER. We will be glad to provide you——

Ms. HOOLEY. Thank you.

Dr. WINKENWERDER. It is sort of wrapped into a single question about how they feel about their health.

Ms. HOOLEY. I yield back, Mr. Chairman.

Mr. BUYER. Dr. Boozman.

Mr. BOOZMAN. Yes. I really think you are kind of going out on a limb a little bit when you talk about—you said that this constitutes an exam. I think if you polled 10 physicians or health care workers, I think they would call it more of a screening, wouldn't they?

Dr. WINKENWERDER. We haven't conducted any such poll. I don't know what health care workers would say. I am giving you my judgement and my opinion.

Mr. BOOZMAN. What do you do about the people—I mean when you do a straight questionnaire, you know, pretty much, what do you do about the people that are asymptomatic that have problems, people with high blood pressure, diabetes, heart arrhythmias.

Dr. WINKENWERDER. Those tests are performed.

Mr. BOOZMAN. So, they are looked at. I mean on the sheet—so, they are examined. I don't understand.

Dr. WINKENWERDER. Certainly, for the pre-deployment, people are getting periodic examinations, and so, with all of those examinations, they are getting their blood pressure and their weight and other medical tests.

Mr. BOOZMAN. So, they are examined—they are examined with the questionnaire thing, but later on, they do get an examination?

Dr. WINKENWERDER. It is a continuum. People on active duty, as I described earlier, are required to get assessments and examinations on a regular basis.

Mr. BOOZMAN. Again, I would disagree. I think the comment that you made that the young people, you know, in medicine saying that, you know, they do not need, you know, periodic physicals or whatever at that age—we are talking about people that are going into combat.

Dr. WINKENWERDER. I didn't say they didn't need physical examinations.

Mr. BOOZMAN. On a regular basis.

Dr. WINKENWERDER. What I said was that the medical literature today does not support physical examinations as a systematic part of health care for young people to be provided, for example, on an annual basis.

Mr. BOOZMAN. Again, versus—you know, every day life versus going into the combat situation, I think the problem that the chairman has—and I have a little bit with—is that the intent of Congress was an examination, and really, the reality is these young men and women, whatever, basically got less than, you know, a cheerleader or a football player does every couple of years.

Now, somebody—you know, some of your colleagues there feel like that is important, and as somebody that, you know—truly, in the those physicals, which are pretty minimal, I mean there are—and I am sure there is literature says, you know, that you are picking up stuff that disqualifies them for those kind of activities.

Like you say, translated, you know, back to the other, certainly when you are in combat, again in the sedentary society that we live—and a lot of these guys are reservists—they really haven't

done a whole lot, and then, all of a sudden, they are thrust into very physical activities.

It does seem like, again, the intent of Congress was that they would get at least what the high school cheerleader and football player, basketball, whatever, gets every couple of years now.

Dr. WINKENWERDER. I am not sure where you are leading. Did you have a question?

Mr. BOOZMAN. Well, I am just saying that that is the frustration, when examination was written——

Dr. WINKENWERDER. Right.

Mr. BOOZMAN. I mean, you know, I don't think Congress felt like they needed to list the components of that, but I will say, just as a normal person, just as a reasonable person, I would expect what they got would be as good as the—as that kind of physical, and it really doesn't sound like it was.

Dr. WINKENWERDER. It is as good.

I think, Congressman, if I can say this, what is important is the whole continuum of care that our active duty—I am not referring to the Reserve situation, but certain our active duty personnel receive all along, and I think the statistic I shared with you suggests that it is a fraction of a single percent, a low fraction of a single percent of people that we learned had a medical problem once they were deployed.

I think our evidence says that we are deploying healthy people.

I don't know what the intent of the Congress was at the time the law was written.

I believe this, that it is appropriate for us to seek to implement the law in the way that we think is best, looking at this as strictly a health issue. This is a health issue, and this is the approach that we think is the most appropriate and is in the best interest of all of the people's health that we take care of.

Mr. BOOZMAN. So, I guess the other side—so, you did discuss with your fellow colleagues and they feel comfortable that the questionnaire constitutes——

Dr. WINKENWERDER. They do.

I mean it is certainly an issue that we can go back and take a look at again to see if there is science that would support physical examination in this way for people, but my clinical experience and my understanding of the science would not support this as being a tool that would screen and uncover medical problems in any more effective way than what we are currently employing.

Mr. BOOZMAN. Thank you.

Mr. BUYER. Looking at the pre- and post-deployment health assessments, I have those forms here, and then I have the "Report of Medical Examination," okay? So, I am trying to figure this out.

On the form on pre- and post-deployment, there is a place where, after the soldier, sailor, airman, marine fills out—or the Reserve component member—fills out the information, an interview is then conducted, and then they are to sign the form.

Who is that interview conducted by?

Dr. WINKENWERDER. With a pre- or post-deployment health assessment?

Mr. BUYER. Yes.

Dr. WINKENWERDER. A physician or a nurse.

Mr. BUYER. Or an nurse.

Dr. WINKENWERDER. Nurse-practitioner.

Mr. BUYER. How about a corpsman?

Dr. WINKENWERDER. No, I don't think a corpsman. Licensed practitioner. Someone that you would normally see in a primary care practice, a physician or a nurse practitioner or physician assistant.

Mr. BUYER. Okay.

When Congress writes it in law that you are to conduct medical examinations, when you gave me a definition of a medical examination, is a licensed practitioner, a nurse-practitioner permitted to give a medical examination?

Dr. WINKENWERDER. Yes.

Mr. BUYER. Okay. Who else, outside of the doctor, can do that?

Dr. WINKENWERDER. Generally a licensed practitioner, which would include a physician, a physician assistant, or a nurse-practitioner.

Mr. BUYER. Why would these forms on pre- and post-deployment be called a health assessment and this other form, then, DD Form 2808, dated January 2003, is called a "Report of Medical Examination"? When do you use this, these health assessments, and when would you use a report of medical examination?

Dr. WINKENWERDER. The health assessments are used pre- and post-deployment.

Mr. BUYER. So, these are medical screenings, as Dr. Boozman mentioned?

Dr. WINKENWERDER. They are health assessments that are part of a medical examination.

Mr. BUYER. For screening purposes? In other words, if they find something that needs a referral, then do you use a medical examination form?

Dr. WINKENWERDER. Because I can't see the form from here, what form are you talking about there?

Mr. BUYER. The law says medical examination. So, I am trying to figure out what you are doing and why.

While the DOD is reviewing this, Dr. Perlin, let me ask you, in the VA, in order for you to be able to do your job, making sure that you have a good baseline for you to be able to make determinations on disability ratings, are you able to get what you need out of these pre- and post-deployment health assessment forms, or are you saying that you would really like a, quote, "medical examination" according to this DD form?

Dr. PERLIN. I would answer your question in two parts. We really haven't tested the case yet, but where we would make the medical determination would be on the uniform separation physical, and that would really be the point where we would help make the determination of compensation for disability.

Mr. BUYER. You have got to look at the totality, right?

Dr. PERLIN. Yes, sir.

Mr. BUYER. So, I suppose if you have a soldier that is physically fit, has no problems, he has filled out his health assessment, spoken to a nurse-practitioner, good to go, comes back like soldiers from the first Gulf War, never had a physical problem in their life,

now all of a sudden have things happening to their body, that provides some form of baseline for you, does it not?

Dr. PERLIN. You are absolutely correct, sir. Any information that came into the system would be evaluated, and ultimately, there would be a compensation/pension examination where there would be a stereotypical examination for the determination, but the totality of information, as you suggest, would be reviewed.

Mr. BUYER. All right.

Help me out here, because I don't want to be wasting a lot of time in trying to do the semantics here. I feel as though I am circuitous. I am about right where I was when I opened up the hearing, when I told you, hey, here is the purpose of the law, here is what I did, and why, and so, we get into this whole thing about are you doing the medical examinations, what is it, how is it defined. I am sure there had to have been some discussions on this in DOD, trying to figure out what exactly the law means and how it is defined. Am I correct, Mr. Secretary?

Dr. WINKENWERDER. I am sure there were at the time it was implemented in 1998, yes.

Mr. BUYER. Had to be.

Let me turn to the VA.

Just tell me, please, what is it that you need to get the proper baseline so, when you get these soldiers who are then being discharged, that you can make those right decisions?

Dr. PERLIN. We believe this information is helpful. We believe it is helpful, because as Dr. Winkenwerder has suggested, the information from the screening assessments provides a survey of the sorts of things that, the patient may be less reticent to provide in written than during an examination. It is necessary that that information be transmitted to the VA, so as that information enters the Federal Health Information Exchange repository, it becomes accessible.

If returning service personnel bring paper records, the totality of information is examined, when information is from outside of either of our systems directly. We do not have the advantage, the luxury of electronic information, but we want all of that information for service personnel, and ultimately, for us to know the frequency of issues that we may be seeing. The roster, the sum of individuals deployed, is the pivotal piece of information.

So, this pre- and post-deployment information about exposures, roster information, are the sorts of information that we have discussed and worked with DOD in terms of our interest in having.

Mr. BUYER. You just testified previously that any information they give you is helpful. I am trying to define what any information is, and when I put into law, medical examination, I had envisioned this DD form.

So, please, Doctor, now that you have had an opportunity to look at this DD form that was issued in January of 2003—was that under your authority at DOD?

Dr. WINKENWERDER. It is a form. I am not sure where you obtained it. It looks like the purpose of the form is for enlistment, commission, retention, separation. So, it would be the form that would be used to obtain physical and other medical information at the time someone enlists or for the purpose of making a determina-

tion about whether they are healthy to come into the service and at the time that they would be separated.

Mr. BUYER. Right. That is what the VA is saying, I need that medical examination at the time of separation in order for you to do your job, correct?

Dr. PERLIN. Yes.

Dr. WINKENWERDER. They should have this.

Mr. BUYER. Right.

Now, here is where I think the problem may have come about, because I also said, you know what, I want a medical examination of these guys before they go. It is what I wrote. It is what is in the law right now.

Now, what gets interpreted by what I wrote is that we are going to do screenings, surveys, that is all we need to do.

Now I have to figure out, are you in compliance, or we can play word games, I suppose. You have got a doctor over here that disagrees with what you have said in your testimony.

Obviously, you are playing semantics with the author. I know what I intended. You interpreted it otherwise and now still think you are in compliance, I suppose.

So, now I have got to figure out whether what you are doing is acceptable. I am looking out for the soldier, sailor, airman, marine, okay, and this committee is looking out for the taxpayer, because I created a problem. It is why I am circuitous, because I wanted to take care of those guys and gals who came back with problems and so we gave compensation for undiagnosed illnesses.

So, I have to now close the access to the treasury and get back to sound science, where we are supposed to be, but I can't do it unless we get the proper baseline, and if you are saying, hey, Steve, you can get the proper baseline strictly by these health assessments, hey, everything is fine, we are good to go.

Is that how the VA is going to testify? Is that what you are going to tell me?

Dr. PERLIN. Sir, what I am saying is that—I want to preface this with it is not about the VA. It is about, really, seamless, good quality care across the life of the service personnel, retiree, and veteran.

From our perspective, the information needs are the information at the entry to service, the information at pre-deployment, the information at post-deployment, at separation, and at entry to VA; that continuum of information is really what we view as necessary.

With respect to this particular deployment, some of the additional information, is what we view as the continuum that allows us, in post-deployment, to give good quality care.

Mr. BUYER. I don't know what all that meant. I know that I can walk right over here on the House floor and talk to our colleagues and they are talking to us about their Reservists and Guardmen that are called up and they didn't get a medical exam.

You see, they voted on that legislation. They know that they thought these guys were going to get medical exams, pre- and post-deployment medical exams, and then they get upset when they find out that they were given little surveys—well, they are not surveys—health assessments, and so, we have a responsibility, because we also have to then, I guess, what, try to explain, then, to

our colleagues that DOD has done it differently but it is going to be acceptable.

I don't know if the VA—if you have told this committee yet.

Is what DOD is doing acceptable and what you need to do your job? That is all I need to know.

Dr. PERLIN. What we need specifically is pre-deployment health assessment, post-deployment health assessment.

I don't have evidence that, if every individual received a physical examination, we would be in a better place. What I think is most important to us is that we have pre- and post-deployment health assessments on every service member, so that we have the information as each veteran approaches us for care.

The particular questions in the health assessment——

Mr. BUYER. You know what I was trying to do—there are two things that are synergistically intertwined here, and that was making sure that we put a very healthy soldier in the field to make sure that that team does what they are supposed to do and are trained to do, and at the same time, I can establish a baseline.

See what I was trying to get at?

If you are saying, you know, Steve, good try, but it is just not worth the effort to do that, it is not worth the cost, you have got time constraints, maybe you were saying time is of the essence, we have got to get troops to the battlefield, it is not worth it to do that, please—if I am barking up the wrong way, tell us.

Dr. PERLIN. I don't want to play a semantic game with you.

I think most people would construe the word "examination" with the other elements.

I think the science points to the data value being in the particular pieces of information that are acquired. I can't tell you that there wouldn't be additional information value, but the specific pieces in the pre-deployment screening and the post-deployment screening really point to the psychological stressors that may have occurred.

Now, if they are positive, I would agree—I don't want to put words in my colleagues' mouth. If they are positive, they absolutely mandate a physical follow-up with what we would all construe as a physical examination.

Mr. BUYER. If I do this—if I ask the committee, not only here but at the Armed Services Committee—change this, we won't play semantics anymore. We are going to make sure that, boy, I will put every word imaginable in this.

I am a clever enough lawyer. Now that I have figured out this is what you want to do, I will make sure that a doctor actually has a hands-on physical with that soldier, sailor, airman, marine, or some member of the Reserve components.

Now, once I do that and write that in a 20-page document, if necessary, is that a good thing to do or a bad thing to do, Doc?

Dr. WINKENWERDER. I will give you my straight advice. I don't think it would be the good thing to do.

Mr. BUYER. Tell me why.

Dr. WINKENWERDER. Because I would agree with Dr. Perlin that it would not—for all the amount of work that that would take—and it would take a huge additional amount of work, time, effort, and cost—I think the yield would be extremely, extremely low.

I think the process that we have, particularly with all of the services and my office overseeing their activities and ensuring that they are in full compliance with it, will provide the information that Dr. Perlin and the VA need and that we need after deployment to ensure that people get excellent quality health care.

Mr. BUYER. On dental, you think you could actually do a dental screening by strictly a written health assessment, or does a dentist have to actually look the mouth?

Dr. WINKENWERDER. Well, our process calls for an oral examination.

Mr. BUYER. An oral examination. Now, that is different? If a dentist does it, it is an oral examination. That is different than a medical examination by a doctor.

Dr. WINKENWERDER. I am not going to try to——

Mr. BUYER. See what I mean? Now you are about to tell me that an oral examination by a dentist is hands-on, looking in the mouth.

Dr. WINKENWERDER. Yes.

Congressman, I am sympathetic to your efforts, and I am absolutely supportive of your leadership on this issue. When you ask the question about whether we should be doing this, the answer, unequivocally, is yes, and then your other question was are we doing this the right way? I believe we are, and are there opportunities to enhance or improve? We are open to that.

We are open to looking at anything that we or others think that would make it better, but I think we are gaining the yield from this that we are looking for. We have pretty good information now that the people that we are sending into theater are healthy.

I think, from my perspective, the great concern is what happens between the time we send them and the time they come back, and what does that deployment—what impact does that have on their health long-term, short or long term, and that is the point, I think, of maximal intervention with an extended questionnaire, an examination, if indicated, and what we are finding out is that about—this is very preliminary but that about 15 percent of people are getting referred on, and that is probably appropriate. I don't know what the right number is, but people are getting referred on through this process, and they are being picked up for immediate medical attention who would not otherwise have been seen.

So, if you take that number, just that figure of, say, 15 percent of a group of four or five hundred thousand deployers, we are talking lots of people—50, 60, 70 thousand people—who might not otherwise have been referred for medical care in a timely way.

Mr. BUYER. All right. Ms. Hooley.

Ms. HOOLEY. Thank you, Mr. Chairman. I will be quick, hopefully.

So, let me see if I understand this. You do an assessment and then you do a dental assessment. When do they have to have gone to the dentist and had an oral dental examination before they are deployed?

Dr. WINKENWERDER. Annual.

Ms. HOOLEY. An annual one.

Dr. WINKENWERDER. Yes.

Ms. HOOLEY. So, if they have had one—and on your assessment, do you ask a question about dental health? Do you have any medi-

cal or dental problems? Then, do you ask anywhere have you had a dental exam in the last year?

Dr. WINKENWERDER. The record is evaluated to see that that has taken place.

Ms. HOOLEY. It is, even though it is not on here at all.

I mean the question asked on your pre-deployment is do you have any medical or dental problems?

So, if you say no—but it doesn't—and so, when they then meet with the nurse-practitioner or the physician's assistant or the physician, they would say have you had a dental exam in the last year. They don't have to answer that question.

Dr. WINKENWERDER. Well, they have their record right there. Their past medical and dental record should be there as they are being assessed, along with this questionnaire.

Ms. HOOLEY. How would they get those records if they are a reservist, for example?

Dr. WINKENWERDER. They would be in the Reserve center or the individual——

Ms. HOOLEY. Okay.

So, the person looking at the assessment would look at their records and see that they had a dental exam in the last year.

Dr. WINKENWERDER. Yes.

Ms. HOOLEY. Is that correct? And that all those issues that they found out in the dental exam have been, in fact, taken care of.

Dr. WINKENWERDER. That is correct.

Ms. HOOLEY. Okay. Then, during the past year, have you sought counseling or care for mental health? That is really the only question that is asked on pre-deployment on mental health.

So, I went to see a counselor, I didn't go see a counselor, right?

Dr. WINKENWERDER. Yes.

Ms. HOOLEY. So, I may have problems, but I just didn't seek counseling.

Then, on this—it requires that they have a blood sample.

So, while they are doing this assessment and speaking with the physician or the nurse-practitioner or the physician's assistant, do they draw blood?

Dr. WINKENWERDER. Yes, if they had not had a blood sample drawn, serum sample within the prior 12 months, they would obtain one.

Ms. HOOLEY. So, no matter what age, they have to have a blood sample——

Dr. WINKENWERDER. Within 12 months.

Ms. HOOLEY (continuing). Within 12 months.

Dr. WINKENWERDER. Yes.

Ms. HOOLEY. That is all there as part of their record and they know all the results of that blood test.

Dr. WINKENWERDER. It would be right there with their medical record.

Mr. BUYER. Aren't you using the HIV—when you are drawing the blood for HIV, you are really saying, hey, our requirement is to draw a blood sample, we are going to let it be the same.

Dr. WINKENWERDER. Yes.

Ms. HOOLEY. Do you test it for anything else other than HIV, or is that the only thing you are looking for?

Dr. WINKENWERDER. It is tested for HIV and then placed in the repository for future reference or testing.

Ms. HOOLEY. So, that is the only thing that you are really looking for at this time, is HIV, right?

Dr. WINKENWERDER. In terms of a blood test, yes.

Ms. HOOLEY. In terms of blood test.

Then, the purpose is not only to send our men and women into battle in a good healthy condition; part of the thinking, I believe, Mr. Chair, was that when they come back, you looked at service-related disabilities, whether that is mental or physical health, so we know, when they go to the VA and get into that system, we can tell whether or not, in fact, that is a disability, a service-related disability.

How closely did the VA and the Department of Defense work together on this health assessment and coming together on what needed to be asked so that, those dual purposes, Mr. Chair, were met?

Did you actually sit down and work together, or was this just strictly Department of Defense?

Dr. WINKENWERDER. There has been a working together to establish this process. Some of the questions that are incorporated now into the new enhanced post-deployment assessment came directly at the suggestion of the VA.

Ms. HOOLEY. Okay.

So, you actually sat down and worked together.

Dr. WINKENWERDER. Yes. We have a deployment health working group that works this issue and others full-time.

Ms. HOOLEY. That working group is Department of Defense and VA? Okay.

Dr. WINKENWERDER. Dr. Kilpatrick and Dr. Hyams and others.

Ms. HOOLEY. Okay. Thank you.

I yield back.

Mr. BUYER. I know you should have been gone a long time ago, I don't mean to be exhaustive.

You know, maybe I ought to turn to you, Dr. Hyams, and I am going to reach out to you, because just as the ranking member, Mr. Evans, sort of reached out as a voice for his Vietnam veteran colleagues and comrades, I am going to do the same to you.

You are the only Gulf War vet. So, you are concerned, just like I was, for a lot of guys who came back with their sicknesses and their illnesses.

So, we try to figure out, you know, what really happened to them, as we also then try to prepare forces in the future, right? Isn't that what we are trying to do here?

Dr. HYAMS. Sir?

Mr. BUYER. That is what we are trying to do here, isn't it?

Dr. HYAMS. Right.

Mr. BUYER. I don't have a problem, you know, if we put a requirement in law that you are to draw blood and you go ahead and hold the blood samples for HIV, that is fine. Why be redundant and hold two blood samples? But when we put that in there, it was—you know, we had so many of these individuals not really knowing or understanding what happened to them. So, we spent millions of dollars on many different multi-faceted forms of medical research,

right, much of which is still outstanding, and I guess, for all our sophistication, we like to think that medical science is an exact science, but there is so much that we just still don't know, right?

It is hard for us to admit that because even in internal medicine, you know, we think that you know, but there are certain things you don't know.

Was it the right thing for us to do, Dr. Hyams, to hold these blood samples, so in the future, when you have a case—let me ask it this way. Has the VA accessed these blood samples in any of your determinations on disability?

Dr. HYAMS. That is a good question for me, because I actually have used the serum repository. I haven't used it while I was in the VA, but when I was in DOD, a question arose about the risk among our troops for Hepatitis C infection. We went back to the serum repository, and I collected 25,000 samples from the serum repository, both samples collected in the past and more recently collected samples.

We tested those samples for Hepatitis C infection and were able to determine precisely what the risk of Hepatitis C is in our military force.

So, yes, I think the serum repository is a very good resource, an asset, and it can be used for certain things, like the study of Hepatitis C. What it can't be used for is everything. You can only test for some things using serum samples. I mean it works for some kinds of tests but not for others.

So, yes, it is an asset, but it doesn't answer all the questions.

Mr. BUYER. Right.

So, I got one thing right, maybe?

Dr. HYAMS. Yes, sir. We actually—you know, although I haven't done it in VA, we have gone back to the serum repository and looked for Hepatitis C infection to see whether or not it occurred before a person entered the military or after they entered the military. Certainly, it is used on occasion.

Mr. BUYER. Do you know whether or not you have had to access these blood samples—I mean they are held by name, rank, are they not, individually identified.

Dr. HYAMS. Yes, sir, they are individually identified.

Mr. BUYER. So, if we have a particular soldier—do you know whether or not you have ever had to access the repository on a particular soldier for a determination on diagnosis or disability rating?

Dr. HYAMS. I mean it is possible. Whether it has been done or not, I don't know.

Mr. BUYER. Does anybody know?

[No response.]

Mr. BUYER. Well, there goes another one. That is one of those assumptions out there.

I mean when you create it and you think that you can gain access to it and it will be helpful to you in your determinations, if it is not being done, what am I doing it for?

I suppose, for this example—you gave me an example of where it was helpful.

You know, I am not a doc, you know. I knew just enough about medicine to be dangerous. See what I mean? I am a lawyer, okay?

You know, I was a former medical service corps officer and grew up in a medical family, so I know—man, I can skate on very thin ice, doc, but I can fall through quick, but I am trying to be helpful, and please, help me as I try to help the force.

If we are doing something—I want to be a good listener to you, Mr. Secretary, okay? I am going to go back and I am going to reassess this. I know GAO may not necessarily agree with you, and I am going to try to figure it out, because I want to be responsive, and at the same time, I have got to determine whether or not—what kind of internal discussions were made and is this going to be the right thing. What is VA really going to tell me on the back side. I don't know.

At the same time, do you really need this depository? Yes? Should we continue to do this?

Dr. PERLIN. Sir, I do think you got it right. I think you got it right in terms of looking out for the interests of our service personnel, retirees, and veterans for this reason.

In terms of us taking care of the veterans, when they come to us as veterans, the information that we have pre-deployment and post-deployment is useful. The intervention is useful.

To the veteran, the laying on of hands is important to answer categorical questions such as the presence of Hepatitis C or certain exposures. That serum is useful in terms of understanding something epidemiologically.

You raise an interesting question. Could it be useful in the individual case? In the individual case, we would tend to evaluate the person, the veteran, then and there and get blood tests.

It may be of use in terms of answering questions, something present, something not present. It may not sort out the particular time-frame, but conceivably, it could be of use, but categorically, as in the example of Hepatitis C, absolutely so.

Mr. BUYER. Okay.

I have some specific questions with regard to—Secretary Winkenwerder, prior to deployment in the Gulf region, were complete immunizations, blood tests, serum tests, DNA tests given to the 3rd Infantry Division?

Dr. WINKENWERDER. The 3rd Infantry Division?

Mr. BUYER. Yes.

Dr. WINKENWERDER. Yes.

Mr. BUYER. The 4th Infantry Division?

Dr. WINKENWERDER. Yes.

Mr. BUYER. The 101st Airborne Division?

Dr. WINKENWERDER. Every deploying group of service members should have had the process that we have described here today.

Mr. BUYER. So, I take that as an affirmative to the 101st Airborne Division? The 82nd Airborne Division?

Dr. WINKENWERDER. Let me make sure I understand which deployment you are talking about.

Mr. BUYER. Were complete immunizations, blood tests and serum tests given as part of the deployment to the Gulf region for Operation Iraqi Freedom?

Dr. WINKENWERDER. Yes.

Mr. BUYER. So, it was done for the 101st Airborne Division, an affirmative answer? 82nd Airborne Division?

Dr. WINKENWERDER. Yes.

Mr. BUYER. The 10th Mountain Division?

Dr. WINKENWERDER. Yes. Every——

Mr. BUYER. The 2nd Marine Expeditionary Brigade?

Dr. WINKENWERDER. If they deployed. You are listing groups—as you got down the list, I recall those specific units—if they deployed, then yes.

Mr. BUYER. All right. I won't continue to go down all the units, then.

All Air Force personnel, Navy personnel, you got deployed, you got your complete immunizations, blood tests, serum tests, DNA tests. Those were done.

Dr. WINKENWERDER. That is the standard. That is the expectation. What we will learn as we collect the information is the degree of compliance.

My expectation is for a very high level of compliance, because that is our policy. That is my expectation.

Mr. BUYER. Yes. I don't share the same. I guess I don't share the same, because I know I had a high expectation, too, and the results maybe weren't the same. I know, obviously—I'm a good listener to you, Ms. Embrey, that basically what you are taking me to school on is that we perhaps weren't in total compliance with regard to Afghanistan but even made improvements with regard to the operation in Iraq.

Dr. WINKENWERDER. We don't know.

Mr. BUYER. Okay.

Ms. Embrey, was it probably?

Ms. EMBREY. I don't have evidence yet, but being somewhat cynical, maybe you are right.

Mr. BUYER. Maybe what?

Ms. EMBREY. Maybe you are right.

Mr. BUYER. Maybe I am right. You sound like my wife. She is always right.

I noticed, on a letter dated June 19th of 2003, signed by you, Mr. Secretary—oh, Ed Wyatt signed it for you, in response to the GAO, and this issue on medical versus physical must have been something of an open discussion, because in the letter, they mentioned the word—you don't even use the word "medical examinations." In your letter, you used the word "physical examinations."

So, I just want you to know I find that really interesting that others—I am not the only one out there, is what I am saying, because you wrote it in your own letter, okay?

In your own letter, you didn't call it "medical examinations." You called it "physical examinations."

Dr. WINKENWERDER. Given my sensitivity to this issue, Mr. Chairman, the fact that I didn't sign that letter——

Mr. BUYER. Okay. Ed Wyatt——

Dr. WINKENWERDER. Ed Wyatt——

Mr. BUYER. Given the fact—here is the one thing that is really interesting—and Ed is not here to defend himself, okay? Who do you think worked on the personnel committee when I was chairman?

Dr. WINKENWERDER. Was it Mr. Wyatt?

Mr. BUYER. Yes.

So, I suppose maybe I am out of school here, but maybe Ed Wyatt, when he was helping me on this stuff—maybe he also was thinking that medical examinations were physical examinations.

I wonder.

He is not here, but I would just have to talk to Ed, wouldn't I?

I just thought that was kind of interesting.

I have some written questions I am going to submit, okay?

Again, my purpose here was not to be exhaustive. The purpose of an oversight and investigations subcommittee is we get into the weeds, and I guess the difference here is I have been in the weeds on this one for a lot of years, and my sense is that we are on parallel tracks, going in the same direction, okay?

I don't see us going this way or that way, and I do applaud you.

I mean there are some things that you have done that I am very proud of, proud that you have done and implemented, and we will never know the things that were done that actually have prevented soldiers from coming down with certain things or exposures or that type of thing.

Before I release you, I do have to ask this question. Have any reports come to you with regard to any form of detections or false positives for chemical or biological in Operation Iraqi Freedom?

Dr. WINKENWERDER. No.

Mr. BUYER. Okay.

I would like for you to research this for me. As I watched, like many Americans, on television, an embedded reporter interviews a soldier with a water purification team that, before they drew water out of the Euphrates, they tested the water, and the water test—the sampling came back of high concentrations of sarin and mustard.

Now, that is not indigenous to water, in my chemistry 101 class in college.

Dr. WINKENWERDER. Yes.

Mr. BUYER. So, could you please try to find that answer for me? I need to know that.

I am no longer over on the Armed Services Committee, but sometimes we find answers through different methods and means, and if, in fact, this water purification team were to come forward or if their soldiers did something stupid or drank water out of a river or did—I don't know, but obviously, what that tells me is that somebody threw something in the Euphrates, and I don't even know where the location of that incident came from.

So, would you please share that intelligence?

Dr. WINKENWERDER. We will. We are glad to do that.

Mr. BUYER. All right.

(The information follows:)

Report of Euphrates River Water Sample Containing Sarin and Mustard Concentrations

On July 9, 2003, Dr. Winkenwerder testified before the House Veteran's Affairs Committee. During that hearing, Mr. Buyer asked a question regarding a water purification team finding high concentrations of sarin and mustard in a water sample from the Euphrates River. Mr. Buyer did not have specific information on the unit, date, or location.

1. Did a water purification team find high concentrations of sarin and mustard in a water sample from the Euphrates River?

Answer: Sarin and Mustard have never been detected in any water sample during OIF. We do not know where or when this alleged event occurred. However, this may be referring to events that occurred during the period March 30—April 5,2003. Marine Preventive Medicine units conducting water tests at various locations along the Euphrates river near Al Kut, Iraq, reported high cyanide levels in a preliminary test. However, this preliminary result was determined to be a false positive, based on operator error. Subsequent tests on the water samples revealed no detectable traces of chemical agents, and the level of cyanide was found to be within acceptable health based guidelines. At the time of this incident, various embedded reporters picked up on the preliminary information. Press accounts reaching U.S. and foreign national media outlets ran stories on unconfirmed reports that U.S. Marines found cyanide and mustard agents in high concentrations in the Euphrates River near An Nasiriyah in Iraq.

Mr. BUYER.I am interested—I know you are going to leave, but I am interested in a further discussion with you with regard to the GAO, and probably the best thing to do is, when the GAO finishes their other report—because Chairman McHugh and I both share the common concern here, because I concur with you, it is the continuum of care.

We get that individual while he or she is on active duty, and then we may possibly end up with him in the VA system. So, that seamless health record is pretty important.

I want to thank you for your good work and acknowledgement that we have some labor ahead of us.

Dr. WINKENWERDER. Thank you.

Mr. BUYER. This panel is dismissed.

Actually, we are going to stand in recess for about 2 minutes.

[Recess.]

Mr. BUYER. The subcommittee will come to order.

The GAO can come forward, and—boy, there's nobody left in the room to hear your excellent testimony that you've worked on through the night.

The good thing, I suppose, is that you got to sit in the back of the room because your document set the groundwork for the hearing. So I appreciate the hard work of your team.

What I would like to do by way of opening is, first of all, ask unanimous consent that staff of the ranking member be permitted to ask questions.

Hearing no objection, so ordered.

Ms. Hooley had to leave, and, hopefully, will be able to return. But in her absence, staff is now permitted to ask questions.

The GAO had the opportunity to sit for several hours here and listen to DOD. By way of opening—I know you have a—your written statement will be submitted for the record.

Dr. KANOF. Thank you.

Mr. BUYER. And I've read it.

Dr. KANOF. You've summarized my oral statement.

Mr. BUYER. And so if you could waive the oral statement——

Dr. KANOF. That would be fine.

Mr. BUYER (continuing). We'll go with your written statement. And I would appreciate any comments that you would like to make based off of the testimony of the Department of Defense and the VA. That's where I would like for you—for your oral statement to be.

STATEMENT OF MARJORIE E. KANOF, M.D., DIRECTOR, HEALTH CARE, CLINICAL AND MILITARY HEALTH CARE ISSUES, GENERAL ACCOUNTING OFFICE

Dr. KANOF. And I would direct you to some of the information that we do have in both the written statement and the report from April. One of the questions we were asked was what was the value of doing—I'll use the word "physical" examinations, as opposed to health assessment forms. And Secretary Winkenwerder was correct in that there is a movement in the health care community to look at the value of health assessments, so I think the importance of that is these assessments are used in a normal community, not in one where you need to be prepared to do a specific service.

And in fact, in other areas, such as the firemen, some of the national park services, where they're concerned about the work that they're asking people to do, they do physical exams every year. And what we had looked at through the literature was the value of doing health assessments and then doing physical examinations. And we don't think that the Department of Defense has sufficient information at this point in time to say that a health assessment is equal to a physical examination.

And while there's some merit in saying a healthy individual who's under the age of 40 doesn't need a physical exam every year or every other year, we don't have evidence that an under 40-year-old military personnel should not have these statutorily required physical examinations every 5 years.

[The prepared statement of Dr. Kanof appears on p. 70.]

Mr. BUYER. Are you saying that DOD would draft policies, and they would say that, for example, someone over the age of 40 in a deploying—fast-deploying unit is required to have a medical examination every 2 years? And then when I put it in law for medical examinations, they interpret the very same thing differently?

Dr. KANOF. Right, I found that interesting.

Mr. BUYER. They're picking and choosing definitions of words, based upon their own expediency perhaps.

Dr. KANOF. And I'm not sure that others in the health care community would make that distinction between examinations. I think the distinction is between examinations and health assessment tools that many people now use. It is a questionnaire.

Mr. BUYER. Are you a medical doctor?

Dr. KANOF. Yes.

Mr. BUYER. With regard to the Secretary's definition, did you agree with his definitions? Or would you have your own?

Dr. KANOF. I think I would have a different definition than the Secretary.

Mr. BUYER. All right, so what is your definition of a medical examination?

Dr. KANOF. Well, interesting enough, a complete medical examination should include a history, in which I ask you questions that are similar to a health assessment form. I should take your weight, I should take your blood pressure, and I should then do a physical—I'll use the word "physical" examination, in which I use my eyes and my hands and examine your body.

And so a complete physical exam includes all those components.

Mr. BUYER. If in medical school, on an examination, for my course in clinicals, I have one question, "what is a medical examination?," and I gave as the answer and drafted the health assessment——

Dr. KANOF. In fact, your grade would not be complete, and not to add additional fuel to this discussion, but in fact if you go to the coding book of medical procedures—the CPT book—they, too, have definitions of what is included in a physical examination that are fairly well defined to obtain reimbursement from the Medicare program, and you need to have all those components that I just alluded to.

Mr. BUYER. All right. Now, let me ask this. And in this I am after your personal opinion.

Was I in error here when I put this in law for it to be a medical examination? I mean I am a lay person, you know? I mean we put this as medical examination, and I assumed that if someone is going to get a medical examination, that it includes something that's hands-on. Was that an error on my part?

Dr. KANOF. In isolation, without any other information, I don't think you were in error. I think the part that we don't know is how often do you need to have that physical examination and at the cost, at least when we examined it for Department of Defense, at $140, you know, on an annual year for an early deploying reservist, I am not sure that is a cost that one should not incur until one knows how often to do that physical exam.

Mr. BUYER. Well, here is where we kind of caught ourselves in this quandary.

If we have got DOD policies that say here is how often you have to get a medical examination, all right, so you go out there and you find out how many times they are complying with that DOD policy, right?

On top of that, in law, we have this expectancy, okay, by a population not only of some in the military but lawmakers that these soldiers were going to get medical exams. Then we have to deal with this issue of I didn't get a medical examination, you know, and so, then we have got all these Congressional inquiries and we have got Members of Congress talking to all of us. Hey, DOD didn't do what they were supposed to do.

Then the question is—now I am being questioned, because I guess DOD is saying, you know what, we don't need that, because if we do our medical examinations like we are supposed to do, according to their policies, then the screening is okay.

Dr. KANOF. Only to a certain degree, and it gets more into the question of where you are sitting from the veterans' committee.

I mean, again, let us not look at the frequency. Maybe DOD should get the data and say it is every 5 years, but I—there is not enough questions I can really ask of you to know are you borderline hypertensive, you know? So, when you are older and you now do have more clinical symptoms of hypertension, I missed an opportunity that I potentially could have treated you and potentially have reduced some of the health care burden and cost.

So, there is a fine line between how much information I can get from a health assessment tool and what I can get from a physical exam.

Mr. BUYER. Oh, gosh. You are singing my song.

You know, we all bring our world experiences to what we do.

My father is a practicing dentist, okay, and I asked—I said, Dad, how come you have never had a dental hygienist, and he said I have never had a dental hygienist because—I am paraphrasing his words—because when I do the dental exam and do the cleaning, I am able to recognize things that the hygienist would never see, and he saved a friend's life that had an oral cancer, and because he saved his friend's life, he would not sacrifice his. Now, these are his own words, so please don't think that because dentists have hygienists, they are sacrificing, but he was unwilling to go down that road. He wanted to make sure that every patient that he had, that he gave them the hands-on clinical exam, so, you know, he put his stamp on it, and when I looked at all of this—I mean I took that—I bring that to my job.

I have never forgotten that because he really changed the scope of his practice because of that experience upon his life, and you know what? I guess he had an effect on me too.

So, when I looked at this and said, all right, how am I best going to prepare the force, okay, and establish that baseline and I know that soldiers that are sick or injured—they are not going to put it on a health assessment, because by golly, they wanted to go to the show, all right, they want to deploy with their unit, but if you are hands-on with them, you might catch something. Later on, we in the VA have got to pay for this stuff.

Dr. KANOF. Right. The unknown is how often does one need a physical, but sometimes it is better to err in obtaining that information by getting a physical, potentially, too often until I know what is the right number.

Mr. BUYER. So, when you did your report, you did this based on the definition of a medical examination to include physical.

Dr. KANOF. Well, we did because, in fact—and maybe we are all reading the statute differently, or citing different statutes, but the statute we were looking at was the early deploying reservists, and that has two separate requirements.

One of those requirements is for a physical examination, and there is another requirement that says an annual medical screening.

So that, to me, it is clearly two very different activities, not being interchangeable.

Mr. BUYER. The section 1074F, medical tracking systems for members deployed overseas, section (b), titled "Elements of system"—"The system described in subsection (a) shall include the use of pre-deployment medical examinations and post-deployment medical examinations, including an assessment of mental health and the drawing of blood samples to accurately record the medical condition of members before their deployment and any changes in their medical condition during the course of their deployment."

Dr. KANOF. Okay. In our report, we cite—and it is probably another section—USC 10206A12—and goes forth—and there, there are specific citings for a physical examination and a separate citing for a medical screening, and we can share with you our references.

Mr. BUYER. Now, also in this law, the post-deployment examination shall be conducted when a member is re-deployed or otherwise leaves the area in the system of operations.

So, you could have an individual in Operation Iraqi Freedom sent to Germany and then, from Germany, sent to Bosnia or somewhere else. Were these examinations being done, the re-deployment, so you have post-deployment, re-deployment?

Dr. KANOF. Right. We are just beginning to look at that.

Mr. BUYER. Okay. That is what you are doing now.

Dr. KANOF. Right.

Mr. BUYER. Okay.

I know you did this with regard to DOD. I am just trying to make sure that when the VA has to make judgements, a soldier has made an application, filed a claim for a disability, and so, they have to go in and try to figure out what this is and—I guess I am asking for your medical opinion here.

Dr. KANOF. As we write in our testimony, we say that we think that the physical examination would, in fact, be helpful for the VA to be able to determine future disabilities.

Mr. BUYER. Well, see, that is what I thought when I did this.

The VA testifies that anything they give us is helpful, didn't go as far as saying that, yes, Mr. Chairman, we also interpret medical examination as a physical examination. The VA didn't go that far, but with regard to the GAO, that is your interpretation, that a medical exam is a physical exam and that sets a better baseline or standard for the—I don't want to put words in your mouth, but——

Dr. KANOF. No, that is what I said.

Mr. BUYER. Oh.

Dr. KANOF. I would agree with you.

Mr. BUYER. Then where does this leave us? We have got DOD going out there doing their own thing and then claiming they are compliant, but your interpretation would be that DOD is not compliant, because you have a different definition of medical examinations, right?

Dr. KANOF. Well, in fact, I mean in our report—and it interesting in that DOD concurred with our recommendations.

So, in the written report back in April, we, in fact, recommended that, in light of the fact that DOD does not have any information to provide us with how frequently they should do exams, so that for—let us go back to the early deploying reservists, where they are supposed to be having it every 5 years.

If you don't have any information to say to me 5 years is too often, then you at least should be complying with the statute, and DOD agreed with our recommendations that, you know, you should be abiding by the statute, which is the exams and the medical assessments.

Mr. BUYER. I was humored to see how the Secretary was going to define oral examinations as hands-on by a dentist but would not define medical examinations as hands-on by a physician.

Did you find that sort of odd?

Dr. KANOF. Yes.

Mr. BUYER. I did, too.

Were there internal debates and discussions within DOD? I mean, you know, lawyers sit around—if there is something that

bothers us, we all talk about it. Obviously, if DOD, within the medical community, begins to define medical examinations differently, that has got to be an area—a subject matter of discussion.

Dr. KANOF. It is, and in fact, the report that people are working on now—so, the work looking at the pre- and post-deployment—some of the discussions with the DOD are similar to some of the discussions that went on today in terms of whether an assessment tool is a physical exam or a medical exam or is it an assessment tool, and the second report is being done by another team within the GAO, and they have, in fact, recently come to me to help them from a medical physician perspective with this definition, and we will not be agreeing with DOD at this point that a physical and medical exam is equal to a health assessment form. We think they are distinct and different.

Mr. BUYER. Dr. Hyams, would you come forward and take a seat here at the table, please?

Is that all right?

Dr. KANOF. Yes, that is fine.

Mr. BUYER. What I am trying to do here is—obviously, we have had DOD in and we have heard from them. GAO has given their opinions, which conflict, I suppose, now with the Secretary's testimony on the definition of what a medical examination is.

The Veterans' Affairs Committee—our interests are multiple, I suppose.

As a servant to the Constitution, we have responsibility to the taxpayer, but we also have a responsibility in making sure the veteran is taken care of.

So I just need some help. I need your guidance here. Should we continue this semantic game and force DOD to provide these physical exams, or should I say—you know, you say, you know, Steve, cool it, let DOD go ahead and do what they are doing, we will back GAO off, we will redefine Congressional intent and say what DOD is doing is acceptable because the VA is comfortable with what DOD is doing?

Dr. HYAMS. I would like to harken back to something that Dr. Perlin said about the lifelong medical record. We think pre- and post-deployment surveillance, or health assessment or whatever it is called, is worthwhile, but I think it would not be useful to put all your eggs in that basket.

What we are looking at is a lifelong medical record. We think—and this is our goal, that we collect comprehensive baseline health information, occupational information, medical history information, everything, at recruitment.

This is collected and computerized.

Then we have periodic health assessments, we do the pre- and post-deployment, and then we do the discharge physical examination.

If you have all that data and it is computerized, that is the ideal system, and you don't necessarily have to do as much as you are thinking about pre- and post-deployment.

Let me just say what I think.

Mr. BUYER. You know, that's providence, my friend.

Dr. HYAMS. Sir?

Mr. BUYER. That's providence. That is where we want to take them. That is why we invested in this electronic medical record. I mean I agree with you.

Dr. HYAMS. I think we will reach that goal.

I think pre- and post-deployment surveillance, again, is very useful, but that is a difficult time to collect all the information that you want or the VA wants in order to do health assessments, in order to provide disability assistance.

I mean when people get spun up for deployment, you know, it is difficult, in that period, to collect comprehensive data.

I mean they have got a lot of other things on their mind. They are not thinking about these things. They are thinking about deploying. When they come home, they are thinking about going home, and they do not want to get held up in medical.

So, these are not good periods of time to try to put all your eggs in that basket to collect information, and I know it sounds a little bit pie in the sky, but the VA really is concentrating on the lifelong record. Pre- and post-deployment is just one aspect of that. That is the way I would answer your question.

So, yes, I mean it is important. Whether you want to go this extra mile and do a physical examination, you know, I think we would put more emphasis on the lifelong record, starting at recruitment, rather than doing such a comprehensive assessment pre- and post-deployment. That is the way we would go.

Dr. KANOF. So, we will have a debate, but I think, along that path, you need to have some physical exam.

Dr. HYAMS. Oh, yes, of course.

Dr. KANOF. We just don't know, if you are under 40 and you are healthy and your assessment is—I spill out nothing, how frequently that assessment should be.

Dr. HYAMS. No, I agree with that, and that is the time to do it, not when a person thinks they are going off to a war zone and they are trying to get psychologically prepared for that.

The time to do the comprehensive physical examination is when they are in garrison. That is the time to get that sort of data.

Mr. BUYER. So, if we can get DOD to be compliant with regard to their oral and physical examinations, then doing the assessments on pre- and post-deployment, it is okay.

Dr. HYAMS. I would add baseline data at recruitment, comprehensive baseline data at recruitment, and also comprehensive data when a person separates from military service.

Mr. BUYER. I guess, mentally, in my mind, I am already thinking about a force that is already out there in place.

Dr. KANOF. In the Reserves, what we found—this didn't have anything to do with pre- or post-deployment. I mean if I am an early deploying reservist, I am supposed to have a physical exam done every 5 years, nothing to do with pre- or post-deployment, but we found that those were not being done.

Mr. BUYER. I know. That is why I am trying to figure out what is the standard?

I mean I can't come in here and make demands on them and get so upset and say you are redefining a word, you are using semantics, you are not following Congressional intent, I want this particular physical exam on pre- and post-deployment, but you will

say, Steve, so what? They are not even following their own policies about their annual physicals for oral and physical, right?

Dr. KANOF. That is what we found, yes.

Mr. BUYER. That is what you found, and that is what is upsetting to us, I guess, because we have made this investment in a soldier, sailor, airman, or marine, and they are not deployable, because we are not even following the procedures for them to get exams.

Dr. KANOF. Right.

Mr. BUYER. Right. So help me here.

So if you say what we should be doing is you focus and you tell the Armed Services Committee over there that if they do their job and they do their physical examinations according to DOD policies and we get to these electronic medical record, so you have a baseline continuum of care, then what DOD is testifying to, that we do health assessments, would be okay to the VA.

Dr. HYAMS. I am going to give you my opinion, and I would say yes, but you know, I cannot speak for all of VA on such a big question, but that would be my opinion.

Mr. BUYER. Okay.

Dr. KANOF. I think the key is that somewhere in this electronic medical record in the future, though, there are some frequency of physical exams.

Dr. HYAMS. I agree.

Dr. KANOF. So that when you are—be it a reservist or an enlisted individual—you know that, in a period of time, there has been an exam.

Mr. BUYER. I yield to counsel for the ranking member for questions that he may have.

Mr. SISTEK. Thank you very much, Mr. Chairman.

Well, good afternoon, Dr. Kanof.

In Dr. Winkenwerder's testimony, on page 9, he discusses service implementation of the plan, and he talks about Air Force compliance, Air Force performance, and he notes that the Air Force self-assessment of the process was characterized by the Air Force as excellent. Before you reviewed the seven Army Reserve units, did they have a self-assessment of their performance before you walked in the door? If so, what was that?

Dr. KANOF. Not that I am aware of. I don't know.

Mr. SISTEK. Okay. Thank you very much.

In your report, you did a great job stating the obvious problems associated with losing resources that you have trained due to medical or dental problems. These folks are un-deployable.

There is a monetary loss there. You cite about $140 a year would even that out for the average reservist, and if you take a look at what the average reservist makes in a weekend drill, well, that might be a weekend once a year well spent. There is another process here, and maybe this question would be better for the DOD, but I am going to ask you to see if you have thought of it or have approached it.

Over in the DOD, the strategic planners have these long lists of active duty service people available, and of Reserve people available. When the Ready Reserve is exhausted, they go to the IRR, and then they go to the retired Reserve. It is a priority system of

calling people up to meet the op plan requirements, to meet the strategic plan requirements in one theater or in multiple theaters. But aren't the numbers in those op plans thrown askew if you only muster 80 percent or 78 percent of your Ready Reserve component because the other 22 percent have dental problems? Does that throw things off?

Dr. KANOF. The other point that throws things off, as we noted in the report, is, for the moment, none of this information is even collected in a centralized computer, so that it is not clear at all, as you are trying to say I need X number of reservists, how many you have that are ready to go.

Mr. SISTEK. Now, Mr. Chairman, if this has been discussed earlier, please just intervene, because I don't want to retrace old ground, but the DOD has the responsibility for policy and seems to have the responsibility for reporting to Congress, but it is the service implementation of the law that I understand had been questioned on panel one. Have you looked at all of the standardization procedures among the services who are implementing these plans? Are they doing it in a similar vein? Are they achieving similar outcomes? Indeed, if you were to computerize the whole mess, would the fields report the same data in a way that would be meaningful to other services?

Dr. KANOF. DOD does have plans that, at some point in time, all the services would be using the same form and be entering the information into the same electronic record. So, that is a long-term plan.

For our report, we looked at the Army. We know that—just from some glimpses—that the Air Force is following these regulations closer than the Army. So, we do know there is some variability in how the services are implementing.

Mr. SISTEK. Thank you very much.

Mr. Chairman, we will have some post-hearing questions. That is all for now.

Mr. BUYER. I had some pre-prepared questions for you, and they have been asked and answered.

Dr. Hyams, I want to thank you for staying. I appreciate that.

Dr. HYAMS. Dr. Perlin had to catch a flight to London.

Mr. BUYER. Oh, okay.

Dr. HYAMS. That is why he had to leave. I wanted to make sure that is clear.

Mr. BUYER. That is pretty good. Cover for the boss.

Dr. HYAMS. He is a nice boss.

Mr. BUYER. He is a good guy, huh? It is on the record.

Even at this vote, I am going to go over and have a chance to talk with Chairman McHugh, because he wanted to know what we discussed here today, and I will have my opportunity to do that, and I suppose that, you know, you are going to be able to—well, I can't change your directives, nor the scope of what you are reviewing.

I suppose you should note, though, in your report that, the author of the bill that became law believed that a medical examination included physical examination but was a good listener with regard to the testimony of the Department of Defense that they would conduct health assessments pre- and post-deployment and

that if a medical examination that included physical was required from the health assessment, that that, in fact, would be done and then so entered into the medical records and that the VA provided testimony before the Veterans' Affairs Committee that if DOD were in compliance with their policies on medical examinations in the continuum of care and they would have a history, that it was at least sufficient baseline to VA to provide a competent decision on medical disability.

I think you need to put that in your report and convey that to the Armed Services Committee. I will do that with Mr. McHugh, but I think it would be helpful if you did that, because we are trying to get, you know, two huge departments or the two largest departments of the Government working in concert with each other.

Would that be accurate, Dr. Hyams, what I just said, because I don't want to go through this again and do this dance.

Dr. HYAMS. I gave you my opinion. What about submitting that as a question and let us answer that—I mean it is a big question. Let the VA answer that as a big question and as an organization.

Mr. BUYER. Why don't you do this? If the VA has an opinion which is different from your testimony, why don't you submit it to me in writing, okay? If the VA concurs with your testimony today, then we will let it stand. Will that be all right?

Dr. HYAMS. Sure.

Mr. BUYER. Okay. All right.

I don't have anything further. This was a lengthy hearing, and I appreciate your sticking around. I appreciate your good work to the GAO, and extend my appreciation to your team.

Dr. KANOF. Okay.

Mr. BUYER. They have done a lot of fine work.

This hearing is now concluded. Thank you.

[Whereupon, at 5:15 p.m., the subcommittee was adjourned.]

APPENDIX

PREPARED STATEMENT OF CHAIRMAN BUYER

Good Afternoon. Today's hearing is of utmost importance to me. As a Gulf War veteran, I know all too well the physical hardships our military men and women endured while serving in the Gulf Region.

What our troops did not expect was to be told upon their return that "perhaps their unexplained illnesses were stress induced." However, that was the conclusion of a Presidential Advisory Commission that attributed the undiagnosed symptoms of the Gulf War veterans to psychological stress. This "stress" has been found and cited after past wars and conflicts dating back to the Civil War in which members of the armed forces had unexplained illnesses that could not be diagnosed. Personally, I find that conclusion unacceptable.

It has been more than a decade since Operation Desert Shield/Desert Storm. What we hope to learn during today's hearing is—were the troops given a full medical screening, what types of vaccines and drugs did they receive prior to this recent deployment, and were they given the appropriate medical examinations and treatment when they returned.

I don't think anyone in this room needs to be reminded about what transpired when the troops returned from the Gulf War in 1991. Since a central repository with a complete medical record was not in existence, there was no way knowing whether the physical illnesses being experienced by many of the troops were service-connected, or whether they had a condition prior to going overseas that was exacerbated by some type of exposure while in the Persian Gulf arena. It is vitally important to have a complete medical history of each an every individual that is deployed overseas period!

I was Chairman of the Subcommittee on Military Personnel of the House Armed Services Committee when we passed Public Law 105–85, the Department of Defense Authorizations for FY 1998, which required the Secretary of Defense to establish a system to assess the medical condition of members of the armed forces who are deployed outside the United States. Public Law 105–85 also requires pre-and post-deployment medical examinations. A primary focus of today's hearing is to learn if such medical screenings were completed prior to deploying troops to Afghanistan and Iraq. And, an equally important question is, what has DOD done since the passage of Public Law 105–85?

On June 19, 1997, the GAO testified before the Subcommittee on Health on the VA's Health Care Treatment for Persian Gulf War Illnesses. Here is what the witness said: "Regarding their satisfaction with the VA care, Persian Gulf veterans appear to be confused by, frustrated with, and mistrustful of VA and the care they receive for their illnesses." I guess we all want to hear from the VA about lessons learned from the first Gulf War and what measures have been taken to ensure that veterans returning home would not be confronted with similar obstacles when seeking health care treatments.

STATEMENT OF

DR. WILLIAM WINKENWERDER, JR.

ASSISTANT SECRETARY OF DEFENSE

FOR

HEALTH AFFAIRS

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

U. S. HOUSE OF REPRESENTATIVES

JULY 9, 2003

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Introduction

Mr. Chairman, thank you for inviting me here today to discuss with you and the members of the Subcommittee the Department of Defense's deployment health efforts associated with recent operations. I am pleased to be here with my VA colleague, Dr. Perlin.

Protecting the health of deployed military personnel is a paramount concern of the Department of Defense and is one of my chief responsibilities as the Assistant Secretary of Defense for Health Affairs. Deployment health assessments are an integral component of DoD's overall Force Health Protection program, which rests upon three pillars: a healthy and fit force, prevention and protection, and medical and rehabilitative care. Force Health Protection is a strategy that applies to the continuum of medical care experienced by each Service member from entrance into the military to separation from the military and transition in many cases to the VA healthcare system. The vigorous requirements of the medical entrance physical examination, the periodic physical examinations, periodic HIV screening, annual dental examination, physical training and periodic testing, and the regular medical record reviews are parts of this continuum.

Deployment Force Health Protection is a comprehensive strategy that promotes and sustains the health of service members prior to deployment; prevents injury and illness and protects the force from health hazards during deployment; and provides quality, compassionate treatment for deployment-related health conditions. These procedures ensure that each service member is healthy prior to deployment. The process begins with a thorough health assessment upon accession into the military and continues with periodic health and performance assessments throughout military service, as well as ready access to comprehensive medical care for all personnel on active duty. Service members are protected against numerous health threats

through immunization programs (tetanus, DPT, MMR, polio, hepatitis, etc), health promotion programs (smoking cessation, hypertension detection and treatment, responsible sexual behavior, etc), health protection training (safety, sanitation, first aid, insect and vector protection, chemical protective suit use, etc), health threat countermeasures (helmets, earplugs, insect repellent, sunblock, etc), and physical and mental fitness programs.

Deployment Health Assessments

Upon selection for deployment, each service member's health is assessed immediately prior to deployment to ensure that medically unfit individuals are not deployed and that deployment-specific countermeasures (e.g., additional immunizations, malaria prophylaxis) and medical threat briefings are implemented. During the deployment, extensive health protection measures are conducted and immediate medical care and medical evacuation are provided. At the time of redeployment, health is again assessed to promptly identify and address any adverse health conditions or concerns the individual has that may need further evaluation, treatment, or follow-up.

Deployment health assessments are also part of a DoD-wide Medical Surveillance System that integrates numerous health, personnel, and deployment data elements, including immunization rates, disease and non-battle injury rates; environmental and occupational health risk assessments; medical record keeping; personnel tracking, medical intelligence, and risk communication.

The primary purpose of deployment health assessments—and especially the more recent enhancements—is to assure a thorough clinical assessment of each individual. The assessment forms are diagnostic tools intended to facilitate communication between the service member and the healthcare provider, and to better assist medical personnel in evaluating the service member's health needs and concerns.

Deployment Health Assessment Process

The requirement for deployment health assessments was established by Congress through Public Law 105-85 in 1997. DoD policy directives were published in 1998, with updates and enhancements in 2001, 2002, and most recently, April 2003.

In 1998, DoD established a pre- and post-deployment health assessment process. This process requires that a health care provider individually certify each individual as having met certain medical requirements prior to deploying and that health status is reviewed by a health care provider for each individual upon return from deployment. The pre-and post-deployment health assessment forms document the process for each individual, and copies are archived electronically in the Defense Medical Surveillance System (DMSS). The Army Medical Surveillance Activity (AMSA), which runs DMSS, has processed over one million of these forms since 1998. AMSA provides periodic tabulations from these forms in its Medical Surveillance Monthly Report, and electronic images of these forms are now available to healthcare providers worldwide through the web-based TRICARE OnLine.

In 2001, after large reserve mobilizations following September 11th, DoD expanded the deployment health assessment process to include reservists called to active duty for 30 days or more even if not deployed overseas. The Joint Chiefs of Staff published expanded guidance in

2002 for pre-, during-, and post-deployment health surveillance that emphasized deployment health assessments, provided detailed implementation procedures, and added instructions on deployment health and environmental surveillance.

Most recently, in April 2003, DoD enhanced the program yet again. The enhanced process mandates standardized implementation of post-deployment health processing with a face-to-face assessment by a trained health care provider for every redeploying individual. It also utilizes an expanded assessment form (with more questions on specific symptoms, exposures, health care, and concerns) which ensures the breadth of that assessment. Most importantly, this enhanced assessment includes an assurance that all health issues detected during this screening process will be fully addressed by health care providers using the Post-Deployment Health Clinical Practice Guidelines (PDH CPG) promulgated last year throughout DoD and the VA.

Pre-deployment processing is required within 30 days prior to deployment and involves medical record review, immunization update, blood draw (within 12 months) and lab check (DNA, HIV, blood type), completion of a pre-deployment health assessment form, healthcare provider review (including mental health), provision of deployment-specific medical countermeasures and 90-day supply of medicines, and a general and area-specific medical threat briefing. The healthcare professional's signature on the assessment form certifies that this process has been completed.

Blood draws are required (usually as an HIV test) for archiving of the sample in the DoD Serum Repository, which is the world's largest serum repository, housing over 30 million frozen samples on over 7 million service members since the 1980s. These samples are obtained routinely from all service members on a schedule varying from every 6 months to five years, and

are required as a baseline within 12 months prior to deployment. Post-deployment blood samples have been required utilizing the routine HIV testing schedules for all service members. In the recent policy change, these post-deployment samples are now mandated to occur within 30 days of redeployment to assure that all service members get a post-deployment sample archived before they separate from the military. The availability of these samples for subsequent analysis relating to military- and deployment-related health issues is a unique capability of the military.

During the deployment there is extensive support with medical and environmental surveillance, emergency health care, combat stress support teams, and chaplains. The DoD now routinely deploys preventive medicine, environmental surveillance, and forward laboratory teams in support of worldwide operations. For example, the Army's Center for Health Promotion and Preventive Medicine (CHPPM) conducted pre- and during-deployment environmental health intelligence studies for the battlefield, and performed extensive environmental assessments of operationally selected staging areas and base sites for both Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). CHPPM also supplies environmental sampling materials for deployed forces, conducts operational risk management estimates for field commanders, and develops pocket-sized "staying healthy" guide books for deployed Service members.

In-theater medical support has been highlighted on numerous newscasts, but less visible are the health surveillance and medical records systems that support the operations. Electronic daily and weekly disease and non-battle injury (DNBI) reporting was implemented for OIF, and a system of electronic medical record-keeping was partially implemented. Early reports from these systems provide lessons for future development and force-wide implementation. Combat

stress teams were also deployed to assist with health risk communication and address specific service member concerns.

Post-deployment health assessments are conducted for all redeploying personnel. Preferably these assessments are done in theater, immediately before return to home station. If not accomplished in theater, they are completed upon arrival at a demobilization site or at home station. Returning personnel are provided information to aid with reunion at home, advised about any needed medical care, and provided instructions for continuing any medical countermeasures, if needed (such as malaria prevention for a short time). Post-deployment processing guidance includes specific instructions for the healthcare provider's face-to-face health assessment, to include discussion and documentation of the individual's responses to the health assessment questions on the post-deployment health assessment form, mental health or psychosocial issues commonly associated with deployments, special medications taken during the deployment, concerns about possible environmental or occupational exposures, and resources available for resolution of deployment health issues. Individuals with health issues are evaluated by their healthcare provider using the Post-Deployment Health Clinical Practice Guideline, which begins with a military specific "vital sign" at every healthcare encounter, asking whether the visit may be related to a deployment. If so, a diagnostic algorithm is utilized to assure that all deployment-related health issues are properly addressed and managed.

There are several options available when there are health concerns related to National Guard and Reserve Personnel who are redeploying. They can be retained on active duty and referred to DoD facilities for further medical assessment and/or treatment or released from active duty with arrangements made for medical follow up utilizing community resources. The

particular health concern and assessment by the health care provider will determine the appropriate option to use.

The Department has also established three Deployment Health Centers and the Millennium Cohort Study to address deployment health concerns in depth. The Deployment Health Surveillance Center is focused on deployment health surveillance and maintains electronic longitudinal records of health care visits, personnel data, immunizations, deployments, and pre- and post-deployment health assessment forms. The Deployment Health Clinical Center focuses on deployment health care and clinical research relating to deployment, and it oversees use of and serves as the referral and consultation center for the Post-Deployment Health Clinical Practice Guideline. The Deployment Health Research Center focuses on deployment health research, concentrating efforts on the prevention, treatment, and understanding of deployment-related health concerns. It is conducting the Millennium Cohort Study, which is an ongoing comprehensive DoD health research initiative that responds to concerns about whether deployment-related exposures are associated with post-deployment health outcomes. A cross-sectional sample of 100,000 military personnel and veterans are being studied prospectively over a 21-year period.

Service Implementation

Service plans provide details for implementation of deployment health assessment policy by the operational and medical units, with quality assurance an integral component of each plan. The Services are monitoring the numbers of personnel redeploying, tracking their post-deployment forms and blood sample processing, and assuring that medical issues are appropriately dealt with. My office is monitoring Service compliance through our medical surveillance system, and

we will be visiting the Services to audit records on a quarterly basis. We have undertaken a comprehensive and complex effort to enhance our entire deployment health program, and we are committed to successful implementation and continuous quality improvement.

We are still in the early stages of the redeployment process. The Defense Medical Surveillance System has received about 70,000 post-deployment health assessment forms since January, and about 16% of those initially reviewed show the need for additional referral/evaluation. Less than 10% of active duty personnel (and a slightly higher percentage of reservists) have identified medical/dental problems or mental health or exposure/health concerns. It is still much too early to establish definitive findings or conclusions.

The Air Force reports that all active duty and reserve component personnel were screened prior to deployment utilizing a medical records review, a review for currency on individual medical readiness requirements, and a pre-deployment health assessment form, when required. About 5% of AF personnel screened required a clinic referral. The Air Force assessed the outcome of this process as excellent. Very few Air Force personnel were redeployed from Operation Iraqi Freedom (OIF) due to problems arising from pre-existing medical conditions – only 0.06% (6 per 10,000) of deployers had medical conditions that were problematic in theater. At least 93% of returning personnel have completed post-deployment health assessments (submitted to AMSA) and have had serum samples collected. Some returning personnel have completed health assessments, but forms have not yet been received by AMSA. The Air Force quality assurance program will ensure that all personnel complete post-deployment requirements within 30 days of return. Air Force reports indicate that 6% of personnel returning since March 1, 2003 have required a referral for clinical evaluation.

The Army reports that 70% of those on deployment rosters already have a centrally documented pre-deployment form; only a small number of soldiers have redeployed, and about half already have centrally documented post-deployment forms on file. This is one of the Army's top priorities.

The Navy implemented enhanced post-deployment health assessment policy by message from the Chief of Naval Operations. Detailed guidance for medical personnel performing the assessments has been made available. While some personnel had re-deployed prior to availability of the revised form, most have used the updated 4-page form and the Defense Medical Surveillance System has begun receiving them. The Navy is accomplishing the post-deployment blood sampling through HIV testing, with excess serum samples routinely going to the DoD Serum Repository. There has been a dramatic increase in the number of blood samples being processed by the Navy indicating compliance with the revised post-deployment health assessment program. Shipboard implementation of the enhanced program is challenging, but the Navy intends and fully expects to be in complete compliance with all required elements.

The Marine Corps leadership has emphasized the importance of the post-deployment health assessment policy. For deployed OIF Marines, the majority of screening is occurring in-theater with the required blood draw occurring in the U.S. The largest combatant Marine force deployed in support of OIF, the First Marine Expeditionary Force in Camp Pendleton, indicates that about two-thirds of their redeploying personnel already have documented completion of the post-deployment health assessment forms and blood draws.

Conclusion

We are working closely with the Services regarding redeployment health and reintegration issues as service members return from the conflict. Commanders have been vigilant in their responsibilities. We are engaged with the Services in developing the medical lessons learned so we can improve our activities in the future. We are working with the Services to document specific details of the deployment health assessment processes and of the environmental hazards and health events experienced during OIF so that they will all be properly addressed. Over the next several months, as the data and facts are compiled, we will be developing an in-depth understanding of the health issues and we will assure that our health care system addresses them thoroughly and that we communicate properly with our service members, Congress, and the public. Proper risk communication to those who think they might have been exposed to harmful agents is critical in alleviating fears and concerns about potential health effects.

Statement of
The Honorable Jonathan B. Perlin, MD, PhD
Deputy Under Secretary for Health
Department of Veterans Affairs
Before the
Committee on Veterans' Affairs
Subcommittee on Oversight and Investigations
on Pre- and Post-Deployment Health Issues

July 9, 2003

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Mr. Chairman, I am pleased to be here to testify before the Subcommittee on VA's role in the care of veterans of Operation Iraqi Freedom. With me today is Dr. Craig Hyams, VA's Chief Consultant for Occupational and Environmental Health.

Because over 200,000 U.S. troops have been engaged in Operation Iraqi Freedom, I am grateful for the opportunity to emphasize that VA is prepared to provide high quality health care and disability assistance to Iraqi Freedom veterans. Since the Gulf War in 1991, VA has developed and implemented improved policies and programs to care for our nation's newest war veterans. As we have all witnessed over the last couple of months, this conflict is not over and our men and women in uniform remain in harms way and deserve our best efforts.

Health Care, Surveillance, Education, and Outreach

Health Care following Combat

It is critical to provide high-quality health care after every war. Congress understands this and under 38 U.S.C. § 1710(e)(1)(D), added by Public Law 105-368, VA was authorized to provide health care for a two-year period to veterans who serve on active duty in a theater of combat operations during a period of war after the Gulf War, or in combat against a hostile force during a period of hostilities after November 1, 1998. Consequently, combat veterans, like those now serving in Iraq, have a two-year period of access to free VA health care, unless there is sufficient medical evidence to conclude that the illness is not attributable to that service.

To date, 22 combat veterans have been transferred to VA from DoD for specialized, long-term health care and rehabilitation. These patients have had spinal cord injuries, gunshot and grenade wounds, and other combat trauma. There have been relatively few veterans of Operation Iraqi Freedom who have

otherwise presented for care at a VA medical center because most combat troops are still serving in Iraq or remain on active duty. The Iraqi war veterans presenting to our clinics have had a varied range of health problems. No illnesses due to chemical or biological agents have been reported.

Assessment of Health Care Needs

In addition to providing high-quality health care for veterans, VA now has the capability to collect and analyze comprehensive health information with its computerized outpatient and inpatient medical records. The capability to assess the health status of veterans has been greatly improved since the Gulf War. Standard health care databases help VA evaluate specific health questions. Importantly, VA clinicians are able to review veterans' prior treatment in VA when the veterans obtain care from the Department. This capability will support broad, long-term, and comprehensive assessment of health status because many veterans return frequently for VA health care and are often seen in different clinics, and may be evaluated in different parts of the country for specialized health care needs.

VA is working with DoD to obtain a roster of recent combat veterans to facilitate analysis of computerized health records. Furthermore, veterans of Operation Iraqi Freedom are eligible for evaluation in the Gulf War clinical registry. Every Iraqi Freedom veteran is being offered an opportunity to participate in this registry, which provides a thorough clinical evaluation and documentation of symptoms and potential exposures.

Supplementary Clinical Programs

VA is developing a new clinical reminder that will pop-up on the computer screens of VA health care providers when they encounter a new patient who may be a veteran of the war in Iraq or Afghanistan. This clinical reminder will ensure that health care providers evaluate veterans for deployment-related medical and psychological risks. It will also provide Internet links with relevant clinical practice guidelines and exposure health risk information.

In addition, the VA Depleted Uranium Follow-Up Program at the Baltimore VAMC is coordinating screening of the urine of veterans who may have been exposed to depleted uranium during Operation Iraqi Freedom. The service is being provided to both VA patients and to the Defense Department for active duty troops. The results of this testing are provided directly to the veteran and their VA or DoD physician.

Ensuring High Quality Post-Deployment Health Care

Specialized health care during the post-deployment period can help prevent long-term health problems. Therefore, VA and DoD developed evidence-based clinical guidance for treating veterans following deployment. Clinical Practice Guidelines (CPG's), which are based on the best scientifically

supported practices, give health care providers the structure, clinical tools, and educational resources they need to diagnose and manage patients with deployment-related health concerns. VA and DoD have developed two post-deployment CPG's: a general purpose Post-Deployment CPG and a CPG for unexplained fatigue and pain. Our goal is to make sure that all VA health care providers are well-informed about specific deployments and related health hazards. Information on these Clinical Practice Guidelines is available online at www.va.gov/environagents.

Assessment of Difficult-to-Diagnose Illnesses

The majority of veterans returning from combat and peacekeeping missions are able to make the transition to civilian life with few problems. Most who come to VA for health care receive conventional diagnoses and treatments. Some veterans have greater problems on their return to civilian life, and a small percentage of them develop difficult-to-diagnose symptoms. Sustained clinical care and research is needed to understand post-deployment health problems. Consequently, VA has established two "War-Related Illness and Injury Study Centers" (WRIISC's), in East Orange, NJ, and Washington, DC, to provide specialized health care for veterans from all combat and peace-keeping missions who suffer difficult-to-diagnose but disabling illnesses.

VA's two WRIISC's focus on determining the causes and most effective treatments for chronic symptoms, which are a problem following all wars. Health care at the centers is available to veterans of all eras -- including recent war veterans -- through referral by primary VA health care providers. The two centers also provide research into better treatments and diagnoses, develop educational materials, and develop specialized health care programs to meet veterans' unique needs. More information on the WRIISC's can be found at the VA website, www.va.gov/environagents.

Veterans Health Initiative

VA has built upon the lessons learned from our experiences with Gulf War and Vietnam veterans' programs to implement innovations and improved approaches to health care for all veterans. The Veterans Health Initiative (VHI) is a comprehensive program designed to improve recognition and treatment of deployment health effects, to better document veterans' military and exposure histories, and to establish a database for further study.

The education component of the VHI prepares VA healthcare providers to better serve their patients. VA has completed modules on spinal cord injury, cold injury; traumatic amputation; Agent Orange; the Gulf War; Post-Traumatic Stress Disorder; ex-POW health effects; blindness/visual impairment and hearing loss; and, radiation. We are currently developing modules on infectious disease health risks in Southwest Asia; sexual trauma; traumatic brain injury; health

effects from weapons of mass destruction; and, occupational lung diseases. These important tools are integrated with other VA educational efforts to enable VA practitioners to more quickly and accurately arrive at a diagnosis and to provide more effective treatment.

Enhanced Outreach

Veterans and their families, elected representatives, the media, and the nation all need timely and reliable information about wartime health risks. Consequently, VA has developed two brochures that addresses the main health concerns for military service in Afghanistan and Iraq. These brochures answer health-related questions that veterans, their families, and health care providers may have about these hazardous deployments. They also describe relevant medical care programs at VA. These two brochures can be accessed at:

- http://www.va.gov/gulfwar/docs/IraqiFreedomMay21.pdf for Operation Iraqi Freedom, and
- http://www.va.gov/environagents/docs/afghanVet302.pdf for the war in Afghanistan.

Another challenge for outreach is to address the specific concerns of veterans and their families over the potential long-term health impact of environmental exposures during deployment. These concerns are addressed through newsletters and fact-sheets to veterans covering health and compensation issues, including environmental health risks; regular briefings of veterans service organizations; national meetings on health and research issues; media interviews; and, other educational material and websites with information, like www.va.gov/environagents.

Very importantly, VA recently published -- in collaboration with DoD -- a new brochure called "A Summary of VA Benefits for National Guard and Reservists Personnel." This brochure does an excellent job of summarizing the benefits available to this special population of veterans upon their return to civilian life. Too often Reservists and National Guard personnel have not received timely information about the benefits they have earned. A million copies of this brochure are being printed and distributed. This brochure is also available on line at: http://www.va.gov/environagents/docs/SVABENEFITS.pdf.

Recruit Assessment Program (RAP)

VA is committed to the development of a life-long health record for all military personnel and veterans. Therefore, VA is supportive of DoD's efforts to develop and implement the Recruit Assessment Program (RAP) that will collect comprehensive baseline health data from U.S. military recruits.

VA Vet Center Program

VA's Vet Centers, originally conceived to provide a wide variety of readjustment services to Vietnam veterans, have been invaluable in providing

similar services to veterans from more recent combat and peacekeeping missions. More than 115,000 veterans of the Gulf War have made use of their services. The VA Vet Centers are now ready to help veterans of the current hostilities in Iraq.

Disability Compensation

To assist in disability evaluations, VA has actively worked with DoD to implement a standardized separation physical examination that thoroughly documents a veteran's health status at the time of separation from military service and that also meets the requirements of the physical examination needed by VA in connection with a veteran's claim for compensation benefits.

Additionally, VA has worked to provide fair compensation for Gulf War veterans with difficult-to-diagnose illnesses. Under 38 U.S.C. § 1117 (as amended by Public Law 107-103), VA has authority to compensate Gulf War veterans for chronic disabilities resulting from an undiagnosed illness or certain medically unexplained chronic multi-symptom illnesses. Service members who serve in the Southwest Asia Theater of Operations during the current conflict with Iraq will also be eligible for compensation for disabilities resulting from undiagnosed illnesses under this authority.

Research

VA places a high priority on the development of improved methods of diagnosis, treatment, and prevention of illnesses related to deployments. In October 2002, VA's Office of Research and Development released a Program Announcement on Deployment Health Research to expand VA's research portfolio on long-term health effects of hazardous deployments, such as the Gulf War, Bosnia/Kosovo, Afghanistan, and the current war in Iraq. Up to 20 million dollars will be spent on research to evaluate deployment health hazards. The results of this research program should provide useful guidance in improving the medical care of veterans who return from combat, and in improving preventive medicine efforts during future deployments.

Coordination with the Department of Defense

Deployment Health Work Group

One of the important lessons learned since the Gulf War was the need for continuous and formal intergovernmental coordination among VA, DoD, and Department of Health and Human Services (HHS). As a result, the Deployment Health Work Group of the VA-DoD Health Executive Council was established in 2002 to ensure interagency coordination for all veteran and military deployment health issues. Governmental coordination will play a critical role in addressing health problems among veterans in future conflicts and peacekeeping missions. This work group has met repeatedly during the recent conflict in Iraq to

coordinate government efforts, such as the development of a roster of deployed troops.

Transmission of Health Data between DoD and VA

VA and DoD are closely collaborating to develop the capability to share medical information electronically. Recently, the VA/DoD Joint Executive Council and Health Executive Council approved the adoption of the Joint VA/DoD Electronic Health Records Plan. This plan provides for the exchange of health data and development of a common health information infrastructure supported by common data communications, security and software standards. This will allow interoperability of DoD and VA high performance health information systems. Since June 2002, VA providers have had online access to health information from DoD's Composite Health Care System for discharged and retired service members. Currently, such information is available for more than 1.5 million separated service members. Key initiatives in the Electronic Health Records Plan are the Federal Health Information Exchange (FHIE) and HealthePeople (Federal), which allows VA clinicians to view DoD health information for separated service members.

Deployment Health

VA applauds the efforts of DoD to prevent health problems among deployed troops and to provide immediate care for combat casualties. DoD has made substantial progress in lowering morbidity and mortality rates on the battlefield. Nevertheless, we have to focus greater attention on the long-term health problems of veterans that occur after every war. The trauma of warfare has lasting effects. The physical and psychological wounds of war heal slowly, and toxic exposures on the battlefield may have enduring health consequences long after the actual war has ended.

The key to addressing the long-term needs of veterans is improved medical record-keeping and environmental surveillance. VA therefore is actively engaged with DoD in obtaining as much deployment health and exposure information as possible, including data on troop locations and data collected as part of pre- and post-deployment health screening.

Summary

A veteran separating from military service and seeking assistance today from VA will receive improved health care and disability assistance. VA has successfully developed new programs and adapted many existing programs for the benefit of combat veterans. VA also has significant experience with the special provisions in law authorizing disability compensation for war veterans with unexplained symptoms. In collaboration with other federal agencies, VA has

initiated new programs for developing and coordinating federal research on veterans' health questions. The Department of Veterans Affairs is committed to helping ensure the health of service members both during deployment and after they leave military service.

Mr. Chairman, this concludes my statement. Dr. Hyams and I will be happy to respond to any questions that you or other members of the subcommittee might have.

United States General Accounting Office

GAO

Testimony

Before the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, House of Representatives

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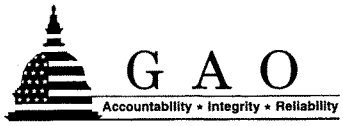
DEFENSE HEALTH CARE

Army Has Not Consistently Assessed the Health Status of Early-Deploying Reservists

Statement of Marjorie E. Kanof
Director, Health Care—Clinical
and Military Health Care Issues



GAO-03-997T

July 9, 2003

GAO
Accountability·Integrity·Reliability

Highlights

Highlights of GAO-03-997T, a testimony before the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, House of Representatives

DEFENSE HEALTH CARE

Army Has Not Consistently Assessed the Health Status of Early-Deploying Reservists

Why GAO Did This Study

During the 1990-91 Persian Gulf War, health problems prevented the deployment of a significant number of Army reservists. As required by the National Defense Authorization Act for Fiscal Year 2002, GAO reported on the Army's efforts to assess the health status of its early-deploying reservists (*Defense Health Care: Army Needs to Assess the Health Status of All Early-Deploying Reservists* [GAO-03-437, Apr. 15, 2003]).

GAO was asked to testify on its findings on the Army's health status assessments efforts and the implications of those assessments for the Department of Veterans Affairs (VA). Specifically, GAO was asked to determine if the Army is collecting and maintaining information on reservists' health and review the value and advisability of providing examinations. For its report, GAO reviewed medical records at seven Army early-deploying reserve units to determine the number of required examinations that have been conducted and obtained expert opinion on the value of periodic examinations.

www.gao.gov/cgi-bin/getrpt?GAO-03-997T.

To view the full testimony statement, including the scope and methodology, click on the link above. For more information, contact Marjorie E. Kanof at (202) 512-7101.

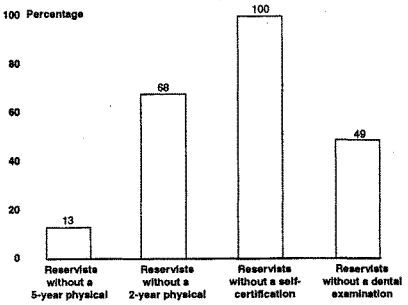
What GAO Found

The Army has not consistently carried out the statutory requirements for monitoring the health and dental status of its early-deploying reservists. As a result, the Army does not have sufficient information to know how many reservists can perform their assigned duties and are ready for deployment. At reserve units GAO visited, approximately 66 percent of the medical records were available for review. At those locations, GAO found that about 13 percent of the 5-year physical examinations had not been performed, about 49 percent of early-deploying reservists lacked current dental examinations, and none of the annual medical certificates required of reservists were completed by them and reviewed by the units.

Medical experts recommend periodic physical and dental examinations as an effective means of assessing health. Army early-deploying reservists need to be healthy to meet the specific demands of their occupations; examinations and other health screenings can be used to identify those who cannot perform their assigned duties. Without adequate examinations, the Army may train, support, and mobilize reservists who are unfit for duty.

DOD concurred with GAO's recommendations to comply with statutory requirements to conduct medical and dental examinations and provide dental treatment. VA's ability to perform its missions to provide medical care to veterans and compensate them for their service-connected disabilities could be hampered if the Army's medical surveillance system contains inadequate or incomplete information.

Site Visit Results for Seven U. S. Army Reserve Units



Source:GAO analysis of Army data.

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here as you discuss health assessments for the men and women in the armed services. Both the Department of Defense (DOD) and the Department of Veterans Affairs (VA) need this information to perform their missions. DOD needs health status information to help ensure the deployment of healthy forces and the continued fitness of those forces. VA's Veterans Benefits Administration (VBA) uses health information to adjudicate veterans' claims for disability compensation related to service-connected injuries or illnesses. In addition, the Veterans Health Administration (VHA) needs this information to fulfill its mission to provide health care services to veterans. In this context, you asked us to discuss our recent report on the Department of the Army's (Army) assessment of the health status of its reserve forces. The Army is increasingly relying on its 560,000 reservists to supplement the capabilities of our nation's active duty forces for peacetime support operations as well as for war.[1]

When reservists were mobilized during the 1990-91 Persian Gulf War, the Army discovered that due to medical reasons or poor dental status a significant number of them could not be deployed or had their deployment delayed.[2] In an effort to help ensure that Army reservists meet the military's health standards and are ready to perform their assigned duties, the Congress augmented health assessment requirements that had been in place prior to the Persian Gulf War. Specifically, the Congress required the Army to monitor the health status of those designated as early-deploying reservists[3] by providing annual medical screenings, annual dental screenings, selected dental treatment, and for those over age 40, physical examinations every 2 years. All reservists, including early deployers, are also required to disclose annually to the Army the status of

[1] The Army reserve components consist of the U.S. Army Reserve and the Army National Guard. The Army National Guard component carries out a dual mission. It is responsive to both the federal government for national security missions and to governors for state missions.

[2] Mobilization is the process by which the armed forces are brought into a state of readiness for war or national emergency or to support some other operational mission. In this report, mobilization means calling up reserve components for active duty. Deployment involves the relocation of mobilized forces and materiel to desired areas of operation.

[3] To support its mission needs and war plans, the Army has established Force Support Packages 1 and 2—a group of reservists who would normally be the first to be deployed in a ground conflict. We refer to these reservists as early-deploying reservists.

their physical and dental condition, and those under age 40 are required to undergo a physical examination once every 5 years.

My testimony today is based on our April 2003 report on the Army's efforts to assess the health status of the approximately 90,000 reservists who are specifically designated as early-deploying reservists.[4] We examined medical records to determine whether the Army is collecting and maintaining information on the health status of its early-deploying reservists. We also assessed the value of periodic physical and dental examinations and determined the advisability of the statutory requirements for the Army's early-deploying reservists.

To do our work, we visited seven early-deploying U.S. Army Reserve units in the states of Georgia, Maryland, and Texas and reviewed all available medical and dental records of reservists assigned to those units. Our analysis of the information gathered at these units is not projectable. We reviewed U.S. Army Reserve medical policies and regulations pertaining to early-deploying reservists. We also reviewed Army National Guard policies and procedures governing reservists' health care but did not review medical or dental records at Army National Guard units. Additionally, we analyzed Army data showing the cost to perform periodic physical and dental examinations[5] and to provide dental treatment. We also reviewed studies and information on the effectiveness of periodic physical and dental examinations published by DOD, the Department of Health and Human Services (HHS), the National Institutes of Health, the American Medical Association, the Academy of General Dentistry, and others. We interviewed DOD officials in the offices of the Assistant Secretary of Defense for Reserve Affairs and the Assistant Secretary for Health Affairs, and officials in the Office of the Surgeon General, U.S. Army Forces Command and the Office of the Surgeon General, U.S. Army Reserve Command to obtain information on the health care provided to Army early-deploying reservists. We conducted our work from May 2002 through April 2003 in accordance with generally accepted government auditing standards.

[4] U.S. General Accounting Office, *Defense Health Care: Army Needs to Assess the Health Status of All Early-Deploying Reservists*, GAO-03-437 (Washington, D.C.: Apr. 15, 2003).

[5] 10 U.S.C. §1074a(d)(1)(C) requires the Army to provide early-deploying reservists with a dental screening. While a dental screening does not have to be performed by a dentist, the Army requires its early-deploying reservists to be examined by a dentist to fulfill the screening requirements. Therefore, in this report we use the term "examination" rather than "screening."

In summary, the Army has not consistently carried out the statutory requirements for monitoring the health and dental status of Army early-deploying reservists. As a result, the Army does not have sufficient information to know how many reservists can perform their assigned duties and are ready for deployment. At the seven units we visited, approximately 66 percent of the medical records were available for our review. Based on our review of available records, we found that about 13 percent of the 5-year physical examinations had not been performed, and none of the annual medical certificates had been completed by reservists and reviewed by the units. Furthermore, 49 percent of early-deploying reservists lacked a current dental examination and 68 percent of those over the age of 40 lacked a current biennial physical examination. In addition, the Army does not have an automated system for maintaining accurate and complete medical information on early-deploying reservists. Periodic physical and dental examinations for early-deploying reservists are valuable for the Army because such examinations provide a means of determining reservists' health status and ensuring the medical readiness of reserve forces. Without adequate examinations, the Army runs the risk of mobilizing early-deploying reservists who cannot be deployed because of their health. In the case of early-deploying reservists who cannot be deployed, the Army loses not only the amount it invested in salaries and training but also the particular skill or occupation it was relying on to fill a specific military need. In addition, for reservists who may become eligible for VA benefits, inadequate health information can make it more difficult to adjudicate claims for service-connected disabilities in an accurate and timely manner and to provide quality medical care.

We made recommendations that the Army comply with existing statutory requirements to help ensure that early-deploying reservists are healthy to carry out their duties. DOD agreed with our recommendations.

Background

In recent years, reservists have regularly been called on to augment the capabilities of the active-duty forces. The Army is increasingly relying on its reserve forces to provide assistance with military conflicts and peacekeeping missions. As of April 2003, approximately 148,000 reservists[6] from the Army National Guard and the U.S. Army Reserve were mobilized to active duty positions. In addition, other reservists are serving

[6] The number of reservists mobilized changes on a continuous basis as certain reservists are released and others are called-up, as mission needs change.

throughout the world in peacekeeping missions. The involvement of reservists in military operations of all sizes, from small humanitarian missions to major theater wars, will likely continue under the military's current war-fighting strategy and its peacetime support operations.

The Army has designated some Army National Guard and U.S. Army Reserve units and individuals as early-deploying reservists to ensure that forces are available to respond rapidly to an unexpected event or for any other need. Usually, those designated as early-deploying reservists would be the first troops mobilized if two major ground wars were underway concurrently. The units and individual reservists designated as early-deploying reservists change as the missions or war plans change. The Army estimates that of its 560,000 reservists, approximately 90,000 are reservists who have been individually categorized as early-deploying reservists or are reservists who are assigned to Army National Guard and U.S. Army Reserve units that have been designated as early-deploying units.

The Army must comply with the following six statutory requirements that are designed to help ensure the medical and dental readiness of its early-deploying reservists.

- All reservists including early-deployers are required to
  - have a 5-year physical examination,[7] and
  - complete an annual certificate of physical condition.[8]
- All early-deploying reservists are also required to have
  - a biennial physical examination if over age 40,[9]
  - an annual medical screening,[10]
  - an annual dental screening,[11] and
  - dental treatment.[12]

[7] 10 U.S.C. §10206(a)(1)(2000).

[8] 10 U.S.C. §10206(a)(2)(2000).

[9] 10 U.S.C. §1074a(d)(1)(B)(2000).

[10] 10 U.S.C. §1074a(d)(1)(A)(2000).

[11] 10 U.S.C. §1074a(d)(1)(C)(2000).

[12] 10 U.S.C. §1074a(d)(1)(D)(2000).

Army regulations state that the 5- and 2-year physical examinations are designed to provide the information needed to identify health risks, suggest lifestyle modifications, and initiate treatment of illnesses. While the two examinations are similar, the biennial examination for early-deploying reservists over age 40[13] contains additional age-specific screenings such as a prostate examination, a prostate-specific antigen test, and a fasting lipid profile that includes testing for total cholesterol, low-density lipoproteins, and high-density lipoproteins. The Army pays for these examinations.

The examinations are also used to assign early-deploying reservists a physical profile rating, ranging from P1 to P4, in six assessment areas: (a) Physical capacity, (b) Upper extremities, (c) Lower extremities, (d) Hearing-ears, (e) Vision-eyes, and (f) Psychiatric. (See app. I for the Army's Physical Profile Rating Guide.) According to the Army, P1 represents a non-duty-limiting condition, meaning that the individual is fit for duty and possesses no physical or psychiatric impairments. P2 means a condition may exist; however, it is not duty-limiting. P3 or P4 means that the individual has a duty-limiting condition in one of the six assessment areas. P4 means the individual functions below the P3 level. A rating of either P3 or P4 puts the reservist in a nondeployable status or may result in the changing of the reservist's job classification.

Army regulations that implement the statutory certification requirement provide that all reservists—including early-deploying reservists—certify their physical condition annually on a two-page certification form. Army early-deploying reservists must report doctor or dentist visits since their last examination, describe current medical or dental problems, and disclose any medications they are currently taking. In addition, the Army is required to conduct an annual medical screening for all early-deploying reservists. According to Army regulations, the Army is to meet the annual medical screening requirement by reviewing the medical certificate required of each early-deploying reservist.

Further, Army early-deploying reservists are required to undergo, at the Army's expense, an annual dental examination. The Army is also required to provide and pay for the dental treatment needed to bring an early-deploying reservist's dental status up to deployment standards—either dental class 1 or 2. Reservists in dental class 3 and 4 are not deployable.

[13]Approximately 22,500 early-deploying reservists are over age 40.

Class 3 reservists could have dental emergencies in the next 12 months, and reservists in class 4 have not had the required annual dental examination.

The Army Has Not Collected and Maintained All Required Medical and Dental Information on Early-Deploying Reservists

The Army has not consistently carried out the requirements that early-deploying reservists undergo 5- or 2-year physical examinations, and the required dental examination. In addition, the Army has not required early-deploying reservists to complete the annual medical certificate of their health condition, which provides the basis for the required annual medical screening. Accordingly, the Army does not have sufficient health information on early-deploying reservists. Furthermore, the Army does not have the ability to maintain information from medical and dental records and annual medical certificates at the aggregate or individual level, and therefore does not know the overall health status of its early-deploying reservists.

Examinations Have Not Always Been Performed and Annual Medical Certificates Have Not Been Completed and Reviewed

We found that the Army has not consistently met the statutory requirements to provide early-deploying reservists physical examinations at 5- or 2-year intervals. At the seven Army early-deploying reserve units we visited, about 66 percent of the medical records were available for our review.[14] Based on our review of these records, 13 percent of the reservists did not have a current 5-year physical examination on file. Further, our review of the available records found that approximately 68 percent of early-deploying reservists over age 40 did not have a record of a current biennial examination.

Army early-deploying reservists are required by statute to complete an annual medical certificate of their health status, and regulations require the Army to review the form to satisfy the annual screening requirement. In performing our review of the records on hand, we found that none of the units we visited required that its reservists complete the annual medical certificate, and consequently, none of them were available for review. Furthermore, Army officials stated that reservists at most other units have not filled out the certification form and that enforcement of this requirement was poor.

[14] There were 504 early-deploying reservists assigned to the seven units we visited. Medical records for 332 reservists were available for our review. Army administrators told us that the remaining files were in transit, with the reservist, or on file at another location.

The Army is also statutorily required to provide early-deploying reservists with an annual dental examination to establish whether reservists meet the dental standards for deployment. At the seven early-deploying units we visited, we found that about 49 percent of the reservists whose records were available for review did not have a record of a current dental examination.

Army's Automated Systems Do Not Contain Comprehensive Health Information on Early-Deploying Reservists

The Army's two automated information systems for monitoring reservists' health do not maintain important medical and dental information for early-deploying reservists—including information on the early-deploying reservists' overall health status, information from the annual medical certificate form, dental classifications, and the date of dental examinations. In one system, the Regional Level Application Software, the records provide information on the dates of the 5-year physical examination and the physical profile ratings. In the other system, the Medical Occupational Database System, the records provide information on HIV status, immunizations, and DNA specimens. Neither system allows the Army to review medical and dental information for entire units at an aggregate level. The Army is aware of the information shortcomings of these systems and acknowledges that having sufficient, accurate, and current information on the health status of reservists is critical for monitoring combat readiness. According to Army officials, in 2003 the Army plans to expand the Medical Occupational Database System to provide access to current, accurate, and relevant medical and dental information at the aggregate and individual level for all of its reservists—including early-deploying reservists. According to Army officials, this information will be readily available to the U.S. Army Reserve Command. Once available, the Army can use this information to determine which early-deploying reservists meet the Army's health care standards and are ready for deployment.

Periodic Physical and Dental Examinations Are Valuable for Assessing Health Status and Provide Beneficial Information to the Army and VA

Medical experts recommend physical and dental examinations as an effective means of assessing health. For some people, the frequency and content of physical examinations vary according to the specific demands of their job. Because Army early-deploying reservists need to be healthy to fulfill their professional responsibilities, periodic examinations are useful for assessing whether they can perform their assigned duties. Furthermore, the estimated annual cost to conduct periodic examinations—about $140—is relatively modest compared to the thousands of dollars the Army spends for salaries and training of early-deploying reservists—an investment that may be lost if reservists can not perform their assigned duties. Such information is also needed by VA to adjudicate disability claims and to provide health benefits.

Experts Look to Screening and Examinations as Key Indicators of Health

Physical and dental examinations are geared towards assessing and improving the overall health of the general population. The U.S. Preventive Services Task Force[15] and many other medical organizations no longer recommend annual physical examinations for adults—preferring instead a more selective approach to detecting and preventing health problems. In 1996, the task force reported that while visits with primary care clinicians are important, performing the same interventions annually on all patients is not the most clinically effective approach to disease prevention.[16] Consistent with its finding, the task force recommended that the frequency and content of periodic health examinations should be based on the unique health risks of individual patients. Today, many health associations and organizations are recommending periodic health examinations that incorporate age-specific screenings, such as cholesterol screenings for men (beginning at age 35) and women (beginning at age 45) every 5 years, and clinical breast examinations every 3 to 5 years for women between the ages of 19 and 39. Further, oral health care experts emphasize the importance of regular 6- to 12-month dental examinations.

Both the private and public sectors have established a fixed schedule of physical examinations for certain occupations to help ensure that workers

[15] The U.S. Preventive Services Task Force was established by the U.S. Public Health Service in 1984 as an independent panel of experts to review the effectiveness of clinical preventive services—screening tests for early detection of disease, immunizations to prevent infections, and counseling for risk reduction.

[16] *Guide to Clinical Preventive Services, Second Edition*—1996, Report of the U.S. Preventive Services Task Force, HHS Office of Public Health and Science, Office of Disease Prevention and Health Promotion.

are healthy enough to meet the specific demands of their jobs. For example, the Federal Aviation Administration requires commercial pilots to undergo a physical examination once every 6 months. U.S. National Park Service personnel who perform physically demanding duties have a physical examination once every other year for those under age 40, and on an annual basis for those over age 40. Additionally, guidelines published by the National Fire Protection Association recommend that firefighters have an annual physical examination regardless of age.

In the case of Army early-deploying reservists, the goal of the physical and dental examinations is to help ensure that the reservists are fit enough to be deployed rapidly and perform their assigned jobs. Furthermore, the Army recognizes that some jobs are more demanding than others and require more frequent examinations. For example, the Army requires that aviators undergo a physical examination once a year, while marine divers and parachutists have physical examinations once every 3 years.

While governing statutes and regulations require physical examinations at specific intervals, the Army has raised concerns about the appropriate frequency for them. In a 1999 report to the Congress, the Offices of the Assistant Secretaries of Defense for Health Affairs and Reserve Affairs stated that while there were no data to support the benefits of conducting periodic physical examinations, DOD was reluctant to recommend a change to the statutory requirements.[17] The report stated that additional research needs to be undertaken to identify and develop a more cost-effective, focused health assessment tool for use in conducting physical exams for reservists—in order to ensure the medical readiness of reserve forces. However, as of February 2003, DOD had not conducted this research.

Cost of Conducting Physical and Dental Examinations and Providing Dental Treatments

For its early-deploying reservists, the Army conducts and pays for physical and dental examinations and selected dental treatments at military treatment facilities or pays civilian physicians and dentists to provide these services. The Army could not provide us with information on the cost to provide these services at military hospitals or clinics primarily because it does not have a cost accounting system that records or

[17] *Report To Congress: Means of Improving the Provision of Uniform and Consistent Medical and Dental Care to Members of the Reserve Components* (Washington, D.C.: October 1999).

generates cost data for each patient.[18] However, the Army was able to provide us with information on the amount it pays civilian providers for these examinations under the Federal Strategic Health Care Alliance program (FEDS_HEAL)—an alliance of private physicians and dentists and other physicians and dentists who work for VA and HHS's Division of Federal Occupational Health. FEDS_HEAL is a program that allows Army early-deploying reservists to obtain required physical and dental examinations and dental treatment from local providers.

Using FEDS_HEAL contract cost information, we estimate the average cost of the examinations to be about $140 per early-deploying reservist per year. We developed the estimate over one 5- year period by calculating the annual cost for those early-deploying reservists requiring a physical examination once every 5 years, calculating the cost for those requiring a physical examination once every 2 years, and calculating the cost for those requiring an initial dental examination and subsequent yearly dental examinations.[19] The FEDS_HEAL cost for each physical examination for those under 40 is about $291, and for those over 40 is about $370. The Army estimates that the cost of annual dental examinations under the program to be about $80 for new patients and $40 for returning patients. The Army estimates that it would cost from $400 to $900 per reservist to bring those who need treatment from dental class 3 to dental class 2.

Benefits of Conducting Periodic Examinations For the Army

For the Army, there is likely value in conducting periodic examinations because the average cost to provide physical and dental examinations per early-deploying reservist—about $140 annually over a 5-year period—is relatively low compared to the potential benefits associated with such examinations. These examinations could help protect the Army's investment in its early-deploying reservists by increasing the likelihood that more reservists will be deployable. This likelihood is increased when the Army uses examinations to identify early-deploying reservists who do not meet the Army's health standards and are thus not fit for duty. The Army can then intervene by treating, reassigning, or dismissing these reservists with duty-limiting conditions—before their mobilization and before the Army needs to rely on the reservists' skills or occupations.

[18] U.S. General Accounting Office, *Department of Defense: Implications of Financial Management Issues*, GAO/T-AIMD/NSIAD-00-264 (Washington, D.C.: July 20, 2000).

[19] The average annual cost does not include allowances for inflation, dental treatment, or specialized laboratory fees such as those for pregnancy, phlebotomy, or tuberculosis.

Furthermore, by identifying duty-limiting conditions or the risks for developing them, periodic examinations give early-deploying reservists the opportunity to seek medical care for their conditions—prior to mobilization.

Periodic examinations may provide another benefit to the Army. If the Army does not know the health condition of its early-deploying reservists, and if it expects some of them to be unfit and incapable of performing their duties, the Army may be required to maintain a larger number of reservists than it would otherwise need in order to fulfill its military and humanitarian missions. While data are not available to estimate these benefits, the benefit associated with reducing the number of reservists the Army needs to maintain for any given objective could be large enough to more than offset the cost of the examinations and treatments. The proportion of reservists whom the Army maintains but who cannot be deployed because of their health may be significant. For instance, according to a 1998 U.S. Army Medical Command study, a "significant number" of Army reservists could not be deployed for medical reasons during mobilization for the Persian Gulf War (1990-1991).[20] Further, according to a study by the Tri-Service Center for Oral Health Studies at the Uniformed Services University of the Health Sciences, an estimated 25 percent of Army reservists who were mobilized in response to the events of September 11, 2001, were in dental class 3 and were thus undeployable.[21] In fact, our analysis of the available current dental examinations at the seven early-deploying units showed a similar percentage of reservists—22 percent—who were in dental class 3.[22] With each undeployable reservist, the Army loses, at least temporarily, a significant investment that is large compared to the cost of examining and treating these reservists. The annual salary for an Army early-deploying reservist in fiscal year 2001 ranged from $2,200 to $19,000. The Army spends additional amounts to train and equip each reservist and, in some cases, provides allowances for subsistence and housing. Additionally, for

[20] The U.S. Army Medical Command's: *Reserve Component 746 Study*, (June 22, 1998), provides no specific number stating only that a "significant number" could not be deployed.

[21] This study included reservists from the U.S. Army Reserve but not reservists from the Army National Guard.

[22] Twenty-two dental examinations listed early-deploying reservists in class 3 out of 101 current (within 1 year) dental examinations. Additional examinations that were available for our review were either out of date or conducted by nondental personnel.

each reservist it mobilizes, the Army spends about $800.[23] If it does not examine all of its early-deploying reservists, the Army risks losing its investment because it will train, support, and mobilize reservists who might not be deployed because of their health.

Benefits of Health Assessments for VA

Both VBA and VHA need health assessment data obtained by the Army to adjudicate disability claims and provide medial care. In general, a reservist who is disabled while on active duty, or on inactive duty for training, is eligible for service-connected disability compensation, and can file a claim at one of VBA's 57 regional offices. To provide such disability compensation, VBA needs to determine that each claimed disability exists, and that each was caused or aggravated by the veteran's military service. The evidence needed to prove service connection includes records of service to identify when the veteran served and records of medical treatment provided while the veteran was in military service. More timely and accurate health information collection by the Army and the other military services can help VBA provide disabled reservists with more timely and accurate decisions on their claims for disability compensation.[24] Complete and accurate health data can also help VHA provide medical care to reservists who become eligible for veterans benefits.

Concluding Observations

Army reservists have been increasingly called upon to serve in a variety of operations, including peacekeeping missions and the current war on terrorism. Given this responsibility, periodic health examinations are important to help ensure that Army early-deploying reservists are fit for deployment and can be deployed rapidly to meet humanitarian and wartime needs. However, the Army has not fully complied with statutory requirements to assess and monitor the medical and dental status of early-deploying reservists. Consequently, the Army does not know how many of them can perform their assigned duties and are ready for deployment.

[23] U.S. General Accounting Office, *Reserve Forces: Cost, Funding, and Use of Army Reserve Components in Peacekeeping Operations*, GAO/NSAID-98-190R (Washington, D.C.: May 15, 1998).

[24] See U.S. General Accounting Office, *Veterans' Benefits: Despite Recent Improvements, Meeting Claims Processing Goals Will Be Challenging*, GAO-02-645T (Washington, D.C.: April 26, 2002) for a discussion of the information needed to adjudicate a disability claim.

The Army will realize benefits by fully complying with the statutory requirements. The information gained from periodic physical and dental examinations, coupled with age-specific screenings and information provided by early-deploying reservists on an annual basis in their medical certificates, will assist the Army in identifying potential duty-limiting medical and dental problems within its reserve forces. This information will help ensure that early-deploying reservists are ready for their deployment duties. Given the importance of maintaining a ready force, the benefits associated with the relatively low annual cost of about $140 per reservist to conduct these examinations outweighs the thousands of dollars spent in salary and training costs that are lost when an early-deploying reservist is not fit for duty.

The Army's planned expansion, in 2003, of an automated health care information system is critical for capturing the key medical and dental information needed to monitor the health status of early-deploying reservists. Once collected, the Army will have additional information to conduct the research suggested by DOD's Offices of Health Affairs and Reserve Affairs to determine the most effective approach, which could include the frequency of physical examinations, for determining whether early-deploying reservists are healthy, can perform their assigned duties, and can be rapidly deployed.

While our work focused on the Army's efforts to assess the health status of its early-deploying reservists, it also has implications for veterans. Implementing our recommendations that DOD comply with the statutory requirements, which DOD has agreed to, will also be of benefit to VA. VA's ability to perform its missions to provide medical care to veterans and compensate them for their service-connected disabilities could be hampered if the Army's medical surveillance system contains inadequate or incomplete information.

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions you or other members of the subcommittee may have.

Contact and Acknowledgments

For further information regarding this testimony, please contact Marjorie E. Kanof at (202) 512-7101. Michael T. Blair, Jr., Aditi S. Archer, Richard J. Wade, and Gregory D. Whitney also contributed to this statement.

Appendix I: Army Physical Profile Rating Guide

Physical profile rating	Assessment areas					
	Physical capacity	Upper extremities	Lower extremities	Hearing-ears	Vision-eyes	Psychiatric
	Organic defects, strength, stamina, agility, energy, muscular coordination, function, and similar factors.	Strength, range of motion, and general efficiency of upper arm, shoulder girdle, and upper back, including cervical and thoracic vertebrae.	Strength, range of movement, and efficiency of feet, legs, lower back, and pelvic girdle.	Auditory sensitivity and organic disease of the ears.	Visual acuity and organic disease of the eyes and lids.	Type, severity, and duration of the psychiatric symptoms or disorder existing at the time the profile is determined. Amount of external precipitating stress. Predispositions as determined by the basic personality makeup, intelligence, performance, and history of past psychiatric disorder impairment of functional capacity.
P1 (Non-duty-limiting conditions)	Good muscular development with ability to perform maximum effort for indefinite periods.	No loss of digits or limitation of motion; no demonstrable abnormality; able to do hand-to-hand fighting.	No loss of digits or limitation of motion; no demonstrable abnormality; able to perform long marches, stand over long periods, and run.	Audiometer average level for each ear not more than 25 dB[a] at 500, 1000, or 2000 Hz[b] with no individual level greater than 30 dB. Not over 45 dB at 4000 Hz.	Uncorrected vision acuity 20/200 correctable to 20/20 in each eye.	No psychiatric pathology; may have history of transient personality disorder.

	Assessment areas					
Physical profile rating	**Physical capacity**	**Upper extremities**	**Lower extremities**	**Hearing-ears**	**Vision-eyes**	**Psychiatric**
P2 (Non-duty-limiting conditions)	Able to perform maximum effort over long periods.	Slightly limited mobility of joints, muscular weakness, or other musculo-skeletal defects that do not prevent hand-to-hand fighting and do not disqualify for prolonged effort.	Slightly limited mobility of joints, muscular weakness, or other musculo-skeletal defects that do not prevent moderate marching, climbing, timed walking, or prolonged effort.	Audiometer average level for each ear at 500, 1000, or 2000 Hz, not more than 30 dB, with no individual level greater than 35 dB at these frequencies, and level not more than 55 dB at 4000 Hz; or audiometer level 30 dB at 500 Hz, 25 dB at 1000 and 2000 Hz, and 35 dB at 4000 Hz in better ear. (Poorer ear may be deaf.)	Distant visual acuity correctable to not worse than 20/40 and 20/70, or 20/30 and 20/100, or 20/20 and 20/400.	May have history of recovery from an acute psychotic reaction due to external or toxic causes unrelated to alcohol or drug addiction.
P3 (Duty-limiting conditions)	Unable to perform full effort except for brief or moderate periods.	Defects or impairments that require significant restriction of use.	Defects or impairments that require significant restriction of use.	Speech reception threshold in best ear not greater than 30 dB HL[c] measured with or without hearing aid, or chronic ear disease.	Uncorrected distant visual acuity of any degree that is correctable to not less than 20/40 in the better eye.	Satisfactory remission from an acute psychotic or neurotic episode that permits utilization under specific conditions (assignment when outpatient psychiatric treatment is available or certain duties can be avoided).
P4 (Duty-limiting conditions)	Functional level below P3.	Functional level below P3.	Functional level below P3.	Functional level below P3.	Functional level below P3.	Functional level below P3.

Source: Department of the Army.

Note: Army Regulation 40-501, Mar. 28, 2002.

[a]dB (decibels), the decibel is a measure of the intensity of sound.

[b]Hz (Hertz), the Hertz is the measure of sound frequency or pitch.

[c]HL (hearing loss).

Related GAO Products

Defense Health Care: Army Needs to Assess the Health Status of All Early-Deploying Reservists. GAO-03-347. Washington, D.C.: April 15, 2003.

Military Personnel: Preliminary Observations Related to Income, Benefits, and Employer Support for Reservists During Mobilizations. GAO-03-549T. Washington, D.C.: March 19, 2003.

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WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSES

CHAIRMAN BUYER TO DEPARTMENT OF DEFENSE

Hearing Date: July 9, 2003
Committee: House Committee on Veterans' Affairs
Member: Rep. Buyer
Witness: Dr. William Winkenwerder
Question # 1

Question: What measures are being taken to ensure that early-deploying Army reserve component personnel are receiving physical examinations on a regular basis (every five years for those under the age of forty, and every two years for those over the age of forty)?

Answer: As you know, the Army is required by law to monitor the health and dental status of early-deploying reservists. The Army's two Reserve Components have undertaken several initiatives to ensure that regular physical examinations are performed. In March 2001, the Army Reserve created an innovative program called the Federal Strategic Health Alliance, or FEDS_HEAL. FEDS_HEAL joins the medical resources of the Department of Veterans Affairs (VA) with those of the Department of Health and Human Service's Division of Federal Occupational Health (FOH) to bring required medical and dental readiness services within 50 miles of the reserve member. A broad panel of civilian providers augments these Federal assets to offer near universal access.

The success of the FEDS_HEAL program can be measured by its performance during the two and a half months leading up to the war in Iraq. During this period, FEDS_HEAL reviewed over 85,000 reserve health records and provided more than 48,000 physical examinations, 31,000 dental examinations, and treated some 3,213 soldiers requiring dental work. The Army National Guard has recently offered the FEDS_HEAL option to the states and territories. Currently there is a pilot program in which fifteen states are using the FEDS_HEAL option to meet medical/dental assessments and requirements. This augments the internal State Area Command (STARC) Medical Detachments. The Army National Guard also uses local contracts with civilian providers as well as VA agreements to insure the medical/dental readiness of their force.

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Committee: House Committee on Veterans' Affairs
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Question # 2

Question: What measures are being taken to ensure that incoming reserve component personnel meet the minimum physical fitness standards to be considered able to perform on active duty?

Answer: The medical and physical standards for people entering the military services are identical for active duty and Reserve Component personnel and are designed to recruit and retain people whose physical and mental status are sufficient for them to withstand the rigors of deployment. During recruitment, every prospective recruit undergoes a medical history, physical examination, and selected laboratory tests. If an applicant for military service meets the accession physical and medical standards, the new recruit is re-evaluated during initial entry training. That evaluation includes not only medical screening but also the challenges of the military training itself. The physical and psychological rigors of this introduction to military service frequently provoke health problems. Often such problems cannot be treated or cured and they prove to be the basis for disqualification from further military service. Attrition during the first year of service is relatively high because of some recruits' inability to meet the standards of retention. The result is a group of trained Service members who have proven to be even healthier than those initially recruited.

After basic training, the most effective tool for assuring that the military is not maintaining reservists who are not deployable is the assessment provided by periodic physical examinations, augmented by the required annual certification of medical conditions. Full implementation of the existing DoD policy that all Reserve members receive annual dental examinations will reduce the incidence of non-deployable members.

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Question # 3

Question: Why doesn't the Army have an automated system for maintaining accurate and complete medical information on early-deploying reservists?

Answer: The Army does, in fact, have state-of-the-art programs for monitoring medical information on early deploying reservists, as well as for all soldiers. The Medical Protection System (MEDPROS) is a web-enabled application developed by the Office of the Surgeon General for monitoring all of the DoD-mandated Individual Medical Readiness (IMR) indicators. MEDPROS, which includes an automated immunization record, is accessible to all three components – Active, Guard and Reserve – and to all Army units world-wide via the internet or by modem through the Pentagon enterprise server and links to other DoD systems through the Defense Enrollment Eligibility System (DEERS) and DEERS Immunization Compliance Reporting System (ICRS).

MEDPROS is not yet operating at its full potential, which will require the input of a tremendous amount of data currently residing in manual records. This is being aggressively pursued. For example, the records review performed by the FEDS_HEAL program on behalf of the Army Reserve in preparation for Operation Iraqi Freedom includes loading of information into MEDPROS. As of July 9, 2003, some 104,000 such records have been transcribed into MEDPROS. In addition, the FEDS_HEAL Program Office tracks services provided to Reserve Component members and is able to both input data and retrieve digital copies of services previously performed.

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Question # 4

Question: What safeguards are in place to guarantee that the military is not maintaining reservists who are not deployable because of health related concerns?

Answer: The most effective tool for assuring that the military is not maintaining reservists who are not deployable is the assessment provided by periodic physical examinations, augmented by the required annual certification of medical conditions. The Services are working to optimize these tools through automation. The Army is preparing to field an automated annual health questionnaire that provides retrievable and analyzable data on individual and aggregate health status. It will also provide automatic referrals to educational and wellness resources, and correlate to the information gathered by the Department of Veterans Affairs, thereby creating a longitudinal health assessment file that follows the member throughout his or her military career and into veteran status. Full implementation of the current DoD policy that all Reserve members receive annual dental examinations will reduce the incidence of non-deployable members. There is an active process underway in the office of the Assistant Secretary of Defense (Health Affairs) to determine how best to accomplish this in a systematic manner. Among the options being examined is the Army Reserve's use of FEDS_HEAL, which supported the treatment of members to deployment standards before movement to the mobilization station. Not one of the soldiers processed through this system was delayed due to dental readiness.

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Question # 5

Question: What steps have been taken to establish a uniform separation physical examination for all the Services in order to help reconcile VA's need for medical information and DoD's need to expedite the separation processing of Service members? Are all returning Service members required to undergo post-deployment physical examinations?

Answer: The Department of Defense is continuing its emphasis on streamlining processes and eliminating duplicative requirements such as physical exams by working with the Department of Veterans Affairs (VA) through a Joint Strategic Plan. Our objective is to smooth the practices that complicate Service members' transition from military to civilian status.

In addition, we continue to work with the VA on the joint-sponsored Benefits Delivery at Discharge (BDD) program, which involves the VA conducting physical examinations for military personnel prior to their discharge. Today approximately 140 military installations actively participate in the BDD initiative. It should be remembered that DoD policy grants Service members the right to waive the separation physical.

Post-deployment physical examinations are not required for returning Service members. All re-deploying personnel complete a four-page Post-Deployment Health Assessment form, and then receive face-to-face individual assessments with trained health care providers. These assessments include a review of potentially harmful exposures and a psychological assessment. Any health issues raised during the assessment result in a review of deployment health records and appropriate referral for follow-up medical evaluation, testing and care. Additionally, all Service members will have blood drawn within 30 days of their arrival at their home station or demobilization site.

When Service members leave active duty, their records are routinely transferred to the custody of the VA. Transfer of electronic records from DoD to the VA has already begun through the Federal Health Information Exchange. These data consist of laboratory results, radiology reports, outpatient pharmacy information, and demographics. Future phases will include admission and discharge transfer data, discharge summaries, allergies, and consult tracking.

Hearing Date: July 9, 2003
Committee: House Committee on Veterans' Affairs
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Question # 6

Question: In 1992, eligibility for VA class II dental treatment was contingent upon DoD's certification that all necessary dental treatment was provided before discharge. The GAO recommended that eligibility be determined by the VA without the legislative requirement from DoD. Has this recommendation been implemented?

Answer: Department of Veterans Affairs officials report that the VA continues to use DoD's certification to determine eligibility for class II dental treatment. The DoD discharge form (DD 214) carries a statement that a dental examination (including dental radiographs) and all dental treatment have been completed at least 90 days prior to release from active duty. That line contains two boxes – one for "yes" and one for "no." If "yes" is marked, the veteran would not be eligible for VA dental care. The VA believes that, regardless of GAO recommendations, legislation would be required to change or repeal the certification requirement. However, DoD personnel routinely check the "no" box, allowing individuals to apply for dental care and be examined by the VA.

Hearing Date: July 9, 2003
Committee: House Committee on Veterans' Affairs
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Question # 7

Question: Please list all ongoing programs that are underway to electronically track all immunizations and to centralize collection of immunization data for surveillance and research purposes.

Answer: Each of the Services fields an electronic immunization tracking system that reaches to medical facilities around the world. The Army uses the Medical Protection System (MEDPROS) Immunization Tracking Module, which is part of the Medical Occupational Data System (MODS). The Air Force system is called the Air Force Complete Immunization Tracking Application (AF-CITA). The Navy, Marine Corps and Coast Guard employ the Shipboard Automated Medical System (SAMS). Additionally, the Preventive Health Care Application (PHCA) also contains an immunization tracking module known as the Record Management System (RMS). It is currently available for use at 55 sites and can store both uniformed members' data as well as beneficiary/dependent immunization data.

All of these systems have the capability to transmit key immunization data on uniformed Service members to the Defense Manpower Data Center's Defense Enrollment Eligibility Requirements System (DEERS) central immunization repository. Personnel with appropriate access can query this data repository for status reports on their military unit via the Immunization Compliance Reporting System (ICRS) web site.

The Service specific systems will eventually be replaced with one DoD immunization tracking system when Composite Health Care System II (CHCS II) and the Theater Medical Information Program (TMIP) are fully fielded.

Hearing Date: July 9, 2003
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Question # 8

Question: Given the possible serious side effects of the drug Larium, as well as other pharmaceutical products, what measures have been taken to monitor the Service members who have been prescribed such medications?

Answer: All Service members who receive drugs like the malaria pre-treatment Larium are screened as part of their mobilization processing for deployment. Their current medications are reviewed as well as any symptoms. Contraindications for any Service member to be placed on any particular medication are noted on their records. Medications dispensed to soldiers are documented in MEDPROS with the medication appropriately packaged and labeled and the soldier is provided a medication information sheet.

Medications like malaria drugs and other deployment-specific drugs are annotated on the pre-deployment health assessment form, and again on the post-deployment health assessment form. The post-deployment health assessment includes a face-to-face individual assessment with a licensed health care provider. These assessments include a review of medications issued, in addition to a review of potentially harmful exposures and a psychological assessment. Any health issues raised during the assessment result in a review of deployment health records and appropriate referral for follow-up medical evaluation, testing and care.

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