

**WOUNDED ARMY GUARD AND RESERVE FORCES:
INCREASING THE CAPACITY TO CARE**

HEARING

BEFORE THE

**COMMITTEE ON
GOVERNMENT REFORM**

HOUSE OF REPRESENTATIVES

ONE HUNDRED NINTH CONGRESS

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**WOUNDED ARMY GUARD AND RESERVE
FORCES: INCREASING THE CAPACITY TO
CARE**

THURSDAY, FEBRUARY 17, 2005

HOUSE OF REPRESENTATIVES,
COMMITTEE ON GOVERNMENT REFORM,
Washington, DC.

The committee met, pursuant to notice, at 10:10 a.m., in room 2154, Rayburn House Office Building, Hon. Tom Davis (chairman of the committee) presiding.

Present: Representatives Tom Davis of Virginia, Shays, Gutknecht, Miller, Porter, Marchant, McHenry, Dent, Foxx, Waxman, Cummings, Davis of Illinois, Clay, Watson, Lynch, Van Hollen, Ruppertsberger, Higgins, and Norton.

Staff present: Jennifer Safavian, chief counsel for oversight and investigations; Rob White, press secretary; Drew Crockett, deputy director of communications; Grace Washbourne and Brien Beattie, professional staff members; Teresa Austin, chief clerk; Sarah D'Orsie, deputy clerk; Kristina Sherry, legislative correspondent; Roody Cole, GAO detailee; Phil Barnett, minority staff director; Andrew Su, minority professional staff member; Earley Green, minority chief clerk; and Jean Gosa, minority assistant clerk.

Chairman TOM DAVIS. Good morning. A quorum being present, the committee will come to order.

I want to welcome everybody to today's hearings on the effectiveness and efficiency of Army medical administrative processes that affect the care of injured Army Guard and Reserve forces.

This hearing is the third in our continuing investigation into the Department of Defense's administrative and management challenges created by the largest mobilization of Reserve Component soldiers since World War II.

For the last year, along with the Government Accountability Office, our committee has been investigating the plight of injured Army Guard and Reserve soldiers seeking quality care, standardized medical and personnel assistance, and comprehensive service. We are here today to ask some basic but troubling questions.

How is it that so many injured and Reserve soldiers have been inappropriately removed from active duty status in the automated systems that control pay and access to medical care?

Why do soldiers languish for weeks or months in medical holding companies, not because of medical care but because of lags in efficient administrative processing?

Why do we all continue to hear from our Reserve Component constituents and their families still struggling under the convoluted current system?

Today the GAO will issue a report on their examination of two Army processes: active duty medical extensions [ADMEs], and medical retention processing [MRPs]. The committee, looking into the Medical Evaluation Board and Physical Evaluation Board processes, has reached similar findings that are, quite frankly, stunning in scope.

Current Army guidance for processing injured Guard and Reserve does not clearly define organizational responsibilities or performance standards. The Army has not adequately educated Reserve Component soldiers about Army medical and personnel processing or adequately trained Army personnel responsible for helping soldiers.

The Army lacks an integrated medical and personnel system to provide visibility over injured or ill Reserve Component soldiers, and as a result sometimes actually loses track of these soldiers and where they are in the process.

Last, and certainly not least, the Army lacks compassionate, customer friendly service. Frankly, I am appalled that these men and women not only have had to face the recovery from their war wounds, but are simultaneously forced to navigate a confusing and seemingly uncaring system of benefits.

What are the effects of these inadequacies? We will listen today to the individual experiences of two Guardsmen whose stories will be hard for us to hear. Sergeant John Allen of the North Carolina National Guard and Sergeant Joseph Perez of the Nevada National Guard will illustrate the price of an Army unprepared to handle their needs.

General Raymond Byrne, the State Adjutant General of Oregon, is also here on behalf of his injured and ill Guardsmen.

We are also pleased to have with us today two individuals who are on the front lines of caring for Reserve Component soldiers and who will explain the difficulties executing Army regulations and policies. An officer from U.S. Human Resource Command will relate the Army's growing pains as it attempts to improve its level of administrative service and care. One will tell about his experience as a Reserve liaison at Walter Reed Medical Center and the challenges he still faces as he tries to help injured Reserve soldiers. Both soldiers have been at their posts since the first return of injured Guard and Reserve soldiers from Operation Enduring Freedom, and both will describe urgent needs that are still unmet.

Certainly, the unprecedented number of Army Guard and Reserves mobilized in the war on terrorism has severely taxed the Army and its resources. We understand the pressures they are under. To their credit, Army leadership has accepted these challenges and has come a long way this past year in trying to repair some of the problems we are addressing today.

From our distinguished second panel we will hear of new management initiatives, increased personnel, enhanced training, and a new interconnectivity between medical and personnel tracking systems. We will hear of the hopes for vast improvement in Reserve Component administration and service under the community-based

health care initiative. We hope to hear of a continued commitment to other major changes that address weaknesses that are still at hand.

Today when we ask who in the Army or the Department of Defense is ultimately responsible for the oversight of injured Army Guard and Reserve soldiers and the commands and agencies providing them care and service, I hope to get a clear answer. But the truth is we are all accountable to the men and the women who have been injured defending this country. I am sure we will listen closely to each witness this morning to better understand what we can do to assist in any way possible, including legislation, resources, and ongoing oversight.

We all look forward to the day when each and every injured Army Guard and Reserve soldier receives the care that they have earned and that they deserve. This distressing period where we have witnessed the equivalent of financial and medical friendly fire must end.

[The prepared statement of Chairman Tom Davis follows:]

**Opening Statement
Chairman Tom Davis**

**“Wounded Army Guard and Reserve Forces:
Increasing the Capacity to Care”
February 17, 2005**

I would like to welcome everyone to today’s hearing on the effectiveness and efficiency of Army medical administrative processes that affect the care of injured Army Guard and Reserve forces. This hearing is the third in our continuing investigation into the Department of Defense’s administrative and management challenges created by the largest mobilization of Reserve Component soldiers since World War II.

For the last year, along with the Government Accountability Office, our Committee has been investigating the plight of injured Army Guard and Reserve soldiers seeking quality care, standardized medical and personnel assistance, and comprehensive service.

We’re here today to ask some basic but troubling questions:

- How is it that so many injured and reserve soldiers have been inappropriately removed from active duty status in the automated systems that control pay and access to medical care?

- Why do soldiers languish for weeks or months in medical holding companies, not because of medical care, but because of lags in efficient administrative processing?
- Why do we all continue to hear from our Reserve Component constituents and their families still struggling under the convoluted current system?

Today, the GAO will issue a report on their examination of two Army processes: Active Duty Medical Extensions (ADME) and Medical Retention Processing (MRP). The Committee, looking into the Medical Evaluation Board and Physical Evaluation Board processes, has reached similar findings that are, quite frankly, stunning in scope:

- Current Army guidance for processing injured Guard and Reserve does not clearly define organizational responsibilities or performance standards.
- The Army has not adequately educated reserve component soldiers about Army medical and personnel processing or adequately trained Army personnel responsible for helping soldiers.
- The Army lacks an integrated medical and personnel system to provide visibility over injured or ill reserve component soldiers

and as a result, sometimes actually *loses track* of these soldiers and where they are in the process; and last but certainly not least:

- The Army lacks compassionate, customer friendly service.

Frankly, I'm appalled that these men and women not only have had to face the recovery from their war wounds, but are simultaneously forced to navigate a confusing and seemingly uncaring system of benefits.

What are the effects of these inadequacies? We will listen today to the individual experiences of two Guardsmen whose stories will be hard for us to hear. Sergeant John Allen of the North Carolina National Guard and Sergeant Perez of the Nevada National Guard will illustrate the price of an Army unprepared to handle their needs. General Raymond Byrne, State Adjutant General of Oregon, is also here on behalf of his injured and ill Guardsmen.

We are also pleased to have with us today two individuals who are on the front lines of caring for Reserve Component soldiers and who will explain the difficulties executing Army regulations and policies. An officer from US Human Resources Command will relate the Army's growing pains as it attempts to improve its level of administrative service and care. One will tell about his experiences as a Reserve

Liaison at Walter Reed Medical Center and the challenges he still faces as he tries to help injured Reserve Component soldiers. Both soldiers have been at their posts since the first return of injured Guard and Reserve soldiers from Operation Enduring Freedom. Both will describe urgent needs still unmet.

Clearly the unprecedented number of Army Guard and Reserve mobilized in the Global War on Terrorism has severely taxed the Army and its resources. We understand the pressures they are under. To their credit, Army leadership has accepted these challenges and has come a long way this past year in trying to repair some of the problems we are addressing today.

From our distinguished second panel, we will hear of new management initiatives, increased personnel, enhanced training, and a new interconnectivity between medical and personnel tracking systems. We will hear of the hopes for vast improvement in Reserve Component administration and service under the Community Based Health Care Initiative. We hope to hear of a continued commitment to other major changes that address weaknesses still at hand.

Today, when we ask who in the Army or the Department of Defense is ultimately responsible for the oversight of injured Army Guard and Reserve soldiers and the commands and agencies providing

them care and service, I hope to get a clear answer. But the truth is, we are *all* accountable to the men and women who have been injured defending this country.

I am sure we will all listen closely to each witness this morning to better understand what we can do to assist in any way possible, including legislation, resources and ongoing oversight. We all look forward to the day when each and every injured Army Guard and Reserve soldier receives the care they deserve.

This distressing period – where we’ve witnessed the equivalent of financial and medical “friendly fire” -- must end.

Chairman TOM DAVIS. I now yield to our ranking member, Mr. Waxman, for his opening statement.

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

I want to thank you for holding this hearing. This is an important hearing, and I especially want to thank our witnesses who have come today.

What we are going to hear about and what this committee will shine a light on is the egregious mistreatment—it is inexcusable—that wounded National Guard and Army Reserve soldiers face. I want to mention the fact that the soldiers and their families who are here with us today deserve praise for their bravery, and especially for speaking out on behalf of their fellow soldiers. I thank you for being here.

Today we are going to hear about the inadequate care that wounded National Guard and Army Reserve receive. Tens of thousands of these Reservists have been called to duty with little notice. They have left their jobs, they have left their homes, they have served honorably far away from their family and loved ones, and, unfortunately for many Army Guard and Army Reserve soldiers wounded in action, the real battle begins when they arrive home.

Let me be blunt. The way the administration is treating wounded soldiers and veterans is a disgrace. As my staff has found in a series of reports, veterans across the country are routinely forced to wait months just to schedule a medical appointment. And when a veteran is severely injured, he or she has to wait months without any income before the Veterans Administration will process his or her disability claim.

While we looked into the complaints that my office was receiving, we found that there were 10,000 veterans in Los Angeles, alone, waiting to have their disability claims processed last year. This was a huge increase from just the year before.

And the problems are only going to get worse. The number of veterans who will need medical care will increase 5 percent next year, but the President's latest budget actually proposes a decrease in real funding for VA health care. To make up the difference, the President proposes large increases in copayments and deductibles that will force hundreds of thousands of veterans to lose their VA health care.

Over the last year, I have released several reports documenting these problems. I would like, Mr. Chairman, to have the report made part of the hearing record.

Chairman TOM DAVIS. Without objection, the report will be put in the record.

[The information referred to follows:]



UNITED STATES HOUSE OF REPRESENTATIVES
COMMITTEE ON GOVERNMENT REFORM – MINORITY STAFF
SPECIAL INVESTIGATIONS DIVISION
OCTOBER 2004

**Disabled Veterans in Southern California Must Wait
Months for VA Assistance**

PREPARED FOR REP. HENRY A. WAXMAN

DISABLED VETERANS IN SOUTHERN CALIFORNIA MUST WAIT MONTHS FOR VA ASSISTANCE

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DISABLED VETERANS IN SOUTHERN CALIFORNIA MUST WAIT MONTHS FOR VA ASSISTANCE**EXECUTIVE SUMMARY**

The VA is having severe problems providing injured veterans with benefits in a timely fashion. In October 2004, VA reported that over 300,000 veterans were currently waiting for disability assessments to determine if they would receive benefits for injuries they received in combat. Many of these veterans must wait months in order to obtain benefits.

At the request of Rep. Henry A. Waxman, this report analyzes waiting times for the processing of disability claims for veterans in Southern California. It finds that almost 10,000 disabled veterans in Southern California are waiting for resolution of their disability claims and that the average veteran in the region must wait over six months before receiving VA benefits. These long waiting times delay millions of dollars worth of benefits for disabled veterans in Southern California.

Potential VA budget cuts could make this problem even worse, particularly as veterans return from operations in Iraq and Afghanistan. Almost 10,000 veterans of the wars in Afghanistan and Iraq are presently waiting for disability assessments, with thousands more expected to file claims in future years. But the President's proposed budget would cut hundreds of VA staff that handle benefits claims, and veterans groups have indicated that funding levels proposed by Congress would have "a devastating impact on the VA's ability to deliver timely services."

BACKGROUND

VA's Disability Benefits Program

The disability compensation program of the Department of Veterans Affairs pays monthly benefits to veterans who suffer from injuries or illness due to their military service. Presently, the VA pays approximately \$18 billion annually in disability benefits to approximately 2.4 million disabled veterans.¹

¹ Department of Veterans Affairs, *Disability/Degree of Impairment and Type of Major Disability by Period of Service, September 30, 2002* (2004) (online at <http://www.va.gov/vetdata/ProgramStatics/index.htm>).

DISABLED VETERANS IN SOUTHERN CALIFORNIA MUST WAIT MONTHS FOR VA ASSISTANCE

In California, there are approximately 2.3 million veterans.² Almost one in ten of these veterans — 215,000 — receive disability benefits from VA.³ Overall, VA pays \$1.65 billion in benefits to disabled veterans in California each year.⁴ The average disabled veteran in California receives compensation of \$639 per month, or \$7,672 annually.⁵

When applying for disability benefits, veterans receive a disability rating of between 0% and 100%, indicating the extent of their disability. Disability benefits are based upon this disability rating. Benefits range from a low of approximately \$106 per month for a veteran with a disability rating of 10% to a high of approximately \$2,239 per month for a veteran who is 100% disabled.⁶

In recent years, the VA has been criticized because of long delays in processing disability claims. Although 70% of all disability claims are ultimately approved, veterans must often wait months for the VA to review and approve their applications.⁷ According to the Government Accountability Office, the VA:

continues to experience problems processing veterans' disability compensation and pension claims. These include large backlogs of claims and lengthy processing times. . . . [E]xcessive claims inventories have resulted in long waits for veterans to receive decisions on their claims and appeals.⁸

In response to these concerns, the VA established an agency goal for FY 2004 of processing all ratings-related disability claims within 105 days.⁹ Yet despite the length of this goal, the VA is not meeting its own target. The VA reports that

² Department of Veterans Affairs, Veterans Benefits Administration, *Annual Benefits Report, Fiscal Year 2003* (June 2004) (online at www.vba.va.gov/bln/dmo/reports/fy2003/2003_abr_rev.pdf).

³ *Id.*

⁴ *Id.*

⁵ *Id.*

⁶ Department of Veterans Affairs, *Disability Compensation: 2004 Rates* (Dec. 2003) (online at www1.va.gov/OPA/fact/04comrates.html).

⁷ Department of Veterans Affairs, *supra* note 2.

⁸ GAO, *Veterans Benefits: Despite Recent Improvements, Meeting Claims Processing Goals Will Be Challenging* (Apr. 26, 2002) (GAO-02-645T).

⁹ VA, *FY 2003-2008 Strategic Plan* (2003) (online at www.va.gov/opp/sps/default.htm).

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nationwide, there are 325,000 disability cases pending nationwide, with veterans waiting an average of 153 days for resolution of their claim. In one of every five cases, veterans have to wait over six months for a resolution.

VA Funding and Its Impact on Waiting Times

The long waiting times for disability assessments are already having a significant impact on veterans of the wars in Iraq and Afghanistan. An estimated 166,000 veterans of these two wars soldiers have left the services, and over 26,000 of these veterans, 16%, have applied for disability benefits from VA. More than one in three — 9,750 veterans — are currently on waiting lists and have yet to receive assessments.¹⁰

These problems could become even worse in future years. The President's budget for FY2005, which began on October 1, 2004, called for cutting over 500 positions from the Veterans Benefits Administration, the VA office that handles disability assessments.¹¹ While Congress has yet to finalize this budget, the proposals currently under discussion would still leave VA well short of meeting the needs of veterans. On September 20, 2004, the leaders of the VFW, Disabled American Veterans, the Paralyzed Veterans of America, and AMVETS wrote that the budget levels under discussion "will have a devastating impact on the VA's ability to deliver timely services."¹²

Noting that in future years the demand for benefits is likely to increase significantly due to veterans returning from Iraq, a spokesman for the Disabled American Veterans concluded that, "[t]he system is already strained, and it's going to get strained even worse. It's not a rosy picture at all, and they can't possibly hope to say they're going to provide timely benefits to the new folks if they can't provide timely care to people already in the system."¹³

METHODOLOGY

Veterans with disabilities submit their claims to one of 57 regional VA offices. On a weekly basis, these offices report their progress on claims to the VA. The data that is reported weekly includes the number of outstanding disability claims

¹⁰ *Influx of Wounded Strains VA*, Washington Post (Oct. 3, 2004).

¹¹ Department of Veterans Affairs, *FY2005 Budget Submission*, Volume 1 of 4 (Feb. 2004).

¹² Letter from AMVETS, Disabled American Veterans, Paralyzed Veterans of America, and VFW, to Member of the House and Senate (Sept. 20, 2004).

¹³ David Autry, Disabled American Veterans, quoted in Washington Post, *supra* note 10.

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and the number of claims that have taken over 180 days to review.¹⁴ The regional VA offices also report the average waiting time for ruling on disability claims, though this data typically lags the weekly data by several months.¹⁵

At the request of Rep. Waxman, the Special Investigations Division obtained both the weekly data and the data on average waiting times at the VA regional office in Los Angeles, which serves disabled veterans throughout Southern California. This data was analyzed to assess how long veterans in Southern California must wait to receive resolution of their disability claims.

FINDINGS

Waiting Times for Evaluation of VA Disability Claims in Southern California

At the regional VA center in Los Angeles, there were 9,880 veterans with pending VA disability claims as of October 2, 2004. Almost one in four of these veterans, 2,257 (23%), have been waiting six months or longer for resolution of their claim.

The most recent data on average waiting times for Southern California veterans was reported by the VA center in Los Angeles in July 2004. According to this data, the average veteran currently on the waiting list has been waiting for 133 days. Most can anticipate waiting even longer before their claims are finally processed. Veterans whose disability claims were finally processed in July 2004 had waited an average of 205 days before their claim was completed. These waiting times are significantly longer than the national average. Nationally, the VA reports that the average waiting time for completed claims in July was 153 days. The average waiting times in Southern California were over 50 days longer.¹⁶

Comparison of Average Waiting Times to VA Goal

The VA has established a goal of reducing average waiting times for resolution of VA disability cases to 105 days. The VA is far from meeting this goal in Southern California. In fact, the average waiting time of 205 days experienced by

¹⁴ Department of Veterans Affairs, Veterans Benefit Administration, *Office of Performance Analysis and Integrity, Monday Morning Workload Reports* (2004) (online at www.vba.va.gov/bln/201/reports/mmrindex.htm).

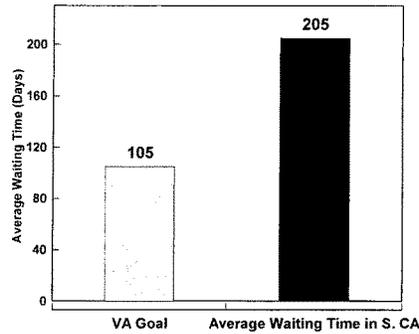
¹⁵ Department of Veterans Affairs, *C&P Average Days to Complete A Ratings Related Action* (Aug. 2004).

¹⁶ *Id.*

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disabled veterans in Southern California is almost twice as long as the VA goal (Figure 1).

Figure 1: Veterans in Iowa Must Wait Months for Resolution of Disability Claims



Waiting Time Trends

The number of Southern California veterans waiting for resolution of disability claims, and the number waiting six months or more, both appear to be increasing. In October 2003, there were 7,213 veterans waiting for resolution of their claim, and 1,106 of these veterans (15%), had been waiting over six months. By October 2004, the waiting list had increased to 9,880 veterans, and over twice as many veterans, 2,257 (23%), had been waiting six months or longer.

Long Waiting Times Can Have Substantial Financial Impacts

The long waiting times for disabled veterans in Southern California can have substantial financial impacts. In Southern California, the average disability payment is \$639 per month. Although veterans who ultimately receive disability benefits will receive payments for the time spent on waiting lists, the months living without benefits can cause financial hardships. For the average disabled veteran in Southern California, the delay will result in delayed benefits of approximately \$4,300. The longest delays can have even larger consequences. If a veteran who is 100% disabled has to wait six months or more to receive benefits, the value of the delayed benefits would at least \$13,400.

An estimated 70% of the 9,880 veterans with pending disability claims in

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Southern California will ultimately receive benefits and they will wait an average of almost seven months for these benefits. The total value of the delayed benefits for Southern California veterans with disabilities will be approximately \$30 million.

CONCLUSION

The VA has had longstanding problems evaluating veterans' disability claims in a timely fashion. These problems have had a significant impact in Southern California. Veterans in Southern California are waiting an average of over six months for their disability claims to be evaluated. These long waiting times, which appear to be increasing, delay the payment of millions of dollars in disability payments. Budget proposals currently under consideration in Congress would make these delays even worse.

Mr. WAXMAN. Today we are going to learn about the plight that wounded National Guard and Army Reserve soldiers face when they return home. Wounded regular duty troops are sent to medical facilities at their home bases when they leave Iraq or Afghanistan, but many wounded National Guard soldiers are placed in what is called medical hold status. As we will learn, these soldiers are sent to shoddy, dilapidated bunkers far from their home bases where they face long delays to receive medical appointments and treatment, and they confront a labyrinth of forms to fill out and offices to visit just to receive the care and benefits due them.

These soldiers have risked their lives for us, and they are returning home with severe and sometimes incapacitating injuries, yet the administration continues to neglect their health care and delay their benefits.

Mr. Chairman, I hope this hearing will be a step toward doing right by our veterans. Guardsmen and Reserve soldiers will be sorely needed for the foreseeable future. Let's give them the respect and care that they all so rightly deserve.

[The prepared statement of Hon. Henry A. Waxman follows:]

**Statement of
Rep. Henry A. Waxman, Ranking Minority Member
Committee on Government Reform
Hearing On
Wounded Army Guard and Reserve Forces: Increasing the
Capacity to Care**

February 17, 2005

Mr. Chairman, thank you for holding this oversight hearing today. I commend you for helping this Committee shine a light on the inexcusable and egregious mistreatment that wounded National Guard and Army Reserve soldiers face. And I welcome the soldiers and their families who are with us today, and praise their bravery for speaking out on behalf of their fellow soldiers.

Today we will be hearing about the inadequate care that wounded National Guard and Army Reserve soldiers receive. Tens of thousands of these reservists have been called to duty with little notice, have left their jobs and homes, and have served honorably far away from their family and loved ones. Unfortunately, for many Army Guard and Army Reserve soldiers wounded in action, the real battles begin when they arrive home.

Let me be blunt: the way the Administration is treating wounded soldiers and veterans is a disgrace.

As my staff has found in a series of reports, veterans across the country are routinely forced to wait months just to schedule a medical appointment.

And when a veteran is severely injured, he or she has to wait months – without any income – before the VA will process his or her disability claim. When we looked into the complaints that my office was receiving, we found that there were 10,000 veterans in Los Angeles waiting to have their disability claims processed last year. This was a huge increase from just the year before.

And the problems are only going to get worse. The number of veterans who will need medical care will increase 5% next year, but the President's latest budget actually proposes a decrease in real funding for VA health care. To make up the difference, the President proposes large increases in copays and deductibles that will force hundreds of thousands of veterans to lose their VA health care.

Over the last year, I have released several reports documenting these problems, and I would like to make them part of this hearing record.

Today, we are going to learn about the plight that wounded National Guard and Army Reserve soldiers face when they return home.

Wounded regular duty troops are sent to medical facilities at their home bases when they leave Iraq and Afghanistan. But many wounded National Guard soldiers are placed in what's called "medical hold" status. As we will learn, these soldiers are sent to shoddy, dilapidated bunkers far from their home bases, where they face long delays to receive medical appointments and treatments. And they confront a labyrinth of forms to fill out and offices to visit just to receive the care and benefits due to them.

These soldiers have risked their lives for us, and they are returning home with severe and sometimes incapacitating injuries. Yet the Administration continues to neglect their health care and delay their benefits.

Mr. Chairman, I hope this hearing will be a step toward doing right by our veterans. Guardsmen and Reserve soldiers will be sorely needed for the foreseeable future. Let's give them the respect and care that they all so rightly deserve.

Chairman TOM DAVIS. Mr. Waxman, thank you very much.

Are there any other Members who wish to make statements? The gentleman from Nevada, Mr. Porter.

Mr. PORTER. Thank you, Mr. Chairman. I appreciate your taking the time to hold this hearing today. I would also like to thank our witnesses for coming here to testify. Sergeant Perez is here today, a constituent of mine, from Logandale, NV. I would like to especially thank him and his wife Elena for traveling this long way to be with us today.

Our country is at war in a war against terrorism. Throughout this war, thousands of our brave men and women have volunteered to wear military uniforms and fight for the freedoms that many of us take for granted. Unfortunately, this war has had its casualties, but it is our job as Members of Congress to make sure that our injured and returning soldiers are cared for in the best possible manner.

The purpose of this hearing today is to examine the effectiveness and the efficiency of Army medical administrative processes and procedures that govern injured Army Guard and Reserve soldiers. Although the majority of these men and women are treated appropriately and above and beyond, we are now aware that many returning soldiers are experiencing difficulties associated with active duty medical extensions, medical retention processing, Medical Evaluation Boards, and Physical Evaluation Boards. With these programs, many returning soldiers are finding that they will have to deal with numerous layers of bureaucratic red tape, significant paperwork, and in some situations problems associated with their pay and benefits.

I have two constituents who have submitted their testimony to the committee regarding this problem. One of my constituents, Brian Robinson, was not able to be here today. Brian was a specialist in the Nevada Army National Guard. During his time in Nevada Army National Guard he was deployed to Iraq, where a vehicle he was riding in was struck by a hand-detonated land mine. As a result of this attack, Specialist Robinson suffered damage to both of his ears, cuts and bruises over his left eye, fractures to his left elbow and left wrist, a crushed index finger, severe head and back pain, whiplash, shrapnel damage, as well as swelling and bruising.

After this attack, Specialist Robinson was flown from Iraq to Kuwait, and then from Kuwait to Germany for additional care. But after about a week in Germany, Specialist Robinson was cleared to return to the United States. Specialist Robinson was then admitted for care at Madigan Hospital and was granted 30 days leave for convalescent care. It was during this time that the U.S. military contacted his parents to notify them that he had been injured and that he was in a hospital in Germany.

Finally, while Specialist Robinson was being cared for by the Air Force physicians at Nellis Air Force Base in Las Vegas while on convalescent leave, the Army decided that Sergeant Robinson would have to return to Madigan for care by Army physicians as opposed to Air Force physicians.

Sadly, Mr. Chairman, Specialist Robinson's story is not unique. Another one of my constituents, Sergeant Joseph Perez, who is

here today, is going to tell a similar story about the difficulties he encountered after being injured in the line of duty in Iraq.

Sergeant Perez is an exemplary American who served this country both since 1988 in the U.S. Marine Corps and later in Nevada Army National Guard, and is certainly someone that we should be proud of, since he received the Naval Commendation Medal, Sergeant of the Year for Western Region, and Recruiter of the Year.

I, of course, will let Sergeant Perez tell his story in person, but I will point out that both Specialist Robinson and Sergeant Perez proudly served our country during the global war on terror, and both have submitted testimony not to bash the Army, but rather to help find a solution to this longstanding problem.

Mr. Chairman, I am hopeful that our Army witnesses will help us look toward an effective, long-term solution, and I firmly believe that our Reserve soldiers who were injured or became ill in the line of duty should be given the pay and the benefits they deserve in an accurate and timely manner.

Again, thank you, Mr. Chairman.

Chairman TOM DAVIS. Thank you very much. Any other Members wish to make statements? Ms. Norton.

Ms. NORTON. Mr. Chairman, I think you do a service for members of our military and for Congress, alike, in holding this hearing, and I appreciate that you have done so. I want to thank the members of the military who have agreed to step forward to help educate the Congress and to help us better prepare for what we should be doing for our members of the military, and especially the Reserve and the National Guard.

Walter Reed Hospital is, of course, located in my District here in the District of Columbia, and I have visited Walter Reed and seen world class treatment of the most seriously injured. I have also seen television reports of state-of-the-art treatment moving people from the battlefield to where they can be treated. So it looks like there are some places in the military where people do get first-class treatment.

Members of Congress are particularly close to the Reserve and National Guard. They are citizen soldiers and we have been hearing complaints now for years, particularly since the Iraqi war. I am concerned on two levels: first and foremost, at the health care that returning soldiers are receiving or not receiving; and, second, with the future of the volunteer Army, itself. We will hear about that. I believe there have been some improvements. There are still complaints. We need to know what the status is today and what we can do about it.

As to the volunteer Army, we are dealing with an unpopular war at home that has already taken its toll on recruitment for the Army Reserve and National Guard. We need to do all we can if we want to have a volunteer Army to make sure that people want to join that Army, particularly at a time when we are engaged and they see it every day on television in a guerilla war on the ground. At the very least they need to know that if they are wounded they are going to get the best health care that the United States has to offer. Every member of this panel I am sure is committed to seeing that happens.

I thank you again, Mr. Chairman.

Chairman TOM DAVIS. Thank you.

Any other Members wish recognition? Mr. Cummings.

Mr. CUMMINGS. Thank you very much, Mr. Chairman, for holding this hearing on medical treatment of injured Army National Guard and Army Reserve personnel.

As I stated at the committee's hearing last year, it is deeply troubling to learn of the pervasive problems associated with pay and medical treatment of Guard and Reserve personnel. I believe—and I am sure that many other members of this committee believe, as well—that this situation is simply unacceptable. While I am comforted to learn of new efforts to help address these important issues, such as the community-based health care initiative, I am equally unhappy with the fact that there are soldiers who shed blood, sweat, and tears in the service of this country experiencing pay disruptions or medical care that is as much a burden as it is a blessing.

Insufficient planning and poor management controls by the Army made it ill equipped to meet the needs of the Guard and Reserve soldiers recently activated and deployed in Iraq, Afghanistan, and elsewhere around the world in the war on terror.

A central focus of this hearing is to examine the quandary many Guard and Reserve soldiers find themselves in when they are classified in a medical hold status while injured or ill. While approximately 5,000 Reservists are in medical hold, too many of our Nation's bravest have to endure long delays in diagnosis and medical treatment in austere facilities far away from friends and family. The consequences of this problem often manifest themselves in pay disruptions, stress, and undermined morale at a period of time when injured Guard and Reserve soldiers should be primarily focused on recuperation.

The GAO has indicated in its report entitled, "Military Pay: Gaps in Pay and Benefits, Etc.," that sensible guarantees could not be given that Guard and Reserve soldiers would receive uninterrupted pay and benefits in the event that they became wounded or sick. The study also indicated a startling finding that a designation of "falling off orders" lead to 24 of 38 Reservists having their pay disrupted while they were undergoing medical care.

Additionally, the GAO cites numerous obstacles to inefficient management in the medical treatment of Guard and Reserve soldiers ranging from poor dissemination of information to soldiers about the active duty medical extension to lack of an integrated personnel system that is updated at all times.

Mr. Chairman, finally I believe that we honor the service and sacrifice of those who risk their lives for our Nation in the Armed Forces by eliminating inefficient, ineffective bureaucracies that undermine their ability to receive the pay that they are entitled to and the benefits that they are entitled to.

I am eager to hear from the witnesses today about what has been done and what is being done to address the pay and benefit problems Guard and Reserve soldiers are experiencing, and I hope, in the words of one of my constituents, that we don't have motion, commotion, and emotion and no results.

Thank you very much, Mr. Chairman. I yield back.

[The prepared statement of Hon. Elijah E. Cummings follows:]

Committee on Government Reform
U.S. House of Representatives
109th Congress

Opening Statement of

Representative Elijah E. Cummings, D-Maryland

Full Committee Hearing on “Wounded Army Guard and Reserve
Forces: Increasing the Capacity to Care”

February 17, 2005

Thank you, Mr. Chairman for holding this important hearing on the medical treatment of injured Army National Guard and Army Reserve personnel.

As I stated at the Committee’s hearing last year, it is deeply troubling to learn of the pervasive problems associated with pay and medical treatment for Guard and Reserve personnel. I believe, and I am sure that many other members of this Committee believe as well, that this situation is unacceptable.

While I am comforted to learn of new efforts to help address these important issues such as the Community Based Health Care Initiative, I am equally unhappy with the fact that there are soldiers who shed blood, sweat, and tears in the service of this country experiencing pay disruptions or medical care that is as much a burden as it is a blessing.

Insufficient planning and poor management controls by the Army made it ill equipped to meet the needs of Guard and Reserve

soldiers recently activated and deployed in Iraq, Afghanistan, and elsewhere around the world in the War on Terror. A central focus of this hearing is to examine the quandary many Guard and Reserve soldiers find themselves in when they are classified in a “medical hold” status while injured or ill.

With approximately 5,000 reservists in “medical hold” too many of our nation’s bravest have to endure long delays in diagnosis and medical treatment in austere facilities far away from friends and family. The consequences of this problem often manifest themselves in pay disruptions, stress, and undermine morale at a period of time when injured Guard and Reserve soldiers should be primarily focused on recuperation.

The GAO has indicated in their report entitled, “*Military Pay: Gaps in Pay and Benefits Create Financial Hardships for Injured Army National Guard and Reserve Soldiers*” that sensible guarantees could not be given that Guard and Reserve soldiers would receive uninterrupted pay and benefits in the event that they became wounded or sick. The study also indicated a startling finding that a designation of “falling off orders” lead to 24 of 38 reservists having their pay disrupted while they were undergoing medical care.

Additionally, the GAO cites numerous obstacles to efficient management in the medical treatment of Guard and Reserve soldiers ranging from poor dissemination of information to soldiers about the Active Duty Medical Extension to lack of an integrated personnel system that is updated at all times.

Mr. Chairman, I believe that we honor the service and sacrifice of those who risked their lives for our nation in the armed forces by eliminating inefficient, ineffective bureaucracies that undermine their ability to receive entitled pay and benefits.

I am eager to hear from the witnesses today about what has been done and what is being done to address the pay and benefit problems Guard and Reserve soldiers are experiencing.

Once again, thank you Mr. Chairman for holding today's hearing.

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The following information was released by the Office of Maryland Congressman Elijah Cummings:

Today, U.S. Congressman Elijah E. Cummings, a Member of the House Government Reform Committee, released the following statement after participating in a Committee hearing that examined the lack of proper medical care for injured Army National Guard and Army Reserve personnel:

"It is inconceivable to me that Reserve and National Guard military personnel who have been wounded or incapacitated in combat are subsequently removed from active duty status, disrupting their access to the medical care and pay they deserve.

"I am particularly concerned after hearing the testimony of Army National Guard Sergeant Joseph D. Perez. He testified that he suffered leg and head injuries after battling insurgents during his service in Iraq. After receiving some medical attention from the U.S. military, he was put on "medical hold." Because of his status as a National Guard member, he was forced to wait for treatment and directed to a World War I barrack with insufficient water and heating, and overall filthy conditions.

"Unlike non-reserve U.S. military personnel, Sgt. Perez was denied a home base and had only minimum contact with his family. His medical condition caused him to miss three pay periods, and disqualified him for home rentals or a home loan, among other mistreatments. In addition, his wife and children were forced to move out of their home and borrow \$10,000 from family for basic living expenses.

"Sgt. Perez's story is not an isolated incident, and represents an overwhelming pattern that has so far affected approximately 5,000 reservists.

"This type of treatment for our reserve and national guard soldiers is unconscionable and unacceptable.

"While I am comforted to learn of new efforts to help address these important issues such as the Community Based Health Care Initiative, our military leadership needs to do more.

"I urge the Secretary of the Army to fully adopt "Military Pay," a report by the Government Accounting Office that outlines 22 recommendations for action, such as:

Establishing comprehensive policies and procedures for managing programs for treating reserve component soldiers with service-connected injuries or illnesses;

Providing adequate infrastructure and resources;

Making process improvements to compensate for inadequate, out-dated systems.

"It is important to recognize the sacrifices made by anyone who serves this country, including active duty soldiers, Reserve and Guard personnel, and veterans. That is the true measure of patriotism."

Devika Koppikar, (202) 225-4741

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Chairman TOM DAVIS. Mr. Ruppertsberger.

Mr. RUPPERSBERGER. Thank you, Mr. Chairman.

First, I would like to begin this opening statement by thanking our brave soldiers for their courage and bravery, not only on the battlefield but for being here today on behalf of your comrades. I was struck to the core when reading your stories. You are quite right in stating you are sadly not alone in this poor treatment. The Nation, the Pentagon, and this Congress owes you better.

Sergeant Allen, you spoke of the responsibility leadership carries, and I commend you for that. Soldiers, particularly disabled soldiers, should not be further burdened by disconnected bureaucracies. As members of this committee and in this legislative body, we must take responsibility and lead better in this area.

This is not a new issue for me. In August 2004 the problems severely disabled soldiers were facing came to my attention and on September 1st I introduced H.R. 5057—and this is a bipartisan bill—with Congressman Jones and Congressman Hoyer to expand the DS3 program in the Pentagon. That bill envisioned a joint command center with an executive agent to be a one-call-fits-all helpline for soldiers, Marines, Sailors, Airmen, and Coast Guardsmen.

It was intended to help with all sorts of problems severely disabled servicemen and women face when they return home, including pay, medical appointments, caseworker management, transportation, employment-related issues, and many other problems. Senators Bond and Kennedy introduced companion legislation in their chamber, and we came very close to passing that legislation before the close of the 108th Congress.

Now, I know we were onto something when Paul Wolfowitz, Secretary Wolfowitz, held a ribbon-cutting ceremony on February 1st of this year to launch the Military Severely Injured Joint Support Operations Center. This center draws heavily from H.R. 5057, and I congratulate the Pentagon on this effort.

We are working with our colleagues in the House and Senate to monitor this program and its progress and to see if it is working and if we can help.

The issue before us today is not just about processing paperwork; it is about the most basic promise we make to all men and women who put a uniform on and take the oath to serve our Nation. As leaders we have the responsibility to take care of these men and women and to leave no one behind and to not ignore them once we bring them home.

One great lesson from today's testimony and the GAO report is that our Federal Government needs to get much smarter in the way we do business. We have spent millions and millions of dollars creating joint weapon systems, open architecture platforms, and other integrated systems to create a more seamless battlefield between our military branches. Certainly we can do the same for our payroll and other processing systems for the Army, Navy, Air Force, and Marines. I fear the stories we hear today are just the

tip of the iceberg and we should draw from the courage of these soldiers to fix this system and to help those who will follow.

Thank you, Mr. Chairman.

[The prepared statement of Hon. C.A. Dutch Ruppertsberger follows:]

Congressman C.A. Dutch Ruppertsberger
House Committee on Government Reform
Wounded Army Guard and Reserve Forces:
Increasing the Capacity to Care
Opening Remarks
02.17.05

Thank you Mr. Chairman. My thanks to you, the ranking member and the other members of this committee for initiating the GAO inquiry resulting in this hearing.

I would like to begin this opening statement by thanking our brave soldiers in uniform for their courage and bravery – both on the battlefield in defense of our nation and here in this committee room in defense of their comrades. I was struck to the core when reading your stories. You are quite right in stating that you are sadly not alone in this poor treatment. This nation, the Pentagon, and this Congress owes you much better.

^{set:} Mr. Allen you spoke of the responsibility leadership carries and I commend you for that. Soldiers, particularly disabled soldiers, should not be further burdened by disconnected bureaucracies. As Members of this committee and in this legislative body, we must take responsibility and lead better in this area.

This is not a new issue for me. In August of 2004 the problems severely disabled soldiers were facing came to my attention and in September I introduced H.R. 5057, a bipartisan bill with Congressman Jones and Congressman Hoyer to expand the DS3 program in the Pentagon. That bill envisioned a joint command center with an executive agent to be a one call fits all help line for soldiers, marines, sailors, airmen, and coast guardsman. It was intended to help with all sorts of problems severely disabled service men and women face when they return home including pay, medical appointments, case worker management, transportation, employment related issues, and many, many other problems.

Senators Bond and Kennedy introduced companion legislation in their chamber and we came very close to passing that legislation before the close of the 108th Congress. I know we were on to something when Paul Wolfowitz held a ribbon cutting ceremony on February 1st of this year to launch the Military Severely Injured Joint Support Operations Center. This center draws heavily from H.R. 5057 and I congratulate the Pentagon on this effort. I am working with my colleagues in the House and Senate to monitor its progress and see what we can do to help.

Many laymen listening to today's hearing will think it is quite wonky and complicated. A lot of detailed military acronyms and jargon complicated further by accounting terms. But as these soldiers before us will testify, this isn't just about processing paperwork.

This is about the most basic promise we make to all men and women who put on a uniform and takes the oath to serve their nation. As leaders, we have the responsibility to take care of these men and women, to leave no one behind, and to not ignore them once we bring them home.

One great lesson from today's testimony and the GAO report is that our federal government needs to get much smarter in the way we do business. We have spent millions and millions of dollars creating joint weapons systems, open architecture platforms and other integrated systems to create a more seamless battlefield between our military branches. Certainly we can do the same for our payroll and other processing systems for the Army, Navy, Airforce and Marines. I fear the stories we hear today are just the tip of the iceberg and we should draw from the courage of these soldiers to fix this broken system to help those who will follow.

Thank you Mr. Chairman.

Chairman TOM DAVIS. Thank you very much.

Any other opening statements?

[No response.]

Chairman TOM DAVIS. Well, if not we will proceed to our first panel of witnesses. We are very honored and grateful that you are here today to share your personal experiences with the committee. I understand that some of you appear with a little apprehension about how your candor today might affect your future careers in the military. Let me just say that we appreciate the opportunity to receive your testimony under oath, and you have our assurances that you will not pay a professional price for sharing your stories with us. In fact, Congress is deeply gratified for your willingness to step forward.

We welcome today Mr. Gregory Kutz, the Director of Financial Management and Assurance at the U.S. Government Accountability Office; Brigadier General Raymond C. Byrne, the acting State Adjutant General of Oregon; Sergeant First Class John Allen, B/3/20th Special Forces Group, North Carolina National Guard.

Sergeant Allen, it is nice to see you again and have the opportunity to publicly thank you for all that you have done to bring the plight of injured Guard and Reserve soldiers to the attention of this committee.

We also have with us Sergeant Joseph Perez, the 72nd Military Police Co., Nevada National Guard; Chief Warrant Officer Rodger L. Shuttleworth, Chief, Reserve Component Personnel Support Services Branch, Army Human Services Command, Maryland National Guard. Chief Shuttleworth is accompanied by Chief Warrant Officer Laura Lindle, who is here to support Chief Shuttleworth's testimony—so when we swear everyone in, if you could rise and raise your right hands—and Master Sergeant Daniel Forney. He is a Reserve Component liaison, Medical Holding Co., Walter Reed Medical Center, an Army Reservist from Pennsylvania.

Sergeant Forney, it is also good to see you again and I want to thank you for your commitment to those soldiers and their families. Give my best to your fellow Reserve liaison soldiers at Walter Reed.

Before we begin, I want to recognize and thank a few more people who are here accompanying our first panel. Along with Mr. Kutz, I want to recognize John Ryan, Gary Bianchi, and Diane Handley of the GAO Special Investigations Office, who over the last 2 years have gone beyond the call of duty to assist this committee with its investigation.

I also want to welcome and thank Mrs. John Allen and Mrs. Joseph Perez for coming here today with your husbands. As we salute your husbands' service and the sacrifices, we salute yours, as well.

There is another husband and wife team I want to recognize and thank who have provided separate written statements today about their experiences: Specialist Brian Robinson of the Nevada National Guard, and his wife, Mrs. Nicole Robinson, whose stories I encourage everyone to read. I think Mr. Porter referred to it in his opening remarks.

I want to thank everybody for taking part in this very, very important hearing. It is our policy that all witnesses be sworn before

their testimony, so if you would rise with me and raise your right hands.

[Witnesses sworn.]

Chairman TOM DAVIS. Thank you very much.

Your entire written testimony is in the record. Questions will be based on that. That is in the public record. There is a light in front of you that will be green when you start. It will turn orange after 4 minutes, and at the end of 5 minutes it turns red. We would appreciate it if you could move to summary after that, but we are not going to gavel you shut if you feel you just need to add something. This is an important issue, and we want to give you time to adequately explain to live Members what we are about today in your experiences.

Mr. Kutz, we will start with you and we will move straight on down the line. Thanks for being with us and thanks for the work that you and your team have done on this.

STATEMENTS OF GREGORY D. KUTZ, DIRECTOR, FINANCIAL MANAGEMENT AND ASSURANCE, U.S. GOVERNMENT ACCOUNTABILITY OFFICE; BRIGADIER GENERAL RAYMOND C. BYRNE, JR., ACTING STATE ADJUTANT GENERAL, STATE OF OREGON, ACCOMPANIED BY COLONEL DOUG ELIASON, M.D.; SERGEANT FIRST CLASS JOHN ALLEN, B/3/20TH SPECIAL FORCES GROUP, NORTH CAROLINA NATIONAL GUARD; SERGEANT JOSEPH PEREZ, 72ND MILITARY POLICE CO., NEVADA NATIONAL GUARD; CHIEF WARRANT OFFICER RODGER L. SHUTTLEWORTH, CHIEF, RESERVE COMPONENT PERSONNEL SUPPORT SERVICES BRANCH, ARMY HUMAN RESOURCES COMMAND, MARYLAND NATIONAL GUARDSMAN, ACCOMPANIED BY CHIEF WARRANT OFFICER LAURA LINDLE; AND MASTER SERGEANT DANIEL FORNEY, RESERVE COMPONENT LIAISON, MEDICAL HOLD, WALTER REED MEDICAL CENTER, U.S. ARMY RESERVIST, PENNSYLVANIA

STATEMENT OF GREGORY D. KUTZ

Mr. KUTZ. Mr. Chairman and members of the committee, thank you for the opportunity to discuss pay problems for mobilized Army National Guard and Reserve soldiers. I previously testified that 94 percent of the soldiers that we investigated had pay problems. My bottom line today is that gaps in pay and benefits cause significant stress and financial hardship for injured soldiers and their families.

My testimony has two parts. First, pay problems for injured soldiers, and second, Army's new process for soldiers injured fighting the global war on terrorism.

First, we found that the Army does not know how many injured soldiers have experienced pay problems. Injured Reserve Component soldiers can request to have their active duty orders extended and their pay and benefits continued. When soldiers fall off of orders, pay and benefits generally stop. Based on our analysis of Army data for 2 months in 2004, 34 percent of the 867 soldiers who applied for extensions fell off their orders before their requests were granted.

We found the following examples of the impact of these problems: soldiers and their families denied medical and dental care, loss of

access to the post exchange and commissary, negative impact on credit due to late payment of bills, soldiers borrowing money from friends and family to pay bills, added stress for soldiers that already had serious medical conditions, and injured soldiers spending incredible amounts of time to obtain entitled pay and benefits.

Of our 10 case study, 2 soldiers are here today, Sergeant First Class John Allen and Sergeant Joseph Perez. They will tell you their own stories.

The key causes of these problems included a weak control environment, a broken process, and non-integrated pay and personnel systems. For example, one Special Forces soldier who lost his leg when a roadside bomb destroyed his vehicle in Afghanistan missed three pay periods totaling \$5,000. Why? Because this soldier's application did not contain adequate information to justify his qualification for an extension.

The financial hardships experienced would be far worse if not for the heroic efforts of people like Master Sergeant Forney and Chief Warrant Officer Shuttleworth, who will also tell you their stories.

Second, there is some good news. The Army's new process for soldiers injured fighting the global war on terrorism appears to have significantly improved the front-end application process. According to Army officials at each of the 10 installations that we visited, they have experienced few delays in obtaining initial orders for injured soldiers. However, several key issues remain, including the Army's lack of visibility over injured soldiers. This problem reflects DOD's many stovepiped personnel systems. For example, the Army contacted one soldier's parents to inform them that their son was injured in Baghdad and was at a hospital in Germany; however, this soldier had been back in the States for 20 days.

In conclusion, this pay issue is another example of the ineffective and wasteful business practices processes that plague virtually every aspect of DOD's high-risk business operations. To its credit, the Army's new streamlined process has significantly reduced the initial delays extending orders; however, many problems remain and must be addressed in a more comprehensive manner with clear leadership and accountability for results. There should be zero tolerance for the poor treatment of our injured heroes.

Mr. Chairman, I look forward to continuing to work with this committee to help soldiers. I am also honored to be at the table with the other witnesses who have each played a significant role helping injured soldiers, and I look forward to their testimony.

[The prepared statement of Mr. Kutz follows:]

United States Government Accountability Office

GAO

Testimony
Before the House Committee on
Government Reform

For Release on Delivery
Expected at 10:00 a.m.
Thursday, February 17, 2005

MILITARY PAY

Gaps in Pay and Benefits Create Financial Hardships for Injured Army National Guard and Reserve Soldiers

Statement of Gregory D. Kutz, Director
Financial Management and Assurance



DRAFT

February 17, 2005

MILITARY PAY

Gaps in Pay and Benefits Create Financial Hardships for Injured Army National Guard and Reserve Soldiers



Highlights of GAO-05-322T, a testimony before the Committee on Government Reform, House of Representatives

Why GAO Did This Study

In light of the recent mobilizations associated with the Global War on Terrorism, GAO was asked to determine if the Army's overall environment and controls provided reasonable assurance that soldiers who were injured or became ill in the line of duty were receiving the pay and other benefits to which they were entitled in an accurate and timely manner. This testimony outlines pay deficiencies in the key areas of (1) overall environment and management controls, (2) processes, and (3) systems. It also focuses on whether recent actions the Army has taken to address these problems will offer effective and lasting solutions.

What GAO Recommends

GAO's related report (GAO-05-125) makes 22 recommendations including (1) establishing comprehensive policies and procedures, (2) providing adequate infrastructure and resources, (3) making process improvements to compensate for inadequate, stovepiped systems, and (4) as part of longer term system improvement initiatives, to integrate the Army's order writing, pay, personnel, and medical eligibility systems. In its written response to GAO's recommendations, DOD briefly described its completed, ongoing, and planned actions for each of the recommendations.

www.gao.gov/cgi-bin/getrpt?GAO-05-322T.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Gregory D. Kutz at (202) 512-9085 or kutzg@gao.gov.

What GAO Found

Injured and ill reserve component soldiers—who are entitled to extend their active duty service to receive medical treatment—have been inappropriately removed from active duty status in the automated systems that control pay and access to medical care. The Army acknowledges the problem but does not know how many injured soldiers have been affected by it. GAO identified 38 reserve component soldiers that said they had experienced problems with the active duty medical extension order process and subsequently fell off their active duty orders. Of those, 24 experienced gaps in their pay and benefits due to delays in processing extended active duty orders. Many of the case study soldiers incurred severe, permanent injuries fighting for their country including loss of limb, hearing loss, and back injuries. Nonetheless, these soldiers had to navigate the convoluted and poorly defined process for extending active duty service.

Examples of Injured Soldiers with Gaps in Pay and Benefits

Soldier	Injuries	Days without orders	Missed pay	Effect on soldier
Case Study #1 Enduring Freedom	Kidney problems, knee injury	92	\$11,924	Medical and financial stress requiring counseling
Case Study #2 Iraqi Freedom	Knee and cervical disc injuries	31	\$3,886	Living with in-laws, no way to show income to qualify for rental
Case Study #3 Enduring Freedom	Lost leg, burns, and shrapnel in face	34	\$4,780	Soldier paid bills late and had to borrow money
Case Study #4 Enduring Freedom	Back injuries	45	\$8,206	Soldier paid bills late and had to borrow money
Case Study #5 Enduring Freedom	Knee injury and cancer	122	\$4,238	Unable to work, soldier lived off savings and credit cards

Source: GAO.

The Army's process for extending active duty orders for injured soldiers lacks an adequate control environment and management controls—including (1) clear and comprehensive guidance, (2) a system to provide visibility over injured soldiers, and (3) adequate training and education programs. The Army has also not established user-friendly processes—including clear approval criteria and adequate infrastructure and support services. Many Army locations have used ad hoc procedures to keep soldiers in pay status; however, these procedures often circumvent key internal controls and put the Army at risk of making improper and potentially fraudulent payments. Finally, the Army's nonintegrated systems, which require extensive error-prone manual data entry, further delay access to pay and benefits.

The Army recently implemented the Medical Retention Processing (MRP) program, which takes the place of the previously existing process in most cases. MRP, which authorizes an automatic 179 days of pay and benefits, may resolve the timeliness of the front-end approval process. However, MRP has some of the same issues and may also result in overpayments to soldiers who are released early from their MRP orders. Out of 132 soldiers the Army identified as being released from active duty, 15 improperly received pay past their release date—totaling approximately \$62,000.

Mr. Chairman and Members of the Committee:

Thank you for the opportunity to discuss the Army's procedures for providing pay and related benefits, including medical benefits, to Army National Guard and Army Reserve soldiers being treated for service-connected injuries or illness. Our related report¹ released today details weaknesses in the Army's control environment, processes, and automated systems needed to provide reasonable assurance that injured and ill reserve component soldiers receive the pay and benefits to which they are entitled without interruption.

In response to the September 11, 2001, terrorist attacks, the Army National Guard and Army Reserve mobilized and deployed soldiers in support of Operations Noble Eagle and Enduring Freedom. When mobilized for up to 2 years at a time,² these soldiers performed search and destroy missions against Taliban and al Qaeda members throughout Asia and Africa, fought on the front lines in Afghanistan and guarded al Qaeda prisoners held at Guantanamo Bay, Cuba. Similarly, reserve component soldiers fought on the front lines in Iraq and are now assisting in peace-keeping and reconstruction operations in Iraq under Operation Iraqi Freedom. Until recently, reserve component soldiers who were mobilized in support of the Global War on Terrorism and were injured or became ill were released from active duty and demobilized when their mobilization orders expired, unless the Army took steps, at the soldier's request, to extend their active duty service—commonly referred to as an active duty medical extension (ADME). During the course of our audit, the Army implemented the Medical Retention Processing (MRP) program, which takes the place of ADME for soldiers returning from operations in support of the Global War on Terrorism³ but is a similar mechanism for providing pay and related benefits to reserve component soldiers being treated for service-connected injuries or illness.

Because the Army did not maintain reliable, centralized data on the number, location, and disposition of mobilized reserve component soldiers who had requested to extend their active duty service because they had been injured or become ill in the line of duty,⁴ it was not possible to statistically test controls or the impact control breakdowns had on soldiers and their families. Instead, we relied on a case study and selected site visit approach for this work—performing audit work at 10 Army installations throughout the country, interviewing and obtaining relevant documentation from officials at the Army Manpower Office⁵ at the Pentagon, all four of the Army's Regional Medical Commands (RMC) in the continental United States, and the Army Human Resource Command (HRC) in Alexandria, Virginia. We also interviewed 38 reserve component soldiers who served in the Global War on Terrorism and had experienced problems with the ADME process at four military installations. Using Army pay and administrative records, we corroborated information provided by soldiers about disruptions in pay and benefits

¹GAO, *Military Pay: Gaps in Pay and Benefits Create Financial Hardships for Injured Army National Guard and Reserve Soldiers*, GAO-05-125 (Washington, D.C.: Feb. 17, 2006).

²For the purpose of this testimony, the term mobilized includes all Army reserve component soldiers called to perform active service.

³ADME will still exist for soldiers who are not mobilized as part of the Global War on Terrorism—such as soldiers injured in Bosnia or Kosovo or during annual training exercises.

⁴The Army maintained data on soldiers who were currently on ADME orders but did not track soldiers who were applying for ADME or who had been dropped from their active duty orders.

⁵Army Manpower is an organization within the Army Deputy Chief of Staff, G-1, formerly the Army Deputy Chief of Staff for Personnel. G-1 is the Army's human resource provider, handling human resource programs, policies, and systems. The Army Human Resources Command is a field operating activity that reports directly to G-1.

but were not always able to validate other assertions made by injured soldiers about their experience. Further details on our scope and methodology and the results of the case studies can be found in our related report.

Today, I will summarize the results of our work with respect to (1) the problems experienced by selected injured or ill Army Reserve and National Guard soldiers, (2) the weaknesses in the overall control environment and management, (3) the lack of clear processes, (4) the lack of integrated pay, personnel, and medical eligibility systems, and (5) our assessment of whether the MRP program has resolved deficiencies associated with ADME and will provide effective and lasting solutions.

Summary

Poorly defined requirements and processes for extending injured and ill reserve component soldiers on active duty have caused soldiers to be inappropriately dropped from their active duty orders. For some, this has led to significant gaps in pay and health insurance, which has created financial hardships for these soldiers and their families. Based on our analysis of Army Manpower data during the period from February 1, 2004, through April 7, 2004, almost 34 percent of the 867 soldiers who applied to be extended on active duty orders—because of injuries or illness—fell off their orders before their extension requests were granted. For many soldiers, this resulted in being removed from active duty status in the automated systems that control pay and access to benefits, including medical care and access to the Commissary and Post Exchange—which allows soldiers and their families to purchase groceries and other goods at a discount. Through our case study work, we have documented the experiences of 10 soldiers who were mobilized to active duty for military operations in Afghanistan and Iraq. Their stories illustrate the tremendous hardships faced by injured and ill reserve component soldiers applying for ADME. Many of the soldiers we interviewed had incurred severe, permanent injuries fighting for their country including loss of limb, hearing loss, and ruptured disks. Nonetheless, we found that the soldier carries a large part of the burden when trying to understand and successfully navigate the Army's poorly defined requirements and processes for obtaining extended active duty orders.

With respect to the Army's control environment and the management controls over the ADME process, we found that the Army has not provided (1) clear and comprehensive guidance needed to develop effective processes to manage and treat injured and ill reserve component soldiers, (2) an effective means of tracking the location and disposition of injured and ill soldiers, and (3) adequate training and education programs for Army officials and injured and ill soldiers trying to navigate their way through the ADME process. For example, many of the soldiers we interviewed said that neither they nor the Army personnel responsible for helping them clearly understood the process. This confusion resulted in delays in processing ADME orders and for some, meant that they fell from their active duty orders and lost pay and medical benefits for their families.

The Army also lacks customer-friendly processes for injured and ill soldiers who are trying to extend their active duty orders so that they can continue to receive medical care. Specifically, the Army lacks clear criteria for approving ADME orders, which may require applicants to

resubmit paperwork multiple times before their application is approved. For example, one Special Forces soldier we interviewed, who lost his leg when a roadside bomb destroyed the vehicle he was riding in while on patrol for Taliban fighters in Afghanistan, missed three pay periods totaling \$5,000 because he fell off his active duty orders. Although this soldier was clearly entitled to a medical extension, according to approving officials at Army Manpower, his application was not immediately approved because it did not contain sufficiently current and detailed information to justify this soldier's qualifications for ADME. In addition, the Army has not consistently provided the infrastructure needed—including convenient support services—to accommodate the needs of soldiers trying to navigate their way through the ADME process. This, combined with the lack of clear guidance discussed previously and the high turnover of the personnel who are responsible for helping injured and ill soldiers through the ADME process, has resulted in injured and ill soldiers carrying a disproportionate share of the burden for ensuring that they do not fall off their active duty orders. This has left many soldiers disgruntled and feeling like they have had to fend for themselves. While most of the installations we reviewed took extraordinary steps to keep soldiers in pay status, these steps often involved overriding required internal controls in one or more systems. In some cases, the stop gap measures ultimately caused additional financial hardships for soldiers or put the Army at risk of significantly overpaying soldiers in the long run.

With respect to the Army's automated systems that control soldiers' pay and benefits, overall, we found the current stove-piped, non-integrated order-writing, personnel, pay, and medical eligibility systems require extensive error-prone manual data entry and reentry. Because the order-writing system does not directly interface with these other systems, once approved, hard copy or electronic copy ADME orders are distributed and used to manually update the appropriate systems. However, the Army's ADME guidance does not address the distribution of ADME orders or clearly define who is responsible for ensuring that the appropriate pay, personnel, and medical eligibility systems are updated. As a result, ADME orders are not sent directly to the individuals responsible for data input but instead, are distributed via e-mail and forwarded throughout the Army and the Department of Defense—eventually reaching individuals with access to the pay, personnel, and medical eligibility systems. Not only is this process vulnerable to input errors, but not sending a copy of the orders directly to the individual responsible for input increases the risk that system updates will not be entered in time to ensure continuation of the pay and benefits to which soldiers are entitled.

The Army's new MRP program, which went into effect May 1, 2004, and takes the place of ADME for soldiers returning from operations in Iraq and Afghanistan, should resolve many of the front-end processing delays experienced by soldiers applying for ADME by simplifying the application process. However, MRP has not resolved the underlying management control problems that plague ADME—including problems associated with the lack of guidance, visibility over soldiers, adequate training and education, and manual processes and non-integrated pay and personnel systems—and in some respects has worsened problems associated with the Army's lack of visibility over injured soldiers. For example, in September and October 2004, the Army did not know with any certainty how many soldiers were on MRP orders, how many had returned to active duty, or how many had been released from active duty early. In addition, although MRP routinely authorizes 179 day extensions and eliminates the need to

reapply for new orders every 30 days, as was sometimes the case with ADME, it also presents new challenges.

If the Army treats and releases soldiers from active duty in less than 179 days, our previous work has shown that weaknesses in the Army's process for releasing soldiers from active duty and stopping the related pay before their orders have expired—in this case before their 179 days is up—often resulted in overpayments to soldiers. Although the Army did not have a complete or accurate accounting of soldiers who were treated and released from MRP early, of the 132 soldiers that the Army identified as released from active duty, we found that 15 were improperly paid past their release date—totaling approximately \$62,000.

Our companion report includes 22 recommendations focused on addressing the weaknesses we identified in the overall control environment; infrastructure, resources and processes; and automated systems used to manage and treat injured reserve component soldiers. To its credit, in response to these recommendations, DOD has outlined some actions already taken, others that are underway, and further planned actions to address the weaknesses we identified.

Injured and Ill Reserve Component Soldiers Experience Gaps in Pay and Benefits, Creating Financial Hardships for Soldiers and Their Families

Poorly defined requirements and processes for extending injured and ill reserve component soldiers on active duty have caused soldiers to be inappropriately dropped from their active duty orders. For some, this has led to significant gaps in pay and health insurance, which has created financial hardships for these soldiers and their families. Based on our analysis of Army Manpower data during the period from February 1, 2004, through April 7, 2004, almost 34 percent of the 867 soldiers who applied to be extended on active duty orders fell off their orders before their extension requests were granted. This placed them at risk of being removed from active duty status in the automated systems that control pay and access to benefits, including medical care and access to the Commissary and Post Exchange—which allows soldiers and their families to purchase groceries and other goods at a discount.

While the Army Manpower Office began tracking the number of soldiers who have applied for ADME and fell off their active duty orders during that process, the Army does not keep track of the number of soldiers who have lost pay or other benefits as a result. Although, logically, a soldier who is not on active duty orders would also not be paid, as discussed later, many of the Army installations we visited had developed ad hoc procedures to keep these soldiers in pay status even though they were not on official, approved orders. However, many of the ad hoc procedures used to keep soldiers in pay status circumvented key internal controls in the Army payroll system—exposing the Army to the risk of significant overpayment, did not provide for medical and other benefits for the soldiers dependents, and sometimes caused additional financial problems for the soldier.

Because the Army did not maintain any centralized data on the number, location, and disposition of mobilized reserve component soldiers who had requested ADME orders but had not yet received them, we were unable to perform statistical sampling techniques that would allow us to estimate the number of soldiers affected. However, through our case study work, we have

The Army Lacks an Effective Control Environment and Management Controls

The Army has not provided (1) clear and comprehensive guidance needed to develop effective processes to manage and treat injured and ill reserve component soldiers, (2) an effective means of tracking the location and disposition of injured and ill soldiers, and (3) adequate training and education programs for Army officials and injured and ill soldiers trying to navigate their way through the ADME process.

Clear and Complete Guidance Lacking

The Army's implementing guidance related to the extension of active duty orders is sometimes unclear or contradictory—creating confusion and contributing to delays in processing ADME orders. For example, the guidance states that the Army Manpower Office is responsible for approving extensions beyond 179 days but does not say what organization is responsible for approving extensions that are less than 179 days. In practice, we found that all applications were submitted to Army Manpower for approval regardless of number of days requested. At times, this created a significant backlog at the Army Manpower Office and resulted in processing delays. In addition, the Army's implementing guidance does not clearly define organizational responsibilities, how soldiers will be identified as needing an extension, how ADME orders are to be distributed, and to whom they are to be distributed. Finally, according to the guidance, the personnel costs associated with soldiers on ADME orders should be tracked as a base operating cost. However, we believe the cost of treating injured and ill soldiers—including their pay and benefits—who fought in operations supporting the Global War on Terrorism should be accounted for as part of the contingency operation for which the soldier was originally mobilized. This would more accurately allocate the total cost of these wartime operations.⁶

The Army Lacks an Effective Means of Tracking the Location and Disposition of Injured and Ill Soldiers

As we have reported in the past, the Army's visibility over mobilized reserve component soldiers is jeopardized by stovepiped systems serving active and reserve component personnel.⁷ Therefore, the Army has had difficulty determining which soldiers are mobilized and/or deployed, where they are physically located, and when their active duty orders expire. In the absence of an integrated personnel system that provides visibility when a soldier is transferred from one location to another, the Army has general personnel regulations that are intended to provide some limited visibility over the movement of soldiers. However, when a soldier is on ADME orders, the Army does not follow these or any other written procedures to document the transfer of soldiers from one location to another—thereby losing even the limited visibility that might otherwise be achievable. Further, although the Army has a medical tracking system, the Medical Operational Data System (MODS), that could be used to track the whereabouts and status of injured and ill reserve component soldiers, we found that, for the most part, the

⁶ We did not audit these costs for the purpose of determining if the Army properly recorded them against available funding sources. Instead, we applied DOD's criteria for contingency operations cost accounting in DOD's Financial Management Regulation, Vol. 12, Chapter 23 (February 2001).

⁷ GAO, *Military Personnel: DOD Actions Needed to Improve the Efficiency of Mobilizations for Reserve Forces*, GAO-03-921 (Washington, D.C.: Aug. 21, 2003)

installations we visited did not use or update that system. Instead, each of the installations we visited had developed its own stovepiped tracking system and databases.

Although MODS, if used and updated appropriately, could provide some visibility over injured and ill active and reserve component soldiers—including soldiers who are on ADME orders, 8 of the 10 installations we visited did not routinely use MODS. MODS is an Army Medical Department (AMEDD) system that consolidates data from over 15 different major Army and Department of Defense databases. The information contained in MODS is accessible at all Army Military Treatment Facilities (MTF) and is intended to help Army medical personnel administer patient care. For example, as soldiers are approved for ADME orders, the Army Manpower Office enters data indicating where the soldier is to receive treatment, to which unit he or she will be attached, and when the soldier's ADME orders will expire. However, as discussed previously, the Army has not established written standard operating procedures on the transfer and tracking of soldiers on ADME orders. Therefore, the installations we visited were not routinely looking to MODS to determine which soldiers were attached to them through ADME orders. When officials at one installation did access MODS, the data in MODS indicated that the installation had at least 105 soldiers on ADME orders. However, installation officials were only aware of 55 soldiers who were on ADME orders. According to installation officials, the missing soldiers never reported for duty and the installation had no idea that they were responsible for these soldiers.

The Army Lacks Adequate Training and Education Programs

The Army has not adequately trained or educated Army staff or reserve component soldiers about ADME. The Army personnel responsible for preparing and processing ADME applications at the 10 installations we visited received no formal training on the ADME process. Instead, these officials were expected to understand their responsibilities through on-the-job training. However, the high turnover caused by the rotational nature of military personnel, and especially reserve component personnel who make up much of the garrison support units that are responsible for processing ADME applications, limits the effectiveness of on-the-job training. Once these soldiers have learned the intricacies of the ADME process, their mobilization is over and their replacements must go through the same on-the-job learning process. For example, 9 of the 10 medical hold units at the locations we visited were staffed with reserve component soldiers.

In the absence of education programs based on sound policy and clear guidance, soldiers have established their own informal methods—using Internet chat rooms and word-of-mouth—to educate one another on the ADME process. Unfortunately, the information they receive from one another is often inaccurate and instead of being helpful, further complicates the process. For example, one soldier was told by his unit commander that he did not need to report to his new medical hold unit after receiving his ADME order. While this may have been welcome news at the time, the soldier could have been considered absent without leave. Instead, the soldier decided to follow his ADME order and reported to his assigned case manager at the installation.

Lack of Clear Processes Contributed to Pay Gaps and Loss of Benefits

The Army lacks customer-friendly processes for injured and ill soldiers who are trying to extend their active duty orders so that they can continue to receive medical care. Specifically, the Army lacks clear criteria for approving ADME orders, which may require applicants to resubmit paperwork multiple times before their application is approved. This, combined with inadequate infrastructure for efficiently addressing the soldiers' needs, has resulted in significant processing delays. Finally, while most of the installations we reviewed took extraordinary steps to keep soldiers in pay status, these steps often involved overriding required internal controls in one or more systems. In some cases, the stop gap measures ultimately caused additional financial hardships for soldiers or put the Army at risk of significantly overpaying soldiers in the long run.

The Army Lacks Criteria for Approving ADME Orders

Although the Army Manpower Office issued procedural guidance in July of 2000 for ADME and the Army Office of the Surgeon General issued a field operating guide in early 2003, neither provides adequate criteria for what constitutes a complete ADME application package. The procedural guidance lists the documents that must be submitted before an ADME application package is approved; however, the criteria for what information is to be included in each document are not specified. In the absence of clear criteria, officials at both Army Manpower and the installations we visited blamed each other for the breakdowns and delays in the process.

For example, according to installation officials, the Army Manpower Office will not accept ADME requests that contain documentation older than 30 days. However, because it often took Army Manpower more than 30 days to process ADME applications, the documentation for some applications expired before approving officials had the opportunity to review it. Consequently, applications were rejected and soldiers had to start the process all over again. Although officials at the Army Manpower Office denied these assertions, the office did not have policies or procedures in place to ensure that installations were notified regarding the status of soldiers' applications or clear criteria on the sufficiency of medical documentation. For example, one soldier we interviewed at Fort Lewis had to resubmit his ADME applications three times over a 3-month period—each time not knowing whether the package was received and contained the appropriate information. According to the soldier, weeks would go by before someone from Fort Lewis was able to reach the Army Manpower Office to determine the status of his application and when they did. He was told each time that he needed more current or more detailed medical information. Consequently, it took over 3 months to process his orders, during which time he fell off his active duty orders and missed 3 pay periods totaling nearly \$4,000.

The Army Has Not Consistently Provided the Infrastructure Needed to Support Injured and Ill Soldiers

The Army has not consistently provided the infrastructure needed—including convenient support services—to accommodate the needs of soldiers trying to navigate their way through the ADME process. This, combined with the lack of clear guidance discussed previously and the high turnover of the personnel who are responsible for helping injured and ill soldiers through the ADME process, has resulted in injured and ill soldiers carrying a disproportionate share of the

burden for ensuring that they do not fall off their active duty orders. This has left many soldiers disgruntled and feeling like they have had to fend for themselves. For example, one injured soldier we interviewed whose original mobilization orders expired in January 2003 recalls making over 40 trips to various sites at Fort Bragg during the month of January to complete his ADME application.

Over time, the Army has begun to make some progress in addressing its infrastructure issues. At the time of our visits, we found that some installations had added new living space or upgraded existing space to house returning soldiers. For example, Walter Reed has contracted for additional quarters off base for ambulatory soldiers to alleviate the overcrowding pressure, and Fort Lewis had upgraded its barracks to include, among other things, wheelchair accessible quarters. Also, installations have been adding additional case managers to handle their workload. Case managers are responsible for both active and reserve component soldiers, including injured and ill active duty soldiers, reserve component soldiers still on mobilization orders, reserve component soldiers on ADME orders, and reserve component soldiers who have inappropriately fallen off active duty orders. As of June 2004, according to the Army, it had 105 case managers, and maintained a soldier-to-case-manager-ratio of about 50-to-1 at 8 of the 10 locations we visited while conducting fieldwork. Finally, to the extent possible, several of the sites we visited co-located administrative functions that soldiers would need—including command and control functions, case management, ADME application packet preparation, and medical treatment. They also made sure that Army administrative staff, familiar with the paperwork requirements, filled out all the required paperwork for the soldier. Centralizing document preparation reduces the risk of miscommunication between the soldier and unit officials, case managers, and medical staff. It also seemed to reduce the frustration that soldiers would feel when trying to prepare unfamiliar documents in an unfamiliar environment.

Ad Hoc Procedures to Keep Soldiers in Pay Status Circumvented Key Internal Controls and Created Additional Problems for Soldiers

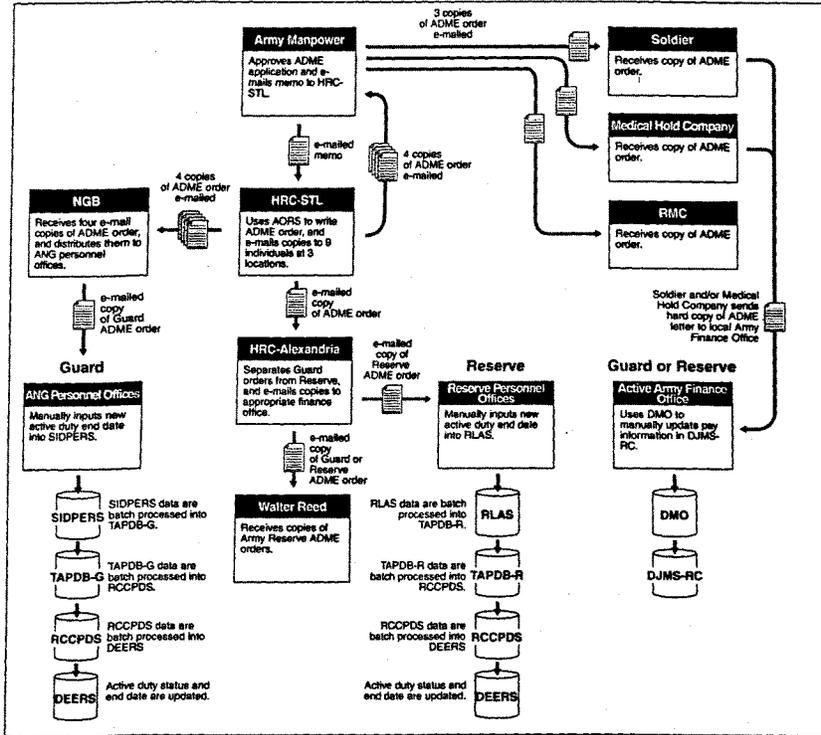
The financial hardships discussed previously that were experienced by some soldiers would have been more widespread had individuals within the Army not taken it upon themselves to develop ad hoc procedures to keep these soldiers in pay status. In fact, 7 of the 10 Army installations we visited had created their own ad-hoc procedures or workarounds to (1) keep soldiers in pay status and (2) provide soldiers with access to medical care when soldiers fell off active duty orders. In many cases, the installations we visited made adjustments to a soldier's pay records without valid orders. While effectively keeping a soldier in pay status, this work-around circumvented key internal controls—putting the Army at risk of making improper and potentially fraudulent payments. In addition, because these soldiers are not on official active duty orders they are not eligible to receive other benefits to which they are entitled, including health coverage for their families. One installation we visited issued official orders locally to keep soldiers in pay status. However, in doing so, they created a series of accounting problems that resulted in additional pay problems for soldiers when the Army attempted to straighten out its accounting. Further details on these ad hoc procedures are included in our related report.

Nonintegrated Systems Contribute to Processing Delays

Manual processes and nonintegrated order writing, pay, personnel, and medical eligibility systems also contribute to processing delays which affect the Army's ability to update these systems and ensure that soldiers on ADME orders are paid in an accurate and timely manner. Overall, we found that the current stove-piped, nonintegrated systems were labor-intensive and require extensive error-prone manual data entry and re-entry. Therefore, once Army Manpower approves a soldier's ADME application and the ADME order is issued, the ADME order does not automatically update the systems that control a soldier's access to pay and medical benefits. In addition, as discussed previously, the Army's ADME guidance does not address the distribution of ADME orders or clearly define who is responsible for ensuring that the appropriate pay, personnel, and medical eligibility systems are updated, so soldiers and their families receive the pay and medical benefits to which they are entitled. As a result, ADME orders were sent to multiple individuals at multiple locations before finally reaching individuals who have the access and authority to update the pay and benefits systems, which further delays processing.

As shown in figure 2, once Army Manpower officials approve a soldier's ADME application, they e-mail a memorandum to HRC-St. Louis authorizing the ADME order. The Army Personnel Center Orders and Resource System (AORS), which is used to write the order, does not directly interface nor automatically update the personnel, pay, or medical eligibility systems. Instead, once HRC-St. Louis cuts the ADME order it e-mails a copy of the order to nine different individuals—four at the Army Manpower Office, four at the National Guard Bureau (NGB) headquarters, and one at HRC in Alexandria Virginia—none of which are responsible for updating the pay, personnel, or medical eligibility systems.

Figure 2: Transaction Flow Between the Army's Order Writing, Pay, Personnel, and Medical Eligibility Systems.



As shown in figure 2, Army Manpower, upon receipt of ADME orders, e-mails copies to the soldier, the medical hold unit to which the soldier is attached, and the RMC. Again, none of these organizations has access to the pay, personnel, or medical eligibility systems. Finally, NGB officials e-mail copies of National Guard ADME orders to one of 54 state-level Army National Guard personnel offices and HRC-Alexandria e-mails copies of Reserve ADME orders to the Army Reserve's regional personnel offices. HRC-Alexandria also sends all Reserve orders to the medical hold unit at Walter Reed Army Hospital. When asked, the representative at HRC-Alexandria who forwards the orders did not know why orders were sent to Walter Reed. The medical hold unit at Walter Reed that received the orders did not know why they were receiving them and told us that they filed them.

At this point in the process, of the seven organizations that receive copies of ADME orders, only two—the ANG personnel office and the Army Reserve personnel office—use the information to initiate a pay or benefit-related transaction. Specifically, the Guard and Reserve personnel offices initiate a transaction that should ultimately update the Army’s medical eligibility system, Defense Enrollment Eligibility Reporting System (DEERS). To do this, the Army National Guard personnel office manually inputs a new active duty order end date into the Army National Guard personnel system, Standard Installation Division Personnel Reporting System (SIDPERS). In turn, the data from SIDPERS are batch processed into the Total Army Personnel Database-Guard (TAPDB-G), and then batch processed to the Reserve Components Common Personnel Data System (RCCPDS). The data from RCCPDS are then batch processed into DEERS—updating the soldier’s active duty status and active duty order end-date. Once the new date is posted to DEERS, soldiers and family members can get a new ID card at any DOD ID Card issuance facility.⁸ The Army Reserve finance office initiates a similar transaction by entering a new active duty order end date into the Regional Level Application System (RLAS), which updates Total Army Personnel Database-Reserve (TAPDB-R), RCCPDS, and DEERS through the same batch process used by the Guard.

As discussed previously, the Army does not have an integrated pay and personnel system. Therefore, information entered into the personnel system (TAPDB) is not automatically updated in the Army’s pay system, Defense Joint Military Pay System-Reserve Component (DJMS-RC). Instead, as shown in figure 2, after receiving a copy of the ADME orders from Army Manpower, the medical hold unit and/or the soldier provide a hard copy of the orders to their local finance office. Using the Active Army pay input system, Defense Military Pay Office system (DMO), installation finance office personnel update DJMS-RC. Not only is this process vulnerable to input errors, but it is time consuming and further delays the pay and benefits to which the soldier is entitled.

The Army’s New Medical Retention Program Will Not Solve All the Problems Associated with ADME

The Army’s new MRP program, which went into effect May 1, 2004, and takes the place of ADME for soldiers returning from operations in support of the Global War on Terrorism, has resolved many of the front-end processing delays experienced by soldiers applying for ADME by simplifying the application process. In addition, unlike ADME, the personnel costs associated with soldiers on MRP orders are appropriately linked to the contingency operation for which they served, and, therefore, will more appropriately capture the costs related to the Global War on Terrorism. While the front-end approval process appears to be operating more efficiently than the ADME approval process, due to the fact that the first wave of 179-day MRP orders did not expire until October 27, 2004, after we completed our work, we were unable to assess how effectively the Army identified soldiers that required an additional 179 days of MRP and whether those soldiers experienced pay problems or difficulty obtaining new MRP orders. In addition, the Army has no way of knowing whether all soldiers that should be on MRP orders are actually applying and getting into the system. Further, MRP has not resolved the underlying management control problems that plagued ADME, and, in some respects, has worsened

⁸ There are over 800 DOD card issuance facilities located in the U.S., many of which are located on Army installations and with Army National Guard and Reserve units.

problems associated with the Army's lack of visibility over injured soldiers. Finally, because the MRP program is designed such that soldiers may be treated and released from active duty before their MRP orders expire, weaknesses in the Army's processes for updating its pay system to reflect an early release date have resulted in overpayments to soldiers.

According to Army officials at each of the 10 installations we visited, unlike ADME, they have not experienced problems or delays in obtaining MRP orders for soldiers in their units. In fact some installation officials have said that the process now takes 1 or 2 days instead of 1 or 2 months. Because there is no mechanism in place to track application processing times, we have no way of substantiating these assertions. We are not aware of any soldier complaints regarding the process, which were commonplace with ADME.

The MRP application and approval process, which rests with HRC – Alexandria, instead of the Army Manpower Office, is a simplified version of the ADME process. As with ADME orders, the soldier must request that this process be initiated and voluntarily request an extension of active duty orders. Both the MRP and ADME request packets include the soldier's request form, a physician's statement, and a copy of the soldier's original mobilization orders. However, with MRP, the physician's statement need only state that the soldier needs to be treated for a service-connected injury or illness and does not require detailed information about the diagnosis, prognosis, and medical treatment plan as it does with ADME. As discussed previously, assembling this documentation was one of the primary reasons ADME orders were not processed in a timely manner. In addition, because all MRP orders are issued for 179 days, MRP has alleviated some of the workload on officials who were processing ADME orders and who were helping soldiers prepare application packets by eliminating the need for a soldier to reapply every 30, 60, or 90 days as was the case with ADME.

While MRP has expedited the application process, MRP guidance, like that of ADME, does not address how soldiers who require MRP will be identified in a timely manner, how soldiers requiring an additional 179 days of MRP will be identified in a timely manner, or how soldiers and Army staff will be trained and educated about the new process. Further, because the Army does not maintain reliable data on the current status and disposition of injured soldiers, we could not test or determine whether all soldiers that should be on MRP orders are actually applying and getting into the system. In addition, because MRP authorizes 179 days of pay and benefits regardless of the severity of the injury, the Army faces a new challenge—to ensure that soldiers are promptly released from active duty or placed in a medical evaluation board process upon completion of medical care or treatment and avoid needlessly retaining and paying these soldiers for the full 179 days. However, MRP guidance does not address how the Army will provide reasonable assurance that upon completion of medical care or treatment soldiers are promptly released from active duty or placed in a medical evaluation board process.

MRP has also contributed to the Army's difficulty maintaining visibility over injured reserve component soldiers. Although the Army's MRP implementation guidance requires that installations provide a weekly report to HRC-Alexandria that includes the name, rank, and component of each soldier currently on MRP orders, according to HRC officials, they are not consistently receiving these reports. Consequently, the Army cannot say with certainty how many soldiers are currently on MRP orders, how many have been returned to active duty, or how

many soldiers have been released from active duty before their 179-day MRP orders expired. As discussed previously, if the Army used and appropriately updated the agency's medical tracking system (MODS), the system could provide some visibility over injured and ill active and reserve component soldiers—including soldiers on ADME or MRP orders. However, the Army MRP implementation guidance is silent on the use of MODS and does not define responsibilities for updating the system. According to officials at HRC-Alexandria, they do not update MODS or any other database when they issue MRP orders. They also acknowledged that the 1,800 soldiers reflected as being on MRP orders in MODS, as of September 2004, was probably understated given that, between May 2004 and September 2004, HRC-Alexandria processed approximately 3,300 MRP orders. Further, as was the case with ADME, 8 of the 10 installations we visited did not routinely use or update MODS but instead maintained their own local tracking systems to monitor soldiers on MRP orders.

Not surprisingly, the Army does not know how many soldiers have been released from active duty before their 179-day MRP orders had expired. This is important because our previous work has shown that weaknesses in the Army's process for releasing soldiers from active duty and stopping the related pay before their orders have expired—in this case before their 179 days is up—often resulted in overpayments to soldiers. According to HRC-Alexandria officials, as of October 2004, a total of 51 soldiers had been released from active duty before their 179-day MRP orders expired. At the same time, Fort Knox, one of the few installations that tracked these data, reported it had released 81 soldiers from active duty who were previously on MRP orders—none of whom were included in the list of 51 soldiers provided by HRC-Alexandria. Concerned that some of these soldiers may have inappropriately continued to receive pay after they were released from active duty, we verified each soldier's pay status in DJMS-RC and found that 15 soldiers were improperly paid past their release date—totaling approximately \$62,000.

Actions To Improve the Accuracy, Timeliness, and Availability of Entitled Pay and Benefits

A complete and lasting solution to the pay problems and overall poor treatment of injured soldiers that we identified will require that the Army address the underlying problems associated with its all-around control environment for managing and treating reserve component soldiers with service-connected injuries or illnesses and deficiencies related to its automated systems. Accordingly, in our related report (GAO-05-125) we made 20 recommendations to the Secretary of the Army for immediate action to address weaknesses we identified including (1) establishing comprehensive policies and procedures, (2) providing adequate infrastructure and resources, and (3) making process improvements to compensate for inadequate, stovepiped systems. We also made 2 recommendations, as part of longer term system improvement initiatives, to integrate the Army's order writing, pay, personnel, and medical eligibility systems. In its written response to our recommendations, DOD briefly described its completed, ongoing, and planned actions for each of our 22 recommendations.

Concluding Comments

The recent mobilization and deployment of Army National Guard and Reserve soldiers in connection with the Global War on Terrorism is the largest activation of reserve component troops since World War II. As such, in recent years, the Army's ability to take care of these soldiers when they are injured or ill has not been tested to the degree that it is being tested now. Unfortunately, the Army was not prepared for this challenge and the brave soldiers fighting to defend our nation have paid the price. The personal toll this had on these soldiers and their families cannot be readily measured. But clearly, the hardships they have endured are unacceptable given the substantial sacrifices they have made and the injuries they have sustained. While the Army's new streamlined medical retention application process has improved the front-end approval process, it also has many of the same limitations as ADME. To its credit, in response to the recommendations included in our companion report, DOD has outlined some actions already taken, others that are underway, and further planned actions to address the weaknesses we identified

Contacts and Acknowledgements

For further information about this testimony please contact Gregory D. Kutz at (202) 512-9095 or kutzd@gao.gov. Individuals making key contributions to this testimony were Gary Bianchi, Francine DelVecchio, Carmen Harris, Diane Handley, Jamie Haynes, Kristen Plungas, John Ryan, Maria Storts, and Truc Vo.

(192156)

Chairman TOM DAVIS. Thank you very much.
General Byrne, thank you for being with us today.

**STATEMENT OF BRIGADIER GENERAL RAYMOND C. BYRNE,
JR.**

General BYRNE. Mr. Chairman, members of the committee, I would like to thank the Committee on Government Reform for the opportunity to speak today.

Over 3,000 Oregon soldiers have served their country as part of the Operation Iraqi Freedom and Operation Enduring Freedom. These citizen soldiers have served bravely with the expectation of returning to home, family, and employer. Currently, over 100 of them have paid a much larger price through injury or illness, and 10 have made the ultimate sacrifice in the service of their Nation.

I am currently serving as the Acting Adjutant General of Oregon and work directly for the Governor of the State of Oregon, the Honorable Ted Kulongoski. This point is important because it highlights where my loyalty and duty reside: to the Governor and the soldiers and airmen of the Oregon National Guard.

Additionally, I have been questioned by some individuals as to my interest in Oregon National Guard soldiers currently in Title 10, active duty status. I have been told they are no concern of mine. The answer I give is that Oregon National Guard is a force provider and has a duty to ensure that the soldiers and airmen on active duty are well taken care of. Their employers, families, friends at "Fort Oregon" all have an interest in their care and well-being. All my soldiers and airmen will come home to Oregon one way or another.

In visiting my soldiers who have returned wounded or injured, I have a few observations which I would like to share with this committee.

First, I applaud the community based health care organizations [CBHCO], which is the single greatest improvement in care for Reserve Component soldiers I have seen in my military career. For the first time we have placed the needs of the soldiers and the Reserve Component on par with the active duty soldiers. This program is critical and should be supported, continued, and, in fact, expanded to allow soldiers to return home, yet receive the care they need and deserve.

Second, we must look at the administrative processes that hold up wounded or injured soldiers at power projection platforms. The soldier whose medical decisionmaking process is complete, a determination has been made, should never have to wait up to 30 days for an order releasing him or her from active duty.

Third, we must provide advocacy for Reserve Component soldiers in helping them through a foreign and often frightening process of determining disability. The Army Medical Department provides first-class care on par with any health care organization in the Nation, but our Reserve Component soldiers are accustomed to a far different system, a much more consumer friendly system with choices, especially when it comes to getting second opinions on procedures that may provide to be life-changing, and the feeling on their part that your health care provider works for you. We need

advocates other than the Inspector General for our Reserve Component soldiers who can break down the perceived and real barriers.

The reality many of our soldiers are faced with after a wound or injury is that they may not be able to return to their civilian occupation, and the financial support that is available through the disability ratings determination may be inadequate to sustain them and their families while they are in the retraining environment.

Their lives and the lives of their families are forever changed. Soldiers that go through the MEB process and are discharged with 0 percent disability receive no disability payment, cannot join a Reserve unit, and in some cases may not be able to return to their previous job.

It is the experience of one VA counselor I talked to in Oregon that it is not uncommon for VA to double the disability rating received by service members going through the MEB/PEB process.

The stress and turmoil a Reserve Component soldier faces not knowing if they will be able to support their family or return to their jobs is a clear impediment to the healing process. We must do a much better job of bridging the gap from AC to RC or to VA when our soldiers are injured or wounded.

Finally, we need to help heal the hidden wounds of post traumatic stress disorder [PTSD], and post deployment readjustment. A recent New England Journal of Medicine study on four battalions of active duty soldiers and Marines provides a valuable insight into future problems and issues. Again, this study was done on active duty personnel, and I would urge a study be conducted on Reserve Component personnel who face far different circumstances as they return to their communities and not active duty posts that contain services and support not found in many remote areas of Oregon.

I have with me today Colonel Doug Eliason, senior medical officer of Oregon and a family practice physician in Salem, OR.

Thank you for your time and your support.

[The prepared statement of Brigadier General Byrne follows:]



OREGON MILITARY DEPARTMENT
JOINT FORCE HEADQUARTERS, OREGON NATIONAL GUARD
OFFICE OF THE ADJUTANT GENERAL
1776 MILITIA WAY
P.O. BOX 14350
SALEM, OREGON 97309-5047

STATEMENT OF
ACTING STATE ADJUTANT GENERAL RAYMOND C. BYRNE, JR. OF OREGON
BEFORE THE
COMMITTEE ON GOVERNMENT REFORM
U. S. HOUSE OF REPRESENTATIVES
FEBRUARY 17, 2005

I would like to thank the Committee on Government Reform for the opportunity to speak today. Over three thousand Oregon soldiers have served their country as part of Operation Iraqi Freedom and Operation Enduring Freedom. These citizen-soldiers have served bravely with the expectation of returning to home, family and employer. Currently, over one hundred of them have paid a larger price through injury or illness and ten have made the ultimate sacrifice in their service to their nation.

I am currently serving as the Acting Adjutant General, Oregon, and work directly for the Governor of the State of Oregon, the Honorable Theodore R. Kulongoski. This point is important because it highlights where my loyalties and duty reside, to the Governor and Soldiers and Airmen of the Oregon National Guard. Additionally, I have been questioned by some individuals as to my interest in Oregon National Guard soldiers currently in Title 10, active duty status. I have been told that they are no concern of yours. The answer I give is that the Oregon National Guard, as a force provider, has a duty to insure that the Soldiers and Airmen on active duty are well taken care of. Their employers, families and friends at "Fort Oregon" all have an interest in their care and well being. All my Soldiers and Airmen will come home to Oregon one way or another.

In visiting my soldiers who have returned wounded or injured, I have a few observations I would like to share with the committee. First, I applaud the Community Based Healthcare Organizations, CBHCO, which is single greatest improvement in care for Reserve Component (RC) soldiers I have seen in my military career. For the first time we have placed the needs of soldiers in the Reserve Component on par with the Active Duty Soldiers. This program is critical and should be supported, continued, and in fact, expanded to allow my soldiers to return home and receive the care they need and deserve.

Second, we must look at the administrative process that holds up wounded or injured soldiers at Power Projection Platforms (PPPs). A soldier whose medical decision making process is complete, a determination has been made, should never have to wait up to thirty days for an order releasing him or her from active duty.

Third, we must provide advocacy for RC soldiers in helping them through a foreign and often frightening process of determining disability. The Army Medical Department provides first-class care equal to any healthcare organization in the nation, but our RC soldiers are accustomed to a far different system, a much more consumer friendly system with choices, especially, when it comes to getting second opinions on procedures that may prove to be life-changing and the feeling on their part that your healthcare provider works for you. We need advocates, other than the Inspector General, for our RC soldiers who can break down the perceived and real barriers. The reality many of our soldiers are faced with after a wound or injury is that they may not be able to return to their civilian occupation and the financial support that is available through the disability ratings determination may be inadequate to sustain them and their families while they are in the retraining environment. Their lives and the lives of their families are forever changed. Soldiers that go through the MEB/Process and are discharged with 0% disability receive no disability payment, cannot join a reserve unit, and in some cases may not be able to return to their previous job. It is the experience of one VA counselor I talked to in Oregon that it is not uncommon for VA to double the disability rating received by service members going through the MEB/PEB process. The stress and turmoil an RC soldier faces, not

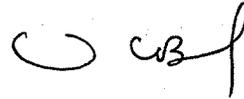
Committee on Government Reform
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knowing if they will be able to support their family, or return to their job is a clear impediment to the healing process. We must do a much better job of bridging the gap from AC to RC or to VA when our soldiers are injured or wounded.

Finally we need to help heal the "hidden wounds" of Post-Traumatic Stress Disorder, and post deployment re-adjustment. A recent New England Journal of Medicine Study on four battalions of Active Duty Soldiers and Marines provides valuable insight into future problems and issues. Again, this study was done on Active Duty personnel and I urge a study to be conducted on Reserve Component personnel who face far different circumstances as they return to their communities and not active duty posts that contain services and support not found in many remote areas of Oregon.

Thank you for your time and your support.

Sincerely,

A handwritten signature in black ink, appearing to read 'C Byrne, Jr.', written in a cursive style.

Raymond C. Byrne, Jr.
Brigadier General
Acting Adjutant General

Encl (3)

INFORMATION PAPER

PURPOSE: To detail the current number of Oregon National Guard in a medical hold status.

1. The attached spreadsheet is a breakdown of Oregon National Guard soldiers currently in a medical hold status.
2. The spreadsheet is broken down by the soldiers rank, unit, current location, date they started in a medical hold status, and the number of days currently in the system.
3. It is summarized by showing the total number of soldiers at specific locations and grouped by the number soldiers in a medical hold status by length of stay.
4. Soldiers names and social security numbers have been withheld for privacy.
5. Point of contact for this information is COL Charles Yriarte, Deputy Chief of Staff, Personnel, (503) 584-3677.

Encl

**Oregon National Guard
Medical Hold Status
as of 17 February 2005**

Name Withheld	SGT	A 2/162nd	IN ROUTE TO LANDSTUHL	11-Feb-05	6
Name Withheld	SGT	C 2/162nd	654th ASG-----FORT LEWIS	9-Feb-05	8
Name Withheld	SPC	C 2/162nd	654th ASG-----FORT LEWIS	8-Feb-05	9
Name Withheld	PFC	2/162nd IN	IN ROUTE TO FT LEWIS	7-Feb-05	10
Name Withheld	SPC	2/162nd IN	650th ASU-----FORT HOOD	4-Feb-05	13
Name Withheld	SPC	2/162nd IN	MAMC-----FORT LEWIS	3-Feb-05	14
Name Withheld	PFC	3/116	BAMC-----FORT SAM HOUSTON	31-Jan-05	17
Name Withheld	SSG	2/162nd IN	654th ASG-----FORT LEWIS	31-Jan-05	17
Name Withheld	SFC	G 82CAV	FORT BLISS	20-Jan-05	29
Name Withheld	SSG	B 3/116	FORT BLISS	10-Jan-05	38
Name Withheld	PFC	HHC 3/116	FORT BLISS	21-Dec-04	58
Name Withheld	SPC	G 82CAV	FORT BLISS	10-Dec-04	67
Name Withheld	2LT	G 82CAV	FORT BLISS	3-Dec-04	75
Name Withheld	SPC	HHC 3/116	MEDHOLD-----BAMC	1-Dec-04	77
Name Withheld	SGT	G 82CAV	CA-CBHCO	29-Nov-04	79
Name Withheld	SGT	B 3/116	CA-CBHCO	17-Nov-04	91
Name Withheld	SGT	TROOP F	CA-CBHCO	10-Nov-04	98
Name Withheld	SPC	TROOP F	CA-CBHCO	8-Nov-04	100
Name Withheld	SPC	A CO 2/162	CA-CBHCO	14-Oct-04	124
Name Withheld	PV2	2/162nd IN	654th ASG-----FORT LEWIS	12-Oct-04	126
Name Withheld	SSG	B 3/116	CA-CBHCO	12-Oct-04	126
Name Withheld	SGT	JFHQ	CA-CBHCO	13-Oct-04	126
Name Withheld	SPC	G/ 82CAV	FORT BLISS	1-Oct-04	138
Name Withheld	SPC	C CO 2/162	CA-CBHCO	1-Oct-04	138
Name Withheld	SGT	D-1 82CAV	CA-CBHCO	1-Oct-04	138
Name Withheld	PV2	2/162nd IN	CA-CBHCO	1-Oct-04	138
Name Withheld	SPC	2/162nd IN	654th ASG-----FORT LEWIS	21-Sep-04	146
Name Withheld	SGT	1/162	CA-CBHCO	17-Sep-04	150
Name Withheld	CW2	HHC 2/162	CA-CBHCO	15-Sep-04	152
Name Withheld	SPC	G 82CAV	CA-CBHCO	24-Sep-04	154
Name Withheld	SPC	B CO 3/116	CA-CBHCO	24-Sep-04	154
Name Withheld	SSG	HHC 2/162	CA-CBHCO	8-Sep-04	159
Name Withheld	PFC	2/162nd IN	654th ASG-----FORT LEWIS	25-Aug-04	173
Name Withheld	SGT	82CAV	CA-CBHCO	30-Aug-04	178
Name Withheld	SPC	2/162nd IN	CA-CBHCO	30-Aug-04	178
Name Withheld	SGT	C CO 2/162	CA-CBHCO	25-Aug-04	183
Name Withheld	SPC	B 2/162	CA-CBHCO	25-Aug-04	183
Name Withheld	SSG	B CO 2/162	CA-CBHCO	24-Aug-04	184
Name Withheld	CPT	HHC 2/162(rear)	CA-CBHCO	23-Aug-04	185
Name Withheld	SGT	1249TH	CA-CBHCO	22-Sep-04	186
Name Withheld	SPC	D 1-186	CA-CBHCO	11-Aug-04	187
Name Withheld	2LT	B 2/162	CA-CBHCO	20-Sep-04	188
Name Withheld	SPC	2/162nd IN	CA-CBHCO	20-Aug-04	188
Name Withheld	SSG	C CO 2/162	CA-CBHCO	19-Aug-04	189
Name Withheld	SGT	A CO 1/186	CA-CBHCO	13-Aug-04	195
Name Withheld	SGT	HHC 2/162	CA-CBHCO	2-Aug-04	196
Name Withheld	SGT	B CO 2/162	CA-CBHCO	2-Aug-04	196
Name Withheld	SPC	HHC 3/116	CA-CBHCO	27-Jul-04	200
Name Withheld	CPT	1249 EN	654th ASG-----FORT LEWIS	18-May-04	201
Name Withheld	PV2	2/162nd IN	654th ASG-----FORT LEWIS	14-May-04	205
Name Withheld	SPC	B CO 3 / 116	CA-CBHCO	19-Jul-04	208
Name Withheld	SPC	HHC 2/162	CA-CBHCO	17-Jun-04	226

**Oregon National Guard
Medical Hold Status
as of 17 February 2005**

Name Withheld	SSG	B CO 2/162	CA-CBHCO	23-Jun-04	238	
Name Withheld	SGT	B 52	CA-CBHCO	22-Jun-04	239	
Name Withheld	SPC	HHC 2/162	CA-CBHCO	1-Jun-04	242	
Name Withheld	SPC	HHC 2/162	CA-CBHCO	10-Jun-04	251	
Name Withheld	SPC	2/146 FA BN	CA-CBHCO	8-Jun-04	253	
Name Withheld	SGT	A Co 1249TH	CA-CBHCO	30-Apr-04	263	
Name Withheld	SPC	1/162nd IN	654th ASG-----FORT LEWIS	19-Apr-04	274	
Name Withheld	SPC	1249TH	CA-CBHCO	19-Apr-04	274	
Name Withheld	SSG	1/162nd IN	654th ASG-----FORT LEWIS	15-Apr-04	278	
Name Withheld	SSG	2/218TH	WALTER REED-----WASH. D.C.	4-Apr-04	289	
Name Withheld	CW4	641st	44th MED-----FORT BRAGG	1-Apr-04	292	
Name Withheld	SGT	C CO 1/162	CA-CBHCO	21-Feb-04	361	
Name Withheld	SFC	B52	CA-CBHCO	20-Feb-04	363	
Name Withheld	SPC	HHC 2/162	CA-CBHCO	9-Feb-04	373	
Name Withheld	SPC	B CO 2/162	CA-CBHCO	4-Feb-04	378	
Name Withheld	PFC	G 82CAV	FORT BLISS	28-Jan-04	384	
Name Withheld	SPC	2/L/151 AVN	654th ASG-----FORT LEWIS	3-Jan-04	409	
Name Withheld	SPC	B CO 2/162	CA-CBHCO	6-Oct-03	496	
Name Withheld	SPC	2/162nd IN	REMOTE CARE----PORTLAND			
Name Withheld	SPC	2/162nd IN	654th ASG-----FORT LEWIS			
Name Withheld	SPC	2/162nd IN	SOLDIER AT HOME			
Name Withheld	SPC	2/162nd IN	654th ASG-----FORT LEWIS			
Name Withheld	SPC	HHC 3/116	FORT BLISS			
Name Withheld	SPC	TROOP F	FORT BLISS			
Name Withheld	SGT	G/ 82CAV	FORT BLISS			
Summary						
FT BRAGG	1		1-198	17		
FT BLISS	13		100-199	30		
FT HOOD	2		200-299	16		
FT LEWIS	17		300-399	5		
CBHCO	43		400-499	2		
WALT REED	2		No accurate start date	7		
OTHER	2		Soldiers in Special Facilities	7		
LANDSTUHL	3					
FT SAM	1					

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Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care

Charles W. Hoge, M.D., Carl A. Castro, Ph.D., Stephen C. Messer, Ph.D., Dennis McGurk, Ph.D.,
Dave I. Cotting, Ph.D., and Robert L. Koffman, M.D., M.P.H.

ABSTRACT

BACKGROUND

The current combat operations in Iraq and Afghanistan have involved U.S. military personnel in major ground combat and hazardous security duty. Studies are needed to systematically assess the mental health of members of the armed services who have participated in these operations and to inform policy with regard to the optimal delivery of mental health care to returning veterans.

METHODS

We studied members of four U.S. combat infantry units (three Army units and one Marine Corps unit) using an anonymous survey that was administered to the subjects either before their deployment to Iraq (n=2530) or three to four months after their return from combat duty in Iraq or Afghanistan (n=3671). The outcomes included major depression, generalized anxiety, and post-traumatic stress disorder (PTSD), which were evaluated on the basis of standardized, self-administered screening instruments.

RESULTS

Exposure to combat was significantly greater among those who were deployed to Iraq than among those deployed to Afghanistan. The percentage of study subjects whose responses met the screening criteria for major depression, generalized anxiety, or PTSD was significantly higher after duty in Iraq (15.6 to 17.1 percent) than after duty in Afghanistan (11.2 percent) or before deployment to Iraq (9.3 percent); the largest difference was in the rate of PTSD. Of those whose responses were positive for a mental disorder, only 23 to 40 percent sought mental health care. Those whose responses were positive for a mental disorder were twice as likely as those whose responses were negative to report concern about possible stigmatization and other barriers to seeking mental health care.

CONCLUSIONS

This study provides an initial look at the mental health of members of the Army and the Marine Corps who were involved in combat operations in Iraq and Afghanistan. Our findings indicate that among the study groups there was a significant risk of mental health problems and that the subjects reported important barriers to receiving mental health services, particularly the perception of stigma among those most in need of such care.

From the Department of Psychiatry and Behavioral Sciences, Walter Reed Army Institute of Research, U.S. Army Medical Research and Materiel Command, Silver Spring, Md. (C.W.H., C.A.C., S.C.M., D.M., D.I.C.); and First Naval Construction Division, Norfolk, Va. (R.L.K.). Address reprint requests to Dr. Hoge at the Department of Psychiatry and Behavioral Sciences, Walter Reed Army Institute of Research, 503 Robert Grant Ave., Silver Spring, MD 20910, or at charles.hoge@na.amedd.army.mil.

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THE RECENT MILITARY OPERATIONS IN Iraq and Afghanistan, which have involved the first sustained ground combat undertaken by the United States since the war in Vietnam, raise important questions about the effect of the experience on the mental health of members of the military services who have been deployed there. Research conducted after other military conflicts has shown that deployment stressors and exposure to combat result in considerable risks of mental health problems, including post-traumatic stress disorder (PTSD), major depression, substance abuse, impairment in social functioning and in the ability to work, and the increased use of health care services.¹⁻⁸ One study that was conducted just before the military operations in Iraq and Afghanistan began found that at least 6 percent of all U.S. military service members on active duty receive treatment for a mental disorder each year.⁹ Given the ongoing military operations in Iraq and Afghanistan, mental disorders are likely to remain an important health care concern among those serving there.

Many gaps exist in the understanding of the full psychosocial effect of combat. The all-volunteer force deployed to Iraq and Afghanistan and the type of warfare conducted in these regions are very different from those involved in past wars, differences that highlight the need for studies of members of the armed services who are involved in the current operations. Most studies that have examined the effects of combat on mental health were conducted among veterans years after their military service had ended.¹⁻⁸ A problem in the methods of such studies is the long recall period after exposure to combat.¹⁰ Very few studies have examined a broad range of mental health outcomes near to the time of subjects' deployment.

Little of the existing research is useful in guiding policy with regard to how best to promote access to and the delivery of mental health care to members of the armed services. Although screening for mental health problems is now routine both before and after deployment¹¹ and is encouraged in primary care settings,¹² we are not aware of any studies that have assessed the use of mental health care, the perceived need for such care, and the perceived barriers to treatment among members of the military services before or after combat deployment.

We studied the prevalence of mental health problems among members of the U.S. armed services who were recruited from comparable combat units before or after their deployment to Iraq or Afghan-

istan. We identified the proportion of service members with mental health concerns who were not receiving care and the barriers they perceived to accessing and receiving such care.

METHODS

STUDY GROUPS

We summarized data from the first, cross-sectional phase of a longitudinal study of the effect of combat on the mental health of the soldiers and Marines deployed in Operation Iraqi Freedom and in Operation Enduring Freedom in Afghanistan. Three comparable U.S. Army units were studied with the use of an anonymous survey administered either before deployment to Iraq or after their return from Iraq or Afghanistan. Although no data from before deployment were available for the Marines in the study, data were collected from a Marine Corps unit after its return from Iraq that provided a basis for comparison with data obtained from Army soldiers after their return from Iraq.

The study groups included 2530 soldiers from an Army infantry brigade of the 82nd Airborne Division, whose responses to the survey were obtained in January 2003, one week before a year-long deployment to Iraq; 1962 soldiers from an Army infantry brigade of the 82nd Airborne Division, whose responses were obtained in March 2003, after the soldiers' return from a six-month deployment to Afghanistan; 894 soldiers from an Army infantry brigade of the 3rd Infantry Division, whose responses were obtained in December 2003, after their return from an eight-month deployment to Iraq; and 815 Marines from two battalions under the command of the 1st Marine Expeditionary Force, whose responses were obtained in October or November 2003, after a six-month deployment to Iraq. The 3rd Infantry Division and the Marine battalions had spearheaded early ground-combat operations in Iraq, in March through May 2003. All the units whose members responded to the survey were also involved in hazardous security duties. The questionnaires administered to soldiers and Marines after deployment to Iraq or Afghanistan were administered three to four months after their return to the United States. This interval allowed time in which the soldiers completed leave, made the transition back to garrison work duties, and had the opportunity to seek medical or mental health treatment, if needed.

RECRUITMENT AND REPRESENTATIVENESS OF THE SAMPLE

Unit leaders assembled the soldiers and Marines near their workplaces at convenient times, and the study investigators then gave a short recruitment briefing and obtained written informed consent on forms that included statements about the purpose of the survey, the voluntary nature of participation, and the methods used to ensure participants' anonymity. Overall, 58 percent of the soldiers and Marines from the selected units were available to attend the recruitment briefings (79 percent of the soldiers before deployment, 58 percent of the soldiers after deployment in Operation Enduring Freedom in Afghanistan, 34 percent of the soldiers after deployment in Operation Iraqi Freedom, and 65 percent of the Marines after deployment in Operation Iraqi Freedom). Most of those who did not attend the briefings were not available because of their rigorous work and training schedules (e.g., night training and post security).

A response was defined as completion of any part of the survey. The response rate among the soldiers and Marines who were briefed was 98 percent for the four samples combined. The rates of missing values for individual items in the survey were generally less than 15 percent; 2 percent of participants did not complete the PTSD measures, 5 percent did not complete the depression and anxiety measures, and 7 to 8 percent did not complete the items related to the use of alcohol. The high response rate was probably owing to the anonymous nature of the survey and to the fact that participants were given time by their units to complete the 45-minute survey. The study was conducted under a protocol approved by the institutional review board of the Walter Reed Army Institute of Research.

To assess whether or not our sample was representative, we compared the demographic characteristics of respondents with those of all active-duty Army and Marine personnel deployed to Operation Iraqi Freedom and Operation Enduring Freedom, using the Defense Medical Surveillance System.¹³

SURVEY AND MENTAL HEALTH OUTCOMES

The study outcomes were focused on current symptoms (i.e., those occurring in the past month) of a major depressive disorder, a generalized anxiety disorder, and PTSD. We used two case definitions for each disorder, a broad screening definition that followed current psychiatric diagnostic criteria¹⁴ but did not include criteria for functional impairment

or for severity, and a strict (conservative) screening definition that required a self-report of substantial functional impairment or a large number of symptoms. Major depression and generalized anxiety were measured with the use of the patient health questionnaire developed by Spitzer et al.¹⁵⁻¹⁷ For the strict definition to be met, there also had to be evidence of impairment in work, at home, or in interpersonal functioning that was categorized as at the "very difficult" level as measured by the patient health questionnaire. The generalized anxiety measure was modified slightly to avoid redundancy; items that pertained to concentration, fatigue, and sleep disturbance were drawn from the depression measure.

The presence or absence of PTSD was evaluated with the use of the 17-item National Center for PTSD Checklist of the Department of Veterans Affairs.^{4,8,18,19} Symptoms were related to any stressful experience (in the wording of the "specific stressor" version of the checklist), so that the outcome would be independent of predictors (i.e., before or after deployment). Results were scored as positive if subjects reported at least one intrusion symptom, three avoidance symptoms, and two hyperarousal symptoms¹⁴ that were categorized as at the moderate level, according to the PTSD checklist. For the strict definition to be met, the total score also had to be at least 50 on a scale of 17 to 85 (with a higher number indicating a greater number of symptoms or greater severity), which is a well-established cutoff.^{4,8,18,19} Misuse of alcohol was measured with the use of a two-question screening instrument.²⁰

In addition to these measures, on the survey participants were asked whether they were currently experiencing stress, emotional problems, problems related to the use of alcohol, or family problems and, if so, whether the level of these problems was mild, moderate, or severe; the participants were then asked whether they were interested in receiving help for these problems. Subjects were also asked about their use of professional mental health services in the past month or the past year and about perceived barriers to mental health treatment, particularly stigmatization as a result of receiving such treatment.²¹ Combat experiences were modified from previous scales.²²

QUALITY-CONTROL PROCEDURES AND ANALYSIS

Responses to the survey were scanned with the use of ScanTools software (Pearson NCS). Quality-

control procedures identified scanning errors in no more than 0.38 percent of the fields (range, 0.01 to 0.38 percent). SPSS software (version 12.0) was used to conduct the analyses, including multiple logistic regression that was used to control for differences in demographic characteristics of members of study groups before and after deployment.^{23,24}

RESULTS

The demographic characteristics of participants from the three Army units were similar. The Marines in the study were somewhat younger than the soldiers in the study and less likely to be married. The demographic characteristics of all the participants in the survey samples were very similar to those of the general, deployed, active-duty infantry population, except that officers were undersampled, which resulted in slightly lower age and rank distributions (Table 1). Data for the reference populations were obtained from the Defense Medical Surveillance System with the use of available rosters of Army and Marine personnel deployed to Iraq or Afghanistan in 2003 (Table 1).

Among the 1709 soldiers and Marines who had returned from Iraq the reported rates of combat experiences and frequency of contact with the enemy were much higher than those reported by soldiers who had returned from Afghanistan (Table 2). Only 31 percent of soldiers deployed to Afghanistan reported having engaged in a firefight, as compared with 71 to 86 percent of soldiers and Marines who had been deployed to Iraq. Among those who had been in a firefight, the median number of firefights during deployment was 2 (interquartile range, 1 to 3) among those in Afghanistan, as compared with 5 (interquartile range, 2 to 13; $P < 0.001$ by analysis of variance) among soldiers deployed to Iraq and 5 (interquartile range, 3 to 10; $P < 0.001$ by analysis of variance) among Marines deployed to Iraq.

Soldiers and Marines who had returned from Iraq were significantly more likely to report that they were currently experiencing a mental health problem, to express interest in receiving help, and to use mental health services than were soldiers returning from Afghanistan or those surveyed before deployment (Table 3). Rates of PTSD were significantly higher after combat duty in Iraq than before deployment, with similar odds ratios for the Army and Marine samples (Table 3). Significant associations were observed for major depression and the misuse of alcohol. Most of these associations re-

mained significant after control for demographic factors with the use of multiple logistic regression (Table 3). When the prevalence rates for any mental disorder were adjusted to match the distribution of officers and enlisted personnel in the reference populations, the result was less than a 10 percent decrease (range, 3.5 to 9.4 percent) in the rates shown in Table 3 according to both the broad and the strict definitions (data not shown).

For all groups responding after deployment, there was a strong reported relation between combat experiences, such as being shot at, handling dead bodies, knowing someone who was killed, or killing enemy combatants, and the prevalence of PTSD. For example, among soldiers and Marines who had been deployed to Iraq, the prevalence of PTSD (according to the strict definition) increased in a linear manner with the number of firefights during deployment: 4.5 percent for no firefights, 9.3 percent for one to two firefights, 12.7 percent for three to five firefights, and 19.3 percent for more than five firefights (chi-square for linear trend, 49.44; $P < 0.001$). Rates for those who had been deployed to Afghanistan were 4.5 percent, 8.2 percent, 8.3 percent, and 18.9 percent, respectively (chi-square for linear trend, 31.35; $P < 0.001$). The percentage of participants who had been deployed to Iraq who reported being wounded or injured was 11.6 percent as compared with only 4.6 percent for those who had been deployed to Afghanistan. The rates of PTSD were significantly associated with having been wounded or injured (odds ratio for those deployed to Iraq, 3.27; 95 percent confidence interval, 2.28 to 4.67; odds ratio for those deployed to Afghanistan, 2.49; 95 percent confidence interval, 1.35 to 4.40).

Of those whose responses met the screening criteria for a mental disorder according to the strict case definition, only 38 to 45 percent indicated an interest in receiving help, and only 23 to 40 percent reported having received professional help in the past year (Table 4). Those whose responses met these screening criteria were generally about two times as likely as those whose responses did not to report concern about being stigmatized and about other barriers to accessing and receiving mental health services (Table 5).

DISCUSSION

We investigated mental health outcomes among soldiers and Marines who had taken part in the ground-combat operations in Iraq and Afghani-

MENTAL HEALTH PROBLEMS AND COMBAT DUTY

Table 1. Demographic Characteristics of Study Groups of Soldiers and Marines as Compared with Reference Groups.*

Characteristic	Army Study Groups			Marine Study Group	Army Reference Group (N=61,742)	Marine Reference Group (N=20,194)
	Before Deployment to Iraq (N=2530)	After Deployment to Afghanistan (N=1962)	After Deployment to Iraq (N=894)	After Deployment to Iraq (N=815)		
	number (percent)					
Age						
18-24 yr	1647 (66)	1226 (63)	528 (59)	652 (80)	32,840 (53)	13,824 (69)
25-29 yr	496 (20)	387 (20)	206 (23)	114 (14)	13,737 (22)	3,174 (16)
30-39 yr	336 (13)	316 (16)	147 (16)	41 (5)	12,960 (21)	2,703 (13)
40 yr or older	34 (1)	28 (1)	13 (2)	4 (1)	2,205 (4)	493 (2)
Sex						
Male	2489 (99)	1934 (99)	879 (98)	815 (100)	61,201 (99)	20,090 (99.5)
Female	26 (1)	23 (1)	14 (2)		541 (1)	104 (0.5)
Race or ethnic group						
White	1749 (70)	1339 (69)	531 (60)	544 (68)	44,365 (72)	15,344 (76)
Black	208 (8)	198 (10)	185 (21)	53 (7)	7,904 (13)	1,213 (6)
Hispanic	331 (13)	254 (13)	102 (12)	143 (18)	6,140 (10)	2,642 (13)
Other	195 (8)	141 (7)	67 (8)	63 (8)	3,262 (5)	867 (4)
Education						
High-school graduate or less	1955 (78)	1514 (78)	726 (82)	728 (89)	48,561 (79)	16,892 (84)
Some college or other	202 (8)	153 (8)	73 (8)	29 (4)	3,260 (5)	346 (2)
College graduate	339 (14)	277 (14)	85 (10)	54 (7)	8,838 (14)	2,945 (15)
Military grade						
Enlisted personnel†						
E1-E4	1585 (63)	1170 (60)	613 (69)	601 (84)	33,823 (55)	13,744 (68)
E5-E6	614 (24)	524 (27)	228 (26)	77 (11)	14,813 (24)	2,850 (14)
E7-E9	116 (5)	91 (5)	23 (3)	8 (1)	3,819 (6)	607 (3)
Officer	200 (8)	168 (8)	30 (3)	26 (4)	9,287 (15)	2,993 (15)
Marital status						
Single	1142 (50)	908 (52)	355 (46)	455 (63)	32,636 (53)	12,332 (61)
Married	936 (41)	685 (39)	338 (43)	204 (28)	27,582 (45)	7,499 (37)
Other	199 (9)	168 (9)	85 (11)	65 (9)	1,485 (2)	363 (2)

* Data exclude missing values, because not all respondents answered every question. Percentages may not sum to 100 because of rounding. Data for the reference groups were obtained from the Defense Medical Surveillance System's deployment rosters of Army and Marine personnel deployed in Operation Iraqi Freedom and in Afghanistan in 2003. The total number of persons on these rosters was 315,999, of whom 229,034 (72 percent) were active-component personnel; the remaining 86,965 were members of the Reserve and National Guard; 97,906 (31 percent) had a designation of a combat-arms occupation. Of the 229,034 active-component service members, 81,936 (36 percent) had combat-arms occupations, including 61,742 soldiers and 20,194 Marines in the reference groups.

† Higher numbers indicate higher grades.

stan. Respondents to our survey who had been deployed to Iraq reported a very high level of combat experiences, with more than 90 percent of them reporting being shot at and a high percentage reporting handling dead bodies, knowing someone who was injured or killed, or killing an enemy combatant (Table 2). Close calls, such as having been saved from being wounded by wearing body armor, were not infrequent. Soldiers who served in Afghanistan reported lower but still substantial rates of such experiences in combat.

The percentage of study subjects whose responses met the screening criteria for major depression,

PTSD, or alcohol misuse was significantly higher among soldiers after deployment than before deployment, particularly with regard to PTSD. The linear relationship between the prevalence of PTSD and the number of firefights in which a soldier had been engaged was remarkably similar among soldiers returning from Iraq and Afghanistan, suggesting that differences in the prevalence according to location were largely a function of the greater frequency and intensity of combat in Iraq. The association between injury and the prevalence of PTSD supports the results of previous studies.²⁵

These findings can be generalized to ground-

Table 2. Combat Experiences Reported by Members of the U.S. Army and Marine Corps after Deployment to Iraq or Afghanistan.*

Experience	Army Groups		Marine Group
	Afghanistan (N=1962)	Iraq (N=894)	Iraq (N=815)
	number/total number (percent)		
Being attacked or ambushed	1139/1961 (58)	789/883 (89)	764/805 (95)
Receiving incoming artillery, rocket, or mortar fire	1648/1960 (84)	753/872 (86)	740/802 (92)
Being shot at or receiving small-arms fire	1302/1962 (66)	826/886 (93)	779/805 (97)
Shooting or directing fire at the enemy	534/1961 (27)	672/879 (77)	692/800 (87)
Being responsible for the death of an enemy combatant	229/1961 (12)	414/871 (48)	511/789 (65)
Being responsible for the death of a noncombatant	17/1961 (1)	116/861 (14)	219/794 (28)
Seeing dead bodies or human remains	771/1958 (39)	832/879 (95)	759/805 (94)
Handling or uncovering human remains	229/1961 (12)	443/881 (50)	455/800 (57)
Seeing dead or seriously injured Americans	591/1961 (30)	572/882 (65)	604/803 (75)
Knowing someone seriously injured or killed	850/1962 (43)	751/878 (86)	693/797 (87)
Participating in demining operations	314/1962 (16)	329/867 (38)	270/787 (34)
Seeing ill or injured women or children whom you were unable to help	907/1961 (46)	604/878 (69)	665/805 (83)
Being wounded or injured	90/1961 (5)	119/870 (14)	75/803 (9)
Had a close call, was shot or hit, but protective gear saved you	—†	67/879 (8)	77/805 (10)
Had a buddy shot or hit who was near you	—†	192/880 (22)	208/797 (26)
Clearing or searching homes or buildings	1108/1961 (57)	705/884 (80)	695/805 (86)
Engaging in hand-to-hand combat	51/1961 (3)	189/876 (22)	75/800 (9)
Saved the life of a soldier or civilian	125/1961 (6)	183/859 (21)	150/789 (19)

* Data exclude missing values, because not all respondents answered every question. Combat experiences are worded as in the survey.

† The question was not included in this survey.

combat units, which are estimated to represent about a quarter of all Army and Marine personnel participating in Operation Iraqi Freedom and Operation Enduring Freedom in Afghanistan (when members of the Reserve and the National Guard are included) and nearly 40 percent of all active-duty personnel (when Reservists and members of the National Guard are not included). The demographic characteristics of the subjects in our samples closely mirrored the demographic characteristics of this population. The somewhat lower proportion of officers had a minimal effect on the prevalence rates, and potential differences in demographic factors among the four study groups were controlled for in our analysis with the use of logistic regression.

One demonstration of the internal validity of our findings was the observation of similar prevalence rates for combat experiences and mental health outcomes among the subjects in the Army and the Marine Corps who had returned from deployment to

Iraq, despite the different demographic characteristics of members of these units and their different levels of availability for recruitment into the study.

The cross-sectional design involving different units that was used in our study is not as strong as a longitudinal design. However, the comparability of the Army samples and the similarity in outcomes among subjects in the Army and Marine units surveyed after deployment to Iraq should generate confidence in the cross-sectional approach. Another limitation of our study is the potential selection bias resulting from the enrollment procedures, which were influenced by the practical realities that resulted from working with operational units. Although work schedules affected the availability of soldiers to take part in the survey, the effect is not likely to have biased our results. However, the selection procedures did not permit the enrollment of persons who had been severely wounded or those who may have been removed from the units for oth-

Table 3. Perceived Mental Health Problems and Percentage of Subjects Who Met the Screening Criteria for Major Depression, Generalized Anxiety, Post-Traumatic Stress Disorder, and Alcohol Misuse.*

Mental Health Problem	Army Study Groups			Marine Study Group			
	Before Deployment to Iraq (N=2330)	After Deployment to Afghanistan (N=1962)	OR (95% CI)	After Deployment to Iraq (N=894)	OR (95% CI)	After Deployment to Iraq (N=815)	OR (95% CI)
Perceived moderate or severe problem	323/2261 (14.3)	303/1769 (17.1)††		153/784 (19.5)††		123/720 (17.1)	
Currently interested in receiving professional help	211/2243 (9.4)	180/1769 (10.2)		131/786 (16.7)††		106/706 (15.0)††	
Received professional help in the past month†	108/2280 (4.7)	118/1780 (6.6)††		91/796 (11.4)††		70/742 (9.4)††	
Definition of mental disorder							
Broad definition							
Depression according to PHQ	275/2418 (11.4)	267/1885 (14.2)	1.29 (1.07-1.54)††	128/840 (15.2)	1.40 (1.12-1.76)††	114/775 (14.7)	1.34 (1.06-1.70)††
Anxiety according to PHQ	375/2419 (15.5)	324/1886 (17.2)	1.13 (0.96-1.33)	147/839 (17.5)	1.16 (0.94-1.43)	122/776 (15.7)	1.02 (0.81-1.27)
PTSD according to PCL	226/2414 (9.4)	224/1956 (11.5)	1.23 (1.03-1.37)†	159/881 (18.0)	2.13 (1.72-2.66)††	161/811 (19.9)	2.40 (1.92-2.99)††
Any of above	322/2500 (20.9)	479/1958 (24.5)	1.23 (1.07-1.41)††	246/882 (27.9)	1.47 (1.23-1.75)††	231/813 (28.2)	1.56 (1.30-1.87)††
Strict definition							
Depression according to PHQ	128/2418 (5.3)	130/1885 (6.9)	1.33 (1.03-1.71)††	66/840 (7.9)	1.53 (1.12-2.08)††	55/775 (7.1)	1.37 (0.99-1.90)
Anxiety according to PHQ	155/2419 (6.4)	140/1886 (7.4)	1.17 (0.92-1.48)	65/839 (7.9)	1.23 (0.92-1.68)	51/776 (6.6)	1.03 (0.74-1.43)
PTSD according to PCL	120/2414 (5.0)	121/1956 (6.2)	1.26 (0.97-1.64)	114/881 (12.9)	2.84 (2.17-3.72)††	99/811 (12.2)	2.66 (2.01-3.51)††
Any of above	233/2500 (9.3)	220/1958 (11.2)	1.23 (1.01-1.50)†	151/882 (17.1)	2.01 (1.61-2.51)††	127/813 (15.6)	1.80 (1.43-2.27)††
Alcohol misuse							
Have you used alcohol more than you meant to?	405/2358 (17.2)	452/1844 (24.5)	1.57 (1.35-1.82)††	198/819 (24.2)	1.54 (1.27-1.86)††	268/736 (35.4)	2.65 (2.20-3.18)††
Have you felt you wanted or needed to cut down on your drinking?	289/2313 (12.5)	331/1821 (18.2)	1.56 (1.31-1.85)††	168/815 (20.6)	1.82 (1.47-2.24)††	219/744 (29.4)	2.92 (2.39-3.57)††

* Each study group who responded after deployment was compared with the group that responded before deployment, with the use of odds ratios (with 95 percent confidence intervals) and chi-square testing. Data exclude missing values, because not all respondents answered every question. OR denotes odds ratio, CI confidence interval, PHQ patient health questionnaire, PTSD post-traumatic stress disorder, and PCL the National Center for Post-Traumatic Stress Disorder Checklist.
 † p<0.01 for the comparison of groups responding after deployment with the group responding before deployment, calculated with the use of the chi-square test.
 ‡ The result remained significant after multiple logistic regression was used to control for age, rank, educational level, marital status, and race or ethnic group.
 § Professional help was defined as help from a mental health professional, a general medical doctor, or a chaplain or other member of the clergy, in either a military or civilian treatment setting.
 ¶ p<0.05 for the comparison of groups responding after deployment with the group responding before deployment, calculated with the use of the chi-square test.

Outcome	Army Study Groups			Marine Study Group
	Before Deployment to Iraq (N=233)	After Deployment to Afghanistan (N=220)	After Deployment to Iraq (N=151)	After Deployment to Iraq (N=127)
Need				
Acknowledged a problem	184/215 (86)	156/192 (81)	104/133 (78)	91/106 (86)
Interested in receiving help	85/212 (40)	75/196 (38)	58/134 (43)	47/105 (45)
Received professional help†				
In past year				
Overall (from any professional)	61/222 (28)	46/198 (23)	56/140 (40)	33/113 (29)
From a mental health professional	33/222 (15)	26/198 (13)	37/138 (27)	24/112 (21)
In past month				
Overall (from any professional)	39/218 (18)	34/196 (17)	44/136 (32)	23/112 (21)
From a mental health professional	24/218 (11)	25/196 (13)	29/136 (21)	16/111 (14)

* Data exclude missing values, because not all respondents answered every question.

† Professional help was defined as help from a mental health professional, a general medical doctor, or a chaplain or other member of the clergy, in either a military or civilian treatment setting.

er reasons, such as misconduct. Thus, our estimates of the prevalence of mental disorders are conservative, reflecting the prevalence among working, non-disabled combat personnel. The period immediately before a long combat deployment may not be the best time at which to measure baseline levels of distress. The magnitude of the differences between the responses before and after deployment is particularly striking, given the likelihood that the group responding before deployment was already experiencing levels of stress that were higher than normal.

The survey instruments used to screen for mental disorders in this study have been validated primarily in the settings of primary care and in clinical populations. The results therefore do not represent definitive diagnoses of persons in nonclinical populations such as our military samples. However, requiring evidence of functional impairment or a high number of symptoms, as we did, according to the strict case definitions, increases the specificity and positive predictive value of the survey measures.^{26,27} This conservative approach suggested that as many as 9 percent of soldiers may be at risk for mental disorders before combat deployment, and as many as 11 to 17 percent may be at risk for such disorders three to four months after their return from combat deployment.

Although there are few published studies of the rates of PTSD among military personnel soon after their return from combat duty, studies of veterans conducted years after their service ended have shown a prevalence of current PTSD of 15 percent

among Vietnam veterans²⁸ and 2 to 10 percent among veterans of the first Gulf War.^{4,8} Rates of PTSD among the general adult population in the United States are 3 to 4 percent,²⁶ which are not dissimilar to the baseline rate of 5 percent observed in the sample of soldiers responding to the survey before deployment. Research has shown that the majority of persons in whom PTSD develops meet the criteria for the diagnosis of this disorder within the first three months after the traumatic event.²⁹ In our study, administering the surveys three to four months after the subjects had returned from deployment and at least six months after the heaviest combat operations was probably optimal for investigating the long-term risk of mental health problems associated with combat. We are continuing to examine this risk in repeated cross-sectional and longitudinal assessments involving the same units.

Our findings indicate that a small percentage of soldiers and Marines whose responses met the screening criteria for a mental disorder reported that they had received help from any mental health professional, a finding that parallels the results of civilian studies.³⁰⁻³² In the military, there are unique factors that contribute to resistance to seeking such help, particularly concern about how a soldier will be perceived by peers and by the leadership. Concern about stigma was disproportionately greatest among those most in need of help from mental health services. Soldiers and Marines whose responses were scored as positive for a mental disorder

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Table 5. Perceived Barriers to Seeking Mental Health Services among All Study Participants (Soldiers and Marines).^a

Perceived Barrier	Respondents Who Met Screening Criteria for a Mental Disorder (N=731)	Respondents Who Did Not Meet Screening Criteria for a Mental Disorder (N=5422)
	no./total no. (%)	
I don't trust mental health professionals.	241/641 (38)	813/4820 (17)
I don't know where to get help.	143/639 (22)	303/4780 (6)
I don't have adequate transportation.	117/638 (18)	279/4770 (6)
It is difficult to schedule an appointment.	288/638 (45)	789/4748 (17)
There would be difficulty getting time off work for treatment.	354/643 (55)	1061/4743 (22)
Mental health care costs too much money.	159/638 (25)	456/4736 (10)
It would be too embarrassing.	260/641 (41)	852/4752 (18)
It would harm my career.	319/640 (50)	1134/4738 (24)
Members of my unit might have less confidence in me.	377/642 (59)	1472/4763 (31)
My unit leadership might treat me differently.	403/637 (63)	1562/4744 (33)
My leaders would blame me for the problem.	328/642 (51)	928/4769 (20)
I would be seen as weak.	413/640 (65)	1486/4732 (31)
Mental health care doesn't work.	158/638 (25)	444/4748 (9)

^a Data exclude missing values, because not all respondents answered every question. Respondents were asked to rate "each of the possible concerns that might affect your decision to receive mental health counseling or services if you ever had a problem." Perceived barriers are worded as on the survey. The five possible responses ranged from "strongly disagree" to "strongly agree," with "agree" and "strongly agree" combined as a positive response.

der were twice as likely as those whose responses were scored as negative to show concern about being stigmatized and about other barriers to mental health care.

This finding has immediate public health implications. Efforts to address the problem of stigma and other barriers to seeking mental health care in the military should take into consideration outreach, education, and changes in the models of health care delivery, such as increases in the allocation of mental health services in primary care clinics and in the provision of confidential counseling by means of employee-assistance programs. Screening for major depression is becoming routine in military primary care settings,¹² but our study suggests that it should be expanded to include screening for PTSD. Many of these considerations are being addressed in new military programs.³³ Reducing the perception of stigma and the barriers to care among military personnel is a priority for research and a priority for the policymakers, clinicians, and leaders who are involved in providing care to those who have served in the armed forces.

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INFORMATION PAPER

PURPOSE: To define issues in the state of Oregon due to not having active military installations.

STATUS: During FY 04, Oregon had approximately 2375 soldiers deployed. Approximately 1120 soldiers have returned from these deployments. Approximately 125 are on alert, set to depart in the next month.

1. With no military installations in Oregon, guard members and their families must rely heavily on the Family Program, National Guard Chaplains, Army One Source and Tri West. Listed below are the primary issues that arise from the lack of military facilities:

* No Army Community Services (ACS) availability – the Oregon National Guard Family Program is run by one full time State Director and a Wing Coordinator at each Wing (Oregon has two). There are seven Family Assistance Centers throughout the state – but the primary source of support is volunteer staffing. There are approximately 80 Army National Guard volunteers. Families are spread throughout the state and into other neighboring states – they don't live on base or post where information and assistance is readily available. Although the Family Program is advertised statewide – phone numbers, web sites, and other information may not be available to all family members in need. ACS have the ability to provide food, clothing and child care facilities – the Family Program does not have space to store food or clothing and does not have the funding or space for child care.

* No Military Medical Treatment Facilities. With the switch to Tri West, many providers have dropped out of the system. With very few remaining providers accepting new patients, families are left with very limited health coverage or high out of pocket expenses.

* No on-going counseling available. Army One Source is a great resource – but only provides six counseling sessions. With so many soldiers returning home, there are potentially hundreds of families at risk who will not get the counseling they need. With all the on-going deployments, many of our chaplains are mobilized, and the few we have left in our state are very busy every day with cases – these are National Guard chaplains – not full time chaplains. These chaplains are volunteering their time and services to families in need.

2. Oregon's needs are great – we have many families who feel isolated and without support due to their geographic location. Due to the deployments, we have soldiers and families at risk – divorce rates, suicide attempts, and abuse are all problems that we have faced. Without a military installation available, many families are going without the support they deserve because they don't know how to access it. When an individual is on active duty, there are always military installations available to care for the family. National Guard spouses and families do not receive the same treatment; even though their National Guard soldier is on active duty for extensive periods of time.

3. Point of contact for this information is Diane Gooding, Director of the Family Program, 503-584-3543.

Chairman TOM DAVIS. Thank you very much.

Sergeant Allen, thank you for being with us. I just want to urge the committee members to listen to his testimony.

This is the equivalent of financial and medical friendly fire from armed services. We met before over at Walter Reed, and I asked you to come forward, and I very much appreciate you and Sergeant Perez being here to share your personal stories, because this puts a personal face on the problems that our troops face when they come back from battle.

Thank you very much.

STATEMENT OF SERGEANT FIRST CLASS JOHN ALLEN

Sergeant ALLEN. Yes, sir.

Mr. Chairman, members of the committee, it is a distinct honor to be here to discuss the important issues affecting National Guard soldiers.

I would like to start by saying that I am definitely out of my element, so I am a little nervous today, so bear with me.

My name is Sergeant First Class John Allen. I am a National Guard soldier from Blairstown, NJ. In my civilian occupation, I am a police officer. In the Army I am a member of Bravo Co. Third Battalion 20th Special Forces Group. I am a U.S. Army Special Forces weapon sergeant responsible for weapons, tactics, and security.

I have been a soldier for 14 years, and while in Afghanistan I was asked to extend my deployment, and I happily did. If medically able to, I would rejoin my brothers in arms, who did some wonderful things to free an oppressed people from a reign of tyranny. It was and is well worth every personal sacrifice I have made.

I tell you my story in hope that after you hear my testimony I will motivate you all to make the necessary changes.

Over a year ago when the GAO investigators first approached me, I was asked what can we do to make things better. My statement then is exactly the same as it is today: to bring to light a broken, dysfunctional system in order to correct it so not one more of my comrades will have to go through what I went through.

I am retiring later this month, and nothing I say or anything you may elect to do as a result of my testimony will personally benefit me.

In the summer of 2002, while deployed in Afghanistan, I sustained multiple injuries from a helicopter accident and a grenade blast. I am currently receiving medical treatment at Walter Reed. After being wounded, I was placed in the Army's active duty medical extension program [ADME]. I have experienced significant problems from ADME program, and by Army regulation it is a 90-day extension. When my orders expire, it creates a multitude of problems for me and my family—no pay, no access to the base, no medical coverage for my family, and the cancellation of all my scheduled medical appointments.

Our wounded soldiers have our share of champions, to include the President, the Secretary of Defense, the Deputy Secretary, and, of course, this committee. I want to personally thank all of you. In regards to what I call the day-to-day survival people who I have been blessed with meeting, such as Gary Bianchi of the GAO,

Grace Washbourne of Chairman Davis' staff, I can never thank you enough for what you have done for me and my family. Most important of all, I want to thank all the doctors and health care professionals at Walter Reed Medical Center for their excellent health care.

We have come a long way since I was wounded, and some significant changes have been made. By working together with my champions, we have already made some significant accomplishments. We brought Walter Reed up to the handicapped access standards, the Reserve Component pay and finance system is being reworked, we have done away with the active duty medical extension program for injured warriors, and we have opened the severely disabled veterans clinic. However, significant problems continue to exist that will require all of our assistance in completing the task.

The problems as I see them are a combination of the system and some of the personnel. Commanders at all levels must be the engines for change, and the subordinates must follow that commander's intent. Unfortunately, there is no overall good guy wearing a white hat and no overall one bad guy wearing a black hat. I wish it were that easy.

I have certainly encountered some lazy, non-caring, even prejudicial individuals along the way, but had an adequate system been in place to take care of Reserve Component disabled veterans, it would have made my situation almost impossible to occur. As long as I have been around the Army, I could not have taken care of my family had I not met some of the prominent people that I have. I shudder to think what would have happened to me and my family without all of you that have helped me.

So what happens to the lower enlisted soldier that knows no one of importance, the young soldiers who don't have any rank? Who are their champions? How does that leave a Reserve Component soldier that gets wounded today? Exactly where I was 2 years ago—left to figure it out on his own.

In my written testimony I have included a detailed timeline of the events related to my ADME issues that clearly demonstrate a broken system. When the people in my life hear my story, they look at me like I am crazy. Even Gary Bianchi of the GAO, when I first met him, looked at me like it was an unbelievable story until I provided him the supporting documentation and proof.

As I was writing my testimony on what happened to me over the last 3 years, I have to agree with them that I must be crazy to put myself and my family through this. A lot of guys can't deal with this, and somewhere along the process they just quit and they go home. I would like to be able to say the problems are fixed; however, this is not the case.

Currently, I still have problems with my orders, and up to last month having pay problems. The system is still broken, and the only way I have been able to get anything done is by knowing the people that I know. What happens if you don't know those people?

My first order I would like to address is the commander's intent and the willingness of the mid-level command personnel to make logistical effective changes.

The President of the United States declared war on the terrorists, and the fact is we are at war. I have met many leaders, to

include the current administration, senior representatives of the Department of Defense, senior leaders of the Army, and some of this great Nation's Congressmen. I personally feel that they all do genuinely care about me and my family. I have seen them get involved in matters and get them fixed. I believe that the breakdown is clearly in the mid-level command.

The hospital administrators are also doctors. What surprises me is their own motto: cause no further harm. How can you allow Reserve Component soldiers to go months without pay, nowhere to live, their medical appointments canceled, and not even being paid? The result is a massive stress and mental pain causing further harm, violating their own creed.

In the Special Forces we have our own motto: free the oppressed. In this case, the oppressed are the Reserve Component disabled veterans that I am here to free today.

I have personally talked to and seen many Marines being treated at Bethesda Naval Station. I was amazed how their stories and care treatment are the complete opposite of my own. Examples of this are contained in my written report and are in detail for your support.

We are at war and Walter Reed is the receiving center for our wounded warriors. I would like to invite each one of you to come to Walter Reed for an unannounced visit and see for yourself. It would be very easy to correct the situation if the command element climate supported it. The command staff at Walter Reed needs to show their care. After what our soldiers have done and sacrificed for our Nation, don't they deserve better?

When a Marine is wounded and can no longer support the team, they are idolized and treated as the heroes they are. When someone asked me about joining the service, I always used to recommend the Army. Now, after what I have lived, if one of my own sons came to me I think I would tell him to join the Marines. After thinking about that, I thought of what my father used to tell me—you were either part of the problem or you are part of the solution. I was wrong to think that. I am part of and I have felt proud to be part of the Army, and I should not let a broken system taint my overall experience. Rather than being part of the problem, I am here today to be part of the solution. We need to fix our Army, my Army.

Case worker confusion—the saying “too many cooks in the kitchen spoils the soup” holds entirely true here. There are too many people involved. Each one thinks that what they do is the most important. The most important thing is what my doctor tells me, not spending my time chasing my tail for their accountability and their paperwork. I only need the U.S. Army Special Operation Command liaisons. These individuals are more than willing and capable of handling all of my needs. Each branch should have their own people helping their own people. If someone is needed, it should go to my liaison and he can schedule it. If there is an argument between my ombudsman and whoever it is, I as the patient can go on about getting better and not being stressed and harassed.

Reserve Component versus active duty—I do not know of any Reserve Component units that have liaisons. Until the U.S. Army Special Operations Command commander sent their liaisons on a

permanent basis to Walter Reed, life was very difficult for me. But what about the Reserve Component soldier that is in transportation company? Who represents him and who is his ombudsman?

I thank God I joined the Special Forces, because the Special Forces are taking care of me. But that shouldn't make me special in terms of care and representation. In combat, I was considered a member of the active duty. Once I was wounded, I was considered a Reserve Component soldier. As a Reserve Component soldier, my family is not authorized on my orders to relocate with me. I am not entitled to use my leave as terminal leave. I am not entitled to have open-ended orders.

My wife and three sons are still living in New Jersey. My oldest son, who was 10 years old when I was mobilized, is going to be 14 in July. I have missed a large part of his life and I can never get it back. When I asked to go home, I was told active service members have to go to a medical treatment facility. I am not an active service member. I am a Reserve Component soldier and my family is at home, a fact that is causing me significant hardship. However, when I tried to get any of the active duty entitlements I am told I am a Reserve Component soldier. I have no problem with either scenario, but make a command decision on which one I am and allow me the benefits of that system.

If I need to come back, do so at the Government's expense, instead of causing me, the soldier, more harm by separating me from my family and having the soldier assume the financial burden of paying to go see his family.

The medical hold company I am sure has some kind of function. To those members of the company that are here today who have given your all, I thank you and I apologize to you for putting you in this category with the rest. If they are supposed to keep our accountability, my liaison does that. If it is handling and processing my orders and ensuring that I am paid, then they are not doing their job. It is to this end that I boldly state there is no reason for the existence of the medical hold company. They are simply another cook in the kitchen just spoiling the soup.

They also need to understand they are not dealing with basic training recruits, but rather our wounded warriors. Requiring amputees to attend formations, demanding you to come any time they need something, and the general lack of caring they have clearly demonstrated by allowing Reserve Component soldiers to go off orders is wrong. The overall attitude toward our Nation's finest is disgusting, and at best they should be ashamed of themselves. This goes on with the full knowledge of the mid-level command philosophy.

Point five, confusion about the system: everything in the Army has some kind of standard. I have not ever seen a standard for medical treatment for Reserve Component soldiers. The overall board process is confusing. Add in the Reserve Component factor and it is even more confusing and complicated. Records for Reserve Component soldiers are kept at their units and their command are not readily available.

Once mobilized, I was assigned to Third Group Special Forces. The day I was ordered to ADME my problems started. From the first day to the present, there is not one set of standards that I

have been provided, and I have not ever submitted the same supporting documentation. Had I been provided a manual for injured National Guard or Reserve soldiers, I could have avoided the majority of the problems that I had.

The Medical Board for Reserve Component versus active duty—the Medical Board for all soldiers should be the same, but it is not. Bullets don't discriminate between Reserve Component and active duty soldiers, and neither should the Army. Once I was identified as an injured soldier, I should have stayed on OEF/OIF orders. The pot of money to run the war should include the price tag for taking care of the wounded for that war.

I was left on open-ended OEF/OIF orders. There would be only two amendments to my orders, instead of the eight or nine I think I have had. My orders would not run out in 90 days or, under the new system, every 179 days. If my doctor knows that my treatment is going to take 14 months, then my orders should be for 14 months, plus processing time. Why is the decision left up to some personnel person to determine how long if my treatment is going to be shorter than the order? If the treatment is longer, there is no problem because it is an open-ended order.

The burden should not be on me every 90 days to get all my paperwork done and turned in, keeping following up on the status of those orders, getting new ID card, a new window sticker for my vehicle, my family have to travel all the way down to get new ID cards at their expense and re-register for Tri-Care. I should be focusing on my medical treatment, the reason that my orders were extended in the first place.

The Board is supposed to be the same for active duty and Reserve Component soldiers, but there is one huge difference that I have contained in my written testimony.

Wounded soldiers are not quitting the team, they are getting out because their disabilities force them to. There is a big, big difference. They should still be considered part of the team.

While talking to a U.S. Army Special Operations commander recently, he told me of an idea of his of tracking soldiers once they are out. This is a great idea, and I think the Army should be helping the disabled veterans after they are out with their employment, getting into the Veterans Affairs system, and their reentry into civilian life.

My conclusion—I believe in utilizing my chain of command. In my case, my chain of command went through military channels and made no progress. I did not start this investigation; my chain of command did on my behalf. I have been cooperative in hopes of fixing a broken, dysfunctional system, and I have been persecuted for my actions.

Mr. Chairman, I am retiring this month and I am not afraid to speak my mind, but for some of the guys still receiving medical treatment and guys that are going to be at Walter Reed testifying today, to quote my father one last time, "Tell the truth and let the chips fall where they may. That way you can always look at the man in the mirror in the eye." I know my father would be proud of me today standing here letting the chips fall by fighting for my

disabled veterans. I am grateful for the opportunity to tell my story. I thank you for all your support and effort. God bless you and the greatest Nation on this planet, the United States of America.

[The prepared statement of Sergeant Allen follows:]

**Prepared Remarks for
Sergeant First Class John Allen
Government Reform Committee
U.S. House of Representatives**

17 February 2005

Mr. Chairman and Members of the Committee, it is a distinct honor to be here to discuss important issues affecting National Guard Soldiers.

My name is Sergeant First Class John Allen. I am from Blairstown, New Jersey where in my civilian occupation I am a police officer. In the Army, I am a member of Bravo Company, 3rd Battalion, 20th Special Forces Group (Airborne) and assigned to Operational Detachment Alpha (ODA) 2081. During our mobilization, this was a Virginia based unit but it is now headquartered in North Carolina. I am a United States Army Special Forces Weapons Sergeant, with primary responsibility for the team's weapons training and employment, tactics and security. I have been a soldier for 14 years. I was asked to volunteer to extend my deployment in Afghanistan and I did. If medically allowed to do so, I would rejoin my brothers and sisters in Afghanistan, Iraq, Malaysia, and elsewhere. It was, and continues to be, well worth every personal sacrifice. My injuries pale by comparison to those who have lost loved ones, or a limb, or have been taken hostage by people who have no value for human life or civilized society.

The decision to testify today was one of the most difficult decisions of my life. It is my fear that my testimony will be twisted, and the perception will be that this is about me rather than the reality of what I am trying to fix. I also considered the huge personal quandary over not wanting to rock the boat, i.e. face possible further retribution, and the duty I feel that I need to help all my fellow comrades currently receiving treatment and for the future wounded Reserve Component wounded soldiers. In the end, I believe the Committee and the Army needs to hear my story.

I come before you today to share my experience in the hope that it might shape the experience of others in the future. While my testimony represents what happened to me and my family, I believe relating this experience ultimately supports my fellow Disabled National Guard and Reserve members, my Army, my Commander-in-Chief and my beloved Special Forces.

Over a year ago, when I was first approached by Government Accounting Office (GAO) investigators, I was interviewed and basically asked “what can we do for you to make things better.” My statement then is exactly the same as today. I am willing to share my story in the hope it will bring to light a broken, dysfunctional system and that my recommended courses of action may help correct these problems so that not one more of my brothers in-arms or their families will experience what my family and I have been through. I am retiring later this month and nothing I say, or anything that you may elect to do as a result of my testimony, will personally benefit me except to ease the mental burden of making it easier for the “Wounded Warriors” who follow.

In the summer of 2002, while deployed to Afghanistan, I sustained multiple injuries from a helicopter accident and a grenade blast that included both of my legs, neck, back, hearing, and vision, and I suffered a Traumatic Brain Injury (this is the clinical name for an illness). I am currently receiving Medical treatment at Walter Reed Army Medical Center for these injuries.

After being wounded, I was placed in the Army’s Active Duty Medical Extension (ADME) program where I have experienced a number of significant problems and then my ‘real’ troubles started. ADME is a program that, by Army regulation, can only allot 90-day extensions. This process was apparently never intended to serve the Reserve Component Forces during a time of war. In accordance with the ADME regulation, I was essentially forced to ‘go off orders’ every three months. I was forced to apply for new orders and was forced to rely on uncaring incompetent people, a process that contributed to a multitude of problems including: no pay; no access to base; no medical coverage for my family; and the cancellation of all my scheduled medical appointments. This, in turn, significantly prolonged my medical treatment, delayed my return to civilian employment, and placed my family under intense and indescribable stress. In short, this by far caused the most burden on my family, my financial situation and my life in general.

Before I get into the problems and my associated recommendations, I want to state up front that our wounded soldiers have our share of champions, to include the President, the Secretary of Defense, the Deputy Secretary, and of course, this Committee. I want to personally thank all of you who have been supportive and personally caring towards my family, and most importantly, towards my fellow comrades that I represent here today. In regards to what I call the “day-to-day survival” people who I have been blessed with meeting, people such as Gary Bianchi of the GAO and Grace Washbourne of Chairman Davis’ staff, I can never thank them enough. The work by the Committee

Members and staff, along with those in the military seeking to improve matters, is an example of how this process should work and can work. Not least, I also want to thank the doctors, nurses, and other health care professionals at WRMAC that continue to do the right thing by delivering quality health care to our wounded soldiers.

It is also important to acknowledge that we have come a long way since I was wounded, and some significant changes have been made to a much unprepared system. By working together with my 'champions', we have already accomplished some significant and positive changes. We succeeded in bringing Walter Reed up to handicapped access standards. The National Guard pay and finance system is being reworked. We've done away with the deplorable Active Duty Medical Extension program for injured warriors, and we've opened the Severely Disabled Veterans Clinic.

However, significant problems continue to exist that will once again require everyone's assistance. This is why I decided to testify and why I am here today.

The problems that exist are in the system and with some of the personnel not doing their jobs or following the Commanders' intent. Commanders at all levels must be the engine for change, and the Commanders' intent must subsequently be followed by his subordinates. Unfortunately, there is not one overall good guy wearing the white cowboy hat and one bad guy wearing the black cowboy hat. I wish it was that easy.

I have certainly encountered some lazy, non-caring individuals, even prejudicial individuals along the way, but had an adequate system been in place to take care of the Reserve Component's disabled veterans, it would have been easier for our Commanders to hold them accountable for their actions (or more importantly, their lack of action) and would have made my situation almost impossible to occur.

As in any profession, the longer you are around the more people you know; it is the same in the military. I am a Sergeant First Class in the United States Army, a Senior Non-commissioned Officer, and yet I could not have taken care of my family had I not met (or previously known) some of the prominent people that I have. I shudder to think what would have happened to me and my family without them.

So what happens to the lower enlisted soldier that knows no one of importance? The young soldiers who do not have any pull by way of rank? Who are their champions? How does that leave a Guard or Reserve soldier that gets wounded today, exactly where I was two years ago, and who is left to figure it out on his own? Hopefully he knows or meets the same people I did. If he doesn't, then what happened to me will happen again and will only repeat itself over and over again unless a system is in place that works for their needs.

The following is a time line of events related to my ADME issues that clearly demonstrate a broken system. Originally much longer in length and condensed for this testimony, I have provided the GAO the original document and all of the supporting documentation.

When my civilian employer, friends and fellow soldiers hear my story about not being paid, being refused medical treatment, not being allowed to take my leave in lengthy block increments, not being allowed to have my family relocated, when they hear of my ruined credit and my treatment after trying to cooperate with the GAO, they look at me like I am crazy. I think Gary Bianchi of the GAO, when I first met him, hardly believed it. That is until I provided the proof in the way of supporting documentation. Even some of my own family members wondered what I had been doing. Where had I been? Why was it taking so long, and when was I going to be home?

As I reflect on what has happened to me over the last 3 plus years, I come to the conclusion that I must be crazy to put myself and my family through this. A lot of the guys can't deal with these bureaucratic problems. They give up somewhere in the process and just go home. I only hope that is not the administration's intent to wear us down, but it sure seems that way. I ask anyone that reads this testimony to please do everything within their power to make sure that situations like that I have faced are never allowed to happen to even one more soldier.

Chronological Accounting of ADME Problems and Related Issues

OCTOBER, 2002. I returned to Fort Bragg and re-joined my company for demobilization. Six of the soldiers from my Company were injured and were to stay at Fort Bragg for medical attention. My chain of command and I found out that Active Duty Medical Extensions must be applied for and were not automatic.

NOVEMBER, 2002. I was seen for the first time in the US for my in the line of duty injuries. For the remainder of November, I saw Dr. Harris at Fort Bragg's Clark Health Clinic in North Carolina. Dr. Harris ordered several tests, and an additional appointment was set for January to review findings. During this same time period of time, my chain of command and I requested ADME orders be extended for 180 days. I continued to have additional testing, to include a CAT SCAN and MRI.

DECEMBER, 2002. I went on leave for the first time to see my family in New Jersey since being deployed, separated from my family, participated in combat and being wounded. On the 27th of December, after less than a week of leave and eight days early, I was ordered to return to Ft. Bragg because the 2125th MUIC Commander was unable to find any of our Active Duty Medical Extension (ADME) paper work that had previously been signed and forwarded as required. Four additional soldiers from my unit experienced the same problem and were all ordered back to Ft. Bragg early. It was later determined that the 2125th MUIC had made an error and had failed to file the appropriate papers for the five service members. I was told that the leave, which he had cut short, would be replaced. As of this writing, that has not happened.

JANUARY, 2003. I had an ADME evaluation with Dr. McClelland. On this same date my active duty orders expired. This subsequently caused me and my family to be removed from the Tri-Care health insurance system, my military ID was no longer active, all of my previously scheduled medical appointments were cancelled, and I would eventually not receive pay for three pay periods. The four other members of my company on ADME and I made over 40 trips to various sites at Ft. Bragg to complete our ADME applications during the period 3-29 January, 2003. It was very apparent that the correct process for completing the ADME orders was a mystery to those who were responsible for processing them. Additional testing continued throughout the month of January.

On or about 28 January, 2003, I had a medical appointment with an orthopedic surgeon, Dr. Santangelo, a respected surgeon.

My first ADME orders were approved 31 January, 2003, and a few days later I was finally given orders. These ADME orders were for 60 days only, turned out to be incorrect and later changed.

FEBRUARY, 2003. On or about 4 February, I reported to the medical hold unit at WOMACK and was questioned as to my whereabouts since the 3rd of January, 2003. I explained that I had no orders and had been reporting to the 2125TH Group, at which time I was advised that I should have been sent to the medical hold unit WOMACK. This clearly demonstrated to me at the time that the MUIC did not know what to do with ADME soldiers. I noted that the clerk at WOMACK made it a point to identify me to others as a National Guard soldier versus an active duty, fulltime soldier. I brought to the clerk's attention that I needed ADME orders to continue to receive my treatment and pay. I told her that the orders were to expire on 3 April, 2003. I was told that Company C at WOMACK had no knowledge or ability to help me obtain ADME orders, and that my problem was a National Guard issue ...WOMACK was for active duty military. I was told to go where I had originally got my orders and have them do it.

I returned to 2125th to get assistance in obtaining ADME orders and was told that that was my company's problem. I continued to receive treatment during February 2003 and received some back pay.

MARCH, 2003. During mid-March, I checked my pay status and determined that my pay was going to terminate as of 3 April, 2003. The issue was partially resolved, but the amount of pay was incorrect. A doctor requests that my ADME orders be extended until January, 2004. As of 25 March, the computer records indicated that my ADME orders would expire on 3 April, 2003, and that my pay was still incorrect.

My ADME request was forwarded to Mr. Jim Jones at the National Guard Bureau for resolution.

April, 2003. I was dropped from the ADME program, was not paid until June, 2003, and then only received a fraction of my earned pay. I continuously spoke with members of the medical hold unit and the 2125th Company concerning my need for ADME orders and pay issues. On or about 9 April, 2003, I received a payment of \$1.20. Still no ADME orders. On April 15th, I received \$401.87, but am still owed well over \$2000. Additionally, my Tri-Care benefits expire and leave my family without medical insurance. Also, my military ID card expires and I am unable to use base facilities.

MAY, 2003. My pay problems continue and I still fail to receive ADME orders. I admit to myself that I am overwhelmed with the financial and medical problems that I am facing, and I request an appointment with a counselor due to the stress I am under. Even after I began counseling sessions, I don't think my counselor believed what was happening to me until I showed him my supporting documentation. He was shocked amazed, and I could tell he didn't know how to advise me.

On or about 13 May, 2003, I contacted the National Guard Liaison Officer, Major Paul Watkins, who knew me from our previous working relationship. Major Watkins recommended that I contact the Inspector General for US Army Special Operations Command (USASOC). I spoke to Mr. Ed Aponte, OIG and was referred to USASOC Surgeon's Office. They assisted me with my additional ADME orders.

Note: An additional ADME request was needed because the date of the request is the date the extension begins, and the June orders would expire in July.

On 19 May, 2003, I went to the Emergency Room at Fort Bragg for vertigo, nausea and because I was vomiting blood. I was initially refused treatment due to the fact that my ID card was expired because of the lapse in my ADME orders. After getting Major Watkins and another officer friend involved, I eventually received treatment and was placed on quarters for 48 hours.

June, 2003. I am placed back on ADME orders and received medical treatment and base benefits.

July, 2003. My ADME orders expire yet again, and I am removed from the system. No pay, no active ID card and no Tri-Care insurance. The financial burden for me and my family is now at a critical stage, and I am forced to borrow \$10,000 dollars from my father-in-law. I will not receive any pay for two periods. (I am finally reimbursed on or about 5 September, 2003, for some of my pay.)

August, 2003. My wife went into labor prematurely. Upon arrive at the hospital at Fort Bragg, my wife was refused treatment because our ID cards were expired due to my lack of orders. The issue had to be resolved by Brigadier General Burford, the acting Commander of the United States Army Special Forces Command. After General Burford intervened, treatment was granted. I received medical bills for the delivery, and my wife had to go through a very long and painful process to get

them resolved. To date, some of the expenses for my family's medical care are still being contested and have not been resolved with Tri-care health insurance.

SEPTEMBER, 2003. I received cartilage replacements and continued testing for infectious diseases related to other medical problems.

NOVEMBER, 2003. I again applied for renewal of my ADME orders with the assistance of Major Watkins. I also contacted Tri-Care for a referral concerning issues with my infectious disease related problems. In late November 2003, the ADME orders expired along with the Tri-Care benefits and my active duty ID card. I did not receive any pay for two pay periods, which once again created a huge burden on my family. I finally received my ADME orders on or about the 16th of December, and back pay on or about the 19th of December, 2003. Up to this date, all treatment had been done at Ft. Bragg, NC. or in Pennsylvania.

On or about this same time period, I received a phone call from SFC Harrelson at Walter Reed Medical Center. I was advised that I needed to appear for additional treatment at Walter Reed on or about January 12th, 2004. SFC Harrelson advised me in a subsequent phone call that I was being sent to Walter Reed for an evaluation of a medical evaluation board (MEB). I explained that I had medical appointments pending and that I had been receiving care at Ft. Bragg. SFC Harrelson asked that someone from the Physical Evaluation Board (PEB) at Walter Reed contact the PEB at Ft. Bragg.

I was then told to disregard all appointments at Fort Bragg and report to Walter Reed Hospital by 12 January, 2004. I told SFC Harrelson I didn't have orders to travel. I was told to proceed without them on verbal orders, therein violating Army Regulation and causing unnecessary liability to me.

JANUARY, 2004. My Sergeant Major, Scott LaMorte, accompanied me on my arrival at Walter Reed to take a battery of tests many of which had previously been conducted at Fort Bragg. Contrary to what my Sergeant Major and I had been told, I had no appointments prescheduled when I arrived at Walter Reed. This move seriously disrupted the continuity of my care.

On or about January 14th, 2004, I had a walk-in orthopedic appointment. I was again accompanied by SGM LaMorte. Dr. Kenneth Taylor asked me why I was at Walter Reed since I did not have any life threatening injuries. I showed him my appointment with the orthopedic surgeon had been cancelled, and the doctor stated he could only refer me to an outside doctor because they were too busy saving life and limb. Dr. Taylor wanted to know who disrupted my continuity of care and sent me to Walter Reed, and most importantly, why?

My doctor and I had a disagreement with Col. Nitschke, a physician working as a Medical Board Case Worker, regarding which injuries took priority, in this case an internal exam verses an MRI for an injured knee. I protested the decision but proceeded as ordered. I told SFC Harrelson that I believed that the order to report for an MRI on a knee instead of an internal examination was an unlawful order and that I planned to file a complaint accordingly.

My chain of command was flat out lied to by the Medical Hold Company and was told I was going to be at Walter Reed for a week. After my arrival I was told I was going to be permanently staying at Walter Reed. I did not bring all of my personal belongings and the following weekend was my anniversary. I explained this to my representative at the Medical Hold Company and was told I could go back to Ft. Bragg on the weekend. I was asked if I still planned to return to North Carolina for my wedding anniversary on 18 January, 2004. I had previously discussed this leave with SFC Harrelson, and had planned to do this over the weekend, not during duty hours, and not interfering with medical appointments. At approximately 5:30 pm, I was advised that I needed the signature of my primary care doctor before I could take leave. At this point, I did not have a primary care physician since I had only been at Walter Reed a couple of days. Because of their failure to tell me this during duty hours while I had access to the doctor, I was unable to obtain a signed pass form from a doctor and was therefore unable to take leave as planned.

Pay Problems Associated with ADME.

As documented in the DFAS system, I was paid late 10 pay periods totaling \$12,185.54.

Original mode orders from 1/3/02-1/3/03.

Active Duty Medical Extension (ADME) orders:

DATE	PERIOD	PAY PERIODS MISSED
1/31/03	1/3/03-4/3/03	2
5/15/03	4/30/03-7/28/03	1
8/27/03	7/28/03-11/25/03	2
12/12/03	11/25/03-5/22/04	1

My credit history prior to being in ADME program was always in the high 700's depending on the credit agency that ran it; after my problems associated ADME orders, my FIS score was 568, which is below average. I was delinquent on 10 payments with four creditors. These were Ford Credit- 1/2004,7/03,6/03, Providian Financial-7/03, 2/04,Bank of America- 5/03,7/03,8/03, Capital One Bank-6/03,3/04. All of these delinquencies coincided with my missed pay periods.

I would like to be able to say that all of this is behind me, and that the system is fixed. However, that is not the case. As recently as December, my orders were due to run out on the 28th. By the second week in December, I still did not have my orders when you, Mr. Chairman, came up to Walter Reed. I brought this up to you in front of my chain of command, who were not very pleased with me for talking to you but afterward told me they would take care of it immediately. I asked my liaison everyday about my orders and finally, on the 23 December. I was in a panic because I knew that this was the last day to get anything done until after the New Year, and I knew the consequences if my orders expired again. I could not financially and mentally handle not being on orders, and I would not be able to provide for my youngest son who requires medication and physicians care. While most people were enjoying and preparing for the holidays with their families, I was fighting to ensure that my family and I could get paid and go to the doctor ...Merry Christmas again.

I have been totally consumed with Reserve Component pay problems. It is probably one of the toughest things in life to not be able to buy your family presents because you know you are either not getting paid or might not be paid in the near future. I called my Sergeant Major asked him what to do, and he told me he was coming right up to try to get me my orders. The Sergeant Major arrived at 3:00 pm and called Chief Lindell (Gary Bianchi of the GAO had introduced us) who works in personnel. Chief told my SGM that she would be faxing over the paper work, which we received in less than 10 minutes. We filled it out and faxed it back and, at 3:52 pm, she emailed me my new orders extending me until the 28 March, 2005. It took her 52 minutes to do what the medical hold

company had been trying to accomplish for over a month! I called my wife and emailed my orders to her immediately, and she called Sergeant Major Lawrence of DFAS (located in the Central time zone region and hour behind us) whom Mary Elene Chervonic of the GAO had put my wife in touch with when we had all the pay problems last year. He entered my pay information in the computer and she was told at 4:58 pm eastern standard time that we would be paid on the 3 January instead of the 1st. It took less than two hours to accomplish the whole task!. At this time, I called my liaison who thought I was calling about the status of my orders. He told me "I have bad news. They haven't even submitted your packet for extending your orders yet". I replied that I had worked the orders myself and gave him the contact information of the people that had helped me. (I hoped they might help other soldiers.) My point here is to demonstrate that the system is still broken, and the only way I could get it done was by 'knowing the right people'. What happens if you don't?

MAJOR PROBLEMS THAT MUST BE ADDRESSED

1. Commanders' Intent, and the willingness of mid-level personnel to make logical, effective decisions.

The President of the United States declared war on terrorists, and the fact is, we are at war. The Army needs to understand this and adjust their systems accordingly. I have personally met many of the leaders of this country, to include people from the current administration, senior representatives of the Department of Defense, some of the most senior leaders of the Army and some of this great nation's congressmen. What is overall amazing to me is that I personally feel that they do genuinely care about me. On many occasions, I have seen them get involved with serious problems and then take the necessary steps to correct those problems. They generally have a clear understanding that we are at war and appreciate that sacrifices need to be made and drastic changes need to occur in order for us to succeed. Having seen all this, I believe that the breakdown is at the mid-command level within the administration. Most of the hospital leaders are also doctors, who amazingly have as their own motto: "Cause no further harm." I do not understand how you can have this as your motto if you only worry about the physical wounds and allow Reserve Component soldiers to go months without orders. This, in turn, contributes to them not having anywhere to live, not being allowed to go to their scheduled doctor appointments, and not even being paid. The result is massive stress and mental pain.

I know I have not only had to face my current disability, something that has caused a huge amount of stress in itself. Everything I have done in my life has revolved around the physical aspects of my ability. From when I was a young lad I tried to be the best runner, the best swimmer, and more recently, to be 'the best of the best' the Army has to offer. Now, for the first time in my life, I have to figure out how I am going to support my family with the only skills I had stripped away. My core being has been changed forever, and that is a very tough thing to deal with. While going through this difficult adjustment in my life, the last thing I [or any soldier] needed was to have a clear lack of caring and leadership demonstrated to me by administrators not doing their job ...it only caused more harm. How can the Commander of the North Atlantic Regional Medical Command, the Deputy Commander of Clinical Services at Walter Reed, the Medical Hold Commander, and most importantly the Reserve Component Medical Board Advisor herself, allow this to happen? I was taught by the United States Army that when you are in a position of leadership, it is not just a title and pay raise ...it is a responsibility. I do not deny that I am bitter toward these people, and I feel I have every right to be. They failed not only me, but I believe they failed my family and my fellow soldiers as well. I have personally talked to and seen many of the Marines being treated at Bethesda Naval Station, and I am amazed how their stories of care and treatment are the complete opposite of my own experience.

A clear example of this is the very significant parking problem at Walter Reed. The administration knows about this problem, and it has been in the Walter Reed paper on several occasions and raised during the town hall meeting with the commander. To see a disabled soldier missing both legs having to park all the way across post and have to wheel him up and down hills, and then still have him receive a parking ticket, is a slap in the face. The command staff at Walter Reed needs to pull their head out of the sand and recognize that the pretty grass and trees need to go and that parking spaces need to be put in.

A related example is that there isn't enough room in the Hospital for all of the injured soldiers to do physical therapy, so they put a trailer up ...all the way across post from where the injured soldiers live with no parking except for two spaces. This forces the wounded soldiers to either walk all the way or catch a bus, all the while when there is a brand new Basketball Gym right next door to the Malogne House [where we live] that could easily hold all of the Physical therapy equipment, offices and at least twice as many wounded soldiers then the current trailer situation. Do we really need a basketball court that badly, or can we forgo it and make a sacrifice during a time of war to do what makes sense? We are at war and Walter Reed is the receiving center for our wounded warriors. I

would like to invite each one of you to come to Walter Reed for an unannounced visit and try to park. It would be very easy to correct the situation if the attitude was that we need to make this more accommodating for our patients and their families ...not the staff and support personnel. Why should the burden once again be placed on the wounded soldier? I believe the day that I no longer support the team is the day I am no longer part of the team. After what our soldiers have done and sacrificed for our nation, don't they deserve better? When a Marine is wounded and can no longer support the team they are idolized and treated as the hero's they are. As a police officer, I would frequently be asked by members of the community where I worked who knew of my Army service to talk to their sons or daughters about joining the service. I used to recommend the Army to anyone who asked. I used to say, what I felt was the truth, was that "it was the greatest thing I ever did." I recently felt, however, that if one of my own three sons came to me and asked for my input about joining the military, if after the way I have been treated he asked me what service he should join, I would tell them to join the Marine Corp. One day I was thinking how wrong that attitude is. We have such a wonderful Army, one that I am part of and have felt proud to be in, why I should let a broken system taint my overall experience? Rather, we need to fix our Army ...my Army. Why should we allow some bad apples ruin the whole cart.

2. Case Worker Confusion.

I honestly still don't know who all of my case workers/liaison's are. I have a National Guard case worker at the medical hold company, a Platoon Sergeant at the Medical Hold Company, a case worker for my medical care, a case worker for the management of my medical board appointments, a case worker for putting my medical board together, the United States Army Special Operations Command liaisons, and the National Guard liaison ...just to name the ones I remember. The saying "too many cooks in the kitchen spoils the soup" holds entirely true here. Throughout the process there are too many people trying to accomplish what they think is the most important area, which invariably is whatever area they are responsible for. They don't consider that when your medical care professional, your doctor, tells you specifically what the most important thing should be, then it should be just that. For example, the doctor might say on a Monday that I should come in for a follow up appointment, then go get x-rays, then go to the MRI center, then go to pool for physical therapy, and then go to pharmacy to pick up the new required medication. In the middle of all this, however, I have to walk out of the hospital and check my voicemail to ensure that I didn't miss any important calls from all of these advisors! I have a message from my Medical Board advisor who tells

me that I immediately need to come by her office for a consultation. I call her office and try to explain what and where I am doing and going, but she insists that "this is the most important thing." While I am on the phone with her, I get another call from the Medical Hold Company telling me that I need to come by there because they need to check my ID card and dog tags, and that this is the most important thing that I need to be doing. I try to explain to them everything that is going on and am told that I need to be there ...that is final. I look at my watch and realize I am now late for a doctor's appointment, despite being exhausted and not feeling well because I am disabled and recovering. None of that is taken into consideration. I still have medical appointments to go to but each one of these people, in order to justify themselves and their positions, needs to be 'in the kitchen'. The easy solution, and my wish if I could have it granted, is that I would be responsible to one person that works with (not against) the patient. In my case I don't need all of these so called case workers and liaisons; I only need to talk to United States Army Special Operations Command liaisons, MSG Dan Thompson and SFC Martv Thompson. These individuals discuss the scheduling and demands on the patient and make a reasonable schedule that is not going to cause more harm to the patient, one that will not set the patient up for failure and only cause more stress. Ideally, I should talk to them and only them. Each branch should have their own people helping their own people. I should not talk to anyone about my board, orders, anything. They can keep all these people in place if they want but leave me alone. If they need something signed it should go to MSG Thompson and he can tell them "Well, John is really busy today and I know his schedule and that is not possible today"; Then if there is going to be an argument it will be between MSG Thompson and who ever it is and I as the patient can go about my business of getting better, not being more stressed and harassed. This will drastically streamline the whole process of all these individuals trying to do their job ...as well as part of someone else's job.

3. Reserve Component versus Active Duty

Instead of spending great sums of money on all of these Case Workers, why not use the funds to establish a liaison from each Reserve Component unit. Until the United States Army Special Operations Command liaisons were sent up to Walter Reed on a permanent basis by the USSOCOM Commander, life was very difficult for me. Well what about the Reserve Component soldier that is in a Transportation company????? Who represents him and is his ombudsman? I thank God that I joined the Special Forces because the Special Forces is taking care of me, but that shouldn't make me more 'special' in terms of care and representation! (The USASOC liaisons are helping the regular

guys as much as the SF guys because they care.) As a Reserve Component soldier, I am not considered the same as if I was in the Active Army once I was wounded. My family is not authorized on my orders to come to Walter Reed. My wife and three sons are currently on their own living in New Jersey. My oldest son from my first marriage, who was ten years old when I was mobilized, is going to be fourteen in July. He lived with me and went to school where I lived. I have missed a large part of his life that I can never get back. My family is allowed to go to civilian doctors when necessary because there is no medical treatment facility near our home. When I asked to go home and go to civilian doctors for my treatment I was told that an active service member is not allowed to go to civilian doctors and has to go to a Medical Treatment Facility. I told them that I am not an Active service member, that I am a Reserve Component soldier and that my family is at home, a fact that is causing me significant hardship. Several of my doctors tried to get me back home and told me I would only be required to come down periodically from time to time for their check ups. I am amazed how I am considered at times to be a Reserve Component soldier, and an Active Duty soldier when it suits them? Under ADME, I am not entitled to move my family. I am not entitled to use my leave as terminal leave. I am not entitled to have open ended orders. However, when I try to get any of my active duty entitlements, I am told I am a Reserve Component soldier. When I tell them I want to go home and be treated as a Reserve Component soldier, I am told I am an active duty soldier. I have no problem with either scenario, but make a command decision on which one and allow me the benefits of that system. (Note: one of the reasons that the Army sticks to this is that the Army doctors need to see me in order to do a medical board. However, there is a better way to do it. When it is determined that an Reserve Component soldier needs to have a medical board, then they have the Reserve Component soldier's evaluation appointments all set up in one week and bring him back to Walter Reed at the Government's expense. This instead of causing more harm to the soldier by separating him from his family and the having the soldier assume the financial burden of paying to go see his family. I have not seen my thirteen year old son since he came down over the Christmas holidays, the main reasons are that I cannot afford it and it is too hard of a trip on me physically.

4. Medical Hold Company.

The Medical Hold Company, I am sure, has some kind of function. There are a couple of really hard working, caring individuals assigned there, but it seems as if any individual there that cares about soldiers is sent packing by the command. (To those members of the Company who have given your all, I thank you and apologize for putting you in the same category as the rest.) If their function

is to keep accountability of the soldiers, well my unit liaison does that; if it is handling and processing my orders and ensuring that I am paid, then they are not doing their job. I have never received an extension on my orders from any medical hold company; rather, it has always been based on my efforts and those who I 'know'. I tried using their dysfunctional system and I went off orders and got ruined ...mentally, physically and financially. It is to this end that, in the case of disabled veterans with a unit liaison assigned, there is no reason for the existence of a Medical Hold Company. They are simply 'another cook in the kitchen ...just spoiling the soup'. I believe I have a thorough understanding of how the Army operates and why. In the case of the Medical Hold Company, however, they need to understand they are not dealing with basic training recruits but rather with Americas heroes ...our wounded warriors. Requiring amputees to attend formation, demanding that the wounded soldier come to them anytime they need something, and the general lack of caring they have clearly demonstrated by allowing RC soldiers to go off orders is wrong. The consequences that go along with that, and the way their overall attitude is toward our Nation's finest, is disgusting and they should be ashamed of themselves. This is a direct result of the mid-level command philosophy that we are an inconvenience.

5. Confusion about the system (SOP).

Everything I have ever done or been associated with in the Military has a regulation, doctrine, or if nothing else, a Standard to conduct the task at hand. I have not seen any such standard for medical treatment nor has one been provided to me throughout my course of treatment. The overall board process is confusing enough, but when you add in the Reserve Component factor, it only becomes that much more confusing. Records for Reserve Component soldiers are kept at their respective units and their personnel records and command are not as readily available as with the Regular Army. When I was mobilized, I was assigned and attached to 2nd battalion, 3rd Special Forces Group. When I was no longer useful to the Active Component, I was placed on ADME orders and my problems started. Active duty soldiers remain under their unit command; their command knows them and will look out for them and therefore they are treated with the respect they deserve. From the first day to the present, there is not one set of standards for an ADME. Every extension I have done right up until December of last year had different requirements and paperwork. If someone in the beginning had come up to me with a manual and said "Here is the manual for an injured National/Guard or Reserve Soldier," I could have ensured that my overall care from start to finish would have taken a lot less time, cost the tax payers a lot less money, and allowed me and my family to get back to our

civilian lives that much quicker. I know for a fact that I am not the only confused individual; even the case workers have shown me their frustration about the lack of standardization.

6. Medical Board for Reserve Component versus Active Duty.

The medical board for Reserve Component soldiers versus Active duty soldiers should never be an issue, but it is. Bullets don't discriminate between Reserve Component and active duty soldiers, and neither should the Army. Once I was identified as an injured soldier, I should have stayed on OEF/OIF orders. The pot of money to run the war should include the price of taking care of the wounded for that war. If I was left on open ended OEF/OIF orders, I would only have had to get an amendment to my original orders to change my orders end date to 'indefinite', and I would not have had to worry about my orders running out every 90 days (or under the new system, even every 179 days). If my doctor knows that my treatment plan is going to be 14 months and wants to add two months for a buffer, then my orders should be for 16 months. Why is the decision left up to some personnel person to arbitrarily determine how long the orders are for? If my treatment is subsequently completed in 10 months, then an amendment to the order can be done and I can return to my civilian life. If there are unforeseen complications to my treatment, then it is no problem as they are open ended orders. The burden should not be on the soldier every couple of months to get all the paperwork done and turned in, to keep pressuring the people that are supposed to get the orders processed, to get a new ID card and a new window sticker for the his vehicle, to have his family travel all the way down to Walter Reed to get new ID cards at their expense, and to re-register for Tri-care. I should be focusing on my medical treatment, the reason that my orders were extended in the first place! The medical board in itself is supposed to be the same for Active Duty and Reserve Component soldiers ...with one huge difference that is being overlooked. If an Active Duty soldier is wounded and receives 10% disability the chances are very good he will be staying in the army and probably staying in his Military Occupational Skill (MOS). If the disability gets worse or was mis-diagnosed at the time he was on active duty, the active duty soldier will be re-evaluated by the Army; and if it becomes so bad that it is up to 30%, then he can retire from the Army at 50% pay and full benefits. If, however, a Reserve Component soldier receives 10% disability for their wound, then he will go back to the civilian world and go through the Veterans Affairs (VA). If his injury progresses or was mis-diagnosed and becomes 30%, he is already out and will not be entitled to an Army retirement and benefits unless they protest the findings of their retirement [which I understand is a very long process], leaving the burden once again on the soldier rather than the system.

7. Handling of Reserve Component after getting out

Wounded soldiers are not quitting 'the team'. They are getting out because their disabilities force them to. There is a big, big difference. They should still be considered part of the team. It seems very apparent, however, that my fellow Reserve Component comrades that are already out are done ...done and forgotten. Those people that do not forget them are unable to help them because they are no longer in the system. While talking to the United States Special Operations Command Commander recently, we discussed the idea of tracking soldiers once they were out. I mentioned to him that this was an excellent idea and that we should go one step further, that the Army should be helping the disabled veterans after they are out by ensuring that they have employment, help with getting into the Veterans Affairs, and the whole process that goes along with reentry to civilian life. Currently, once a soldier is done, he is done and the Army tells him "Thanks for your service and good bye." The current disabled veterans' civilian organizations that were founded because of need are currently over tasked and should not be responsible for transitioning America's heroes back into the civilian work force. There is a civilian organization just starting up that is going to be geared toward disabled Reserve Component soldiers. If they are creating an organization, then this clearly demonstrates there must be a greater need.

CONCLUSION

If you do not think it is acceptable to go months without pay, lack medical coverage for you and your family, and cannot continue your medical treatment because you are off orders, then some folks believe you are 'wrong'. I am not concerned about their opinion.

I have always believed in utilizing my chain of command. In this case, my chain of command tried everything to correct my situation and felt they had exhausted all other avenues within military channels. They were not making any progress, and subsequently started the congressional investigation into the situation. I was approached by the GAO for an investigation that my chain of command initiated ...not me. I was, and still am, being cooperative, open and honest in hopes of fixing a broken, dysfunctional system. I understand the law and I certainly would never lie to a federal investigative body. In cooperating, I have been persecuted for my actions by the certain vindictive Medical Hold personnel and labeled as a trouble maker. I have been given highly

questionable verbal orders to come to Walter Reed, scheduled for appointments that don't exist just to harass me (on record with the GAO), and time and time again have had personal medical information discussed in public to try to embarrass me.

Mr. Chairman, I am getting out very soon, and am not afraid to speak my mind. I am grateful for the opportunity to tell my story, and I hope it will help my fellow wounded soldiers. In concluding, I would ask that you and your colleagues, along with the 'champions' I mentioned earlier within the Army and the Administration, do what you can to protect the guys who remain in the system but fear the consequences of 'rocking the boat'. Only when these folks feel they can be part of the solution can we fix this broken system.

Chairman TOM DAVIS. Thank you very much, Sergeant Allen.
Thank you.
Sergeant Perez.

STATEMENT OF SERGEANT JOSEPH PEREZ

Sergeant PEREZ. I would like to begin by conveying my sincere appreciation to all the committee members today for this opportunity to help my fellow soldiers.

It is my belief that everyone here today is ultimately here for the same reason: for love of country and for the heart of the armed forces. It is my hope that what is conveyed here today is taken in a positive force, and the steps to improve the policies and/or administration issues that have been found lacking, which applies to all U.S. soldiers and their families.

I am a 38-year-old Nevada National Guard. I was on active duty ever since the Twin Towers fell. I wanted to serve and defend my country. I was deployed with the 77nd Military Police Co. in September 2001 for Operation Noble Eagle in Monterey, CA. During this deployment, two Army stop loss orders affected my enlistment. My second stop loss regarding specific MOS extended my service again for 12 months, but after revision put my ETS to April 2003.

Shortly after our 13-month deployment ended, I took a position as a Federal fire fighter at the Department of Air Force, Hill Air Force Base, Layton, UT. However, I was ordered to come back to Nevada to redeploy for Operation Enduring Freedom. I was notified that I was to be placed on a third involuntary stop loss order that extended me to full length of the deployment plus an additional 3 months. Our deployment orders sent us to Fort Lewis, WA, to prepare, be evaluated, and deploy to Iraq.

In late April I was deployed to serve my country as a 95 Bravo military police sergeant. My unit provided critical support in theater operations in criminal and security detention missions. We worked endless hours in weather conditions exceeding 130 degrees in order to build and establish confinement operations in an area which is well known as extremely hostile to coalition forces. We endured over 22 days of rocket-propelled grenades, mortar attacks, and with performing MP missions in Iraq under the most dangerous and hostile conditions such as several vehicle escort missions to various locations in downtown Baghdad and nearby cities.

I was also selected to play a vital role in transporting detainees to and from the courthouse in downtown Baghdad and was subject to daily threats of ambush and attacks during these convoys.

On July 13, shortly after returning from the convoy with my squad releasing detainees in the Baghdad area, we were alerted to rush to the prison compound area. An uprising within the insurgent detainees led to a prison riot. The insurgents were armed with sharpened tent poles, tent spikes, and rocks. They had already injured one soldier, and there was another pinned down. We led a group of soldiers into the compound as a quick reactionary force. While under fire, we helped the downed soldier and quelled the prison riot with physical force. During these actions I injured my left knee while taking down a combative. I also received a strong hit to my head.

That night again, just like so many other nights, we continued to be RPGed and mortar attacked. On occasions, these mortars entered the confined areas, killing and wounding numerous detainees. They also took the lives of two MI soldiers working with us. I remember the day working on the tower and witnessing part of our own company of 11 soldiers, many of them being close friends, load onto a military deuce truck. They were struck by an IUD just outside the prison walls. It blew them all out of the vehicle, causing many injuries. I still to this day relive these moments and feel helpless and have rage.

While on a family related emergency leave, I reported to Nellis Air Force Base to have my knee examined and x-rayed. They found my knee injury causing me to be unfit for deployment and in need of medical attention. I notified the Army National Guard. I was informed that because the physical profile was conducted by the U.S. Air Force, I could not receive care until I returned back to Baghdad, Iraq to be examined by an Army medical doctor. Not wanting to get into trouble, I returned back to my unit without delay.

On September 2, 2003, I finally had a chance to be seen by the 28th CSH unit—combat support hospital—in Baghdad, Iraq. Because of the injuries to my knee, I was placed on medical evacuation orders to Landstuhl, Germany. After further examination and x-rays in Germany, they put me on a plane to Fort Lewis, WA, to be attached to the 2122 GTSB Medical Hold Co. for treatment. I was put in the Reserve platoon under National Guard sergeant on orders. He stated his unit was on orders to work with injured soldiers of the National Guard and Reserves. He also stated that they were overwhelmed with the amount of soldiers and the host of medical and personal problems they were coming home with. I was given old sheets and led to an old World War I barrack with insufficient water, heating, limited access for injured soldiers, and with mold growing on the walls. I was given a bus schedule and told to find a case manager at Madigan Hospital.

I found and reported to my case manager. I was set up to see medical staff within a few days. I was told they wanted to start my medical process with physical therapy, which was set 3 weeks away. During this time many of the medical hold soldiers felt like they were lost and thrown away.

When you come back to the States, you figure that flashbacks and nightmares were a normal stress that you go through when you come out of a war zone. Soldiers still say, however, that, despite the Army's efforts, languishing in medical hold compounds one's medical and psychological issues. Everything is uncertain. You are denied care, and you feel that they don't give a damn whether you get better or not.

During the month of November 2003, my National Guard unit was REFRAD and returned home for Thanksgiving. They were given a hero's welcome. The ones in medical hold watched it on TV.

On December 8, 2003, I was finally allowed to take convalescent leave. At this point my wife had to care for me, and I couldn't see any hope of getting my position back as a fire fighter at Hill Air Force Base. My wife was beginning to see signs of change in me and she was worried about my mental health because of the nightmares and always wanting to be alone. I couldn't even enjoy the

time with my children and visit family without putting up a front. It was my case manager, Captain Boardman at Madigan, who promised to get me remote care through the VA so I could heal and start physical therapy near my family.

I reported to the VA in Las Vegas in January 2003. I met with my primary care provider and began medical treatment. That care I received at the VA was outstanding. Most of my care and surgery was contracted through a VA fee base program. I was able to get x-rays, MRIs, physical therapy, surgeries to my knees and my neck. My appointments were handled quickly and with the best of care. I also started a veterans PTSD focus group at the vet center in Las Vegas. My wife and I do believe that they saved my life. For the first time I felt that my medical and psychological issues were finally being handled properly.

During my stay in medical holdover, I received little to no counseling regarding traumatic events I experienced during war. Why didn't I or others ask for help? The culture here is that unless your leg has been torpedoed off or your arm shot off, then it is not a combat-related injury. Many servicemen here fear to be stigmatized for being able to deal with their problems on their own. I did the same thing that everyone else does in the military—you suck it up. You don't whine. But I am sure during the course of treatment a soldier will display signs that will suggest that an individual is in need of mental health counseling of some kind.

My National Guard unit was demobilized February 10, 2004. Because of this, my family and I fell off the Army records. After many calls to the National Guard and hearing that, because I was still on Title 10 orders, it was an active Army problem, I started to call Fort Lewis. I was told the exact opposite. I was finally told that there was confusion about how to handle the ADME orders and line of duty packages. I asked to speak to my case manager, to find out he was replaced by a new case manager who didn't have a clue who I was or what my situation was. My family went 3 months without military IDs, Tri-Care health, pay, and even denied entrance onto Nellis Air Force Base to shop.

Not being able to work, I had to borrow money from family members to make ends meet. At the same time, I was still receiving phone calls from the 2122nd medical hold company saying they couldn't fix anything unless I came back, or I had to come back or I would be placed on AWOL. This caused more stress because I had just had surgery to my cervical spine.

I was low on funds, didn't have orders, or even a military ID card. My wife and family members couldn't believe all the problems, and started to think that maybe I did something wrong and I was being punished. All this made me feel worthless, and I ended up on April 22nd in a mental health unit at Mike O'Callaghan Hospital for PTSD and again suicidal thoughts.

After two extension orders and a back-dated ADME to report back to Fort Lewis to be attached to the Madigan Medical Hold, I finally was able to get my family updated in DEERS and have military ID again. I was finally able to show proof of employment and get a rental house for my family. I reported back to Madigan Medical Hold on July 8, 2004. I was glad to see that the troops did not have to stay in the old barracks any more, but a lot of the same

problems still remained. Many of the soldiers were still having pay and order problems. I started to try to help as much as I could.

I have been involuntarily medically separated because of the injuries I accrued for my country in Iraq in combat. I have gone through a major life change, and within the next month I am having to endure another. I have always had pain in my knees, and if I walk long distances or lift anything the pain is greater. Pain in my knees is from the injuries and the past two knee surgeries for tears, damaged cartilage, micro fractions, and lateral release.

I also had cervical fusion. I have lost some range of motion in my neck. I sometimes can't turn my head to the left and if I look down for a long time, such as reading a newspaper, my neck locks up. I have chronic neck pain which starts in my neck and ends in my lower back. I have taken large doses of hydrocodone throughout the day and the night for relief. This prevents me from performing tasks that I feel that I need to be sharp mentally. This medication, along with other medication, keeps me balanced. I have to take the medication for the rest of my life.

I can't get to sleep most nights, and I must sleep with a CPAP machine strapped to my face because of severe obstructive sleep apnea. I also sleep with a hard mouth brace because of the TMJ surgeries to my jaw. I still do my therapy with the VA in Las Vegas.

I continue to take my PTSD group meetings every week at the Las Vegas Vet Center because it works for me. It helps keep me strong and centered. I and many of my colleagues say such problems are particularly acute among the National Guard and Reserve soldiers, who make up 40 percent of the deployed troops. I don't think it has been budgeted for the Reserve and Guard components, and now they want us to suck it up. An injured soldier shouldn't be thought of less because he is a Guard member or a Reserve. I am very displeased how my family has been treated during my medical holdover. But the issues that are mostly directly affecting my future is my dispute with the Army over disability ratings.

Most of my conditions are chronic and I can't perform many of my functions as a fire fighter nor law enforcement. These were my chosen fields I have strived to be proficient and professional at. I am told to look forward to a VE rehab program to help with education and training into a new field starting me over again. My family and I live in a rural city outside of north Las Vegas. Our closest health care, hospital, major food shopping, fitness center, and largest gas station has always been Nellis Air Force Base, Las Vegas, NV. My first daughter was even born here when I served with the U.S. Marine Corps. It is very hard knowing that this has been taken away from us.

As a Nation, we should note the special contributions of our National Guard and Reserves. Since the attacks of September 11th, and extended into the Iraq conflict, demands placed on citizen soldiers and their families have been extraordinary.

I make this statement today not to complain or look for pity, but to finally have my chance to tell my story. I don't believe or want to presume that I have a well-rounded knowledge of military procedures. I do believe this committee has a vigilant desire to make provisions to the adjustment and strengthening of these programs.

I would like to make the following considerations: National Guard and Reserve forces face challenges that their active duty avoid. When part-time soldiers do return home, they have little interaction with other soldiers and sometimes feel that they are the only ones going through these emotional adjustments. I feel a bit isolated, like the rest of the world has just gone by me for the past 3 years. For these reasons, I feel that remote care would benefit and aid the recovery of individual soldiers and their families. I would recommend the Veteran Association in ways of medical care.

The medical holding companies have full control over the soldiers to be able to utilize them in tasks that don't hinder their care as soldiers. This could help the soldiers progress in the military and have an active duty component to handle problems that arise. Many of these soldiers fall through the cracks when it comes to promotions, educational benefits, and awards.

The wounds of the battle frequently do not require hospital attention. There are severe long-term physical and psychological disabilities that prevent veterans from attaining positions in our Nation's work force. When a soldier returns, they have to go through a complex workman's comp type paperwork to prove that there is something that they did in war, which is the reason that they are sick. That can take from 4 to 16 months. They come home injured, and rather than being integrated into society they are stuck in medical limbo waiting for their disability ratings and then being diagnosed with pre-existing conditions that imply that they shouldn't have been sent overseas in the first place.

For these reasons, I believe there should be a seamless transition from going from medical hold status to veteran status. I feel that the veterans service organizations should have more access to bases to help the injured soldiers deal with the MEB and PEB issues. Families would be free to focus on physical and emotional recovery progress in lieu of following up on paperwork, policies, and medical care on their own financial and emotional expense.

I have found that many of the problems occurred during my medical care because the DOD and the VA create an independent patient record. Records are hand carried to and from agencies. I also found, unfortunately, that the current VA/DOD process for sharing information about eligible service members does not facilitate quickly and there is not a smooth transition into enrollment into the VA programs.

There seems to be a great deal of difference in the policies regarding the medical care and treatment of soldiers between the branches of the military. I feel that the treatment to an injured should be written and maintained as one standard. A medical doctor's opinion shouldn't change based off of the uniform that they wear.

Last, I would like to see more progress and emphasis on mental health services available in post traumatic stress and depression. It has made a difference in my life, and I feel that the programs such as at the vet center will give a great deal of comfort to many of the returning veterans as they undergo their personal struggles.

It is because I have a great deal of love for my country and family that I write this statement. I have cherished much of my life in the armed services. I have taken pride in wearing the uniform.

I have made great friends and I have seen and accomplished many things throughout my deployments. There can be no doubt of the commitment of those in uniform, whether active, National Guard, or Reserve. When we speak words of sacrifice, courage, and conviction it touches my heart as a former Marine and a soldier, as they do for those who are serving in uniform today in the defense of our safety and liberty.

I thank you again.

[The prepared statement of Sergeant Perez follows:]

**STATEMENT OF JOSEPH D. PEREZ
SERGEANT ARMY NATIONAL GUARD
BEFORE THE
COMMITTEE ON GOVERNMENT REFORM
WOUNDED ARMY GUARD AND RESERVE FORCES:
INCREASING THE CAPACITY TO CARE**

**FEBRUARY 17, 2005
10:00 a.m.**

I would like to begin by conveying my sincere appreciation to all committee members today for this opportunity to help my fellow soldiers. It is my belief that everyone here today is ultimately here for the same reason... for love of country and for the heart of the Armed Forces. It is my hope that what is conveyed here today, is taken as a positive force in the steps to improve the policies and/or administration issues that are found to be lacking as it applies to all US Soldiers and their families.

My name is Joseph D. Perez, and I'm 38-year-old Army National Guard Member. I was on active duty since seeing the Twin Towers fall on TV. I wanted to serve and defend my country. I was deployed with the 72nd Military Police Company in September 2001 for Operation Noble Eagle in Monterey, California. During this deployment, two Army stop-loss orders affected my enlistment time. The second stop-loss order regarding specific MOS extended my service again for a period of 12 months but after revision placed my ETS to April of 2003. Shortly after my 13-month deployment ended, I took a position as a Federal Firefighter for the Department of the Air Force at Hill Air Force Base in Layton, Utah. However, I was then ordered to report back to Nevada for redeployment for Operation Enduring Freedom. I was notified that I was placed on a third involuntary stop-loss order that extended me the full length of the deployment plus an additional three months. Our deployment orders sent us to Fort Lewis, Washington to prepare, be validated, and deployed to Iraq.

In late April I was deployed to serve my Country as a 95B Military Police Sergeant. My

unit provided critical support for Theater Operations in criminal and security detainee detention missions. We worked endless hours in weather conditions with temperatures exceeding 130 degrees in order to build and establish confinement operations in an area that is well known as extremely hostile to coalition forces. We endured over 22 days of rocket-propelled grenades and mortar attacks. Along with performing MP missions in Iraq under the most dangerous and hostile conditions, such as several vehicle escort missions to various locations within downtown Baghdad and other near by cities, I was also selected to play a vital role in transporting detainees to and from the courthouse in downtown Baghdad and was subjected to daily threats of ambush attacks during these convoys.

On June 13, 2003, shortly after returning from a convoy mission with my squad to release detainees into the Baghdad area, we were alerted to rush to the prison compound area. An uprising within the insurgent detainees led to a prison riot. The insurgents were armed with sharpened tent poles, tent spikes, and rocks. They had already injured one soldier and had another soldier pinned down. We led a group of soldiers into the compound as a quick reaction force, while under fire to help a downed soldier and quell the prison uprising with physical force. During these actions I injured my left knee while taking down a combated insurgent. I also received a strong hit to my head.

That night again like so many other nights, we continued to be RPG and mortar attack. On occasion the mortars entered the confinement area killing and wounding numerous detainees. It also took the lives of two M.I. soldiers working with us. I remember a day working a tower and witnessed part of our own company of 11 soldiers, many being close friends, loaded onto a military deuce truck. They were struck by an IUD just outside the prison walls. It blew them all out of the truck causing many injuries. I still to this to this day relive those moments of feeling helpless and having rage.

While on a family-related emergency leave, I reported to Nellis Air Force Base to have my knee examined and X-rayed. They found my knee injury causing me to be unfit for deployment and in need of medical attention. I notified the Army National Guard. I was

informed that because the Physical Profile was conducted by the U.S. Air Force, I couldn't receive care until I returned to Baghdad, Iraq to be examined by an "Army" Medical Doctor. Not wanting to get into any trouble, I returned back to my unit in Iraq without delay.

On September 2nd, 2003, I finally had a chance to be seen by the 28th Combat Support Hospital in Baghdad, Iraq. Because of the injuries to my knee I was placed on Medical Evacuation Orders to Landstuhl Army Regional Medical Center, Germany. After further examination and X-rays in Germany, they put me on a plane to Fort Lewis, Washington, to be attached to 2122 GTSB Medical Holding Company for treatment. I was put in a reserve unit platoon under a National Guard Sergeant on orders. He stated his unit was on orders to work with injured soldiers of the National Guard and Reserve Components. He also stated that they were over whelmed with the amount soldiers and the host of medical and personal problems they were coming home with. I was given old sheets and lead to the old World War I barracks with insufficient water, heating, limited access for injured soldiers, and there was mold growing on the walls. I was given a bus schedule and told to find a Case Manager at Madigan Hospital.

I found and reported to my case manager. I was set up to see medical staff within a few days afterwards. I was told they wanted to start my medical process with Physical Therapy which was set three weeks away. During this time many of the medical hold soldiers like me felt lost and "thrown away." When you come back to the States, you figure that flashbacks and nightmares were a normal stress you go through when you come out of a war zone. Soldiers still say, however, that despite the Army efforts, languishing in medical holdover only compounds one's medical and psychological issues. Everything is uncertain, you're denied care, and you feel they don't give a damn whether you get well or not.

During the month of November 2003 my National Guard Unit was REFRAD and returned home for Thanksgiving. They were given a Hero's welcome and the ones in med-hold watched on TV.

On December 8, 2003 I was finally allowed to take convalescent leave. At this point my

wife had to care for me and I couldn't see any hope of being able to getting my position back as a Firefighter at Hill Air Force Base. My wife was beginning to see signs of change in me and she worried about my mental health, because of nightmares and wanting to be alone. I couldn't even enjoy this time with my children or visit family without putting up a front. My Case Manager Capt. Boardman MAMC promised to get me on remote care through the VA so I could heal and start physical therapy near my family.

I reported to the VA in Las Vegas in January 2003, I met with the primary care provider and began medical treatment. The care I received at the VA medical center was outstanding. Most of my care and surgery were contracted through the VA fee base programs. I was able to get X-rays, MRI, physical therapy, surgery to my knees and neck. My appointments were handled quickly and with the best of care. I also started in a Veterans PTSD focus group at the Vet center in Las Vegas. My wife and I do believe that they saved my life. For the first time I felt that my medical and psychological issues were being handled properly. During my stay in medical holdover I received little to no counseling regarding traumatic events I experienced during the war. Why didn't I or others like me ask for help? There's a culture here that unless your legs have been torpedoed off or your arm's shot off, then it's not a combat injury. Many service members have fear of being stigmatized for being unable to deal with their problems on their own. I did the same thing that everyone does in the military, "You suck it up." You don't whine. But, I'm sure that during the course of treatment a soldier will display signs that will suggest that the individual is in need of mental health counseling of some kind.

My National Guard Unit was demobilized February 10, 2004. Because of this my family and I some how fell off the Army records. After many calls to the National Guard and hearing that because I'm still on Title 10 Orders it was the active Army's problem. I started to call Fort Lewis and was told the exact opposite. I was finally told that there was confusion on how to handle ADME Orders and Line of Duty packages. I ask to speak to my case manager to find out he was replaced and a new case manager, who didn't have a clue to who I was or my situation. My family went three months without Military ID cards, Tricare Health, pay and was even denied entrance onto Nellis Air Force Base to shop.

Not being able to work I had to borrow money from family members to make ends meet. At the same time I was receiving phone calls from the 2122nd Medical Hold Company saying they couldn't fix anything until I came back and I had to get back or be placed as AWOL. This caused more stress because I just had surgery to my cervical spine, I was low on funds, didn't have orders, or even a military ID. My wife and other family members couldn't believe all the problems and started to think that maybe I did something wrong and was being punished. All this made me feel worthless and I ended up April 21, 2004 at the mental health unit at Mike O'Callaghan Federal Hospital for PTSD and again suicidal ideation.

After two extension orders and a back dated ADME Order to report back to Fort Lewis to be attached at this time to Madigan Medical Hold Company, I was finally able to get family updated in DEERS and have a Military ID again. I was finally able to show proof of employment and get a rental house for my family. I reported back to Madigan Medical Holding Company on July 08, 2004. I was glad to see that the troops did not have to stay in the old Barracks. But a lot of the same problems still remained. Many of the soldiers were still having pay and order problems. I started to try to help as much as I could.

I have been involuntary medically separated because of injuries I accrued while serving my Country in Iraq in combat. I have gone through a major life change and within the next month I'm about having to endure another. I always have pain in knees and if I have to walk a long distance or lift anything from the ground the pain worsens. Pain in my knees is from the injury and past two knee surgeries for tears, damage to cartilage, micro fracture and lateral release. After cervical fusion I have lost some range of movement in my neck. I sometimes can't turn my head to the left and if I look down to long (such as reading a paper) my neck locks up. I have a chronic neck pain, which starts in my neck and ends in my lower back. I have to take large doses of Hydrocodone throughout the day and night for relief. This prevents me from performing tasks where I feel I need to be sharp mentally. This medication along with other medication, keeps me "balanced." I will have to take medication for the rest of my life. I can't get to sleep most nights and I must sleep with a CPAP machine strapped to my face because of severe obstructive sleep

apnea. I also sleep with a hard mouth spilt because of TMJ surgery I'm still doing therapy though the VA in Las Vegas. I also sleep with wrist splits because of Carpal Tunnel Syndrome so I don't wake up with painfully numb hands. I'll continue to make my PTSD group meetings every week at the Las Vegas Vet Center because it works for me and helps keep me strong and center. I and many of my colleagues say such problems are particularly acute among National Guard and Reserve soldiers, who make up about 40 percent of the deployed troops. I don't think it's been budgeted for the Reserve and Guard component, and now they want to make us suck it up. An injured soldier shouldn't be thought less of because he's a Guard or Member of the Reserve. I'm very displeased how my family had been treated during my medical holdover. But the issue that will most directly affect my future is my dispute with the Army over my disability rating.

Most of my conditions are chronic and I can't perform many of the functions as a Firefighter nor Law Enforcement. These were my chosen fields, which I strived strongly to become proficient and professional. I'm told to look forward to a VA Rehab Program to help with education or training in a new field, starting me over again. My family and I live in a rural city outside of North Las Vegas, Nevada. Our closest health care, Hospital, major food shopping, fitness center and largest gas station has always been Nellis Air Force Base, Las Vegas, Nevada. My first daughter was born there while I served in the Marine Corps. It is very hard to believe that this has been taken from us.

As a nation, we should note the special contributions of our Nations Guard and Reserves. Since the attacks of September 11, and extended into the Iraq conflict, demands placed on citizen soldiers and their families have been extraordinary.

I make this statement today not to complain or look for pity, but to finally have my chance to tell my story. I don't believe or want to presume to have a well-rounded knowledge of military procedures. I do believe this committee has a vigilant desire in making provisions to adjust and strengthen these programs. I would like the following be taken in consideration.

- Nation Guard and Reserve soldiers face one challenge their active-duty comrades

usually avoid, when part-time soldiers do return home, they may have little interaction with other soldiers and sometimes feel like they are the only ones going through the emotional adjustment. I felt quite a bit isolated, like the rest of the world around me went on with their lives for the past three years. For this reason I feel remote care would benefit and aid in recovery for individual soldiers and their families. I would recommend the Veteran Administration in ways of medical care.

- That Medical Hold Companies have full control of soldiers and be able to use soldiers in tasks that don't hinder the care of the soldiers. This could help a soldier's progress in the military and have an active duty component to handle problems that arise. Many of these soldiers fall through the cracks when it comes to promotion, educational benefits, and awards.
- The wounds of the battle frequently do not just require hospital attention. There are severe long-term physical or psychological disabilities that prevent veterans from attaining positions in this nation workforce. When soldiers return, they have to go through complicated workman's-comp-type paperwork to prove that something they did in war is the reason they're sick. That can take from four to sixteen months. They come home injured, and rather than being integrated into society they're stuck in Medical Limbo waiting for their disability rating and then being diagnosed with preexisting conditions that implies they shouldn't have been sent overseas in the first place. For these reasons I believe that there should be a seamless transition from going from Medical Hold status to veteran status. I feel that Veteran Service Organizations should have more access to Bases to help injured soldiers deal with MEB and PEB issues. Families would be free to focus on the physical and emotional recovery progress in lieu of following up on paperwork, policy and medical care at their own financial and emotional expense.
- I have found that many problems occurred during my medical care was because the DOD and the VA create independent patient medical records. Records are hand

carried to and from agencies. I also found unfortunately the current VA/DOD process for sharing information about eligible service members does not facilitate quickly and there is not a smooth transition for enrollment into VA programs.

- There seems to be a great deal of difference in policy regarding medical care and the treatment of a soldier between the branches of the military. I feel the treatment to the injured should be written and maintained as one standard. A medical doctors' opinion shouldn't change based off the uniform they wear.
- I would like to see more programs and emphasis on mental health service available in Post Traumatic Stress Disorder. It made a difference in my life and I feel programs such as the VET Center will give a great deal of comfort to the many returning veterans as they undergo their own personal struggles.

It's because I have great love for my County and family that I write this statement. I cherish much of my life in the armed services. I took great pride in wearing the uniform. I have made great friends and have seen and accomplished many things throughout my deployments. There can be no doubt of the commitment to those in uniform whether on Active, National Guard or Reserve. When we speak words like sacrifice, courage, and conviction, it touches my heart as a former Marine and Soldier - as they do to those who serve in the uniform today in the defense of our safety and liberty.

Sincerely,

Joseph D. Perez

Chairman TOM DAVIS. Sergeant Perez, thank you very much for sharing that with us. Mr. Shuttleworth, thank you.

STATEMENT OF CHIEF WARRANT OFFICER RODGER L. SHUTTLEWORTH

CWO SHUTTLEWORTH. Mr. Chairman, members of the committee, it is a distinct honor to be here to discuss important issues affecting injured Reserve Component soldiers, including those injured as a result of the global war on terrorism. Our Reserve Component soldiers have born the brunt of growing pains necessary to change a system that was not designed to support Reserve Component soldiers.

My name is Chief Warrant Officer Rodger Shuttleworth. My military career began in 1973, where I served in the active Army until 1981. I then joined the Maryland Army National Guard and became a full-time employee of the National Guard Bureau of 1988. I was assigned to my current position as Chief, Reserve Component Support Services Branch, Army Human Resources Command, in February 2003. My responsibilities include all aspects of personnel for Reserve Component soldiers ordered to active duty under Title 10.

Prior to September 11th, there were only two programs that dealt with injured Reserve Component soldiers—active duty medical extensions and incapacitation pay. Incapacitation pay and allowances are paid to soldiers without them being on active duty. There are a lot of soldiers on incapacitation pay. Over \$3 million monthly is spent on their care. Without proper oversight, questions to the best use of the money remains. If these soldiers were placed on active duty medical extension, they would be better managed and the Army would spend less money getting them returned to duty or placed in the physical disability system.

The numbers of injured soldiers in these programs prior to 2001 was manageable, but due to the largest mobilization of Guard and Reserve since World War II in the global war on terrorism, the amount of injured needing assistance grew beyond the capacity to assist.

For example, I started with a staff of six. At the time, the Adjutant General of the Army gave me a mission: to do all I could to increase the capacity to care of our injured Reserve Component soldiers. At that time, the only process was active duty medical extension and incapacitation pay. An active duty medical extension prior to September 11, 2001 was used to order drilling soldiers injured during training to active duty for medical care. Because we were not prepared for the disaster of September 11, ADME had to be used to support GWOT soldiers injured in the line of duty. Because ADME was not specifically designed for GWOT, soldiers were being denied eligibility, fell off pay systems, and lost benefits for their families.

ADME was supposed to be a 179-day program, longer than the 30 days given, but the Army G-1 who was responsible for establishing and interpreting ADME policy also chose to execute it, and they became a major stumbling block, shortening extensions as we tried to ensure GWOT soldiers were treated equally to their active component counterparts.

These problems continued until the creation of medical retention process in March 2003. This was an improvement, better because the application process was easier, the requirements were streamlined, and all extensions were automatic for 179 days. We also directly submit the soldiers' orders to the Defense Finance and Accounting Service so pay problems and benefits will end.

In January 2004, I established the Medical Services Section of my branch to facilitate MRP processing, Medical Board process, and other RC personnel functions for medical reasons. During this time, we began to realize that we were also responsible to train and assist Reserve Component and active Army personnel in medical care facilities who had any questions at all on Reserve Component processing.

Some calls are from the medical holdover companies who do not always know how to process or help Reserve or Guard soldiers being treated in their facilities, but most of the callers are Guard and Reserve soldiers who have not gotten any answers from their chain of command at the facilities and have exhausted all other avenues in health and service.

One of the major problems is that Army medical personnel do not interface with Army personnel specialists. This continues to cause serious misunderstandings, delays, and holdups in personnel services.

Another of the major problems is that we have a medical command telling an injured Guard or Reserve soldier one thing and we tell him another.

Another continuing source of inter-Army command difficulties for us involves our relationship with the Army G-1. The Army G-1 is by definition supposed to be a source of policy decisions, innovation that the Army Human Resources Command are executors of, but this is not always the case. This causes the following problems: great delays in the approval in each soldier's paperwork, causing increased days in treatment; pay problems and benefits; and great family stress. We have spent far too much time debating between our offices on the most effective way to support injured Reserve Component soldiers.

In regards to these difficulties, I am happy to report that 2 days ago the Army G-1 transferred functional responsibility for all types of Reserve Component personnel management in regards to medical processing to my branch.

I want to bring forward another problem that my staff and I encounter every day. Reserve Component soldiers are remaining on active duty for long periods of time without being injured into the physical disability process and remain in a medical board process for long periods of time. Of the paperwork we review, approximately 80 percent of ADME and MRPE Reserve Component soldiers will end up in a physical disability system. Part of the problem is the shortage of trained manpower, both at medical command and the U.S. Army Physical Disability Agency. Injured Reserve Component soldiers have paid the price for this, but we are trying to improve manning and training.

Guard and Reserve soldiers have so many difficulties because the active Army tries to treat them like active Army soldiers in all cases, and in some instances they cannot. An example is when an

active Army soldier is med-evac'ed from a theater of operation to a Stateside medical facility and determined to be an outpatient, they are returned to their home unit for a period of recovery. The Reserve Component soldier may not have a home station because his unit has been mobilized and there may be no one left at home station to assist them. This causes us to lose accountability for these soldiers. All of them are authorized to receive medical care and treatment and should be reported through active Army organizations prior to returning to their home of record.

To alleviate this problem, the Army has created the community based health care initiative. This initiative will allow some Reserve Component soldiers, after being processed through an active Army organization, to return to their home of records and their families, remain on active duty, and receive medical care. Each community based health care organization is responsible for the care and accountability of the soldiers assigned them. My office assists in training the staff personnel of these newly created facilities. In addition to that, I have placed over 80 NCOs at Army treatment facilities in the United States and Germany to assist in patient tracking and Medical Board processing. Because of the placement of these NCOs, completed Medical Board ratios have now improved. Over 400 are being done annually.

We have also placed personnel at the U.S. Army Physical Disability Agency, the DOD Defense Finance and Accounting Service, and at the CBHCOs. We were also asked very recently by the Army Installation Management Agency to provide experienced Reserve Component command and control staff onsite at the installation because there is a shortage of permanent staff at the installation medical readiness processing units and CBHCOs.

There is still a need to sustain this staff currently and at least 2 years after the current contingency operations end. As of last week, the Director of the Army staff has approved my office to fill these leadership voids with the Army extended active duty program.

I hope from my testimony you understand how important it is to me that my staff and the Army continues to resource and improve policies aimed at supporting injured Guard and Reserve soldiers.

There are four things I want to bring to your attention.

One involves a needed change to Title 10. Under the current law, Reserve Component soldiers not injured in the line of duty are entitled to a retirement benefit that soldiers that are injured in the line of duty are not entitled to. That bothers all of us. I respectfully ask that Congress change this unfair law. Right now, if you are injured prior to entering the armed forces and have 15 years of credible service and are found to be non-retainable, you are eligible to retire and obtain benefits at age 60. But if you agree to come to active duty and fight for your country and are injured in the line of duty, you are not entitled to this benefit.

Second, I have deep concerns about current Army procedures for injured Reserve Component soldiers at certain Army installations, including Walter Reed, Fort Bragg, Fort Bliss, Fort Lewis, Fort Dix, and Fort Drum. These installations do not provide timely and accurate medical personnel records or line of duty investigations that are vital to Reserve Component soldiers who are leaving active

duty and will need future medical care. At these installations there is no standard for consistency in who is responsible for providing us timely and accurate records or applications for MRP extensions so that the soldier is entered into the system. If this doesn't change, Army case managers will not have access to the records they need, orders will be cut too late and pay and benefits will be affected.

I ask the Army Installation Management Agency to help create standards for installations so that we will have the same policies in place to assist these soldiers.

Third, even with the new influx of medical case workers assigned to assist injured Guard Reserve soldiers, the ratio between patient and care manager is still too high at at least 50 to 1 at each hospital and now 30 to 1 at the CBHCO. These people are crucial to making appointments, liaisoning with families, liaisoning with doctors on treatment time tables, and also entering correct information into the mod system, one of the many data bases tracking medical data, timely and accurately. If you can, please help us with this.

Last, my office needs more resources. I have space issues, funding issues to visit facilities for training and assistance, and equipment shortages. I have time and again asked my budget office for the ability to use reimbursable GWOT funds to cover these expenses and am denied. I don't understand the reluctance to use already dedicated funds. I look to Congress to consider line item appropriations to help us in the Guard and Reserve.

Thank you, Mr. Chairman.

[The prepared statement of CWO Shuttleworth follows:]

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STATEMENT OF CHIEF WARRANT OFFICER RODGER L. SHUTTLEWORTH
CHIEF, RESERVE COMPONENT PERSONNEL SUPPORT SERVICES BRANCH,
U. S. ARMY HUMAN RESOURCES COMMAND

BEFORE THE COMMITTEE ON GOVERNMENT REFORM
UNITED STATES HOUSE OF REPRESENTATIVES
HEARING
“WOUNDED ARMY GUARD AND RESERVE FORCES: INCREASING THE
CAPACITY TO CARE”

THURSDAY, FEBRUARY 17, 2005

Mr. Chairman and Members of the Committee, it is a distinct honor to be here to discuss important issues affecting injured Reserve Component soldiers including those injured as a result of the Global War on Terrorism. Our Reserve Component soldiers have bore the brunt of growing pains necessary to change a system that was not designed to support Reserve Component soldiers.

My name is Chief Warrant Officer Rodger Shuttleworth. My military career began in 1973 where I served in the active Army until 1981. I then joined the Maryland Army National Guard and became a full time employee with the National Guard Bureau in 1988. I was assigned to my current position as Chief of the Reserve Component Support Services Branch, Army Human Resources Command in February 2000. My responsibilities include all aspects of personnel issues for Reserve Component soldiers ordered to active duty under Title 10, but not all active Guard and Reserve issues.

Prior to September 11, 2001, there were only two programs that dealt with injured reserve component soldiers, ADME and Incapacitation Pay. Incapacitation pay and allowances are paid without a soldier being ordered to active duty. There are a lot of soldiers on incapacitation pay, over \$3 million monthly is spent on their care and without proper oversight, questions on the best use of this money remains. If these soldiers were placed on ADME, they would be better managed and the Army would spend less money on getting them returned to duty or entered into the Physical Disability System.

The numbers of injured RC soldiers in these programs prior to 2001 were manageable, but due to the largest mobilization of Guard and Reserve since WWII in the Global War on Terrorism, the amount of injured needing assistance and help grew beyond our capacity to assist.

For example, I started with a staff of six. At that time, the Adjutant General of the Army gave me a mission to do all I could to increase our capacity to care for injured Reserve Component Soldiers. At this time, the only process to help injured Guard and Reserve was Active Duty Medical Extension (ADME) and incapacitation pay. ADME, prior to September 11, 2001, was only used to order drilling reservists injured in the line of duty during training to active duty for medical care. Because we were not prepared and the disaster on 9/11, ADME has to be used to support GWOT soldiers injured in the line of duty. Because ADME was not specifically designed for the GWOT, soldiers were being denied eligibility, fell off the pay system and lost benefits for their families. ADME was supposed to last 179 days, longer than the 30 days given, but the Army G-1, who was responsible for establishing and interpreting ADME policy, also chose to execute it and they became a major stumbling block, shortening extensions, as we tried to insure GWOT soldiers were treated equally to their active duty counterparts.

These problems continued until the creation of Medical Retention Process (MRP) in March 2003. This was an improvement better because the application process was easier, the requirements were streamlined, all extensions were now automatically 179 days, and we also directly submit soldiers orders to Defense Finance and Accounting Service so problems with pay and benefits will end. In January 2004, I established the Medical Services Section of my branch to facilitate MRP processing, medical board processing, and other RC personnel system for medical reasons. During this time, we began to realize we were also responsible to train and assist Reserve Component and active Army personnel in medical care facilities who had any questions at all on reserve component processing. Some calls are from medical holdover companies who do not always know how to process or help the Reserve and Guard being treated at their facilities. But most of our callers are Guard and Reserve soldiers who have not gotten answers from their chain of command or command at their facilities, and have exhausted all other avenues of help and service.

One of the major problems is that Army medical personnel do not interface with Army personnel specialists, and this continues to cause serious misunderstanding, delays and holdups in personnel services. Another of the major problems we have is that Medical Command personnel tell injured Guard and Reserve one thing, and we tell them another.

Another continuing source of inter- Army command difficulties for us involve our relationship with Army G-1. Army G-1 is by definition supposed to be a source of policy decisions and innovation, and we at Army Human Resources Command are the executors, but it hasn't always been the case. This causes the following problems: great delays in approval on each soldier's paperwork causing increased stays in treatment, pay problems, benefits and great family stress. We have spent far too much time debating between our offices on the most effective way to support injured Reserve Component soldiers. In regard to our difficulties, I am happy to report that two days ago, Army G-1 transferred functionally responsibility for all types of reserve component personnel management with regard to medical readiness processing to my branch.

I want to bring forward another problem that my staff and I encounter every day. Reserve Component soldiers are remaining on Active Duty for long periods of time without being entered into the Physical Disability Process and remain in the Medical Board Process for long periods of time. Of the paperwork we review, approximately 80% of ADME and MRP Reserve Component soldiers end up in the Physical Disability System. Part of the problem is a shortage of trained manpower at both Medical Command and the US Army Physical Disability Agency. Injured Reserve Component soldiers have paid the price for this, but we are trying to improve manning and training.

Guard and Reserve soldiers have so many difficulties because the active Army tries to treat them like active Army soldiers in all cases, and in some instances you cannot.

An example is, when an active army soldier is medi-vaced from a theater of operation to a stateside medical facility and is determined to be an outpatient, they are returned to their home unit for their period of recovery. A Reserve Component soldier may not have a home station because his unit has been mobilized, and there may be no one left at the home station to assist them. This causes us to lose accountability for these soldiers. All of them are authorized to receive medical care and treatment, and should be reported through an active Army organization prior to returning to their home of record. To alleviate this problem, the Army has created the Community Based Health Care Initiative (CBHCI). This initiative will allow some injured Reserve Component soldiers, after being processed through an active Army organization, to return to their home of record and their families, remain on active duty and receive medical care. Each Community Based Health Care Organization is responsible for the care and accountability of soldiers assigned them. My office assists in training the staff and personnel in these newly created facilities. In addition to that, I have placed over 80 NCO's at Army treatment facilities in the United States and Germany to assist in patient tracking and medical board processing. Because of the placement of these NCO's, completed Medical Boards ratios have improved.....now over 400 are being done annually. I have also placed personnel in the US Army Physical Disability Agency, DOD's Defense Finance and Accounting Service and at the CBHCOs. We were also asked very recently by the Army Installation Management Agency to provide experienced Reserve Component command and control staff on site in installations because there is a shortage of permanent staff at installation Medical Readiness Processing units and CBHCOs. There is still a need to sustain this staff currently and at least 2 years after current contingency operations end. As of last week, the Director of the Army Staff has approved my office to fill this leadership void through the Army-Extended Active Duty program.

I hope from my testimony, you understand how important it is to me and my staff that the Army continues to resource and improve policies aimed at supporting injured Guard and Reserve soldiers.

There are four things I want to bring to your attention:

One involves a needed change in Title 10. Under current law, Reserve Component soldiers not injured in the line of duty are entitled to a retirement benefit that soldiers who are injured in the line of duty are not entitled too, and that bothers all of us. I respectfully ask that Congress change this unfair law. Right now, if you are injured prior to entering into the armed forces and have 15 years of credible reserve service, and are found to be non-retainable, you are eligible to retire and obtain benefits at age 60. But if you agree to come to active duty and fight for your country, and are injured in the line of duty, you are not entitled to this benefit. The Law is Title 10, Subtitle E, Part II, Chapter 1223, Section 12731b.

Secondly, I have deep concerns about current Army procedures for injured Reserve Component soldiers at certain Army installations including Walter Reed Medical Center, Fort Bragg, Fort Bliss, Fort Lewis, Fort Dix and Fort Drum.

These installations do not provide timely or accurate medical personnel records or line duty investigations that are vital to the reserve component soldiers who are leaving active duty and will need future medical care. At these installations, there is no standard or consistency in who is responsible for providing us timely and accurate records or applications for MRP extensions so that a soldier is entered in the system. If this doesn't change, Army case managers will not have access to records they need, orders will be cut too late, and pay and benefits will be affected. I ask the Army Installation Management Agency to help create standards for installations so that we all have the same policies to in place to assist these soldiers.

Thirdly, even with the new influx of medical caseworkers assigned to assist injured reserve and guard, the ratio between patient and care manager is still too high at 50 to 1 at each hospital, and now 30 to 1 at each CBHO. These people are crucial to making appointments, liaising with families, liaising with doctors on treatment timetables

and also entering correct information into MODS, one of the many databases tracking medical data, timely and accurately. If you can, please help us with this.

Lastly, my office needs more resources. I have space issues, funding issues to visit facilities for training and assistance, and equipment shortages. I have time and again requested from my budget office the ability to use reimbursable GWOT funds to cover these expenses and am denied and I don't understand the reluctance to use already dedicated funds. I look Congress to consider line item appropriations to help us help the Reserve and Guard.

Chairman TOM DAVIS. Thank you very much.
Sergeant Forney, thank you.

STATEMENT OF MASTER SERGEANT DANIEL FORNEY

Sergeant FORNEY. Mr. Chairman and members of the committee, it is a distinct honor to be here to discuss active duty medical extension, the medical retention process, and life at medical hold at Walter Reed for injured Guard and Reserve soldiers.

I am Master Sergeant Forney, an Army Reservist from Pennsylvania with almost 25 years of proud service. I arrived at Walter Reed Army Medical Center in July 2002, after I volunteered and received orders from Chief Warrant Officer Shuttleworth of the Human Resources Command. Chief Shuttleworth saw the need for someone to help the administrative process for Guard and Reserve soldiers because the active duty medical hold company did not know how to help these soldiers.

I was the first Reservist liaison to be sent to Walter Reed to help soldiers. I was the only one there in that capacity for over 1 year. When I first arrived, there were only about 10 injured Army Reserve and National Guard soldiers on ground. I assessed the situation and determined that the process was broken. Soldiers fell off orders and had delayed pay and lost medical care. The soldiers' families also lost Tri-Care benefits.

Then came the task of keeping them on orders. This is where the real trouble started. Because I had to send their packets to the Army G-1 at the Pentagon to be signed and approved, sometimes it would take up to 4 months to get their orders. Although doctors had requested extensions for soldiers for up to 179 days and we submitted those requests, G-1 sometimes did not grant this much time, instead approving 90-day extensions. This caused more workload for us and put the soldiers at risk of falling off orders. This caused great hardship for the soldiers and their families, not only monetarily but because medical care for soldiers and their families stop when soldiers are not on orders.

G-1 requirements for valid support for an extension often changed, sometimes without notice. For example, at first a form 46-2-R was acceptable for doctors to sign off, and this worked well. However, after about 6 months this form was no longer taken. Now a letter from a doctor was needed that included significantly more information, such as the diagnosis, prognosis, and medical treatment plan. This then slowed down the process even more, because a soldier would have to get his or her doctor to take time and write the letter.

In April 2004 the medical retention process was implemented. This was a great step forward, reducing the process of getting orders down to an average of 7 days.

There are still stipulations for getting MRP orders. They have to be on 12301 orders. These are the mobilization orders. There are still some bugs in the system and we are working with the Human Resources Command to fine tune the process.

In addition to the problem with extending orders for soldiers and lost pay and benefits, there are other issues I want to bring to the committee's attention. For example, during all this we encountered

even more problems with the active duty, as they did not know how to deal with the Reserves and National Guard soldiers.

When I first arrived at Walter Reed in 2002 I found a soldier from California that was living in the hotel on ground. He had been living there for 3 months paying out of his own pocket. He had fallen off orders 2 months before. When he went to active duty, he was told that there was nothing they could do for him because he was National Guard. I did get him his back pay, and that took 2 months because it took a month to get him back on orders. As far as I know, he has never been reimbursed the total cost for his out-of-pocket expenses, approximately \$5,000.

Mr. Chairman, my staff and I do whatever it takes to make sure that soldiers are taken care of. The motto for the medical hold company at Walter Reed is soldiers first. My staff and I have spent approximately \$2,000 of our own money in the past 2 years and are continuing to pay out of our own pockets for a lot of the supplies we use to uphold the motto. The medical hold company only gets so much money a year, and my office is at the bottom of the list for funding. What makes this so bad is the Reserves and Guard are fighting next to the active duty, and still we treat them like second class citizens. We do not want to be treated special, just equal.

Thank you, sir.

[The prepared statement of Sergeant Forney follows:]

STATEMENT OF MASTER SARGEANT DANIEL FORNEY
RESERVE LIASION, MEDICAL HOLD, WALTER REED MEDICAL CENTER
U. S. HUMAN RESOURCES COMMAND
BEFORE THE COMMITTEE ON GOVERNMENT REFORM
U. S. HOUSE OF REPRESENTATIVES
"WOUNDED ARMY GUARD AND RESERVE FORCES: INCREASING THE
CAPACITY TO CARE"
FEBRUARY 17, 2005

Mr. Chairman and Members of the Committee, it is a distinct honor to be here to discuss Active Duty Medical Extension, the Medical Retention Program, and life in medical hold at Walter Reed for injured Guard and Reserve soldiers.

I am Master Sergeant Forney, an Army Reservist from Pennsylvania, with almost 25 years of proud service.

I arrived at Walter Reed Army Medical Center in July of 2002, after I volunteered and received orders from Chief Warrant Officer Shuttleworth of Human Resources Command. Chief Shuttleworth saw the need for some one to help with administrative processes for USAR/NG Soldiers because the Active Duty Medical Hold Company did not know how to help these soldiers. I was the first reservist liaison to be sent to Walter Reed to help soldiers, and was the only one there in that capacity for over one year. When I first arrived there was only about 10 injured Army Reserve and National Guard Soldiers on the ground at Walter Reed. I assessed the situation and determined that the process was broken. Soldiers fell off orders had delayed pay and lost Medical care. The soldiers' families also lost tricare benefits.

After a short time at Walter Reed I was given three 3-ring binders with over 800 sets of orders. These were orders for injured and ill soldiers from all over the North Atlantic Regional Medical Command. After contacting 98% of the Soldiers I was able to drop the number of Soldiers down to about 250 (ADME) orders and was told that we had to track and find the Soldiers we had orders on.

Then came the task of keeping them on orders. This is where the real trouble started because I had to send their packets to Army G-1 at the Pentagon to be signed and approved. Sometimes it would take up to 4 Months to get their orders. Although doctors had requested extensions for soldiers up to 179 days and we submitted those requests, G-1 sometimes did not grant this much time, instead approving 90 day extensions. This caused more workload for us and put the soldiers at risk of falling off orders.

This caused great hardship for the Soldiers and their families not only monetarily, but because Medical care for soldiers and their families stops when soldiers are not on orders.

G-1 requirements for valid support for an extension often changed, sometimes without notice. For example, at first a form 46-2-R was acceptable for doctors to sign off, and this worked well. However, after about 6 months this form was no longer taken and now a letter from a Doctor was needed that included significantly more information such as the diagnosis, prognosis, and medical treatment plan. This then slowed down the process even more because the Soldier would have to get his or her Doctor to take time and write the letter.

In April of 2004 the Medical Retention Process was implemented. This was a giant step forward, reducing the process for getting orders down to an average of 7 days. There are still stipulations for getting on MRP orders they have to be on 12301 orders these are mobilization orders there are still some bugs in the system and we are working with Human Resources Command to fine tune the process

In addition to the problems with extending orders for soldiers and lost pay and benefits, there are other issues I want to bring to the Committee's attention. For example, during all this we encountered even more problems with the Active Duty, as they did not know how to deal with the Reserves and National Guard Soldiers. When I first arrived at Walter Reed I found a Soldier from California that was living in the hotel on ground. He had been living there for 3 months paying out of his own pocket. He had fallen off orders 2 months before when he went to the Active Duty. He was told that there was nothing they could do for him because he was National Guard. I did get him his back pay and that took 2 months because it took a month to get him back on orders. As far as I know he has never been reimbursed the total cost for 3 months at 65 dollars a night, which is around 5,000 dollars, and that's not even the worst of it.

After a few months they said everybody would have to move out of the barracks at Walter Reed. When I asked where they were going to move I was told that the Soldiers would have to get their own place to live because they were getting housing allowance after trying to explain that Guard and Reserves can not get the housing allowance for the Washington DC area. That they were Guard and Reserves they would get the rate for their home of records. Because Reserves and Guard can not be (PCS) Permanent Change of Station they can only be (TCS) Temporary Change of Station.

I even showed them the Regulation and went up the chain of command with this. Still I was told that they would have to move off post at their own cost. After 6 months of doing this I finally e-mailed the post commander within one hour I had an e-mail back from him. He said he was not aware of this and that he would do something about it. After two hours I was called in front of the Sergeant Major and was asked why I did what I did and then I was told that we did not do things this way.

I told the Sergeant Major that I was sent there to take care of Soldiers and that is what I was doing. Within a week the post commander had a meeting with all the key personal to get housing for the Soldier. I was marked as a trouble maker by some of Soldiers that were involved. After that we were treated differently. We are the last to get anything we

even had to get our first set of computers out of the trash along with our desks. We now have new computers paid for by GWOT.

We have paid and are continuing to pay for a lot of the supplies we use out of our own pockets. The Medical Hold Company only gets so much money to spend for the year. This put us at the bottom of the list for money. My staff and I do whatever it takes to make sure the Soldiers are taken care of. What makes this so bad is the Reserves and Guard are fighting next to the Active Duty and still we are treated like Second class citizen. We do not want to be treated special, just equal.

My staff and I even came up with a way to save the Army a considerable amount of monies and have better command and control over Soldiers. They spend about 60,000 dollars a month just for the Reserves and Guard to stay at the apartment complex. By moving the Soldiers to FT Meade the Army would save a considerable amount of monies.

We went to FT Meade and found that there was a building that was empty. We were told that we could have the building. I went to my chain of command with this they went forward with it but the Active Duty does not want this to happen. They say it is because they would lose command and control of us.

My chain of command has taken this to the top and it looks like this will happen. This should not have taken this long because there are a lot of avenues to this for the Soldiers they would be in a safer place to be there would be more for them to do. There is a movie theater a bowling alley and they have a post shuttle.

Mr. Chairman, my staff and I do whatever it takes to make sure the Soldiers are taken care of. The motto for the Medical Hold Company at Walter Reed is, "Soldiers First". My staff and I have spent approximately \$2000.00 of our own money in the past two years and are continuing to pay out of our own pockets for a lot of the supplies we use to

up hold that motto. The Medical Hold Company only gets so much money a year, and my office is at the bottom of the list for funding.

What makes this so bad is the Reserves and Guard are fighting next to the Active Duty and still we are treated like Second class citizen. We do not want to be treated special, just equal.

Chairman TOM DAVIS. Thank you very much. That was very compelling testimony. It shows what happens when you don't get information sharing between the Guard and the Reserves and military and we are not interconnected and we are just letting regulations drive this whole process and we are forgetting about the people.

I am going to start the questions with Mr. Porter.

Mr. PORTER. Thank you, Mr. Chairman. Again, thank you to the panelists for pretty compelling testimony.

I have a specific question for Sergeant Allen. You had mentioned in your testimony and your backup regarding being persecuted for actions, vindictive medical hold personnel, and have been labeled as a troublemaker. Can you give me a little more details about that? How are you being labeled, and what are they doing to cause you additional pain and suffering right now?

Sergeant ALLEN. At the time, sir, when the original GAO investigation was started with Mary Ellen Tribanic—she is a great help—my chain of command started the investigation. They came to me. I was forthcoming, provided the information that was asked of me.

Shortly thereafter the first GAO report came out. The information that was contained in that report was very specific. It stated something to the effect, if my memory recalls correctly, "A Virginia Special Forces National Guard police officer from New Jersey—" something to that effect—"receiving medical treatment at Fort Bragg," which I was the only one of. When that happened I had on different occasions be called late at night, 8:30, 9 p.m., be told that I had a 4:30 or 4 a.m. appointment, medical appointment that is, sir.

And on more than one occasion I went to the appointment, documented when, where I was told to go. On one occasion at 4:30 a.m. I was told to have an MRI done. I went there. The NCOIC, the non-commissioned officer in charge, told me that he had told my medical administrator that they would not do my appointment at 4:30 a.m. and that I should come back Friday when my original appointment was scheduled.

I had the NCOIC write a letter, memorandum for record, stating that, turned it over to GAO, and continued to have those type of problems. I do have them documented. I have filed them all with the GAO. It is very unfortunate. I consider myself a big boy. I can take care of myself, and I have taken care of myself. But my concern has been and will be for the lower enlisted guy that can't take care of themselves. That is one of the examples.

Mr. PORTER. Thank you.

Mr. Chairman, if I could ask an additional question. Mr. Perez, again, thank you for being here. I know that you are a long way from home. I appreciate it very much. Very compelling testimony.

Can you kind of explain the difference between when you were in the Marines and your most recent service? Was there different treatment? Was there substantial difference in culture and procedures?

Sergeant PEREZ. Yes, I would go ahead and answer that. I enjoyed both the services, but I did feel that the care and the commitment that I received while in the Marine Corps, even like it was

stated, your mid-level sergeant positions, a gunnery sergeant or an E-6 or an E-7 took great pride in taking care of their under-enlistment soldiers. They didn't try to pass it up the chain of command for the next level to try to take care of it. I found when I got into the Army once again that, even though we were serving side by side with the active, when we got back it was just—there seemed to be a complete discomfort on how we were treated as National Guard and Reserves.

Many of our command, when they come back to the States, they are coming back—when they come back to the States they are getting demobilized. They are going back to their job, going back to 1 weekend out of the month, 2 weeks out of the summer time. So when you are trying to get in contact with the same command that you are serving active duty with, a lot of times you can't get in contact with them, not even e-mails or replies back. That is real discomforting, because this is the command group that you are hoping would be there for you the same way you were there for them.

Mr. PORTER. Thank you.

Chairman TOM DAVIS. Ms. Norton.

Ms. NORTON. Thank you, Mr. Chairman.

Mr. Kutz, in trying to get our arms around this process, your own work has been important to us. We recognize that part of what has happened with the medical hold has to do with the planning connected with the overall war effort. But when we hear this testimony and we read your report, it has all the appearance of a start-up effort. Can I ask you whether or not medical holds have been used? Is it because we have such a large—in other wars? I mean, it is as if we haven't done this before. Does this have to do with the fact that we are using such a large Reserve and Guard component to fight this war in the first place?

Mr. KUTZ. Yes. Under the old active duty medical extension program that was really not designed for the kind of operational tempo we have today. The medical retention process that they have in place now is probably more equipped with what is going on, although that has risks also.

But really what you are talking about here is that they have a process, not a program that is being managed. There is no one really in charge, no one responsible. There is a lot of organizations, but there is no one that you can go to and say that you are accountable for this.

So the kinds of stories that you have heard from the witnesses here, you can't go hold anyone accountable at this point, and so I think someone does need to be put in charge, made responsible. Put a general in charge of this, an ombudsman, or someone, because this is clearly reflective of not being prepared to handle the kind of operational tempo that you have today.

Ms. NORTON. In that regard I would like to get a clarification from Chief Warrant Officer Shuttleworth who said in one section of his testimony he was happy to report that G-1 transferred functionally "responsibility for all types of Reserve Component personnel management with regard to medical readiness processing to my branch." I wonder if you are saying that you are in charge. What are the specific effects you expect from the transfer you describe in your testimony?

CWO SHUTTLEWORTH. The G-1 has transferred all orders processing and for the most part the approval process except for those cases that may be in question or may have some specific things that doctors and medical professionals need to look at. But what that does is what we had before we did this was that we had several different agencies within the Army publishing orders, depending on the kind of active duty that you were going to place that soldier on.

As of this month, we now own all the orders, ADME, medical readiness processing both one and two, and all the other processes that keep these global war on terrorism soldiers on active duty. Therefore, the soldier now has one place to go and one place to get those orders from and doesn't have to go wondering where they are going to get their next order from.

Ms. NORTON. Do you believe, for example, if you would just take me through a scenario—you have heard them here—that this would solve the problems we have heard and the testimony we have received here this morning?

CWO SHUTTLEWORTH. Yes. ADME was never designed to be a 30 or 60 or 90-day program. ADME was a program that was designed to be just what MRP is, but for a smaller number of people. It was designed to be a 179-day program, 6 months for each soldier, but because the individuals who managed the program chose to decide for themselves how much care a soldier really needed based on the number of days they wanted to put them on orders, those soldiers began to fall off orders, which was the wrong thing to do and that will be fixed. No order is cut for less than 179 days, and they are all directly fed to the finance accounting office so they will not drop off the system.

Ms. NORTON. We are going to really be expecting real improvements here. You talk about debates back and forth over what to do. It seems a pretty simple remedy that somebody has come up with. I can't imagine why it took so long if this is, in fact, centralizing control that was the answer all along.

May I ask, because it looks like some progress was being made on the front end, that there were additional personnel that many on the front end were no longer falling off of their orders and pay, and there were housing standards. As a result of some of the work of this committee, it looks like some improvements have been made.

Now, given the improvement you spoke of, it seems to me a signal improvement in your testimony. You nevertheless have a real mop-up job to do here, and therefore I am really interested in corrective efforts. My question really goes to part of, I guess, Mr. Kutz' testimony where he says we need advocates. I am sorry, this is General Byrne's testimony. He says we need advocates other than the Inspector General for our RC soldiers who can break down the perceived and real barriers.

I wish you would explain what you mean. It certainly is true that you have to go all the way to that high level, a pretty nuclear level to get problems dealt with. I wonder what you have in mind, what kind of—are you talking about some kind of ombudsman, some kind of better troubleshooting? Does what we have heard from Mr. Shuttleworth take care of it in terms of the support you would need

other than the advocate general in order to get these problems dealt with?

General BYRNE. Ms. Norton, I will go ahead and start it, and then I would like Dr. Eliason. Essentially, what I would be looking at is some sort of form of an ombudsman, someone who knows the system, who can take the part of the soldier. For example, in the process each of the soldiers is given a case worker, but the case worker doesn't necessarily work for the soldier, it works for the system in working through getting the soldiers to the end of the process, the medical process. So they are not neutral necessarily or for the soldier, and so as a soldier does go through the process they are not familiar with the process.

Now, what we have done in Oregon is periodically we send our medical personnel plus our administrative personnel papers now up to the various places we have soldiers all across the Nation, and they go through and they assist them in any pay, personnel actions, and in some cases any medical actions that they can assist in.

Let me turn it over to Colonel Eliason. He can better explain.

Colonel ELIASON. The uncertainty of medicine causes concern for our soldiers. When I as a private physician am asked by a soldier for my medical opinion, there is a relationship built on trust that has happened because they have selected me. They have come to me to be their doctor. They know that they have choices, that they can go and get second opinions, they can ask other physicians. Our soldiers, when they become injured—

Ms. NORTON. You said they can get second opinions, although that was one of the areas that Mr. Kutz' testimony said raised issues for members of the Reserve and Guard.

Colonel ELIASON. Yes, ma'am. I guess what I was trying to highlight is that the uncertainty happens frequently because of the fact that you will hear two separate stories, not because one system has better medicine than the other, but because of the fact that there is uncertainty and that different treatment plans vary based on different physicians.

The problem is our soldiers are looked at. When they arrive at a medical facility they see a green-suit doctor who is the company doctor, the Army doctor. They don't always see this as their physician, a person they can trust and establish that kind of relationship. What advocacy is about is somebody who can help break down those barriers and explain the uncertainty in medicine, explain and advocate for the soldier, maybe even attend an appointment with them to settle a misunderstanding about their treatment plan.

As General Byrne has said earlier, the Sergeant General has wonderful indicators of the quality of care that he provides in the system. The problem is our soldiers often begin with an element of distrust or at least concern about what health care they can receive, and this is their physician telling them that they need surgery or that it is better not to have surgery and maybe physical therapy first.

Chairman TOM DAVIS. Thank you very much. I am going to take—

Ms. NORTON. Mr. Shuttleworth had—

Chairman TOM DAVIS. Did you want to say anything, Mr. Shuttleworth, on that?

CWO SHUTTLEWORTH. No, sir.

Chairman TOM DAVIS. OK. I will take my 5 minutes. It looks to me like what we have, gentlemen, is a breakdown in the chain of command. I mean, it is very clear here that this is absolutely broken, and when people who are in the system tried to move forward and tried to be advocates they were ostracized, they were slapped down. We heard this from Sergeant Forney's testimony.

Maybe a designated ombudsman whose job it is to get to the bottom of this and that is their job and nobody questions them is something that you need. We had people who tried to step up to that role, but the system tended to swallow them.

You have so many different stovepipes in the military right now, so many chair fights, so we are not getting the information sharing back and forth. This has taken 30, 40 years to get it this way. Everybody wants to do it their own way. They want their own legacy system. They want this or that. We come into a war at this point and we can't put it together, and these people, these soldiers who are on the front lines taking fire, some of them killed, some of them injured coming back, we have a system that has been so turf driven that it is beyond the power of one or two people to fix.

One of the purposes of this committee is to try to get Government to work as a unit. We don't have the jurisdiction of a lot of the other authorizing committees. We try to work across those lines to make it work. This is just an indication with some very sad consequences, and I think, from the perspective from the Department of Defense, some very embarrassing consequences of what has happened with years and years and years of these systems that are jealously guarded, that are stovepipes, that are not communicating with other systems, and the people that fall through the cracks.

It gets so regulation driven at this point we forget about the mission, which is getting these people back on their feet, getting them the health care that they have earned, that they deserve, and getting them back out in society. It is embarrassing for all of us.

Yes, I think there will be some appropriate followup action on this. The Armed Services Committee is also very, very concerned about this. But if these gentlemen hadn't taken their initiative to come forward—and we asked them to come. We asked them to come here. We begged them to come here. Nobody wants to embarrass anybody, but it wouldn't get fixed. We have more and more people in queue. I think people are trying to make it better, but I am not sure this isn't so stovepipe driven at this point it becomes more and more difficult all the time.

General Byrne, can you give me some examples of some specific problems soldiers encountered during their time at Fort Lewis? And also you made the statement about these soldiers were of no concern of yours, which is a typical stovepipe answer that now they are under Army care and you guys back out. It is the typical turf fight. Who said that?

General BYRNE. I would rather not say.

Chairman TOM DAVIS. I know you wouldn't, but I am asking you who said it at this point. Do you want to get with the committee

later on? You know, it is not what ought to be happening. You agree with that, don't you?

General BYRNE. Yes, sir.

Chairman TOM DAVIS. I mean, somebody has to be accountable somewhere when they are saying this kind of stuff, so I am not going to ask you to say anything but we are going to ask you afterwards. Will you help us? Because this should not be allowed to continue, and the person who said that needs an attitude adjustment.

Go ahead, though. Tell me some of the problems.

General BYRNE. What concerned me, just to followup on that, the conversation I had with the individual, what concerned me most in the conversation was the fact that nowhere in our conversation did taking care of soldiers come up. It was the fact that there was a newspaper article that had been published, the fact that potentially I was not following procedures as far as how we went and did business. As a result of maybe a news article that came out, my intent was not to raise major issues, was not to—

Chairman TOM DAVIS. Of course not.

General BYRNE [continuing]. Embarrass anybody, was not to create major problems. My whole purpose in going to Fort Lewis in this case was to take care of soldiers. The way I run things in Oregon, and I hold my subordinates accountable for this, is I don't place blame. What is the problem? Let's put our effort and energy into taking care of the problem, the issue. That is the way I do business. And so I sometimes, when things get sidetracked, I get real excited and it bothers me.

Chairman TOM DAVIS. I think the statement is less reflective of the individual, I am afraid, and more reflective of the system.

General BYRNE. I would agree.

Chairman TOM DAVIS. That is why I understand you don't want to come forward.

General BYRNE. Yes.

Chairman TOM DAVIS. It probably is reflective of the system.

General BYRNE. I can't speak to it. I can only speak to individuals.

Chairman TOM DAVIS. Yes.

General BYRNE. Very similar to what the soldiers here today have talked about, very similar things related: pay issues, promotion issues. I own some of that, and part of the reason why I went to Fort Lewis was to find out what is—after I finished the visit I divided up my findings what I had. I divided it up into three parts: what is it that I owned? What is it that maybe the medical folks owned? And what is it that maybe the post owned? Then I sent that off to Fort Lewis, and then I sent my folks the piece that I had.

I deal with families, so any issues that were related to families and families not being taken care of I worked at.

Chairman TOM DAVIS. That is fine. I am glad somebody was looking after them at this point.

General BYRNE. Well, I do.

Chairman TOM DAVIS. Right.

General BYRNE. That is my job.

The second piece that I worked on was there are pay issues. Again, we need one system, one pay system, and at this point in

time that is not there, but strides are being made, and so I own some of the pay issues that the soldiers have. I also own some of the personnel issues, for example, promotions and things like that, so I own those, too. But as services and similar instances that these soldiers have testified toward, those are things that I had concerns of, and then I turned those back over to Madigan Hospital.

Chairman TOM DAVIS. Right.

General BYRNE. I would like to compliment Dr. Dunn, who is the commander at Madigan Hospital. When he knows the information, he works it hard.

Chairman TOM DAVIS. Thank you. My time is up, but let me just ask for Sergeant Allen and for Sergeant Perez and also to Mr. Shuttleworth and Forney, I mean, the two individual cases we heard about are not isolated cases, are they? Is that correct, Sergeant Forney?

Sergeant FORNEY. Right.

Chairman TOM DAVIS. Unfortunately, these are just two people. One, we had a long talk with Sergeant Allen, but he had a half dozen other people with him that had similar problems just over at Walter Reed, and this is just 1 day going through. Unfortunately, we are not taking one or two nit-picky instances. This is a problem that has been endemic throughout the system. Would you agree with that, Sergeant Allen?

Sergeant ALLEN. Yes, sir, I would. From the six injured soldiers from my unit, all six of us had significant pay problems, significant problems with our orders not being renewed in a timely manner. And from the other National Guard and Reserve soldiers that are at Walter Reed with me, they were having significant problems.

One of the caveats that I do want to add is there is a couple really good guys that were trying hard that were getting squashed, like Sergeant Forney.

Chairman TOM DAVIS. Yes.

Sergeant ALLEN. And Chief Shuttleworth and Chief Laura Lindle that was in my testimony, last month when I talked to you and I was having the pay problems and you read my testimony about the 23rd, well, that was due to Chief Shuttleworth and Laura Lindle. Hopefully now that he has gotten command of that structure, it is going to make a change for all these guys and we are not going to have what we have had.

Mr. KUTZ. Mr. Chairman, I would say that we looked at this overall. We are talking about hundreds, possibly over 1,000 soldiers that have had this type of problem, based on our overall look.

Chairman TOM DAVIS. Yes. And you don't think that is going to help recruiting and retention, do you, Mr. Kutz?

Mr. KUTZ. That is an issue, because the soldiers that aren't injured are very well aware of what is happening to the injured soldiers.

Chairman TOM DAVIS. And they should be, frankly. I mean, this is just something that we weren't ready for.

Mr. RUPPERSBERGER, 5 minutes.

Mr. RUPPERSBERGER. Thank you, Mr. Chairman.

I have a whole list of questions, Mr. Chairman, I would like to leave with GAO and have written answers given back, but I have another hearing I have to go to at 12.

The one issue that I would like to talk about right now with respect to Walter Reed, I had one of my staff people go to a briefing this past Monday for the care that wounded soldiers currently were receiving at Walter Reed, and she left with the impression that even though there are still a lot of issues out there that we have discussed here today with respect to the Army and DOD and the problems from pay to care, but she left with the impression that a lot of the issues that we talked about here today, that Walter Reed has really resolved some of those problems.

Now, when you go to a briefing sometimes you only hear what the top people want you to hear. I want to make sure, to hear from you all whether or not—I guess you, Chief Shuttleworth—are there problems that still exist at Walter Reed? What are they? We have heard these problems today. If they are, let's talk about them.

CWO SHUTTLEWORTH. Obviously I can't speak for the medical care. That is a medical professionals' issue, but from the administration—

Mr. RUPPERSBERGER. I am talking about paperwork issues, which is what you testified to.

CWO SHUTTLEWORTH. From a personnel/administrative standpoint—

Mr. RUPPERSBERGER. Right.

CWO SHUTTLEWORTH [continuing]. As far as soldiers dropping off orders and dropping out of pay, I believe that we have fixed that problem. There are still some accountability issues within the system that we are still trying to get our hands wrapped around, but I believe that we have about a 99 percent accountability of those Reserve Component soldiers that we didn't have before. So we are improving the process. We may not be there yet, but we are about 90 percent there.

Mr. RUPPERSBERGER. OK. Well, in my opening statement I talked about a bill that we are still attempting to work. I really would like to meet with you and maybe Sergeant Forney to get further information.

Just one question, though. You say the paperwork system seems to be doing better. That is why we are here. That is why we want to move forward. How about the system entirely, not just Walter Reed? Do you have any knowledge of other problems that are out there? Since Walter Reed has gone a long way in relation to paperwork, that should be a model for the other areas.

CWO SHUTTLEWORTH. Well, the good news is that when we fixed the system we didn't just fix Walter Reed. We looked at everybody. So when we started fixing the program, we fixed the entire program. When we developed the MRP process, it was for the entire Army and not because of what was happening at Walter Reed at the time. So we really have wrapped our arms around the whole thing, and the whole thing is being fixed at the same time, rather than one piece at a time.

Mr. RUPPERSBERGER. You feel it is beyond just Walter Reed then?

CWO SHUTTLEWORTH. It was, yes.

Mr. RUPPERSBERGER. Mr. Kutz, the questions that I am going to present to you are questions about solving the problem, I mean, our whole system, the priority of funding, our technology and how we are using it. One of the things, it seems to me, the problem is that it all starts at the top, and upper-level management has to hold middle-level management accountable for the follow-through and it just hasn't happened. That was your testimony all day through. We have to start at the top, see what the system is, make sure the resources are given, and hold the people accountable so that this will not happen.

Thank you all for being here to day.

Chairman TOM DAVIS. Thank you.

Mrs. Miller.

Mrs. MILLER. Thank you, Mr. Chairman. First of all, Mr. Chairman, let me thank you for holding this hearing today and all of these witnesses for coming here. This is an unbelievable issue. I shouldn't say unbelievable. I suppose we should be shocked by some of the testimony, but unfortunately we are not. We do recognize that this is a problem, perhaps a manifestation of the high degree of the amount of people, Guard and Reserve, that we have as a component of the total force in today's world and today's military.

But, you know, at a time when our country is successfully prosecuting the war on terror, at a time I think when our country is needing to be so focused on recruitment and retention and these kinds of things, the testimony that we have heard today is certainly distressing. It does call for action by the Congress, by the DOD, and, as the chairman has said, that is something that our committee I think can very much be a conduit of as we investigate some of these different situations.

I have a question for General Byrne. Let me preface the question by telling you a bit. In my particular Congressional District we have what is known as Selfridge Air National Guard Base, which is a unique kind of facility in the inventory of the Guard, as you know. It is unusual, the exception rather than the rule, that the Guard would actually own a base, own the real estate. They do. Normally they are an appendage off of a commercial airport or something, and of course the armories. We have all of that also.

But we have at this particular base every facet of the military represented there, not only the Air Guard, but the Air Force Reserve, the Marines, the Navy. It is not only a critical component in the recruitment in an urban area, of course, but it has been a major deployment area as we are in theater here for the Guard and Reserve forces. In fact, my husband, after having served as a fighter pilot in Viet Nam in the Air Force, finished his military career as a Air Reserve, Michigan Air National Guard Reserve officer. He was the base commander there.

I will tell you one of my other committee assignments is also serving on the House Armed Services Committee, and so, as the chairman has said, our committee also has been looking at some of these kinds of problems.

To the extent that in our last Defense authorization, reauthorization bill, we actually titled it "2004, the Year of the Troops." With all of the tremendous expenditures our country does make on armaments and various systems, there is no second, obviously, for

our troops. So we were very pleased to have as a component of the Defense Reauthorization Act a real emphasis on creating parity for the Guard and Reserve to the active duty. As one of you mentioned, the bullet doesn't know if it is hitting an active duty or a Guard or Reserve. I think that was you, Sergeant Allen. That is so true.

We have had, I won't say huge strides, but we made a lot of improvements last year in having parity, I think, between the active duty and the Guard and Reserve, not only with pay, but with commissary privileges. One of you mentioned about commissary privileges. As you know, previously you could only go once a month, which is crazy. Actually having parity with all of this is so important, as well.

And, of course, as we mentioned, now if you go and look in theater, in the high 30 percentile is the component you will find of our Guard and Reserve, whether you are in Iraq, Afghanistan, Uzbekistan, what have you. Many of the Guard and Reserve, unfortunately perhaps maybe for them, have such a tremendous skill set that they are called for longer deployments, depending on what the mission is there. We are finding that those kinds of things are happening with extended tours.

That is a sort of long lead-up to the question, General, but I actually have a unit coming home to our base tomorrow, I believe, that has had some similar instances that you have articulated a little bit in your testimony, as well, to some of your Reserve units. It is a group that actually—there was also a newspaper article about them. They process through Fort Bliss.

We actually had called the processing personnel from our office and said we were going to send a person down there to make sure that these Guard and Reserve, as they were coming back home, that their needs were being met, etc., and that we weren't absolutely convinced because they had a bad experience as they began their deployment, quite frankly, not having—I won't go into all the details, but similar to what you have found with some of your units, perhaps, in Oregon there.

I would ask you, General, do you think that the respective adjutant generals—my adjutant general for Michigan is General Tom Cutler. Now, he is a blue-suiter. I hope you won't hold that against him. But is it possible for the adjutant generals, as we are calling on all of our Guard and Reserve forces in the universe or in the Nation to do more, is it possible for the adjutant generals to have a more forceful role perhaps as a fraternity in making sure that their units—and I also appreciate the chairman's comments, which you said you were told that your troops were no longer a concern of yours now that they weren't active duty and how outrageous that comment actually is.

How can the adjutant generals perhaps be a more effective conduit to making sure that as your units are called up, as they begin deployment, as they are processed into theater and then all the way through their deployment and coming home, is there something else that the AGs could do or that Congress could help you to do?

General BYRNE. I am sure that each of the adjutant generals takes a very profound interest in deploying and redeploying their units, whether they are Army or National Guard, Air Force. I know

that they advocate for their personnel. Also, there is an organization, the Adjutant General Association of the United States, which also collects commonalities and works through those. I know that organization works very hard to develop agendas and items related to deployment and re-deployment. So we do work it.

Mrs. MILLER. I mean, I think you have to. I am sure that every AG across the Nation shares your consternation, if they are getting those kinds of answers. My adjutant general has never mentioned anything quite like that, but there is a different culture, I think, and so I wondered about that.

Thank you. And thank you, Mr. Chairman.

Chairman TOM DAVIS. Thank you very much.

Mr. Shays.

Mr. SHAYS. General Byrne, you provided a list of 84 of your soldiers that are now in medical hold status. Of the 84, 73 have been in longer than the current reported Army standard of 67 days, 35 of them have been in longer than 6 months. Is this the standard you have found?

General BYRNE. I would like to let Dr. Eliason answer the question. This is his area. He follows a lot better.

Mr. SHAYS. Sure. I thought all you were going to say is no.

Colonel ELIASON. Well, sir, I can't speak to the Army standard. When soldiers are put in medical holdover, under the MRP processing there is supposed to be a determination made relatively early whether they can eventually return to theater, which I suspect is where the 67-day rule is.

Our major concern is getting our soldiers home. What we would like and what we have asked and, quite frankly, what has improved markedly in the last year is getting them into programs like community based health care organizations. Their length of treatment is their length of treatment. People heal as they heal. But the sooner we get them home, we believe they are going to heal better, and so that is our push—as rapidly as possible getting them returned to their State for care, where they are living in their own home with their family and their support system around them.

Mr. SHAYS. That is your answer?

Colonel ELIASON. Yes, sir.

Mr. SHAYS. Well, frankly, this is an old story, and it is shocking except it is an old story, which kind of makes it even more shocking. I am pretty convinced that in Congress we have tried to put enough focus on this to embarrass a solution, and yet that doesn't seem to work. So I am somewhat lost for why this continues to persist, and I am just wondering if any of you could suggest to me why it continues to persist.

I would like, Mr. Kutz, for you to tell me why you think it persists.

Mr. KUTZ. You are talking about the Medical Board process? I am not familiar with that, so I can't really comment on that. I mean, we heard from the soldiers that we talked to that had the MRP problems and the medical extension problems that they were in hold waiting for the Medical Boards for hundreds of days in some cases, and that is about all the knowledge that I would have on that.

Sergeant ALLEN. Sergeant Allen, sir. I think it is a serious lack of leadership ability in the mid-level command. People aren't willing to step up to the plate and just do what is necessary. If something is identified that is wrong, then it needs to go away. What has perplexed me this whole time living this nightmare is how could something be so wrong and continue to go on and on and on and just keep perpetuating itself? It is generation after generation.

A perfect example, I just went to get my orders to out-process and they were wrong and they had me as a specialist in the Army. I talked to my friend that got out 2 months ago and I said, "I can't believe this. I feel like I am the first guy to go through this." His name is Ryan Kelly, and he said, "Well, that is funny, because I thought I was the first guy 2 months ago to go through it." And so I think it is a serious lack of people just stepping up to the plate and coming up with a solution. I think if somebody can come up with a solution, then it would be implemented and there wouldn't be the problem.

Mr. SHAYS. See, usually what happens in something like this, when Congress decides that we are going to conduct a hearing on it, it is such a shameful thing that people start to take action. Sometimes the problem is resolved before we even have a hearing. In this case, this is not the first hearing and the problem continues. That is what I find, frankly, a bit discouraging. It clearly has to be the stovepipe nature of it, and no one taking responsibility.

Sergeant ALLEN. To add to that, sir, some very senior high people in DOD and the Army have been trying to help us, the guys that aren't getting paid, aren't getting orders. I mean, the one-star, two-star, three-star generals, people over at DOD, and you would think that would encourage things to be changed, but there again, you know, it is got to be in the mid-command level of the philosophy, command philosophy as a whole, which is what I put in my testimony, that people, they don't take the time to care.

Mr. SHAYS. My conclusion is it is just not a priority of DOD. That is the only conclusion I can get.

If I told my Dad when I was young, "Well, I forgot," he would say to me, "If I gave you \$100, you wouldn't have forgotten." It was a clear message to me. In other words, if it had been a priority, I wouldn't have forgotten. And in the case of DOD, this has been a longstanding problem. We have too many of our Reservists and National Guard risking their lives, and they get treated like dirt. That is the bottom line.

Thank you, Mr. Chairman.

Chairman TOM DAVIS. Yes. Thank you very much.

Ms. Norton.

Ms. NORTON. I just have two short questions. My colleague from Connecticut is pressing toward a remedy when he says why has this gone on so long, and I just want to understand what the testimony here has been with respect to remedy. Do I understand—and perhaps it was General Byrne—that you endorse the notion of some form of ombudsman attached to these companies that would perhaps do some of what, or at least bring to earlier attention some of what we have heard about in these work-around procedures I think that GAO reported where people are in an ad hoc business running around trying to straighten these out.

I am asking would an ombudsman help that. And I am also asking Officer Shuttleworth whether he would endorse the notion, whether it would help his work now that he says this has been centralized with him, to have an ombudsman connected to these holding companies.

First General Byrne.

General BYRNE. Ms. Norton, yes, a neutral party, someone who is educated in the process that can, one, explain and, two, be an advocate for the individual as they go through the process.

Ms. NORTON. Do you endorse that notion, Officer Shuttleworth?

CWO SHUTTLEWORTH. We can use all the help we can get. I will tell you that as far as the comment on the Medical Board process a while ago, understand that prior to September 11th the amount of Medical Boards that were pushed through for Reserve Component soldiers in a year was very low, sometimes not even 100. If you look at the statistics from prior to that, what happened—and the liaison offices for those medical facilities are staffed with civilian employees, and not very many of them, I will tell you, to work with the active Army soldiers that get hurt.

So after September 11th trying to push 400 and 500 boards through every 3 months or 4 months on a Guard or Reserve soldier is just overburdening the system. That is why there are in my testimony 80 NCOs out there at treatment facilities who have Guard and Reserve experience to help these soldiers with that.

So to have someone else out there helping us? Absolutely. We can use anything that we can get in order to get these soldiers through the system timely and fairly.

Ms. NORTON. Mr. Chairman, I wouldn't want it to go unnoticed, because I think this comes out of the hearings you have held, the GAO report you ordered, not only the notion this notion of ombudsman is endorsed here, but also I would not want to go unnoticed what, again, Officer Shuttleworth said here today. I believe that has come out of your work in this hearing, where he announced that 2 days ago they centralized these concerns for processing in his branch, and therefore we are going to look to that person in charge now for improvements on the theory that it will help the process.

One final question. It was very compelling testimony about what we in civilian life call post traumatic problems or syndrome, very, very disturbing. I wonder whether somebody could tell me whether or not in this war and other wars that qualifies for disability or if it should qualify for disability.

CWO SHUTTLEWORTH. I believe that on the next panel there is a colonel from the Physical Disability Agency.

Ms. NORTON. Thank you. I will ask them.

Chairman TOM DAVIS. Can I just say thank you to all of you. Sergeant Allen and Sergeant Perez, very, very compelling testimony. I think the Members were very moved by it. Let me thank your wives, who have had to stick through this thing. This has been a family issue for a long time, and we appreciate your loyalty. You are all heroes and heroines in my book.

To Mr. Shuttleworth and Sergeant Forney, you tried to be ombudsmen, but we have a system right now that just really doesn't embrace that concept. Maybe we ought to formalize it a little bit.

General Byrne, thank you for your continued concern for your troops there. I think what you have shown is that it is a systematic problem, just in terms of the troops go from you to the Federal system, the Federal system says, "It is not your concern, it is ours," and then they don't take care of them. I mean, what are you supposed to do?

And Mr. Kutz, you laid the groundwork in your report, you and your team. We want to thank you for that. Hopefully we can limit the damage in the future because of what people have been able to come forward with today and testify to, so this is not in vain. It is important, and we appreciate it.

I will dismiss this panel and move on. We will take a 1-minute recess and move on to the next panel. Thank you very much.

[Recess.]

Chairman TOM DAVIS. We welcome our second panel. I want to thank them for taking the time from their schedules to come today.

We have Ms. Ellen Embrey, the Deputy Assistant Secretary of Defense for Employment Health from the U.S. Department of Defense; Daniel Denning, Principal Deputy Assistant Secretary of the Army for Manpower and Reserve; Lieutenant General Franklin Hagenbeck, the Deputy Chief of Staff, G-1, U.S. Army; Lieutenant General Kevin Kiley, M.D., U.S. Army Surgeon General; Major General Charles Wilson, Deputy Commander, U.S. Army Reserve Command; and Mr. Philip Sakowitz, who is the Deputy Director, U.S. Army Installation Management Agency.

It is our policy that all witnesses be sworn, so please rise with me and raise your right hands.

[Witnesses sworn.]

Chairman TOM DAVIS. Thank you very much for being with us today. I think you have heard the first panel and I think we agreed you wanted to go after the first panel, give them an opportunity to air some of the problems that we have encountered.

We have a 5-minute rule. We were a little lax on it in the first panel. We wanted to give some of the people just an opportunity to tell the whole story. We will try to ask you to be a little more accommodating of it.

We have votes that could come up at any time, and it is my intention, if votes come up, to move straight through the panel, and I will stay as long as I can and then let Ms. Norton finish with votes, give her questions, and then close the panel at that point and recess, if your time permits, until after votes, and then we would come back and the rest of us ask questions. Ms. Norton would be able to go ahead with her questions. We have done that before. Unfortunately, we are allowed to do this because Ms. Norton doesn't get a vote on the House floor, something that Mr. Shays and myself are trying to rectify. I just wanted to add that.

Ms. Embrey, we will start with you. Thank you for being with us.

STATEMENTS OF ELLEN EMBREY, DEPUTY ASSISTANT SECRETARY OF DEFENSE FOR EMPLOYMENT HEALTH, DEPARTMENT OF DEFENSE; DANIEL DENNING, ACTING ASSISTANT SECRETARY OF THE ARMY, MANPOWER AND RESERVE AFFAIRS, ACCOMPANIED BY LIEUTENANT GENERAL ROGER SCHULTZ, DIRECTOR, ARMY NATIONAL GUARD; LIEUTENANT GENERAL FRANKLIN L. HAGENBECK, DEPUTY CHIEF OF STAFF, G-1, U.S. ARMY; LIEUTENANT GENERAL KEVIN C. KILEY, M.D., U.S. ARMY SURGEON GENERAL; MAJOR GENERAL CHARLES WILSON, DEPUTY COMMANDER, U.S. ARMY RESERVE COMMAND; AND PHILIP E. SAKOWITZ, JR., DEPUTY DIRECTOR, U.S. ARMY INSTALLATIONS MANAGEMENT AGENCY

STATEMENT OF ELLEN EMBREY

Ms. EMBREY. Thank you, Mr. Chairman and distinguished members of this committee. I appreciate the opportunity to talk today about the force health protection programs in the Department and how they impact the care that we provide to wounded service members. I want to reiterate that the Department is firmly committed to protecting the health of our active and Reserve Component members before deployment, while they are deployed, and, of course, upon their return.

I am pleased to join my colleagues today on this panel to address your specific concerns regarding the care for soldiers injured in Operations Enduring Freedom and Iraqi Freedom. Today I will outline the Department's current management practices, technological advances, and initiatives underway to address this very important issue, with a particular focus on the Army Reserve components.

With your permission, Mr. Chairman, I would like to submit my written testimony for the record and then just discuss—

Chairman TOM DAVIS. Let me note, everyone's entire written testimony is in the record and is a part of it, and questions will be based on the entire, so it will allow you 5 minutes to kind of accent what you want.

Thank you.

Ms. EMBREY. Terrific. Thank you.

As you know, the global war on terrorism is the largest ongoing mobilization of the Reserve Component since World War II. In fact, since September 11, 2001, approximately 475,000 Reserve Component members have been mobilized to support the global war on terrorism. Of those mobilized, 376,000, or roughly 79 percent, of the Army Reserve Component were mobilized.

Virtually all operations yield lessons learned, and our OIF and OEF experience has been no different. Early on we recognized that many rules and procedures that worked well for smaller mobilizations of shorter durations are very well unsuited for a large and prolonged mobilization that we are currently experiencing in OIF and OEF.

The Department and the services recognized these shortfalls and undertook several initiatives over the last 2 years to improve the medical readiness of the force overall and the Reserve Components in particular. These include: establishing a deployment health quality assurance program, establishing individual medical readi-

ness standards for the total force, refining and expanding the post-deployment health assessment screening processes, establishing ability to capture electronically the pre- and post-deployment assessment information so that it could be used by medical professionals later on. And finally, since November 2003 we have routinely monitored and reported to the Secretary of Defense and the Under-Secretary for personnel and readiness the status of service members in a medical hold status.

The Army, with the majority of the total mobilized force, has taken very seriously its responsibility to provide world class care to the Army's sick and injured combat veterans. They recently have taken several initiatives to enable the Reserve Component soldiers in the medical hold status to receive treatment and recuperate at or near their homes when appropriate care is available locally.

These ongoing efforts have resulted in significant improvements, but we recognize that there is still much work to do. We are exploring new initiatives to further enhance medical readiness and to ensure timely and effective care of deployment-related illnesses and injuries. These include: establishing a standard annual periodic health assessment program applicable to the total force; working with the VA to identify better ways to leverage specialty care capabilities that they have to support our service members' needs, especially for Reservists; investigating options to enhance awareness of the health status of Reserve Component members over time. We do not have access to their health records as civilians, only when they are under our care. And, last, we are also working with VA to access medical records of the Reserve Component members, help VA get access to those records while they are continuing their service to us.

I would like to also add that we are working to streamline the cumbersome line of duty determination process that the Reserve Component members have to go through in order to access care for illnesses and injury, so we will be working on that.

Mr. Chairman and members of the committee, I thank you for the opportunity to be here, and I defer to the other members of my panel to address their particular issues.

[The prepared statement of Ms. Embrey follows:]

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Statement by

Ms. Ellen P. Embrey

Deputy Assistant Secretary of Defense (Force Health
Protection and Readiness)

Before the U.S. House of Representatives

Committee on Government Reform

February 17, 2005

**Not for public release prior
to 10:00 am on February 17, 2005**

Mr. Chairman, and distinguished members of this committee, thank you for the opportunity today to discuss the Department of Defense's (DoD's) force health protection programs and how they impact the care provided to wounded service members. The Department is firmly committed to protecting the health of our active and reserve component members, before deployment, while they are deployed and upon their return. I am pleased to join my colleagues on this panel today to address your concerns regarding care for soldiers injured in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF).

Today, I will outline the Department's current management practices, technological advances, and initiatives underway to address this very important issue, with a particular focus on the Army Reserve Components (RC).

Since September 11, 2001, approximately 475,000 RC members have been mobilized to support the Global War on Terrorism. Of those mobilized, 376,000, or 79 percent were Army RC soldiers. This unprecedented and sustained mobilization stressed vital Service and Departmental support systems and processes, and brought attention to the need for emphasis on achieving and sustaining medical readiness throughout the total force.

During the initial call-up of RC personnel for OIF and OEF there was no consistently reliable method of capturing and monitoring the health status and medical readiness of active component (AC) and RC members. Of the 158,381 Army RC members mobilized early in OIF/OEF (Dec 2002 thru Oct 2003), more than 4,850 were identified as not meeting medical readiness standards for deployment and were placed into medical hold

status. Although this represented only 3 percent of the Army RC members initially mobilized, it still created significant medical processing and management challenges.

In response to these challenges, the Army effected several changes to its RC mobilization procedures and successfully reduced the percent of its RC soldiers entering active duty with deployment limiting medical conditions. Many of these changes were designed specifically to improve individual and commander emphasis on achieving individual medical readiness and health status reporting.

Medical readiness is assessed by determining the extent to which individual service members are free from health-related conditions that could limit their ability to participate in military operations. Historically, the Army monitored reserve component member medical readiness by requiring a medical evaluation every five years, supplemented by an annual health certification from reserve component members that no significant health status changes had occurred. In order to gain better visibility of individual medical readiness across the force, we established Individual Medical Readiness (IMR) standards and required the Services to provide quarterly reports on the extent to which the total force meets those standards across the following six elements:

- Dental Readiness: Applying DoD's existing dental classification system, measures if individual service member is in category 1 or 2 of dental readiness.
- Immunization Status: Measures if individual service member has received all required vaccinations, including those specific to the operation at hand.

- Medical Readiness Labs: Measures if individual service member has undergone required HIV testing, DNA sampling, and other required labwork.
- Absence of Deployment Limiting Medical Conditions: Applying Service-specific and occupation-specific medical standards for retention and worldwide qualification, measures if individual service member has no deployment limiting medical conditions.
- Periodic Health Assessments: Measures if individual service member has fulfilled required periodic health assessments.
- Medical Equipment: Measures if individual service member has universal and occupationally-specific protective equipment, such as eyeglasses, gas mask inserts, hearing protection, laser eye protection, etc.

Based on the above elements, the status of each individual is classified using the following system:

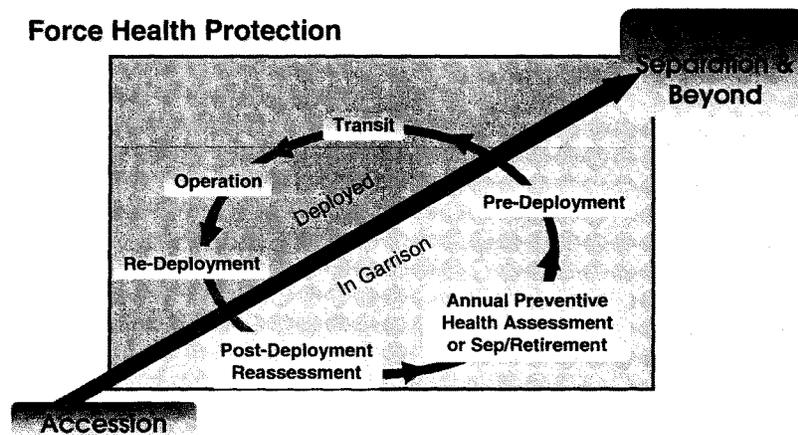
- Fully Medically Ready: current for all elements.
- Partially Medically Ready: lacking only items that can be obtained relatively easily near the time of deployment, such as immunizations, readiness labs, or medical equipment.
- Not Medically Ready: a deployment limiting condition exists, including hospitalization or convalescence due to serious illness or injury.
- Medical Readiness Indeterminate: unable to determine health status because of missing health records or an overdue periodic health or dental assessment.

These categories and elements provide a mechanism for commanders to monitor the medical readiness of their troops and units. The quarterly reports provide a mechanism to ensure routine focus on medical readiness matters needing attention for each individual. The IMR standards and reporting system was established in May 2003. The Military Departments are required to measure against these standards and report on the medical readiness of the force.

Achieving medical readiness requires a strong partnership involving the individual soldier, their commander, and the medical and personnel communities. Maintaining individual medical readiness to deploy is a condition of continued employment in the armed forces. Commanders must visibly support existing standards and policies, and provide a supportive environment that ensures accurate reporting of health status by the troops. The medical community monitors individual medical readiness data, provides summary reports to commanders, and serves as a liaison between the individuals, commanders, and the personnel system. The personnel community provides advice and assistance regarding personal entitlements and benefits and is responsible for determining whether a service member remains suited for military service after significant changes in health status.

Each service member is responsible for meeting health and fitness standards by employing appropriate physical exercise and nutrition guidelines. He or she is required to immediately inform the commander and medical staff of any new medical diagnosis, serious injury, hospitalization, or major surgery (requiring anesthesia). Additional opportunities for updating their health status are available during the periodic health

assessments, pre- and post-deployment health assessments, and planned post-deployment reassessments. The figure below depicts a simplified career experience of a service member and what events during that career that trigger health promotion, prevention, health screening and health assessments.



Periodic health assessments occur annually. Another health assessment occurs just prior to deployment using the DD Form 2795, Pre-deployment Health Assessment questionnaire following a medical screening process. This gives health care providers a chance to screen for any deployment-limiting conditions that may have surfaced since the last periodic health assessment. A service member's final military assessment occurs at the time of separation or retirement.

At the time of redeployment the service member is required to complete, as part of the redeployment process, a DD Form 2796 Post-deployment Health Assessment questionnaire. This process and questionnaire provide each service member an

opportunity to document in detail their views about how their deployment has affected their health. This assessment includes a face-to-face meeting with a health care provider to raise any concerns they may have, including possible hazardous exposures during the deployment. The service member may be referred for further medical follow-up by the provider based on this process.

Last month we announced a new policy that requires all redeploying service members to undergo, during the period 90-180 days after returning home, an additional assessment to evaluate their health and identify any delayed physical or behavioral health problems that may be associated with their most recent deployment.

My office carefully tracks Service execution of the Pre- and Post-deployment Health Assessment program. Since January 2003, active and reserve service member's have completed a total of 573,799 pre-deployment health assessment questionnaires and 510,146 post-deployment health assessment questionnaires. Approximately 5 percent of all deployed service members were found to need a medical referral during the pre-deployment screening process. As of February 7, 2005, referrals from post-deployment assessments were more common among reservists, 23 % versus 16% among active duty members.

Post-deployment questionnaires completed by Army Reservists received between January 1, 2003 and February 7, 2005, indicated the following:

- 168,609 Army Reservists submitted a post-deployment questionnaire

- 89 percent indicated that their general health was “good” or “excellent”
- 78 percent did not indicate any health concerns
- 25 percent received a referral and 77 percent of those visited a military medical provider within six months after their redeployment

Some referrals identified conditions that require the members to enter into Medical Hold status. RC members most often enter into medical hold status because they have sustained injuries and/or illnesses during deployment that require a recovery time that exceeds the termination date of their orders to active duty.

Total RC members in Operation Noble Eagle (ONE)/OEF/OIF include (as of January 31, 2005):

Currently Mobilized:	180,250
Demobilized to Date:	294,504
Total Mobilized to Date:	474,754

The Military Departments routinely provide reports to my office which detail the number of personnel, both AC and RC, who are in various categories of Medical Hold. As of January 21, 2005, there were 6,640 total service members in these categories. Army personnel make up 89 percent of that total – with 15 percent of the Army cohort from the AC and 85 percent from the RC. As part of the Medical Hold process, some service members will be identified as needing a Medical Evaluation Board (MEB), leading to a Physical Evaluation Board (PEB).

A MEB and PEB – are the Department’s formal mechanisms to assess an individual’s ability to continue in military service following a serious illness or injury. These are convened as appropriate, on a case by case basis.

Medical standards for service suitability are service-specific. The most stringent standards are for accession into military service and designed to exclude individuals with known medical conditions that would limit their ability to serve fully on active duty. Once an individual has entered into military service, there are separate standards that apply to retention, reflecting the reality that humans develop medical conditions and suffer injuries as part of life, but they may still be able to serve their country honorably in some capacity.

When a military member is diagnosed with a new medical condition or suffers a serious injury, a military health care provider is required to review the applicable standards to determine if the individual’s ability to serve fully as required by their job may be diminished. If so, a physical profile is generated and sent to the individual’s commander and the personnel system to alert them that the condition exists, and should be monitored.

A MEB may not be immediately initiated, allowing the service member time for the normal healing and rehabilitation process. This is especially important after serious injuries when considerable time may be needed before determining the level of individual health after rehabilitation. A premature MEB may negatively impact the individual’s ability to continue serving. Such actions are not taken lightly, and military medical

providers allow individuals the fullest opportunity to recover before making such determinations. Currently, this period of observation or "time to heal" for OEF and OIF soldiers averages 121 days, but varies considerably depending on the medical condition and healing process.

However, once there is a determination that the expected final level of capability will fall short of published standards, a formal MEB process begins. Physicians at a military treatment facility meet to review all available medical information and make a determination as to the capability of a patient to return to full duty. The board reviews the condition and prognosis, and compares them to the prevailing standard. The board then recommends that the case be referred to a PEB for final disposition (this is the most common result), recommends additional evaluation or a longer period of observation, or recommends returning the individual to full duty. Current DoD guidance stipulates a peacetime standard of completion within 30 days. From November 1, 2003 to February 2, 2005, a total 15,485 Army soldiers in Medical Hold have been medically evaluated for retention in the military. Of these 15,485 soldiers, 65 percent were retained while 35 percent were released from the military. Army MEBs are currently taking up to 67 days to complete.

The PEB is a decision making body convened to make personnel decisions based on input from the MEB. This board is convened as needed within each Service's personnel community and makes determinations on whether to reclassify and retain a service member, or to separate them from military service. DoD guidance stipulates a peacetime

standard for completing PEBs is within 40 days. The average PEB completion time since OIF/OEF began ranges between 87-280 days.

The Global War on Terrorism is the largest ongoing mobilization of the reserve component since WWII. Many rules and procedures that worked well for smaller mobilizations of shorter durations are unsuited for the large and prolonged mobilizations we are currently conducting. The Department and the Services recognized shortfalls and undertook several initiatives to improve the medical readiness of the force overall, and the reserve components in particular. These include:

- Establishing a Deployment Health Quality Assurance Program in 2003 to monitor Service compliance with Department policies governing the administration of the Pre- and Post-Deployment Health Assessments and the documentation of health care received during deployments. In 2004, the program was expanded to encompass all major areas of DoD's Force Health Protection Program.
- Establishing IMR standards and quarterly reporting requirements in May 2003 and continuing to aggressively monitor improvements in the capture and reporting of IMR data forcewide.
- Refining and expanding the Post-Deployment Health Assessment process and questionnaire in May 2003, to capture servicemember exposure and mental health concerns. In January 2005, the Department announced a

new policy requiring a follow-up post-deployment health reassessment within 90 to 180 days of redeployment to proactively screen all returning service members for health problems that do not present immediately upon redeployment.

- Establishing the capability to electronically capture and store Pre- and Post-Deployment Health Assessments was introduced by the Army in January 2004. Since then, the Army has aggressively implemented this capability and as a result, more than 90% of all Army pre- and post-deployment questionnaires are being completed electronically. This allows pre and post assessment data to be made available to physicians' use during follow-on care encounters as well as providing a link for such data to service members' electronic medical records.
- Since November 2003, my office has been routinely reporting the changes in status of DoD-wide servicemembers in medical hold to Under Secretary of Defense (Personnel and Readiness). The Army, with the majority of the total mobilized force, has taken very seriously its responsibility to provide world class care for the Army's sick and injured combat veterans. They recently have taken the initiative to enable RC soldiers in a medical hold status to receive treatment and recuperate at or near their homes, when appropriate care is available locally.

These ongoing efforts have resulted in significant improvement, but we recognize that we still have much work to do. We are exploring new initiatives to further enhance medical readiness, and to ensure timely and effective care of deployment-related illnesses and injuries. These include:

- Establishing a standard annual periodic health assessment program, applicable to the Total Force.
- In conjunction with the Department of Veterans Affairs (VA), identifying ways to better leverage VA specialty care capabilities to support service members' medical needs, especially Reservists.
- Investigating options to enhance awareness of the longitudinal health status of reserve component members over time.
- Exploring ways to improve VA's access to the medical records of reserve component service members who are eligible for care in the VA, and are continuing their service to the military.
- Working to streamline the cumbersome Line of Duty determination process to provide separated RC service members easier access to care for illnesses and injuries sustained while on active duty.

Mr. Chairman, once again, thank you for the opportunity to provide you and members of the Committee with an overview of the Department's programs, policies and initiatives to improve medical readiness, enhance our ability to diagnose and treat deployment related injuries and illnesses, and better support our service members in recovery and rehabilitation.

Chairman TOM DAVIS. Thank you very much.
Dr. Denning.

STATEMENT OF DANIEL DENNING

Mr. DENNING. Mr. Chairman, members of the committee, I am Dan Denning, Acting Assistant Secretary of the Army for Manpower and Reserve Affairs. To my left with me today are Lieutenant General Franklin Hagenbeck, Deputy Chief of Staff G-1; Lieutenant General Kevin Kiley, the Surgeon General of the U.S. Army; Major General Charles Wilson, Deputy Commander of the U.S. Army Reserve Command; and Mr. Philip Sakowitz, Deputy Director of the Installation Management Agency. Also with us today is Lieutenant General Roger Schultz, the Director of the Army National Guard.

Thank you for inviting us to discuss the medical holdover program. I would also like to thank panel one for their candor and for their obvious desire to improve the U.S. Army.

I would like to take a moment to introduce to the committee two more fine soldiers currently in the medical holdover program: Staff Sergeant Salvatore Cerniglia, who is an Army Reserve soldier from Florida who was wounded during a rocket propelled grenade attack in Iraq. He is assigned to the community based health care organization in Plant City, FL. This program allows him to reside at home and receive his medical care locally.

Sergeant Jamie Brown is an Indiana National Guard soldier—my home State—who has spent the past 15 months at Walter Reed Army Medical Center recovering from wounds he received from rocket fire during an ambush. In addition to his status as a medical holdover soldier receiving treatment, Sergeant Brown has actively assisted the medical holdover company by serving as an assistant platoon sergeant.

Could those soldiers just stand for a moment? You can see them in the back.

Chairman TOM DAVIS. Thank you very much for being with us.

Mr. DENNING. As you know, the Army continues to face many challenges, including the global war on terrorism and the continuing operations in Iraq and Afghanistan. In all of this, the Army is absolutely committed to taking care of its soldiers and families and providing them the best possible health care. This is true regardless of whether a soldier is a member of the active Army or Reserve Components, and regardless of the nature of the soldier's injury or illness, whether it occurred in combat or in training.

The Army continues to intensively manage the health care and disposition of Reserve Component soldiers in a medical holdover status. My office provides oversight over the medical holdover operations and, along with forces command, the executive agent for this program, is engaged in monitoring effectiveness.

A system analysis and review team comprised of personnel from my office, from FORCECOM, from the Office of the Surgeon General, from Human Resources Command, and from the Installation Management Agency, has visited and assessed the operations at every installation managing medical holdover soldiers, and we plan to continue to actively monitor our performance in support of soldiers.

In late 2003, the large number of medical holdover soldiers at Fort Stewart and Fort Knox exceeded the capacity of the military infrastructure to adequately house and provide expeditious medical care management to soldiers assigned to these installations. Upon review, we realized this problem was not confined to just these installations and immediately embarked on a series of actions to address this unacceptable situation. In the interest of time today I am not going to cover those here. My colleagues will cover it in much more detail later.

Rotation of forces for Operation Iraqi Freedom and Operation Enduring Freedom is expected to significantly increase the total medical holdover population in the coming months. We have taken precautionary actions to ensure this surge will not exceed medical command's medical support capacity during the third quarter of 2005.

One of the key initiatives we are currently executing will increase our medical support capacity and expand the Army's commitment to taking care of soldiers. This is the community based health care initiative. It began as a way of providing high quality care to Army Guard and Reserve soldiers near their homes while maintaining administrative control and relieving pressure on Army medical facilities at power projection platforms.

It has also proved itself as a means of providing a way for the Army to meet its obligation to provide quality health care for Reserve soldiers who require protracted treatment to achieve full recovery from their injuries and illnesses and to allow Reserve soldiers who are medically able to live at or near their homes and families, and finally to leverage sister services, VA and civilian health care assets.

I can state without reservation that the community health care initiative has been an unqualified success for soldiers, their families, and for the Army. It has evolved into an innovative program designed to manage the prolonged health care treatment needed by some Reserve Component soldiers in order for them to fully recover.

The community health care initiative ensures that the same high standard of care we require for all soldiers is met while effectively managing their health care and recovery. It helps alleviate stress caused by the separation of soldiers from their families by allowing many to reside at home during treatment and recovery.

The original five community based health care organization sites managing health care delivery to soldiers in some 23 States is expanding this month with the addition of Alabama, Virginia, and Utah, and with three satellite operations in Hawaii, Puerto Rico, and Alaska. These additions, plus increases in capacity at our existing five sites, will provide for 50-State coverage.

We will continue to work closely with FORCECOM, the Installation Management Agency, Office of the Surgeon General, and the Army G-1 to assist in the prompt return to duty or release from active duty of our dedicated soldiers who serve our country.

Thank you.

[The prepared statement of Mr. Denning follows:]

**STATEMENT BY
DANIEL B. DENNING
ACTING ASSISTANT SECRETARY
MANPOWER AND RESERVE AFFAIRS**

Chairman Davis and members of the committee, thank you for inviting us to discuss the Medical Holdover (MHO) program. As you know, we continue to face many challenges, to include the Global War on Terrorism (GWOT) and the continuing operations to rebuild Iraq. In all of this, the Army is absolutely committed to taking care of its Soldiers and families and providing them the best possible health care. This is true regardless whether a Soldier is a member of the Active Army or Reserve Components, and regardless of the nature of the Soldier's injury or illness, whether it occurred in combat or training.

The Army continues to intensively manage the health care and disposition of Reserve Component (RC) Soldiers in an MHO status. As a review, MHO Soldiers are mobilized RC Soldiers, pre-deployment or post-deployment, no longer located with his/her unit, in need of definitive health care based on medical conditions identified while in support of the GWOT. Soldiers whose mobilization orders have expired and were placed on Active Duty Medical Extension (ADME) are included in this population.

The Office of the Assistant Secretary of the Army for Manpower and Reserve Affairs (ASA (M&RA)) provides oversight over MHO operations and, along with Forces Command (FORSCOM), the Executive Agent for the program, are engaged in monitoring the effectiveness of the MHO program. Under the auspices of ASA (M&RA), a system analysis and review team (SAR) has visited and assessed the operations of every installation that has MHO Soldiers.

Execution of the MHO program is comprised of three major functional areas: outpatient medical care, command and control, and administration. Multiple Army organizations are involved in executing these functional areas. Leaders from these organizations are here to speak in more detail on their areas of responsibility.

We all remember what happened at Fort Stewart and Fort Knox. The large number of MHO Soldiers on those installations exceeded the capacity of the military infrastructure to adequately house them and provide expeditious medical care management. Upon review, we realized this problem was not confined to just these installations and, thus, we immediately embarked on a series of actions to address this unacceptable situation. Let me quickly review what occurred:

- In November 2003 we modified appropriate mobilization orders to ensure the Soldiers identified during the first 25 days of mobilization with pre-existing medical conditions that made them non-deployable were released from active duty and returned to their civilian status.
- The Army instituted new and specified standards ensuring more rapid delivery of care in key areas such as screening, specialty appointments, surgery, etc. For example, the Army Surgeon General specified 72 hours for initial specialty consultation, one week for magnetic resonance imaging and other diagnostic studies, two weeks for surgery, and 30 days for Medical Evaluation Board (MEB) processing. We also provided more military personnel to provide command and control to ensure that Soldiers were treated expeditiously and we assigned at least one Case Manager for every 50 MHO Soldiers and at least one Physical Evaluation Board Liaison Officer (PEBLO) for

every 65 active Medical Evaluation Board (MEB) cases.

- Increased the medical infrastructure—hired/mobilized nearly 800 additional physicians, nurses, clerks and case managers—to provide more responsive, high quality treatment at Medical Treatment Facilities (MTF).
- Upgraded the billets in which MHO Soldiers are housed to ensure the facilities met Soldiers' medical needs and were as good as or better than the billeting for Active Army Soldiers on the same installations (Fort Campbell has moved Soldiers off-post into hotels until adequate housing can be provided).
- Established a dedicated chain-of-command at each installation to monitor MHO Soldiers' medical care progress and provide necessary overall support while they are in a MHO status.
- Established the Medical Retention Processing (MRP) program, providing the means to more efficiently transition MHO soldiers from mobilization status to medical Extension. The MRP program has been instrumental in eliminating pay and order issues previously experienced by some MHO Soldiers under GWOT ADME. We are currently in the process of converting all GWOT ADME Soldiers to the MRP program. This should be completed by the beginning of next month.

A frequent misconception with the MHO program is that we are retaining the injured or ill soldiers on Active Duty against their will and on installations far from their homes and families. This is not the case. Medical Retention Processing (MRP) and its predecessor for GWOT ADME, are voluntary programs. Once our military medical authority determines that the Soldier cannot be expected to heal within 60 days, the Soldier is provided the choice to be released from Active Duty and receive his line-of-duty medical care locally from

Tricare providers in his home area or elect to remain on Active Duty in a voluntary status specifically to have his medical issues addressed. If the Soldier elects to remain on Active Duty, the Soldier will continue to receive full pay and allowances while he moves through the healing process. Furthermore, if the Soldier elects to remain on Active Duty, the Army will then assign the Soldier to a duty location where the Army can best support the necessary medical care appropriate for the Soldier. Where practical and supportable, the Army tries to place the Soldier at an installation near his home, however, availability of medical and support assets must ultimately determine the appropriate location.

On 1 November 2003, a total of 4452 RC GWOT Soldiers were at Army installations in an MHO status and 400 on GWOT ADME. As of 1 February 2005, 351 of the 1 November 2003 population remain in a MHO or ADME status for a total of 95% processed. These remaining 351 Soldiers are either undergoing extensive medical treatment or moving through the medical evaluation board/physical evaluation board (MEB/PEB) processes. Though substantial numbers of Soldiers have completed the MHO process (15,338), a growing number of Soldiers continue entering the system as deployments and redeployments continue.

Rotation of forces for Operation Iraqi Freedom/Operation Enduring Freedom is expected to significantly increase the total MHO population in the coming months. This surge could exceed Medical Command's (MEDCOM) medical support capacity by the 3rd Quarter 2005. One of the key initiatives we are executing to increase our MHO medical support capacity and expand the Army's commitment to taking care of MHO Soldiers is the Community Based Health Care Initiative (CBHCI). Today, I would like to provide details on this highly successful program.

The CBHCI began as a way of providing high quality care to Army Guard and Reserve Soldiers nearer to their homes while maintaining administrative control of MHO Soldiers and relieving pressure on Army medical facilities at Power Projection Platforms—installations with Active Army tenant units that also function as mobilization sites for Army Guard and Reserve Soldiers. The CBHCI has proved itself as a means of providing a way for the Army to: 1) meet its obligation to care for Reserve Soldiers who require protracted treatment to attain full recovery from their injuries/illnesses, 2) exercise compassion for Reserve Soldiers who endured separation from their families, and 3) leverage sister Services, Veterans' Administration, and civilian health care assets. Key highlights of this initiative:

- We began with five Community Based Health Care Organizations (CBHCO) in a pilot program to test if they would be effective in accomplishing their intended missions. Upon evaluation, CBHCOs proved to be a viable and effective means to improve our health care apparatus—providing first rate care for MHO Soldiers and expanding billeting capacities at installation health care facilities.
- The initial five CBHCOs are located in Plant City, Florida; Little Rock, Arkansas; Sacramento, California; Boston, Massachusetts; and Madison, Wisconsin. They service associated geographical regions, in an area totaling 23 States. For example, the Wisconsin CBHCO covers the states of Wisconsin, Iowa, Illinois, Indiana, Michigan, and Minnesota.
- CBHCOs are manned by mobilized Reserve Component Soldiers and are supported by the First and Fifth Armies which bear responsibility for training and mobilizing the Guard and Reserve nationwide.

- Of the 5112 total MHO Soldiers, the five CBHCOs currently are managing 1480 MHO Soldiers between them. That's 29% of the total MHO population. The success of the program has led to its expansion. Three additional locations being activated are Alabama (Birmingham) and Virginia (Virginia Beach) (both become operational this month and Utah (Salt Lake City) (will be operational in a few weeks). Concurrently, three additional CBHCO-hybrid (smaller version of the CBHCO) sites are being planned for Alaska, Hawaii, and Puerto Rico. When fully operational, complete regional coverage of the 50 states and four territories will be provided by these 11 organizations.
- Fully manned, each individual CBHCO is designed to support a total sustained capacity of 500 Soldiers. The CBHO program currently has a total sustained capacity of 2500 Soldiers across five CBHCOs. When the three additional sites are activated, the combined CBHCO program would support a total capacity of 4000 Soldiers. With the addition of the three smaller planned CBHCO-hybrid sites, 100 Soldiers can be accommodated at each of these locations, thereby increasing the total MHO Soldier capacity to 4300.
- The bottom line is that the CBHCO program is a success story for Soldiers and their families and the Army. CBHCOs have evolved from a reactive response to substandard situations at a few posts to an innovative program designed to manage the prolonged health care treatment needed by some Reserve Component Soldiers in order for them to fully recover...CBHCOs ensure the same standard of care we require for all Soldiers is met while providing a means of accounting for Soldiers and expanding our billeting capacity Army-wide...and CBHCOs alleviate the stress

caused by the separation of Soldiers from their families by moving MHO Soldiers closer to home.

We will continue to work closely with FORSCOM, the Installation Management Agency, the Office of the Surgeon General, Headquarters Department of the Army, G-1, and various other Army organizations and staffs to identify and remove barriers to expeditious evaluation and treatment, and to assist in the prompt return to duty or release from active duty those Soldiers serving in our Reserve Components. I thank the committee for its continued commitment and support to quality care for our Soldiers and to the readiness of our forces and for giving us the opportunity to address the committee about our Medical Holdover program.

Chairman TOM DAVIS. Thank you very much.
General Hagenbeck.

**STATEMENT OF LIEUTENANT GENERAL FRANKLIN L.
HAGENBECK**

General HAGENBECK. Mr. Chairman and members of the committee, it is a great opportunity and I appreciate being invited here this afternoon to talk about this very important topic. It is essential for the Army in both maintaining the morale and the welfare of our soldiers who serve this grateful Nation.

As you know, the Army will continue to be deployed worldwide. We currently have 640,000 soldiers serving on active duty, and of those, 315,000 soldiers are deployed for overseas in over 120 different countries. These soldiers are from all the components, active duty, 155,000, our Army National Guard, 113,000, our Army Reserve, 47,000. Even with this expansive rotation of troops, the soldier remains the centerpiece of the Army formations, and as such it is the Army's pledge to remain dedicated to the well-being of the soldiers and their families.

Since the beginning of the global war on terrorism, we have witnessed the largest mobilization of the Reserve Component since World War II. The exemplary performance of the Guard and Reserve soldiers alongside that of the active component is testimony that we are, indeed, one Army, an Army whose components explicitly link and complement each other. I know our Nation is very proud of the performance of our Guard and Reserve folks, and you have seen them firsthand both at home and on these contingency missions, and I know that you are as equally proud of them.

These soldiers deserve our continued commitment to training them to do their jobs and taking care of them and their families throughout their association with the Army. This includes providing the best care available to soldiers who become injured or ill in the line of duty while serving our country.

Though this effort has not been without challenge, we continue to improve our processes and strive to deliver compassionate and timely care to the medical holdover soldier. The soldiers reporting to mobilization stations and returning from the theater to the evacuation chain or demobilizing, the medical holdover population grew quickly. In the midst of supporting the war fight, we realized that existing MHO policy and infrastructure were inadequate, and we immediately embarked on a series of corrective actions.

As the G-1, I am the proponent for the active duty medical extension program and am responsible for its implementation, policy execution, and program management. The medical retention processing program is an Assistant Secretary of the Army Manpower and Reserves policy, but I am responsible for its implementation of guidance and the execution of the policy. And the medical retention processing two program is also Acting Secretary Denning's program. It is still being staffed for approval, but upon that process being concluded I will be responsible for its implementation, guidance, and execution of the policy once the program, as I mentioned, is finally approved.

Today we are processing large numbers of soldiers with disabilities, the likes of which we haven't experienced in over 30 years.

In 2004 we processed approximately 15,000 disability cases, nearly a 50 percent increase from the number of cases processed during the years before G-1. We are witnessing an even higher percent increase in the number of mobilized Army Guard and Reservists entering into the disability system, 134 percent increase during fiscal year 2004.

Now, to meet this caseload we have added additional members to the three physical evaluation boards, we have increased the number of JAG officers assigned, we have created a mobile PEB, a three-member board that travels to each of the fixed PEB sites to augment their efforts there, and we placed liaison NCOs at each of the medical treatment facilities and at the Physical Disability Agency headquarters to assist in processing Reserve and National Guard cases.

These efforts have paid off. In June 2004 there were 900 mobilized Reserve and National Guard cases pending PDA, and today that number has been reduced to 344. PDA still receives about 159 new mobilized Reserve and National Guard cases each month. While much has been accomplished, more needs to be done. Acting in concert with the U.S. Army Medical Command and the Installation Management Agency under the direction of the Assistant Secretary of the Army for Manpower and Reserve Affairs, the following initiatives are underway: Structuring a comprehensive reporting system that tracks the soldier as he or she is medically evacuated from the area of operations until returned to duty or separated or retired from the U.S. Army. A high priority, this task force will present its initial recommendations to the Director of the Army staff within the next 2 weeks.

Second, as part of the information gathering and sharing enterprise, we are working closely with the Department of Veterans Affairs and the Defense Finance Accounting Services to better coordinate the termination of military pay and the initiative of Veterans Administration payments. An important linkage to this process is access to the Reserve Component soldiers' personnel documents for the calculations of retired and severance pay, and efforts are ongoing to bring automation solutions to this process.

Through weekly reports, inspections, and personal visits, the Army is keeping a close watch on the processing of the soldiers through the PDE system. Though we have challenges ahead, I am confident that we are taking the right path, the right direction to do this.

I will tell you that I am personally committed. Sergeant Allen, who was on panel one, was serving with me in Afghanistan when he was injured. I have a son who is a Reserve officer in the U.S. Army Reserves who was deployed once to the Gulf and is alerted to do again. So beyond my professional interest in this I have a personal interest and responsibility, as well.

Thank you, ma'am.

[The prepared statement of Lieutenant General Hagenbeck follows:]

STATEMENT BY
LIEUTENANT GENERAL FRANKLIN L. HAGENBECK
DEPUTY CHIEF OF STAFF, PERSONNEL

Chairman Davis, Congressman Waxman and Members of the Committee, I am Lieutenant General Franklin L. Hagenbeck, the Army's Deputy Chief of Staff for Personnel. Thank you for the opportunity to appear before your Committee today to discuss the Wounded Army Guard and Reserve Forces: Increasing the Capacity to Care.

Soldiers remain the centerpiece of our Army. It is the Soldier — fierce, well-trained, well-equipped and well-led — who serves as the ultimate expression of the capabilities the Army provides to the Joint Force and to the Nation. As always, we remain dedicated to the well being of our Soldiers and their families.

The Global War On Terrorism (GWOT) has triggered the largest mobilization of the Reserve Component (RC) since World War II. The exemplary performance of our Guard and Reserve Soldiers along side of their active component counterparts continues to demonstrate that we are indeed one Army...an Army whose components are practically indistinguishable from one another. I can assure you from firsthand experience that the Nation is completely justified in its pride of the performance of our Guard and Reserve soldiers in overseas contingency operations as well as here at home.

These soldiers deserve our continued commitment to training them to do their jobs and taking care of them and their families throughout their association with our Army. This includes providing the best care available to Soldiers who become injured or ill in the line of duty while serving our Country. Though this effort has not been without challenge, we continue

to improve our processes and strive to deliver compassionate and timely care to the Medical Holdover Soldier (MHO).

With Soldiers reporting to mobilization stations and returning from the theater through the evacuation chain or to demobilize, the Medical Holdover population quickly grew. In the midst of supporting the war fight, we realized that existing MHO policy and infrastructure were inadequate and immediately embarked on a series of corrective actions.

As the Deputy Chief of Staff (DCS), G-1, I am the proponent for the Active Duty Medical Extension (ADME) program and am responsible for the implementation guidance, execution of policy, and program management. The Medical Retention Processing (MRP) program is an Assistant Secretary of the Army (Manpower and Reserve Affairs) (ASA(M&RA)) policy. The G-1 is responsible for implementation guidance and execution of the policy. The Medical Retention Processing 2 (MRP2) program is an ASA(M&RA) program that is still being staffed for approval. The G-1 will be responsible for implementation guidance and execution of the policy once the program is approved.

The Active Duty Medical Extension (ADME) Program

The ADME program was established in July 2000 for Reserve Component Soldiers who incur or aggravate an injury, disease, or illness in the line of duty while on active duty or while performing in an Inactive Duty Training (IDT) status. Public Laws 105-85 and 106-65 of the National Defense Acts of 1998 and 2000, authorize Reserve Component members found by military medical authority to be unable to perform normal military duties in their Military Occupational Skill (MOS) or Area of Concentration (AOC); and if the condition requires treatment that will extend beyond 30-days, to voluntarily submit a written request for placement onto active duty for medical care. The Soldier is placed on

active duty pending the resolution of their medical condition or completion of the Physical Disability Evaluation System (PDES). While on an ADME order, the Soldier and his or her family receive all benefits commensurate with any other Soldier on active duty to include retirement points towards a Reserve retirement. Based on historical flow at the creation of the program, the ADME program was not staffed to accommodate a large numbers of mobilized Reserve Component Soldiers. Beginning in December 2003, the ADME policy and program office started receiving approximately 25 to 30 cases for review daily. At that time, the office staff consisted of three people. Many of the packets arrived incomplete or as the Soldiers' current orders were about to expire or had expired, causing Soldiers to fall off of the pay system and the Defense Enrollment Eligibility Reporting System (DEERS).

The 25-Day Policy

In November 2003, the 25-day rule was instituted to identify mobilizing Soldiers with pre-existing medical conditions. This policy was designed to decrease the number of Soldiers entering the MHO system during the mobilization process and permit mobilizing units to get a replacement for non-deployable Soldiers while remaining within the personnel mobilization cap of the unit.

Within the first 25-days of the mobilization process Soldiers identified with non-deployable medical conditions are now immediately released from active duty. This policy prevents the Army from assuming the responsibility for medical care to Soldiers who have pre-existing medical conditions.

The Medical Retention Processing (MRP) Program

The MRP program was specifically designed for the GWOT contingency operation MHO Soldier and to eliminate the pressure on the

ADME program. It provided a personnel management tool to transition Reserve Component MHO Soldiers from a partial mobilization order to a voluntary retention on active duty order for medical care. This allowed the unit to receive a replacement and not exceed the unit's personnel mobilization cap. As a general rule, a mobilized Reserve Component Soldier remains on partial mobilization orders until a medical authority determines that the Soldier will not be able to perform required duties or that the Soldier will not have a sufficient number of days remaining on active duty after the medical condition improves to permit return to duty. The following guidelines are provided:

1. If the Soldier is expected to return to duty within 60-days from the time he or she is injured or becomes ill and will have at least 120-days left on partial mobilization upon return to duty, then the Soldier will be kept on partial mobilization orders and managed by the installation or unit to which he or she is assigned.

2. If a Soldier is expected to return to duty within 60-days from the time he or she is injured or becomes ill; or if the Soldier could return to duty within 60-days, but has fewer than 120-days beyond the expected return to duty date left on the partial mobilization order and can perform limited duties, then the soldier may consent to conversion from a partial mobilization order to a MRP order. If the Soldier does not consent to be retained on active duty, then he or she will be considered no longer operationally required and will be released from active duty.

3. A Soldier who arrives at the demobilization station who must remain on active duty beyond the period of the partial mobilization order to determine if further medical care or evaluation is warranted may be retained on active duty with his or her consent and the approval of the Commander, Human Resources Command.

4. If treatment through a Community Based Health Care Organization (CBHCO) is approved, the Soldier will convert from his or her

mobilization order to a MRP order with a further attachment to the appropriate CBHCO.

5. A Soldier who is eligible for demobilization who elects not to stay on active duty to receive medical evaluation or treatment, will sign a declination statement and be provided face-to-face counseling and referral for continued medical care while not on active duty.

Human Resources Command (HRC)

The Reserve Components Branch of the Human Resources Command's Personnel Services Support Division supports wounded reserve component Soldiers in two broad areas: manning Medical Retention Processing Units (MRPU) and publishing orders for wounded Soldiers.

The MPRUs, staffed reservists and national guardsmen, provide administrative and command and control. To meet current requirements, HRC has expanded the manning pool to include Soldiers from the Sanctuary program, Extended Active Duty (EAD) and retiree recall programs. This facilitates the wounded Soldier's progress through the system. Reserve Soldiers assigned by HRC also provide much needed liaison to Medical Evaluation Boards that determine Soldier disposition. The other critical mission HRC provides is publishing orders in a timely manner to preclude problems in pay and benefits and ease the Soldier through this complex process. This involves publishing orders moving soldiers from under the authority of Title 10 USC 12302 (Partial Mobilization) to Title 10 USC 12301 (d) (Medical Retention Processing) status. This moves the Soldier from mobilized status to voluntary status and extends their active duty 179 days to preclude "falling off" orders. This also reassigns the Soldier to the installation or garrison Medical Retention Processing Unit (MRPU).

Initiatives to overcome coordination challenges include assuming responsibility for orders as a "one stop shop". These orders include Active Duty Medical Extension, Medical Retention Processing, Contingency Operation Temporary Tour of Active Duty, Extended Active Duty, Contingency Operation Extended Active Duty and Temporary Tour of Active Duty. Effective, February 15, 2005, HRC Reserve Branch is the responsible agency for all but mobilization orders. This allows both flexibility to meet a Soldier's needs and visibility of the Soldier throughout this process.

Physical Disability Agency

The following outlines the roles and responsibilities of the G1 and Human Resources Command in the U.S. Army's Physical Disability Evaluation System (PDES). It comments on lessons learned, challenges, recent initiatives, and offers direction on improving the process, thereby improving the wellbeing of injured Army Guard and Reserve Soldiers and their families. Additionally, it reviews the processing through the Physical Disability Evaluation Systems (PDES) and discusses our direction in improving this process.

We are processing large numbers of disabilities, the likes of which we have not experienced in more than 30 years. In 2004, we processed approximately 15,000 disability cases, nearly a 50% increase from the annual number of cases processed during the years preceding the GWOT. That caseload was distributed across 3 Physical Evaluation Boards (PEBs) in 2 states and the District of Columbia – Ft Lewis, WA, Ft Sam Houston, TX, and at Walter Reed Army Medical Center, and a total of 70 employees. The last time we had that many cases was in 1972, when the PDA processed 19,000 cases. At that time, there were 6 PEBs across 5 states and the District with a total of 260 employees.

We are witnessing an even higher percent increase in the number of mobilized Army Guard and Reservists entering into the disability system, a 134% increase during the last three years. Throughout CY 2004, we applied resources to respond to the wave of new Reserve and National Guard cases. To meet this case load, we increased the staff of the PDA from 60 to 77, a 26% increase; added members to each of the PEBs; increased the number of JAG officers assigned to disability hearings; created a mobile PEB - a 3-member board that travels to each of the fixed PEB sites - to augment their efforts; and placed liaison NCOs at each of the Medical Treatment Facilities and the PDA Headquarters to assist in processing Reserve and National Guard cases. These efforts have paid off. In June 2004, there were 900 Mobilized Reserve and National Guard cases pending in the PDA. Today that number has been reduced to 344. The PDA still receives about 150 new Mobilized Reserve and National Guard cases each month.

For our most seriously injured Soldiers, we created the Disabled Soldier Support System (DS3) that provides the severely disabled Soldiers and their families with a system of advocacy, follow-up and personal support, assisting our heroes as they transition from military service to the civilian community. This program will integrate the many existing programs to provide holistic support services for our severely disabled Soldiers and their families throughout their phased progression from initial casualty notification to their return to home station and final career disposition.

Now I would like to outline the responsibilities of Human Resources Command in the disability process, recognizing that this is a team effort that crosses many command lines. To begin, the Soldier enters the Physical Disability Evaluation System (PDES) when the medical community makes the determination that the Soldier falls below medical retention standards. This requires a Medical Evaluation Board (MEB).

Upon completion of the MEB, the Soldier is referred to one of three Physical Evaluation Boards (PEBs), who will normally adjudicate the case within two days. The Soldier does not appear at this informal board. The informal disposition is conveyed to the Soldier normally by the Physical Evaluation Board Liaison Officer (PEBLO), located at the Medical Treatment Facility, who serves as the Soldier's main point of contact and counselor throughout the disability process. After the PEBLO has presented the disability disposition to the Soldier, he or she can accept the recommended findings or request a formal board with or without personal appearance. At the formal board the Soldier may appear and be represented by legal counsel. Formal boards for mobilized Reserve and National Guard Soldiers are scheduled within thirty days of the Soldier's request. Dispositions can range from the Soldier being found unfit and permanently retired to the Soldier being found fit for duty and returned to duty. Following the completion of an informal and/or formal board, the case is forwarded to the United States Army Physical Disability Agency (USAPDA) for approval and final processing. Once the case has been approved, the USAPDA notifies the command and the transition center of the Soldier's disposition. Once final disability processing is completed, the Soldier is given thirty days to comply with the separation orders. Beginning with the initial portion of the medical board process, the Soldier can submit a request for Continuance in Active Duty Reserve (COAR) in an effort to remain in the military, if determined to be found unfit by the PEB. If the Soldier's request for COAR is approved, then the disability process is terminated at that point. If the Soldier's request for COAR is disapproved by the Soldier's major command (Army National Guard or USAR at HRC St Louis), then the disability process continues as before.

This overview of the disability process only hints at the complexity of what a Soldier goes through when processed through the PDES. As you can see, it is joint effort by multiple commands, who assemble the

required medical information to make a fitness/disability determination; provide sufficient administrative information to process the Soldier for separation or retirement; and provide supportive and caring counseling to the Soldier in order for that Soldier to make a career and, sometimes, life changing decision based on the outcome of the proceedings.

Over the past eighteen months the following actions were taken to improve the processing of the mobilized RC Soldier through the PDES:

1. Stood up the Community Based Health Care Option, presently at five (5) locations and will be eight (8) by April 2005.
2. Established RC LNO positions at the major Medical Treatment Facilities, Regional Medical Commands, power projection platforms and the Defense Finance Accounting Service (DFAS).
3. Revised Army regulations to allow the Mobilization Station Commander to return Soldiers found non-deployable back to the unit, and reduced the out processing time from 90 to 30 days.
4. Established a detailed monitoring network that reports the status of mobilized RC Soldiers in the PDES to the Senior Army Leadership on a biweekly basis.
5. Increased the staff of affected agencies to meet this increased workload, where required.
6. Established the Disabled Soldiers Support System (DS3) to assist the severely injured Soldier and their families, irrespective of component.

While much has been accomplished, more needs to be done. Acting in concert with MEDCOM and the Installation Management Agency, under the direction of ASA(M&RA), the following initiatives are underway:

1. Structuring a comprehensive reporting system that tracks the Soldier as he or she is medically evacuated from the Area of Operation until returned to duty or separated /retirement from the

US Army. A high priority, this task force will present its initial recommendations to the Director of the Army Staff within the next two weeks.

2. As part of the information gathering/sharing enterprise, we are working closely with the Department of Veterans Affairs and the Defense Finance Accounting Services to better coordinate the termination of military pay and the initiation of Veterans Administration Payments. An important linkage to this process is access to the RC Soldiers personnel documents for the calculations of retired and severance pay. Efforts are ongoing to bring automation solutions to this manual process.
3. Through weekly reports, inspections and personal visits, the Army is keeping a close watch on the processing of the Soldiers through the PDES.

Though we have challenges ahead, I am confident we are ensuring that the proper systems are in place and that Soldiers receive the care they deserve.

Ms. NORTON [presiding]. Thank you, General.
Lieutenant General Kiley, 5 minutes.

STATEMENT OF LIEUTENANT GENERAL KEVIN C. KILEY, M.D.

General KILEY. Thank you, Mr. Chairman and distinguished members of the committee. I appreciate the opportunity to make a couple of opening comments.

I would like to start by echoing the comments of the rest of the panel in thanking the soldiers that sat on panel one for their courage, their honesty, and for helping us in the U.S. Army Medical Command and the rest of the Army to make this process better and more effective. We are very proud of those soldiers. Every one of them has put a uniform on and reported to the deployment station, and we feel that pride when we care for those soldiers upon their return from combat, either as injuries or as illnesses.

In that context, I think it is important to remember that, as has been stated, this is a medical support to a global war on terrorism that is not just about medical holdover soldiers but about casualty receiving and the deploying and re-deploying and demobilizing of large numbers of Reserve and National Guard.

I am very proud of the members of the U.S. Army Medical Command, of the larger AMED, active and Reserve, that have participated in and cared for these great soldiers in their time of need. We have processed over 16,000 soldiers through the medical hold-over process, 9,000 of which we have returned to the Army fit and healthy, another 5,000 of which have successfully negotiated the MEB/PEB process. And in doing that we have learned a great amount about the PEB process, Reserve and National Guard policies, and our own operations at our installations and MTFs.

I am happy to answer any more of your questions either from these comments or from my written statement.

Thank you.

[The prepared statement of Lieutenant General Kiley follows:]

UNCLASSIFIED

RECORD VERSION

STATEMENT BY

LIEUTENANT GENERAL KEVIN C. KILEY M.D.
THE SURGEON GENERAL OF THE UNITED STATES ARMY

BEFORE THE

U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON GOVERNMENT REFORM

FIRST SESSION 109TH CONGRESS

WOUNDED ARMY GUARD AND RESERVE FORCES:
INCREASING THE CAPACITY TO CARE

FEBUARY 17, 2005

NOT FOR PUBLICATION
UNTIL RELEASED BY THE
HOUSE GOVERNMENT REFORM COMMITTEE

UNCLASSIFIED

Statement by

LIEUTENANT GENERAL KEVIN C. KILEY M.D.
THE SURGEON GENERAL OF THE UNITED STATES ARMY

Thank you for inviting me here today to discuss the medical holdover (MHO) program and for allowing me the opportunity to tell you about the extraordinary efforts of our Army Medical Department (AMEDD) team as they work with our partners represented here. Let me begin by describing the magnitude of the effort. Eight percent of the mobilized force eventually enters MHO. About 2 percent come in during pre-deployment training, another 3-4 percent as medical evacuations from the theater of operations, and another 2-3 percent upon redeployment. That translates into approximately 1,000 new MHO patients every month. We finalize and out process about the same number each month. Since November 1, 2003 we have processed nearly 16,000 MHO patients through the MHO system. Of those, nearly 10,000 were successfully returned to their units, fit to re-mobilize. We performed Medical Evaluation Boards (MEB) on the remainder, and assisted them through the Physical Disability Evaluation System (PDES). More than 90 percent of those Soldiers were either medically separated or medically retired from military service.

Sixteen thousand patients is a large number of patients. However, that number alone does not fully describe the level or complexity of effort necessary to care for these Soldiers. Consider for a moment that the average Soldier uses our medical treatment facilities about four times a year. The average MHO patient uses our services four times a month, and is with us between five and seven months. That culminates in a tremendous amount of health care being delivered at our camps, posts, stations, and now at the Community Based Health Care Organizations (CBHCO).

The CBHCOs actually belong to Forces Command, but since the AMEDD provides quality oversight for their medical operations, I'll say a word about them. The true measure of their success will be their ability to heal Soldiers, and either

return them to their units or assist them through the PDES. Thus far, the CBHCOs are receiving high marks from our patients because the CBHCOs allow Soldiers to live at home while receiving care. One of the other, more tangible benefits of the CBHCOs is that they allow us to better leverage the capabilities of the TRICARE Network, Veteran's Affairs health care facilities, and Navy and Air Force military treatment facilities (MTFs). For instance, CBHCO patients who live in the catchment areas of Navy and Air Force MTFs are enrolled to those MTFs.

As Mr. Denning indicated, we had problems in the MHO arena in the October / November 2003 time frame. I would like to spend just a moment letting you know how far we have come since then.

One of our first improvements was the 25-day rule. That tool allows us to screen mobilized Soldiers, and send home those who have pre-existing conditions that make them non-deployable. Since November 1, 2003 we have successfully screened and sent home 8,758 non-deployable RC Soldiers. That's 8,758 people who would have otherwise been MHO patients.

For those who do become MHO patients at our MTFs, we have enhanced access standards: 72 hours for specialty referrals, one week for magnetic resonance imaging (MRI) and other diagnostic studies, and surgery within two weeks of the time the doctor says the patient is ready. I am pleased to report that our health care professionals meet those standards 89% of the time.

Enhanced access standards are a success story and one with a surprising lesson learned. In our efforts to put MHO patients at the front of the line, we asked Soldiers "Are you Guard or Reserve?" For some of them, that question made them think "Why are they asking? Isn't it all One Army? Aren't we all active duty once we're mobilized?" And quite frankly, some of them were more than offended; they were suspicious of our motives. The lesson was that we should not ask the question "Are you Guard or Reserve?" Now we look at the patients' records to determine if they are Guard or Reserve.

Even before we had the CBHCOs, we recognized that we could – and should - allow some of our MHO patients to live at home simply because they lived near one of our installations. In conjunction with our partners at the Installation Management Activity (IMA) and their garrison commanders, we instituted a policy to move patients from their mobilization stations to the installations and MTFs closest to their homes whenever possible. Today, in addition to the CBHCOs, we have 278 patients who are obtaining care at MTFs near their homes, living with their families and sleeping in their own beds at night.

In December 2003 we asked our manpower experts at the Medical Command (MEDCOM) to tell us how many people we needed to clinically manage the MHO patients. Their analysis told us we needed 967 doctors, nurses, technicians, and other staff to provide the dedicated level of care necessary for this population. Due to shortages of qualified people in some areas of the country, not all of these positions are filled. However, between mobilizations, hiring actions, and contracts, we have professionals in 772 of those positions dedicated solely to the MHO effort.

As I alluded earlier, most MHO Soldiers heal and are able to return to their units. Nearly 36 percent, however, require a Medical Evaluation Board. In that process, our physicians make a simple determination: does the Soldier meet retention standards? If not, the Soldier is referred to a Physical Evaluation Board (PEB), operated by the Physical Disability Agency (PDA) under the auspices of the Army Deputy Chief of Staff for Personnel (G1). They determine if the Soldier is fit for further service, and if not fit, they determine the Soldier's level of disability. Our collective staffs work continually to make the transition from MEB to PEB seamless and efficient.

I know the Committee is interested in how we track Soldiers through MHO. Since the inception of MHO, we have used the Medical Operational Data System (MODS) to track where our patients are physically located, as well as their medical progress. All of our partners in the MHO program recently agreed to use MODS as the one overarching source of data and reports on MHO patients. To

that end, we have already tied in the tracking systems used by Human Resources Command, Defense Finance and Accounting Service, the Physical Disability Agency and others so that the various systems automatically update each other. That work is ongoing as we continue to identify data sources and systems necessary to the clinical and administrative management of these patients.

These are just some of the improvements we have made in the MHO process. My colleagues on the panel will discuss even more. Let me close with two points. First, MHO is a good news story. We in the AMEDD have provided an enormous amount of world class health care to the MHO Soldiers, and have assisted Forces Command in the establishment of the CBHCOs so that as many MHO Soldiers as possible can receive care at home. Second, the AMEDD, like the rest of the Army and the rest of the Nation, recognize the patriotism and vital importance of our Guard and Reserve Soldiers. We truly are One Army, and we are proud to care for our patients.

Ms. NORTON. Thank you very much, General Kiley.
Major General Wilson.

STATEMENT OF MAJOR GENERAL CHARLES WILSON

General WILSON. Chairman Davis, members of the committee, I am Major General Charles E. Wilson, Deputy Commanding General for the U.S. Army Reserve. Thank you for inviting me to appear before your committee to discuss the effectiveness of Army medical administrative and support processes and procedures that govern injured Army Reserve soldiers.

During the past months, the U.S. Army Reserve Command and its leadership has listened to the concerns of all of its soldiers, especially injured Army Reserve soldiers and their families. This command has explored ways to provide the best health care possible, to improve administrative processes for the soldiers and their family, before, during, and after mobilization.

Since we know the combat and commander need a force that is medically fit, ready, and responsive, the Army Reserve has placed greater stress and scrutiny on management of medical readiness. We have worked hard to update our policies and procedures to create efficiencies, to develop compassionate and effective strategies for supporting our soldiers and their families as they prepare for war, as they wage war, as they endure the separation and the worry and stress that accomplish this as a family unit.

We work hard on the return home to address the challenges and stress of family and community reintegration. Our solutions are still being realized and perfected. They remain very much a work in progress. You, as a committee, have been concerned and supportive during this very trying period. With your help, we will succeed in meeting our mission and also providing our Army family with all it needs and deserves as we serve our Nation at war.

Again, thank you for this opportunity to discuss the health care and well-being of our soldiers and their families. I will be happy to answer any questions that you may have.

Thank you.

[The prepared statement of Major General Wilson follows:]

RECORD VERSION

STATEMENT by
MG CHARLES E. WILSON
DEPUTY COMMANDING GENERAL
UNITED STATES ARMY RESERVE COMMAND

before the

COMMITTEE on GOVERNMENT REFORM
UNITED STATES HOUSE of REPRESENTATIVES

FIRST SESSION, 109TH CONGRESS

WOUNDED ARMY GUARD and RESERVE FORCES:
INCREASING the CAPACITY to CARE

FEBRUARY 17, 2005

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COMMITTEE on GOVERNMENT REFORM

Chairman Davis and Members of the Committee, I am Major General Charles E. Wilson, Deputy Commanding General for the Army Reserve. Thank you for inviting me to appear before your Committee to discuss the effectiveness of Army medical administrative processes and procedures that govern injured Army Reserve Soldiers.

During the past months, the Army Reserve Command listened to concerns of all its Soldiers, and especially injured Army Reserve Soldiers and their families. This command explored ways to provide the best healthcare possible and improve administrative processes for Soldiers and their families – before, during, and after mobilization. Since combatant commanders need a force that is medically fit and ready, the Army Reserve placed greater emphasis on medical readiness.

The Army Reserve recognized early on in the Global War on Terrorism that medical readiness problems existed within the mobilization process. To address these issues, the Army Reserve increased its focus on medical and dental fitness during the pre-deployment screening phase.

During the pre-mobilization phase, 90-day pre-mobilization TRICARE benefits authorized in the FY04 NDAA and the Federal Strategic Health Alliance Program are used to improve medical readiness of Army Reserve Soldiers. The Federal Strategic Health Alliance, also known as (FEDS_HEAL), is a huge success story for the Army Reserve. FEDS_HEAL is actually a joint venture between the Army Reserve and the Department of Health and Human Services. This unique program utilizes civilian medical and dental services across the United States to provide care to Army Reserve Soldiers in their local neighborhoods. The program allows alerted Soldiers to receive required medical and dental services before they arrive at the mobilization site so they are medically ready to deploy with their unit.

Because of its remarkable effectiveness, the FEDS_HEAL Program has expanded eightfold in the past four years. To give you an idea of the scope of the

program, Army Reserve Soldiers received 47,500 dental exams; 20,600 physical exams; 58,100 immunizations; 3,600 eye exams; and 4,000 dental treatments through FEDS_HEAL in FY04. This clearly has had a tremendous impact on Army Reserve Medical Readiness.

FEDS_HEAL also provides outstanding support to the Army Reserve's regional readiness commands through scheduled Soldier readiness processing events. During these events, Soldiers who are not on alert orders receive medical and dental assessments to determine their readiness. While these assessments are critically important, the documentation of these services is equally important. In order to ensure accurate tracking of medical readiness data, the FEDS_HEAL staff, working at the readiness sites, immediately enters this readiness information directly into the Medical Protection System. This system, also known as MEDPROS, is a web-accessed medical database that is used throughout the Army Reserve to track medical readiness. Commands and units at all levels have access to MEDPROS, which allows them to instantly determine the current medical readiness status of their Soldiers.

The Army Reserve carefully analyzed the mobilization process and determined a need to better track the periodic physical exams for Army Reserve Soldiers. To address this issue, the Army Reserve Command established a centrally located, Standardized Medical Fitness Review and Medical Hold Program. This process, established last year, markedly streamlined the identification of all potentially limiting and/or disqualifying conditions noted on Soldiers' periodic physical examinations. Although the program is only a few months old, it is already up and running and making a discernable difference in the way our Soldiers' physical exams are processed and reviewed. Through the early identification of Soldiers' significant medical and dental problems, this program significantly reduced the number of Soldiers who had to be released from active duty at mobilization sites because of medical and dental issues that could not be resolved prior to their being deployed.

Once mobilized, Army Reserve Soldiers are entitled to the same care and treatment as any Active component Soldiers. Army Reserve Soldiers who are seriously injured during a mobilization are typically evacuated out of the combat zone to a military hospital or medical center in the United States. While some of these soldiers are able to return to full duty upon discharge from the hospital, others need ongoing outpatient care in a medical holdover status. Two mobilization installations controlled by the Army Reserve, Fort Dix, New Jersey, and Fort McCoy, Wisconsin, oversee treatment of Army Reserve Soldiers in medical holdover status. The medical holdover program currently has a total of 1,700 Army Reserve Soldiers, with Fort Dix and Fort McCoy managing 12.5 percent of these Soldiers. Because installation medical assets are limited at these posts, Army Reserve Soldiers receive the majority of their health care through local providers and facilities.

Using a personnel module located on the Medical Operational Data Systems database, Army case managers carefully track and monitor Army Reserve Soldier data in the highly sophisticated Medical Holdover/Active Duty Medical Extension database. This database is an effective tracking system that ensures the Army Reserve Command is continuously informed about the medical readiness status of its Soldiers in medical holdover status.

The Army recognized that most Soldiers in medical holdover status were receiving medical treatment some distance from their homes and families. In order to ease this hardship, the Army developed the Community Based Health Care Initiative. This program provides opportunities for Soldiers to return home and continue to receive required medical care through providers in their local communities. This program also allows Soldiers to visit their local Army Reserve units, thereby promoting unit camaraderie and a sense of belonging.

Another program that supports Army Reserve Soldiers is the Disabled Soldier Support System, also known as DS3. This initiative supports severely disabled Soldiers by providing assistance throughout their transition from the Army back into their civilian lives by addressing issues such as special equipment or home modifications that are needed to accommodate each Soldier's combat-related disability. Army Reserve Soldiers are fully integrated into this program, which begins at Landstuhl and continues throughout their hospitalization and discharge from Walter Reed Army Medical Center or any other military medical facility.

In addition to Soldier medical readiness, the Army Reserve Command is concerned about Soldier and family wellness. The Army Reserve Deployment Cycle Support (DCS) Program is a commanders' program that ensures all Soldiers and families are properly reintegrated when Soldiers return from a deployment. Soldier mental health is a key element in this program. Education, assessment, and processing are also major components of Deployment Cycle Support. Army Reserve chaplains provide marital assessments, counseling, and voluntary marriage enrichment workshops for all Soldiers. Post-deployment, the Army One Source (AOS) Program provides personalized support and private consultation, 24/7, either by telephone and/or via the internet.

Finally, the Welcome Home Warrior Citizen Award Program recognizes the outstanding service of mobilized and deployed Army Reserve Soldiers. During a special recognition ceremony, each redeployed Soldier receives a shadow-boxed American flag, a special commemorative coin and certificate, and lapel pins for the Soldier and spouse or other family member. The Army Reserve will present these to 70,000 Soldiers by the end of October 2005. This formal recognition program provides a public thank-you to families and Soldiers who answered the call to duty and served their country during these operations.

Soldiers and all their family members are important to the Army Reserve, and we realize that their support of the Global War on Terrorism presents significant

challenges to their family unity. Our programs help ensure medical readiness of Soldiers, and provides for family needs before, during, and after mobilization. The Army Reserve values Soldier and family sacrifices and their personal commitment to this war. Taking care of Soldiers and their families is a top priority for the Army Reserve.

Ms. NORTON. Thank you very much, General Wilson.
Mr. Sakowitz.

STATEMENT OF PHILIP E. SAKOWITZ, JR.

Mr. SAKOWITZ. Mr. Chairman and members of the committee, I am Phil Sakowitz, the Deputy Director of the U.S. Army Installation Management Agency. I thank you for the opportunity to discuss our contribution to the medical holdover program.

On a daily basis we are responsible for the equitable, efficient, and effective management of installations worldwide, but we are particularly honored by our role in support of injured soldiers and their families. Our headquarters and region staffs, in close cooperation with Forces Command and the 1st and 5th Armies, as well as the staffs of my fellow panel members, oversee our medical holdover effort. Together we monitor the current and projected medical holdover populations assigned to each installation to determine if current capacity levels for command and control and billeting are sufficient, and, if not, what steps we need to consider to mitigate the situation.

The Installation Management Agency has supported over 3,000 injured Guard and Reserve soldiers in the medical holdover program at any one time at 36 installations in the continental United States, Alaska, Hawaii, and Puerto Rico. Our specific roles and responsibilities fall into three areas: command and control of medical holdover soldiers, billeting, and transition processings. Let me very quickly review these three areas of support.

Each installation with a significant medical holdover population now has a dedicated command and control unit called a medical retention processing unit. This unit is under the oversight of our garrison commander, who is ultimately responsible for the installation medical holdover program. These units are commanded by a commissioned officer and provide soldiers with leadership and basic administrative and logistical support. From the time the soldier is processed to the time the soldier is out-processed we ensure we address the soldier's needs. This ranges from daily requirements for food and shelter to assisting with legal assistance, religious support, and transportation to and from medical appointments.

The units work closely with the medical team to monitor the well-being of the soldier and track progress through the medical retention process. The bottom line: the basic responsibility of this unit is no different than any other—accomplishing their mission while caring for soldiers and families.

We also take our responsibility for billeting soldiers very seriously and continually improving their status. Today all medical holdover soldiers are provided with a safe, secure, climate controlled room with inside latrines and accommodations for their medical conditions as needed. This is the standard. To meet these standards, we house soldiers in on-post barracks. When that type of accommodation is not available, we use temporary relocatable buildings designated for medical holdover soldiers, or Army on-post transient lodging, or off-post hotels. Billeting medical soldiers is and continues to be a high priority.

Our last area of support is in transition processing, which is performed at each installation transition center. These centers process

soldiers for retirement, return to Guard or Reserve status, or return to civilian life. The Army standard is to out-process these soldiers not later than 30 days after receipt of orders. To get there we added 24 support personnel across 13 key installations. However, we have not only met these standards but today our Installation Management Agency transition centers are out-processing soldiers in 16 days. This is a good news story and we are continuing to work to improve these times.

I want to assure the committee that the Installation Management Agency remains fully committed to support the medical hold-over program.

Once again, thank you for the opportunity to address you, and I will answer any questions at this time.

[The prepared statement of Mr. Sakowitz follows:]

STATEMENT BY

PHILIP E. SAKOWITZ, JR.

PRINCIPAL DEPUTY DIRECTOR

ARMY, INSTALLATION MANAGEMENT AGENCY

Mr. Chairman and Members of the Committee, I am Phil Sakowitz, the Principal Deputy Director of the US Army Installation Management Agency (IMA). Thank you for the opportunity to appear before your committee to discuss our contribution to the medical holdover program. The Installation Management Agency is a relatively new organization established in October 2002. We are the "city managers" for the United States Army providing what we call base support at 179 Army installations world-wide. These installations are decisively engaged in supporting the Global War on Terrorism. Secretary of the Army Harvey recently stated that providing for the well-being of Soldiers and their families is his most important priority; the IMA is at the forefront of this effort. While our agency delivers quality base support services to the Army, we are particularly honored by our role in support of injured Soldiers and their families.

We manage these Army installations from our headquarters in Crystal City, Virginia through seven regional offices. Our headquarters and region staffs, in close cooperation with Forces Command and the First and Fifth Armies as well as the staffs from the Offices of the Surgeon General and Assistant Secretary of the Army for Manpower and Reserve Affairs, oversee the Agency's medical holdover effort. Together we monitor the current and projected medical holdover populations for each

installation to determine if current capacity levels for command and control and billeting are sufficient and if not what additional resources will be needed to accommodate or if the medical holdover load should be diverted to another installation. We stay engaged through periodic meetings and conferences incorporating all team members.

As of February 9, 2005, the IMA supports 3421 injured Army National Guard and Army Reserve Soldiers in the medical holdover program at 36 installations in the Continental United States, Alaska, Hawaii, and Puerto Rico. Our specific roles and responsibilities fall into three areas - Command and Control of medical holdover Soldiers, billeting, and transition processing. Over the last 18 months, since the challenges at Fort Stewart and Fort Knox, the Installation Management Agency has been decisively engaged with all Army stakeholders to improve the support we provide. Let me review these three areas of support:

Each installation with a significant medical holdover population has a dedicated command and control unit called a medical retention processing unit (MRPU). This unit is under the oversight of the garrison commander who is ultimately responsible for the medical holdover program at the installation. These MRPU's are commanded by a commissioned officer and provide Soldiers with leadership and basic administrative and logistical support. From the time the Soldier is in-processed to the point the Soldier is out-processed from the installation; whether to go to another installation for specialized care, to transfer to a community based health care organization, to return to civilian life, or to

their home station unit; MRPU personnel ensure we address Soldier needs. This ranges from daily requirements for food and shelter to assisting with military finances, legal assistance, and religious support. They work closely with the medical team to monitor the well-being of the Soldier and track progress through the medical retention process. Arranging for transportation and other support needed to get Soldiers to medical and administrative appointments is a major daily routine. Another important function of the leadership is to assign meaningful jobs to each Soldier to give them a sense of purpose, which contributes to his or her well-being. A Soldier's medical limitations are always taken into account and the job never interferes with the medical process. Bottom line: It's important to note that the basic responsibility of the MRPU is no different than any Army unit - Caring for Soldiers and their families while accomplishing the mission. The mission in this case is: To heal the Soldier and return him or her to fighting strength. For those we cannot heal, then with dignity and compassion, we will assist them in making the transition to civilian life. This is incredibly important and difficult work and the men and women performing this service, almost all of them Guardsmen and Reservist themselves, are outstanding and improve daily.

This command and control (C2) function is critical to our success and we continue to learn from our experiences. Some lessons learned from our involvement in recent assessment team visits were the need for improved command emphasis and a forum for periodic program review. As a result in September 2004, the IMA Director reemphasized that the garrison commander was ultimately responsible for the medical holdover program and tasked each commander to form and chair a multi-functional weekly meeting to review each medical holdover case and provide a

forum for stakeholders to resolve any issues hindering the success of the program. This forum includes the unit leadership and medical case managers, but also includes chaplains, counselors, transition center staff as well as other key support personnel. This practice continues to be instrumental in improving quality of life and the effectiveness of the medical review process.

We recently established a new command and control structure to improve the ratio of platoon sergeants to medical holdover Soldiers. Additional manpower is being assigned to installations to reach an ideal ratio of 1 to 35. Fourteen Soldiers have been received in the last few months. We feel this ratio will improve our command and control and the efficiency of a Soldier's progress through the program. Over 25 of our MRPU cadre also participated in a training conference from January 30th to February 5th at Camp Robinson (Little Rock) Arkansas to exchange ideas and lessons learned as well as to review key medical and administrative processes. We will continue these training events to improve our support to medical holdover Soldiers.

The IMA is responsible for all Soldier billeting and that includes those in the medical holdover program. We are continually improving in this area of support and today, all medical holdover Soldiers are provided with a safe, secure, climate-controlled room with inside latrines and accommodations for their medical conditions as needed. This is the standard. To meet these standards we house medical holdover Soldiers in the following priority: (Note that some Soldiers who live near the installation do reside at home)

- On-post barracks in compliance with DOD standards for transient soldiers as a minimum. For junior enlisted, that is 90 square feet net living area and not more than 4 to a room.
- Temporary relocatable buildings designated for medical holdover Soldiers. As an example, Fort Stewart has 300 billet spaces in this category that were leased in February 2004 to improve living conditions.
- Army lodging. This is on-post hotel space. As an example Fort Bragg relies on this option.
- Off-post lodging. Hotels off-post, as well as Army lodging, are in some cases required if the Soldier, for example, needs access to a bathtub for their medical care. Fort Campbell is using this option pending available adequate housing on-post.

Billeting medical holdover Soldiers continues to be a high priority and we are meeting, and will continue to meet, standards. The IMA has made great strides in refurbishing barracks spending over \$6.8 million last year to upgrade and furnish barracks dedicated for medical holdover Soldier use at five installations.

The last area of support is transition processing, which is performed at each installation transition center. These centers process Soldiers for retirement, return to National Guard or Reserve status, or return to civilian life. The Army standard for processing orders is three days after entry into the transition processing system (TRANSPROC) by the Physical Disability Agency and the Soldier must then be out-processed no later than thirty days after receipt of orders. During the initial days of the medical holdover program, this process was slow and often delayed a Soldiers return home.

We responded by improving procedures and adding 24 support personnel across 13 key installations to meet these standards. Today, IMA Transition Centers are currently issuing orders on average within four days and out-processing Soldiers in 16 days. This is a good news story and we are continuing to work to improve these times.

Before I close I want to echo what you have heard today about the Community Based Health Care Initiative. This program has been a win – win situation for the Army and our Soldiers. Allowing eligible Soldiers to heal at home relieves pressure on our installations, resulting in greatly improved quality of support to all Soldiers.

I want to assure the Committee that the IMA remains fully committed to its mission and its support to the medical holdover program. Once again thank you for the opportunity to address the committee and for all the support you provide to our Soldiers and families, to our Army, and to our Nation engaged in the Global War on Terrorism.

Chairman TOM DAVIS [presiding]. Let me start. You heard the testimony in the previous panel. I read an article in the “Orlando Sentinel” on Sunday that tells of 15 wounded or injured Guardsmen who arrived at Fort Stewart, and they have been blocked from seeking medical treatment at home under the community based health care initiative that we have just heard touted here. An Army colonel in Army Forces Command in Atlanta states that the reason is a very complex budget and statutory problem all wrapped up in legalese.

I want to refer you to these three charts over here that display the offices involved, the medical administration process involved in the Guard and Reserve and the processes, themselves. I mean, it looks—I think I am pretty competent, guys, a lawyer, and I spent 8 years in the Guard, but it looks pretty complicated.

I mean, who is getting these people through these mazes? It is no wonder people are falling through right and left. I know everybody is trying, but we end up, instead of a mission driven Government here, just wrapped up in rules and regulations, and the result is what we see. In wartime, it has just almost been embarrassing. I think you all would agree to that. I think we are all trying to fix it.

I guess my first question is: what do we do for these 15 people in Florida? And how did this all happen?

Dr. Denning, let me start with you.

Mr. DENNING. Sir, my university would be happily surprised, I suppose, if I was really a doctor, but I am not.

Chairman TOM DAVIS. That is what it says on there.

Mr. DENNING. I know. My Mom would appreciate it.

Chairman TOM DAVIS. Well, congratulations. We held a hearing on diploma mills a couple weeks ago. I can get you up there pretty quick for \$15.

Mr. DENNING. I may need to take you up on that.

Sir, I will give you an alibi, I guess, or plead guilty. No. 1, we have a medical system in my judgment and a set of processes that were sized for a peacetime Army and we are fighting a two-front war right now, indeed, a worldwide war, and it is loading our systems like they haven't been loaded since World War II.

Chairman TOM DAVIS. Correct.

Mr. DENNING. No. 2, some of our processes were simply not designed to handle large numbers of mobilized soldiers. The ADME process you have heard about, for example, was designed to take care of soldiers injured during their 2 weeks of active duty a year. It took us, frankly, some time to realize the system was under strain and breaking, and it took those stories in late 2003 from Fort Stewart. But the Army really swung into motion there.

Are there the stories you heard this morning? Every one of them I am absolutely certain is true, and your heart goes out to those soldiers and their families. I think we have addressed these. That is why you heard about medical readiness processing. Those charts you have over there, it is a complex process. Caring for soldiers, managing their care, taking care of their finances, shifting them between the kinds of orders that the statutes require us to work under is a complex process. I think we have it about to the point now that it will work very well in the future.

Will there be problems? I am sure there will be some—

Chairman TOM DAVIS. I was in the Guard. I understand a little bit how it works. You call these soldiers up. They go into basically Federal service by going abroad, and at that point why don't they just stay on that payroll until they are discharged and sent back to their units? Once they come back and they are injured, you ought to just keep them and give them all the Federal benefits. What is so complicated about that? What am I missing here?

Mr. DENNING. Well, first of all, sir, the soldiers are mobilized under partial mobilization authority, involuntarily mobilized, 12-302.

Chairman TOM DAVIS. I understand. I mean, we can make this—I was a lawyer. I understand how this stuff gets written. But once they are over there, they are fighting side by side in many cases—

Mr. DENNING. Yes, sir.

Chairman TOM DAVIS [continuing]. With regular military personnel. I have been over to Iraq several times. I understand that you can't tell the difference, and certainly the enemy can't tell the difference when they are shooting at them or putting something on the side of the road. So why not, before they come back, if they are ready to go back to their unit that is easy; otherwise, just keep them under some kind of Federal purview where they get the commissary and they get the PX and they get the medical and everything else? Why is it so complicated?

Mr. DENNING. Many soldiers, sir, when they are Med-Evac'ed, they stay on their mobilization orders. Their pay systems aren't affected. Their benefits aren't affected. Nothing changes. When we hit that 24-month brick wall—well, it could be up to 24 months. Many soldiers are called up for 18 months. It varies by unit. But once that soldier hits the extent of his original set of orders, he was placed then on ADME orders, and that is what we have resolved now. They are going to go on to—

Chairman TOM DAVIS. But some of the people in charge of the ADME orders were telling people 30 and 60 days. They just took it on themselves, even though the law allows them to do longer. That was the testimony.

Mr. DENNING. That is right, sir. That is what we have corrected. Soldiers will be put on for longer periods.

Chairman TOM DAVIS. Well, why would they do that? I mean, what is the rationale?

Mr. DENNING. Well, sir, the ADME process, as I mentioned, was designed as a peacetime system for the Reserve Components, for soldiers injured during that 2 weeks of active duty every year. It was never envisioned as a system to take care of soldiers who required long-term medical care.

Chairman TOM DAVIS. What do you think about the idea—and I am asking all of you—about an ombudsman or case worker or somebody who that soldier can call and is the soldier's advocate instead of an advocate for "the system?"

Mr. DENNING. I am open to that. I think we have done a lot though with Installation Management Agency—

Chairman TOM DAVIS. Well, we have, but I hear—not according to the "Orlando Sentinel." There are still people falling through the

cracks as late as last Sunday. Everything is fine, but I am just saying at the end of the day it doesn't help that soldier to know that everybody is up there trying and that we are getting more people. Just having someone that they can call as their advocate, they shouldn't have to call my office or Ms. Norton's office, which is what they are doing and that is why we are here.

Mr. DENNING. I understand, sir. We are open—

Chairman TOM DAVIS. How does everybody feel about an ombudsman in a case like that? Are we open to that when there is somebody in a situation like that? Assign them an advocate, somebody that can walk them through the maze and look out for them. These people have taken time away from their families, away from their jobs. They have interrupted their careers. Some of them come back in body bags.

Mr. DENNING. Yes, sir.

Chairman TOM DAVIS. Some of them come back missing limbs. The least we could do is, when they come back, have somebody there that is going to advocate for them and get them the maximum the system allows. We owe them that.

Mr. DENNING. We agree completely, sir. I thought—and I will let the other generals speak for themselves—when we set up the medical readiness processing units, that is what we expected of those platoon sergeants and those leaders in there, to assist those soldiers, if they encounter difficulties, to help them work through the maze.

Chairman TOM DAVIS. Well, let me ask another question while I have the brass up here. This is just a yes or no. Can we be assured there will be no retaliation against the people who testify here today?

Mr. DENNING. Yes, sir.

General HAGENBECK. Absolutely.

Chairman TOM DAVIS. OK. Is that right?

General KILEY. Yes, sir.

General WILSON. Yes, sir.

Mr. SAKOWITZ. Yes, sir.

Chairman TOM DAVIS. They were very nervous. They did not want to come forward. They are very respectful of everything everybody is doing. If you heard, there is a frustration there. We really asked them to, because there is nothing like having the victim sit up there and tell the story. We are not trying to embarrass, but this is an ongoing problem and I think we all agree they deserve better, and I think it helps you act better when you see something like that and you are trying to move something through. You have to go through lawyers to get stuff done, too. You just can't wave a wand and make it happen.

I think hopefully we are helping you get this job done, as well. Ms. Norton.

Mr. SAKOWITZ. Mr. Denning, did you want me to talk about—

Chairman TOM DAVIS. Sure. Go ahead.

Mr. SAKOWITZ. Sir, what Mr. Denning was referring to is the medical retention processing unit, which is fairly new in the Army. When the soldiers first came back a couple of years ago we didn't even have an Installation Management Agency. Each installation decided how to handle their medical holdovers. Now we have a

standard process with these units that is to do pretty much what you just said from an ombudsman standpoint. Now, sir, it is not one-to-one. We have established—

Chairman TOM DAVIS. Of course not.

Mr. SAKOWITZ. We have established a basic military structure, company structure. We have a commissioned officer with NCOs that we have now especially assigned, which we never had before, to handle those particular needs. Sir, there are going to be areas where we might miss one or something happens.

Chairman TOM DAVIS. Sure.

Mr. SAKOWITZ. But in general I would say at those sites with the significant medical holdover populations, these units who only do that job and are assigned for them and are, in fact, Reservists themselves, sir, who we have called up to handle this, could answer, I would say, most of the questions that you talk about from an ombudsman standpoint and are doing that.

Chairman TOM DAVIS. Let me ask General Wilson, General Helming has expressed deep concerns about the retention rate of Army Reservists, and recent reports confirm unmet recruitment goals. Do you think that the current administrative problems that we are seeing for the injured has contributed to this decline?

General WILSON. I can't directly attribute that specifically.

Chairman TOM DAVIS. It doesn't help though, obviously.

General WILSON. It doesn't help, and soldiers have, sir, as you are well aware, very strong, informal communication network that works very strongly on their behalf. But I think the continued force of our leadership to rectify these problems and to deal with these issues, more importantly than soldiers, the families and the wives have become a strong advocate and a very stringent questioning body and query body. So anything we can do to deal with the issues that the soldier faces will always help us in the area of recruitment and retention.

Chairman TOM DAVIS. I think the one thing in the first panel that caught me, in a couple of instances where you had—in one case you had the adjutant general from Oregon, in another case you had one of the sergeants that were assigned to Walter Reed trying to do things. Someone upstairs—and this didn't come from you. I don't think it is in the regulations, you know, "Why are you rocking the boat," you know, basically saying, "It is not your problem. Why are you rocking the boat? Why are you doing this?" I understand how that occurs. But at the end of the day those kind of advocates really help make things go, and we need to get that word to you as quickly as possible. The faster the word that something has gone wrong gets to you, the better able you are to correct it.

I think it was in that vein that we called them forward today. Do you understand what I am saying? Nobody likes blowing a whistle. These guys would go back again if they were able to do it. They believe in the mission. They weren't here denouncing the administration or the President or anybody else. So I think we just need to work together on this, but we are going to continue to overlook it, because when you look up there and see a chart like this, I can just tell you things fall through. Maybe what we need to do is establish and work with you to make sure those advocates are

in place and working and trained to get the right answers for these soldiers who deserve that.

Ms. Norton.

Ms. NORTON. Thank you very much, Mr. Chairman.

I was very pleased to hear your response to the chairman's question about ombudsmen. Let me be clear what the word means, and then ask you about two examples. An ombudsman has his allegiance to the person, not to the system. One of the problems with the caseworker system is those people are, of course, caught between their obligation to the system, that is to the service, and to the service person, as well.

Do I understand you to say that an ombudsman—and, by the way, we don't mean one-to-one in the sense that it would be one person for every member of the service, but an ombudsman who would have a collection, a set of members. Do I understand your answer to the chairman's question to be that you endorse the notion of an ombudsman whose allegiance would be to the soldier, alone, who would be an advocate for the soldier, who might be, therefore, advocating to people within the system and not feel that he had responsibility for the system or could be penalized for pressing the case of the soldier?

And, of course, everybody who presses a case has common sense on when he has gone as far as he can. Can I understand whether you mean a soldier's advocate by the word "ombudsman," which is the general meaning of the term, not some caseworker type person within the system? Did everybody have that same understanding?

Mr. DENNING. Ms. Norton, I indicated I am open to that idea. I think I would first like to investigate the limitations of the medical readiness processing units. As I indicated we have NCOs there who this is their job already.

Chairman TOM DAVIS. Would the gentlelady yield for just a second?

Ms. NORTON. I would be glad to yield.

Chairman TOM DAVIS. I think the idea of an ombudsman—you can call them whatever you want, but for a soldier, particularly one who has been having trouble, whether it is getting paid, whether it is medical, there is still a whole series of problems. There ought to be a number they can call and a person that is assigned to look after them.

I am not talking about a gripe session. I am not talking about they didn't like their orders or they got KP too much. I am talking about something related specifically to organized benefits—pay, medicine. There ought to be a number and a person assigned, and sometimes that person may say, you are all wet on this. It is just not going to work.

But right now they go up through the chain of command, and that has just not seemed to work, simply because people in the chain have other activities as they see their mission, not that they are against the soldier, but they are trained to do other things, somebody who's trained to know all the ins and outs of the benefit structure, of the pay structure, of the problems that can occur, the orders not being cut in time, those kinds of things. That is all we are asking.

Obviously, we are not asking you to sign off on a blanket. The concept of that seems to me—I am talking about an injured soldier coming back from the war. There is a person that they can call on the ground if they have a problem.

One of the biggest problems we had here was they couldn't get orders cut. They didn't know where they were going to live. They didn't know what their families were going to do. They couldn't get leave. Do you understand what I am saying? That is what we are talking about.

General HAGENBECK. Sir, if I could, we have established that inside what we call our "disabled soldier support system." It only involves right now about 260 soldiers, and those are most seriously wounded soldiers, those that have lost limbs, eyesight, have been paralyzed. We have set up an office—we have funded it last fiscal year with \$4 million. I believe it is \$7 million for this fiscal year—to be exactly what you described.

So I think we have taken the first step, and I think conceptually we are supportive of that, understanding that we never want to take away that responsibility that chain of command has, that first sergeant company commander that needs to work in concert. But we do agree that there has to be someone that soldier can go to to cut across the bureaucratic lines at some of these stovepipe organizations when he can't get resolution.

Chairman TOM DAVIS. And you agree that today, the couple of situations we heard, that would have helped a lot?

General HAGENBECK. Absolutely would have helped. Yes, sir.

Chairman TOM DAVIS. Yes.

Ms. NORTON. And, of course, the command structure needs all the help it can get. I am sure they would be the last people to say that they wanted to handle these everyday, run-of-the-mill complaints rather than have it go to somebody whose job it was to followup.

I want to just test to see how this would work, because let's say that we have countless examples of relatives—wives, parents, members of the military who are not able to maneuver for themselves, call their Congressman. You really do not want Chairman Davis and I to be the advocate. I am sure that is the last advocate you need. But that is what happens.

Chairman TOM DAVIS. I am not sure they want to answer to you.

Ms. NORTON. Exactly. So all we are saying about ombudsman is it is in your best interest, as well. But we are very worried about what happens to the relatives, because we are getting the same kind of terrible, horrific complaints from them, being on the phone for hours, being passed from one part of the Army to the next part of the Army.

I wonder if there is a, let's say even for these 200 or so, or for any others, if there is a central location or phone number where someone who is a relative of the Reserve or National Guard can call and get answers to the question about the treatment and the Army or about some of the issues that have been raised here so that this would not be passed on to the already anxious relatives of these members of the service to whom they turn when they are not able to get any answer themselves.

General HAGENBECK. If I could answer that initial question, we have established an 800 number for what we call "DS3," disabled soldier support system. So I think conceptually we know how to do that, I mean not just conceptually but in concrete terms. But, again we would need to—

Ms. NORTON. That 800 number directs them to where?

General HAGENBECK. They have a case manager, exactly that, an ombudsman who then takes—

Ms. NORTON. Don't call the case manager the ombudsman. We have had all kinds of problems with case managers.

General HAGENBECK. I am perhaps defining it differently than you, but the point is that is their go-to person by name and who they are. They keep a complete file on them and they are responsible for that soldier, and they are responsible for being their advocate, whether it is entry into the VA system, they are having problems medically, financially, or whatever it happens to be.

Ms. NORTON. General Wilson, you had a response?

General WILSON. Yes. Given much like the Guard, most of our soldiers, the overwhelming majority comes from the community, itself. Between the Guard and the Reserve there are over 3,000 local locations that soldiers are mobilized from. In our case, we have the Army one source, which is a 24-hour, 7-days-a-week, 365-day telephonic or web-based source for dealing with the full range of issues, from medical and dental benefits, training and support to help readjustment and reintegration into civilian life and their jobs, reunion and marital reintegration with spouse, children, and personal social adjustment. The beauty of this program, it is one source. We publicize it in all of our family support and our rear detachment operation sites. With this program they have a benefit of receiving up to seven in-person consultations relevant to issues.

So the Army Reserve and I believe the Army National Guard, but I can't answer for sure with that, have the Army one source where they can go out and find this type of information or be referred to a specific source for support.

Ms. NORTON. Thank you very much.

Ms. EMBREY. Excuse me?

Ms. NORTON. Yes, Secretary Embrey.

Ms. EMBREY. I would like to also add that just 2 weeks ago we had a ribbon-cutting ceremony announcing a DOD-wide program for the severely injured joint support operations center, and the objective of that center is to provide 24/7 access to anyone who is unaware of the service specific program so they can get information about how to access and resolve their problems in navigating. It specifically is designed for the injured service member and their families.

We recognize this is an important emerging issue that sometimes information about what is available is not known to individuals at the ground level. This is a way in which to have DOD-wide access to get that information and to refer to the programs that are viable and active in each of the services.

Ms. NORTON. You have to believe these soldiers have e-mail and voice mail. They know how to phone home when in trouble.

I have a very specific question, a concern I have about Walter Reed here in the District, where I am told that as of January of

this year, just this past month, that soldiers being held there on medical hold are being compelled to pay for their own meals. I need to know if this is true. Enlisted soldiers apparently—again, according to the information I have been able to get hold of—get \$267 in allowances per month to pay for meals.

At Walter Reed, after a soldier has returned from the battlefield, the cost would be \$450 a month. I would like to know is it true that these soldiers on medical hold have to pay for their own meals that other soldiers receive free of charge? That is a pretty specific question and I need to know yes or no if that is the way it works.

General KILEY. Those medical hold soldiers that are in an outpatient status during basic allowance subsistence allowance are required, when they use the dining facility at Walter Reed, like all the other soldiers assigned to Walter Reed, both active duty and Reserve, are required to pay for their meals as they go through the food line. They have an option to go on separate rations, as I understand it, and give up that \$280 a month of subsistence allowance, at which time their meals in the dining facility are free.

That is no different than any other hospital—

Ms. NORTON. Wait a minute. Let me understand this. I thought that the \$267 was for enlisted soldiers to pay for their meals, but that at Walter Reed that is not what you got. You had to pay for all three meals. Is that not the case?

General KILEY. If you are an outpatient. If you are an inpatient, you are not paying for your meals.

Ms. NORTON. Of course.

General KILEY. But because if you are—

Ms. NORTON. But you are in a hold company. You are trapped there.

General KILEY. If you are assigned to Walter Reed or if you are assigned to the medical holdover unit at Walter Reed in an outpatient status, then you are authorized to pay and privileges for a soldier that is not living in the barracks and having a mess hall to go to, a dining facility to go to. So under those circumstances, the Army gives those soldiers money to buy their meals at the dining facility, or to buy meals—

Ms. NORTON. So they receive—

General KILEY [continuing]. Or Burger King or McDonald's.

Ms. NORTON. So this soldier in medical hold receives how much money to buy his—

General KILEY. As far as I understand it, just like every other soldier on active duty who is not sick in hospital and not on a meal card, which is the Army's way to give them free meals—you either get a meal card and you don't get any monthly allotment and then you either eat at the mess hall with this meal card free, or you have to go find—

Ms. NORTON. So they can get this meal card?

General KILEY. Yes, ma'am, that is my understanding. That is my understanding.

Ms. NORTON. And then they could have three meals a day—

General KILEY. Free.

Ms. NORTON. Free?

General KILEY. Yes, ma'am. But when they get the meal card they give up the monthly what is called subsistence allowance, the—

Ms. NORTON. Wait a minute. The monthly subsistence allowance, that is not just for food?

General KILEY. Yes, ma'am. For food.

Ms. NORTON. So they give up the whole thing then?

General KILEY. Well, they are getting three meals a day, 30 days out of the month.

Ms. NORTON. And they are living free of charge on the base, is that it?

General KILEY. Yes, ma'am. They are in the barracks or in the hotels.

Ms. NORTON. I see. OK.

Could I ask you about the—we are interested particularly in equal treatment between the Guard, Reserve, and the enlisted members. As I understand it, for some of the active duty medical extension soldiers prior to this war, for example, in Bosnia, the way it works apparently is that some of the injured Army Reserve Component soldiers in prior wars like Bosnia used the active duty medical expense process, whereas for these soldiers you have to apply through the medical retention process. Why were they not allowed to use the active duty medical expense process, especially since some of the soldiers in Bosnia were allowed to do so?

General KILEY. If I understand—

Ms. NORTON. Why isn't there a single system, in other words, no matter what theater of war you are in, you use the same process?

General KILEY. I think the key—and I could be corrected if I am wrong, but I think the key in this process, which is where the ADME process evolved from, started with soldiers that were injured during training. A medical assessment was made of the nature and extent of their injury, depending on the circumstances under which they were activated, and then a decision was made as to how long they would remain on ADME.

Even during Bosnia, the numbers of soldiers that flowed back to continental United States, Reserve and National Guard soldiers, was small enough that the administration of the ADME process, to include consultation with physicians repetitively, was robust enough to handle those relatively small numbers. I think what we experienced—and as you know I was at Walter Reed from 2002 to 2004 as a commander—the numbers just exploded on us.

And so, in attempting to follow the regulations and attempting to be good keepers of the faith, as it relates to the law and the regulations, we had to work through this very burdensome system, and hence we discovered, frankly, pretty early on that soldiers were dropping off. We were hearing this, frankly, at morning report at the hospital, and that hold knew about it. It was a function of coming to the realization that we needed to change the way we were doing business.

It took us a little while to do it, and I believe by the first of March we will have just about everybody off ADME. But that is just an older system that served us well when the numbers were real small under the circumstances we were operating under.

Ms. NORTON. Mr. Denning.

Mr. DENNING. Yes, ma'am. Since the fall of 2003 and the Fort Stewart incidents, we all at this table, particularly the Surgeon General, have worked—I think “tirelessly” may be too strong a word, but really hard to ensure that the AC soldiers and the RC soldiers were treated absolutely the same, that there was no discrimination. In fact, I can sit here before you today and tell you that the RC soldiers are treated at least as well if not better than their AC counterparts in terms of access to the medical care system.

The Surgeon General has established very specific guidelines in terms of waiting time for appointments, priority order, to ensure that RC soldiers get the best quality health care available.

Ms. NORTON. Ms. Embrey, I just have to ask, the total failure of the planning process, so that after troops were in there you all began to somehow understand that you would have people back here that would be held in companies like the company at Walter Reed. What was the flaw in the planning process? Did you expect simply to get into, let us say, Iraq and get out with almost nobody injured and that would be it?

You had a long time to plan for this. The discussion on whether or not we would go to war had to have gone on for at least a year. You had to go back and forth to the United Nations. It was very controversial. There was lots of things. I mean, why wasn't the planning done there? What was the flaw in the planning?

Was it that you anticipated not having or having almost no injuries and therefore didn't plan on having this number of Guard and Reserves there? And if so, if that was your thinking, on what basis did you believe that you did not have to plan for so many injured members of the Guard and Reserve?

Ms. EMBREY. I think I will answer this in a couple of different ways. The first is there are a number of factors that have contributed to the situation we are in. The first is that we organize as units and there are various specializations in a unit, and one of the specializations in those units is to understand how to navigate the process in your command and control structure.

When we mobilize, especially Guard and Reserve, they go and there is a pre-deployment process screening where we try to identify those who are not physically or medically ready to deploy. There is a certain percentage of those folks that stay back, but the rest of the unit goes, along with the expertise to help them navigate the process.

Then, while they are there, those who get injured are, if they are severely injured, are medically transported back to the States through various points of care, returned to a place where their special requirement can best be provided, and again their expert that helps them navigate the system from their unit is not with them.

When they return, through a post-deployment process individuals identify their concerns, their physical problems. They are referred and then taken care of, and some of them end up in medical hold. Again, the rest of their unit and the expertise to help them navigate the system has gone home.

That is part of the problem, and I believe that—

Ms. NORTON. Yes, we understand the problem. My question was: what was the flaw in the—was this all unforeseeable?

Ms. EMBREY. I don't think it was unforeseeable. I cannot speak for the Department on failure to plan. I think there was a very good understanding that we were trying to screen individuals who would not deploy with medical problems. I think we thought that our peacetime structure would be able to handle the anticipated casualties. We realized going in that this is a marathon, not a sprint, and we are now having to make adjustments based on what we are learning.

Ms. NORTON. That is precisely my question. The President warned everybody from the beginning of September 11 don't expect this to be over soon. I only dated back to when we began to discuss going in Iraq.

Ms. EMBREY. Would Congress have agreed to a surge in the force structure in order to accommodate these requirements?

Ms. NORTON. Do you for a moment believe that if you had come to this committee or to the Armed Services Committee and said, we expect real problems to develop because of the number of injured soldiers who may be coming home for a system that is not equipped to handle them on base, and so they will be held in medical hold, do you for a moment believe that Congress would have said, go away?

I mean, you are returning your question to me? We expect you to do the planning, come to us, and say, this is a warning, everybody. We are not equipped to handle this. It is a question of resources. You need to alert us. Are you saying you alerted us and we did not respond?

Ms. EMBREY. No.

Ms. NORTON. Well then don't come and tell me, would we have responded. The question is why did you not alert not only this committee but a number of other committees who first and foremost think of the men and women on the ground and then think about everybody else? So I can only take yours to be a rhetorical question.

Now, let me finally say—and the reason we ask it, very frankly, is that the committee, you know, is really looking for remedies. The message we are sending is that we very much respect the way the military fights wars. We have not respected the way the military has cared for these injured soldiers coming home. We don't think that the people on the ground or what happens on the ground is broken. I think you will agree that this was broken, is being fixed. We have noted the way it is being fixed, are appreciative, but because we are involved in a longtime conflict the message is plan, plan, plan, just like you plan to go to war in some respects and not other respects.

It is absolutely inexcusable not to do the proper planning that will help us take care of people who have been injured in war. It has been heartbreaking to hear the testimony of these soldiers here today, and we just want to make sure the planning is done to make sure it doesn't happen again.

I have only two more questions. We heard testimony from one of the prior witnesses, Sergeant Forney, again over a situation at Walter Reed where he had to use his own funds to buy supplies and equipment. I need to know whether that has been entirely cured, why it was that anybody would have been responsible for

having to do that, why a soldier had to put out his own funds. I am not even sure whether he was repaid.

General KILEY. I have no idea either, Congresswoman.

Ms. NORTON. Well, would you followup on his testimony—

General KILEY. I certainly will.

Ms. NORTON [continuing]. And report back to this committee what you were able to find?

Final question: I asked the prior panel and was told by that panel that you would be the appropriate panel to ask for answers to some of the most disturbing testimony about post traumatic stress disorder. We are told that it may arise some time after, some months, for example, after the soldier is back, may linger for some time.

We wonder whether or not, under your current system and regulations, whether or not somebody who suffers from post traumatic stress disorder can ever be considered to have a disability as described under Army regulations, or, if not, how such a person who now must come back to civilian life is expected to navigate through the rest of his problem.

General KILEY. I would be happy to try to answer that question. I think it is a very good one, frankly, and the Army Medical Department and the Army and, frankly, the Department of Defense has taken a great interest in this process. As you know, there was an article published recently in the New England Journal by one of our medical health care screening teams that documented a not insignificant number of soldiers who, on a survey, answered that they were having problems, be it nightmares, anger, alcohol, or family disturbance issues. We recognize that, recognized it in terms of the pre- and post-deployment screening that we do for every single soldier who comes back, both active and Reserve, National Guard. They get a face-to-face screen during the demobilization process.

We have also recognized that process, alone, may not be enough—specifically, that soldiers won't admit that they have issues, or they think that once they are back at home, they demobilize, they are looking forward to getting back with their family, that some of the issues they may or may not have been worried about are now going to be resolved.

There is no question that every soldier that mobilizes and deploys goes through a traumatic experience just in the mobilization and deployment, and then with combat operations it can be a significant shock to the system, so to speak. Like everything else in human nature, there is a bell-shaped curve of resiliency associated with that.

But we have gotten more sensitive and more aggressive in seeking out soldiers and asking them how they are doing. We have actually done some followup on soldiers who went through the original screening and found that over time they actually start to admit and recognize that some of the problems they have been struggling with haven't gone away. So we are in the process of identifying that systemically and clearly offering opportunities for soldiers to come back and see us.

Just recently, as you probably know, the Secretary directed the services to begin a formalized process at the 90- to 180-day mark

to bring soldiers back and screen them, and we are in the process of working our way through the policies and the resources required to execute that.

The second part of that is once we have identified soldiers that may need counseling or help, it is collating the resources to provide that. The mental health communities in general are already very busy—psychiatrists, psychologists, social workers, and other counselors—and we want to make sure we have some place to refer our soldiers, Sailors, Airmen, Marines when they do recognize that they have some problems.

Our experience is that most of those soldiers, almost all of them will resolve these issues, particularly with some assistance, but PTSD is recognized and I am understood to believe that in its most severe forms it is recognized as a disability with sort of the PEB system and soldiers do get recognition of that, depending on the nature and the extent of their symptoms.

It is often a temporary position that does heal itself over time, and so in some cases those soldiers will go into a TDRL status and come back in 18 months, and we will sit down with them again and see how they are doing.

We are very sensitive to this. Some of this is an outgrowth of the first Gulf war and our work in dealing with and the development of the diagnosis of post traumatic stress syndrome.

I hope that answers your question.

Ms. NORTON. I appreciate your answer, because I could not agree more when somebody comes back from war the notion of stress, waiting to see whether or not or at least following the soldier to see if that stress will develop into some long-term problem, that is a close call. As long as you are following the soldier, I think we would be satisfied.

Let me tell you what leads me to ask about disability. When you see the number of soldiers—I mean, appalling number—from the Viet Nam war that are on the streets homeless, you recognize that you never want to see that happen again. I realize that was a draft. There may have been many there who are very unlikely volunteer soldiers.

But it has seared itself into the consciousness of Members of Congress, because those are people who will call our offices, whose families will call our offices, the notion that, as difficult as it is to decide whether or not we are dealing with something that can truly be called a disability and, hey, that is your job as well, as long as that is something that is not off the table or impossible to get in appropriate places, that would certainly satisfy me.

I am particularly concerned in the volunteer Army about that because one's heart goes out as one hears interviews on television members of the service who are asked, well, would you go back, or who volunteer that they want to go back. These are people who have lost limbs or worse. These are folks who have imbibed the notion that they have done a service for their country, who say, I have somehow or feel often I have abandoned my fellow soldiers, and what I need to do in order to feel right about myself is to go right back there and serve as long as they serve. That is the psychology one hears over and again.

I have to tell you I believe the press goes around trying to find somebody who will say the opposite, and they just can't find people. They all seem to say, I want to go back, or, I would go back if I could. That leads me to believe that what you just said, General Kiley, is the case. Hey, that is not the right thing to say if you are a soldier, that you are feeling any pain, that you don't want to go back. Therefore, the possibility that these volunteer soldiers who have absorbed the notion that they are first and foremost a soldier need to be followed very, very carefully, because their reluctance to admit is perfectly understandable.

Finally, in closing this hearing, I want to thank all of our witnesses, and I especially thank you. This has been an accountability hearing. You can imagine that we feel a very special obligation when we continue to hear in our own offices about these problems. We know that you have responded to some of the problems that have been brought to your attention through the GAO and through hearings of this committee, and I want you to know that, despite our questioning, we appreciate the fact that the Army has been responsive to the committee, and we will press you further until we think the system has been entirely fixed. That is our obligation. We think you believe it is yours.

Before we adjourn, the chairman has asked me to say that he has a request of the Army. As you have done for this committee on the issues of the Guard and Reserve pay, he requests quarterly briefings to be provided to the committee on the state of the medical administrative treatment of Guard and Reserve forces. It appears that you have some distance to go to improve the oversight, infrastructure, patient service, and efficiency of your policies.

Also, to better address the questions of Reserve Component members, their families, and congressional case workers, he also asks that the Army takes steps to provide a one-call ombudsman office, and, if I may add, described the way we described it, differently from the case worker who is torn between the system and the soldier—a one call ombudsman office where staff trained in all Reserve Component administrative issues can answer questions in a timely and comprehensive manner.

We would also like to add that the record will be kept open for 2 weeks to allow witnesses to include additional information into the record. That includes witnesses from the service, witnesses who may be family members, or members of the service.

Again, we thank you for coming.

The hearing is now adjourned.

[NOTE.—The GAO report entitled, "Military Pay, Gaps in Pay and Benefits Create Financial Hardships for Injured Army National Guard and Reserve Soldiers," is on file with the committee.]

[Whereupon, at 1:40 p.m., the committee was adjourned.]

[The prepared statements of Hon. Candice S. Miller and Hon. Brian Higgins, and additional information submitted for the hearing record follow:]

**Statement
Rep. Candice Miller**

House Government Reform Committee

**“Wounded Army Guard Reserve Forces: Increasing the Capacity to Care”
February 17, 2005**

Mr. Chairman, thank you for holding this hearing today. Our soldiers deserve the very best healthcare whether they are guard, reserve or active duty. This is an important issue that needs to be addressed.

At this time, we have guardsmen and reservists in medical holding facilities. In some cases they are hundreds of miles from home and their families. While at these facilities, a great burden is placed on the soldier and their families. While visiting loved ones, families incur great financial stress as well. This is a problem that should not be passed on to the men and women that volunteer their time and life to defending our freedom. I personally know this is an issue because of numerous constituents that have been detained for unreasonable amounts of time at these holding facilities.

Healthcare facilities are available to any person anywhere in our nation. This should apply to our soldiers as well. Unfortunately, military medical facilities are few and far between. When servicemen have been injured in the line of duty or become ill, they should have ready access to the very best healthcare available. While serving our country and defending our freedom, the least we can do is make treatment available closer to their homes.

Another area of concern is the lack of administrative support for injured reservists and guardsmen. Medical information should be readily available and case workers should have this information in real time. In addition, families and servicemen should not have to work through multiple offices to address medical and financial problems. This just causes undue stress that these families do not need at this time in their life.

I am truly interested to hear the testimony of the witnesses before us today. Thank you for coming. There are many questions that still need answers and obviously a few new ones that have yet to be asked.

Thank you.

**Opening Statement
Representative Brian Higgins
Committee on Government Reform
“Wounded Army Guard and Reserve Forces: Increasing the Capacity to
Care”
February 17, 2005**

Mr. Chairman and Mr. Ranking Member, thank you for calling this hearing today to discuss the care and health of some of our nation’s most important resources – the Army Guard and the Reserve. Reservists and National Guardsmen are the backbone of our military and make up nearly 40 to 50 percent of the American forces deployed in Afghanistan and Iraq. These brave men and women give up their careers, their families and the comforts of home to go abroad and defend our shared beliefs and way of life. I want to begin by thanking their representatives here today for their courage and for their sacrifices on our behalf.

Because these men and women give up so much to protect us, we owe them quite a bit in return. We are not living up to our end of the bargain. National Guardsmen and Reservists across the country, including those from Buffalo, Jamestown, Batavia and Dunkirk in my district in Western New York, deserve better. Approximately 11 departments, agencies and administrations are responsible for the care of injured Guard and Reserve forces; those administrations are not talking to each other and if they are, they are not doing it effectively. And worse, approximately 5,000 reservists are stuck in a “medical hold,” a bureaucratic term for a real life problem under which soldiers wait months for evaluation and treatment on bases far from their homes and scattered across the country. I am convinced that we can and we must do better.

I applaud the idea behind the Community Based Health Care Initiative, which would allow Guard and Reserve soldiers to get treatment closer to home and to continue working, but there are limitations – soldiers must live near a VA hospital or near a doctor who can care for their particular illness and yet they must also be near a military facility if they intend to work. We should not require our injured soldiers, who have just returned from dutiful service in a time of war, to jump through hoops to get the care they need.

We owe our soldiers and their families better care; we owe them better communication between the administrations responsible for their paperwork; we owe them more than lying for months in an overcrowded military base in Georgia when their families are home struggling in New York or Michigan. Mr. Chairman, Mr. Ranking Member, members of the panel, I was at the Veterans Hospital up on Bailey Avenue in Buffalo, New York just last week and I know we can do better.

Thank you.

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TESTIMONY OF

SPECIALIST BRIAN D.ROBINSON AND MRS. NICOLE ROBINSON
NEVADA ARMY NATIONAL GUARD

BEFORE THE COMMITTEE ON GOVERNMENT REFORM
U. S. HOUSE OF REPRESENTATIVES

“WOUNDED ARMY GUARD AND RESERVE:
INCREASING THE CAPACITY TO CARE”

FEBRUARY 17, 2005

Hello, my name is Brian D Robinson. I was a Sergeant in the Nevada Army National Guard for close to four years. I would like to begin my testimony by conveying my sincere appreciation to all of you here today. It is my belief that everyone here today is ultimately here for the same reason... for love of Country and for love of our Armed Forces. My family and I could not more proud of our Country's roll in the world and we could not be more proud to have been part of something that always stands for the greater good, namely, the United States of America and its Armed Forces. It is my hope that what is conveyed here today, be taken as a positive force in the steps to remedy any policies and/or administrative issues that are found to be lacking as it applies to any and all US Soldiers and their families.

From September 30, 2001, to November 1, 2002, I was deployed on Operation Noble Eagle. I was deployed as a member of the Nevada Army National Guard (NVANG), 72nd Military Police Company. After 12 to 13 months of Active Duty Deployment in California, I returned to my home in Las Vegas where just four (4) months later, on February 10, 2003, my unit was called to active duty again, for Operation Enduring Freedom. We were mobilized through Ft. Lewis Washington where we were bound for Iraq.

On June 27, 2003, while on duty in Baghdad, the vehicle I was riding in was struck by a hand-detonated land mine. I sustained several injuries and was rendered unconscious for just over 40 minutes. The areas of my injuries were as follows: Both ears (blown ear drum in right ear with complete hearing loss and partial hearing loss in left ear) – large cut and bruises over left eye and forehead requiring several stitches – Radial Had fracture to the left elbow – Fractured left wrist – crushed (deformed) right index finger, - sever head, back and neck pain, - whiplash - Shrapnel on left side of upper body accompanied by swelling and bruising. I was medically evacuated from the scene of the attack to LSA Dogwood where I received surgery on my left elbow and was treated for my other injuries. I was then flown from Iraq to Kuwait and then from Kuwait to Lundstul Hospital in Germany for additional care.

After a week or so at the Hospital in Germany, I was informed that I was cleared medically to go back to the United States to continue my medical care. A member of the flight crew briefed me on flight information. During that briefing I was told that I must have "closed toe shoes" in order to take the flight home without being strapped down to a gurney the entire flight. I only had "flip-flops" with me because at the time of the attack, it was necessary to cut my clothing and shoes from me in order to care for my injuries. I was in a great deal of pain and a bit overwhelmed by the situation and I could not imagine having to be strapped to a gurney for such a long flight. I spoke to my nurse regarding the need for closed-toe shoes and she told me to

see the Army Liaison in order to get money from the Army emergency relief fund in order to purchase clothing/shoes. I then went to meet with the SGT on duty at the Army Liaison Office where I was assisted with filling out the detailed paperwork required. I did not however, have the complete information that I needed to process the request due to the fact that during the attack and the medical care that followed, I had lost the necessary unit information to complete the paperwork. After spending a great deal of time explaining this to the Army Liaison SGT several times, the SGT became very frustrated and said (exact quote) "You're starting to piss me the f___ off". At that time I left the Army Liaison Office. I went back to my hospital ward, told the story to my nurse. The nurse called the Army liaison and confronted him about the situation, however, because I did not have some of the necessary information to complete the required form, there was nothing more that could be done from the Army Liaison's Office to help me get the shoes and clothing that I needed. I then went to the Hospital Chaplain to request shoes and I was told that they did not have any shoes at this time... "can't help you". I then returned to my hospital room, explained the situation to my nurse and was then given permission to leave the hospital in order to supply myself with shoes and clothing. I proceeded to take the hospital shuttle bus to Ramstien Air Base, approximately 15 minutes away. The shuttle did not go all the way to the PX so I was dropped off approximately 2 miles from the PX where I walked a considerable way before an off duty MP stopped and offered me a ride. I would like to add that while I was attempting to supply myself with shoes and clothing to return to the United States, that I was in nothing more than flip-flops, torn, bloody clothing from the attack, stitches, slings, almost completely deaf...and in pain.... It started to rain..... After purchasing shoes and toiletry items, at my own expense, I then took a cab back to Lunstool hospital because the shuttle bus was no longer running.

On July 4th 2003, I flew from Germany to Maryland where I stayed for 2 days in a gymnasium filled with cots (with air mattresses) for soldiers. I was then flown to Travis AFB in California where I stayed at the hospital for one night. From there he was flown to Ft. Lewis Washington.

Once I got to Ft. Lewis a bus picked up me and other wounded soldiers to take us to Madigan Hospital. I was seen and evaluated by a Doctor as well as my caseworker. I was required to turn my medical records over to the doctor during evaluation. (The next day my medical records were no where to be found... they still have not been found)

I was kept at Madigan Hospital for about 5 to 6 hours then from there I was taken by a SGT to the 2122nd Medical Hold Company CQ desk. Upon reporting to the CQ desk I was informed that I would be sleeping on a cot in the back room of the CQ office because they did not have beds or any other space for me. It was

at that point that I decided that it was in my best interest to rent a room at the hotel lodging on post at my own expense. I informed the SGT that I would be doing that and had him give me a ride to the hotel.

The next day I had several medical appointments to meet. I was not given any information regarding transportation so at that point I decided that in order to make my appointments I would need to rent a car... again at my own expense.

I went to the Hospital and was there all day and was seen by several doctors. While I was at the hospital, Nicole McGeary, my fiancé at the time, was called at my home in Las Vegas. The military person that called her said that they did not know where I was and wanted to know if she did. They thought I might be AWOL. Nicole informed them that I was getting medical care and gave them my contact information.

After "in processing", I was introduced to and assigned to a Sergeant First Class (SFC). At the time of our meeting this SFC informed me that he had 46 soldiers in his platoon, and that I would be number 47. He informed me that he didn't have time for me and that I better be able to take care of myself. He also informed me that the cut off uniform that I was wearing was inappropriate and that I needed to get a new uniform ASAP but he did not offer any assistance or direction on how to go about doing that. I reported the SFC's comments to a member of my unit that was working in the 2122nd office. The SFC's comments were reported to a "higher up" and I was then transferred to a different platoon. After transfer to a different platoon I was assigned a room and a bed.

My fiancé flew to Ft. Lewis just a few days after I arrived back in the United States. We were married just off base on July 14, 2003. She accompanied me to all of my doctor's appointments and physical therapy appointments where she began a quest to understand the policy and procedures of the US Army as it applied to injured soldiers. She became very involved in my care on all levels. From the moment she learned of the attack she began making phone calls and writing letters to understand what steps would come next regarding my care. She had hoped to be a positive force in any care and recovery I would be needing. She was never given definitive answers and it was as if no one really knew what policy applied to a National Guard Soldier. She was often given the brush off and treated with a condescending attitude. She was very tenacious in her approach and let nothing discourage her. She was told by several sources that I would need about 18 months of medical care and recovery and that I would need to remain in Ft. Lewis to obtain that care. Please keep in mind that I had been deployed for 19 months out of 23 months with the Nevada Army National Guard. We as a family were also of the opinion that physical and emotional well being went hand and hand. The thought of spending an additional 18 months without my family and trying to heal physically and

emotionally was almost more than I could bare. It was also incredibly traumatic to my family. We were told that "this is how it is" and my wife was told that she should not worry because the Army would take care of me. To this point, we had seen little to no evidence of that and were very concerned. Quite simply, the answers we were getting from the military were just not acceptable. What we were being told simply did not make sense.

We decided that convalescent leave would be appropriate to the situation and my doctors and the 2122nd Medical Hold Company granted me 30 days convalescent leave. While on convalescent leave, back home in Las Vegas, a member of the US Military contacted my parents to let them know that I had been injured in Baghdad and to tell them that I was in a hospital in Germany. This was the first time since my deployment that we, as a family, had something to laugh about. I was in fact not in Germany, I was home on convalescent leave in Las Vegas and had been back in the States for about three weeks. The military person that made the phone call said that she did not have any additional information but should have something more to report in a week or so. This is the second time that the US Army had, for all practical purposes, lost me.

My wife and I arranged for my medical care to be continued at Nellis Air Force Base, near my home. I was very pleased with the medical care I received there and after a month of care developed a trust and relationship with my doctors there. Finally, with the excellent medical care I was receiving and the active support and love of my family, there was light at the end of the tunnel. We petitioned to continue my care at Nellis Air Force Base while I reported to the Armory in Las Vegas. We began our fight for Remote Care Orders so that I could continue the type of care that I believed would increase my chances of a full emotional and physical recovery. It was a long and arduous battle. It became a full time job to manage the red tape, medical care and the fight to receive Remote Care Orders. Eventually I did receive my remote care orders. I do need to add that the Remote Care Orders that I received was what I consider to be the most important tool to my recovery. Should I have had to continue my medical care without the active support of my family; I honestly do not believe that I would have recovered as quickly or as well as I have. The Military personnel that assisted us in this were some of the hardest working, competent and knowledgeable individuals that I have had the honor of associating with. A few of them fought hard to protect the integrity of military policy at the same time as understanding the needs of an individual soldier and his family. We will never be able to thank them enough for their efforts in what we consider to be an administrative, red tape, policy nightmare. But please know that there were many other people that did nothing but make things as difficult as one could imagine. We were amazed at how Soldiers and Military personnel, in general, continued to focus on policy and evidently policy that they did not fully understand or that was in direct conflict with the emotional and

physical well being of a soldier and his family. We were even more astonished at the administrative procedures that were so time consuming that it prolonged the suffering of the individual soldier. The great differences in the way different departments interpreted the same policy was frustrating as well. The fight that my family and I had to go through on a daily basis just to "get things done" and to get correct information... and to simply have this soldier's best interests met.... were simply unacceptable. No soldier or soldier's family should have to endure what we have... It has made us wonder what happens to the soldier and his/her family that do not have the strength or "know how" to fight the good fight in order to insure that the needs of the individual soldier is placed before administrative policy?

My original deployment orders and remote care orders were done on February 10, 2004. As my medical treatment was not yet completed, we then began the process of securing documentation for ADME (Active Duty Medical Extension) orders. We provided all of the necessary information approximately 60 days prior to the end of my orders. We were told that it would take approximately 30 days to complete ADME orders. We followed up by making phone calls asking about the progress of the ADME orders and were continually told that they were being processed. Around mid December 2003, we were told that the paperwork had actually not been processed and in order to begin the ADME process, the paperwork and doctors statements would have to be re-done as they were now too "old" to be acceptable for processing. We again provided all necessary documentation and new physician's statements. After the second attempt at completing ADME orders ... we followed up again ... and again were told that they were being processed and not near completion. As we stated, my original orders were "up" on February 10, 2004. After that date my ADME orders were still not complete.... my pay was suspended on this date as a result. It was shortly after this that we contacted a high ranking Military member. He investigated this for us. Just a few days later, but still several weeks after my original orders were "up", my ADME orders were being completed. My pay was re-instated on or about March 1, 2004. Just a note, as much as this interruption in pay was just one more frustrating and stressful situation... it did not leave us financially destitute... we were able to pay our bills and so on.

After my doctors completed their medical treatment, I began the MED Board process.. a new fight. We provided all of the necessary documentation from my physicians; however, because my care was carried out by Air Force physicians rather than Army Physicians, I needed to return to Ft. Lewis to be re-evaluated by Army Physicians. This was one more issue that shocked and amazed us. The Army and the Air Force, in our opinion, are on the same team... Do they not go through the same training as physicians? Do they not both represent the United States Soldier? When it came to medically evaluating my injuries and condition, it

became painfully obvious that the two branches were not only NOT on the same page, but appeared that there was an underlining conflict that I was caught in the middle of.

We were originally told by military personnel that the MEB process would take 30 days, but we continually heard from many other soldiers who had been through the process that it was actually taking 9 months or longer. My family and I pushed very hard for a quick MEB possess with steady follow up phone calls, letters and adamant requests for timely appointments. Finally, though our diligent efforts and with the support of our Congressman and other Military Personnel that we had developed relationships with through this ordeal, I completed the MEB process within a fairly reasonable amount of time. I was found fit for duty by the Army Physicians and then completed my commitment and separated from the Military on July 13, 2004.

We, as a family, do not pretend to know what the answers are, we would not presume to have such well rounded knowledge. We do however believe the following:

- Remote Care for Guard and Reserve Military members is paramount to the successful recovery for the individual soldier and their families.
- Policy regarding medical care and treatment of soldiers should be written and maintained across the board between all branches of the military.
- Policy should bring strength and organization but should never become harmful to the progress and medical treatment of an individual soldier.
- Forms and paperwork are important, however, just because a form can not be 100% completed should not mean that an individual should restrict them from helping an injured soldier obtain adequate footwear or using their own common sense to help care for their fellow soldier.
- Individuals carrying out policy and administrative functions should have a full understanding of its function and its consequences.
- Medical Evaluation should not be a sentence to be waited out by soldiers but should rather be a natural part of the recovery and re-unification process.
- Families should be free to focus on the physical and emotional recovery process in lieu of following up on paperwork, policy and medical care at their own financial and emotional expense.

Today my wife and I consider ourselves lucky and look to our future with optimism and excitement. But the journey has been a long one and the trauma of the administrative process has had far reaching consequences.

It left us with little time and energy to devote to anything other than red-tape and the fight "to make the right things happen", this unfortunately came secondary a majority of the time to my physical healing. That fight continued for so long that we had almost forgotten how to live.

Even today we struggle with the residual effects of Tri-Care (the military medical insurance program). Do to inadequate technology, in-effective Tri-Care case management and lack of communication between military entities, my wife and I were "kicked out" of the computer system many times after my ADME. There were several times that we were left with no medical coverage or were categorized under the wrong insurance plan. We had interruptions to our health care and a very difficult time getting crucial medical treatment approved. This was especially devastating for my wife who became disabled after problems with a major surgery in April of 2004. The lack of adequate coverage left us with yet another desperate fight to get the proper care; unfortunately, we ran out of time and lost that fight when we became ineligible for military medical insurance in January 2005. My wife was never able to get all of the necessary medical procedures she needed and had to cancel several physical therapy/pain management sessions. In addition to the inability to obtain specific authorization for certain care, the interruption in insurance has caused billing problems and we are in the process of re-submitting claims for payment for medical treatment. We believe that they will be remedied in time... but in the mean time, it still requires diligent attention and careful follow up so that our credit will not be affected.

Tired and worn from the fight, ... now the real healing begins...

This testimony has been provided with a heavy and conflicted heart. As many military families, the love of our Country, our Military and the support of our government officials remains strong and steadfast. We believe that the issues that have been conveyed in this narrative are fixable. We believe that there should be light shed on these issues so that the Military can take direct action to remedy the situation so that the Military can stand strong and unified on all levels.

We have faith that you will all keep in mind that today, you have heard only the negative issues that this family has been faced with. For the purposes of this testimony, that is what was appropriate, however; the other side of this is that I am now and always will be proud to have been a US Soldier. I will always consider my experiences with the US Army to be a privilege, and an honor. I will always be a Soldier at heart.

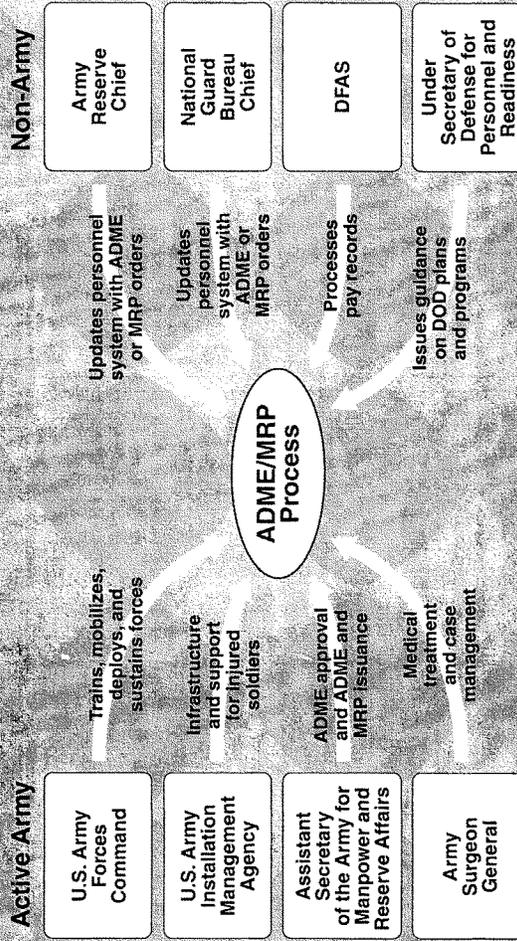
Here is to doing the right things for the right reasons.

Sincerely.

Brian D Robinson And Nicole McGeary Robinson (Spouse)
702-617-1777 Home
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nmcgeary@cox.net
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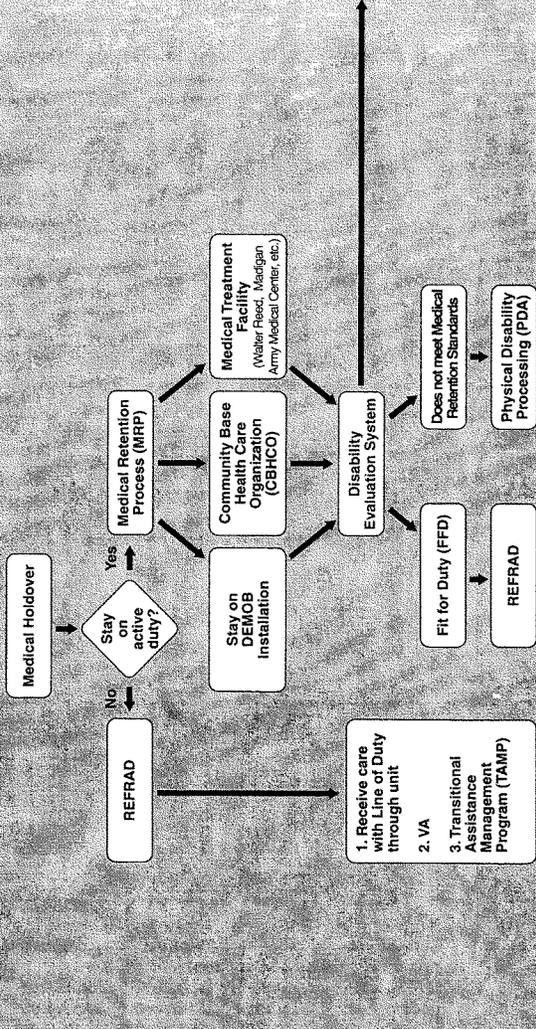


ADME/MRP Process: Participants and Roles



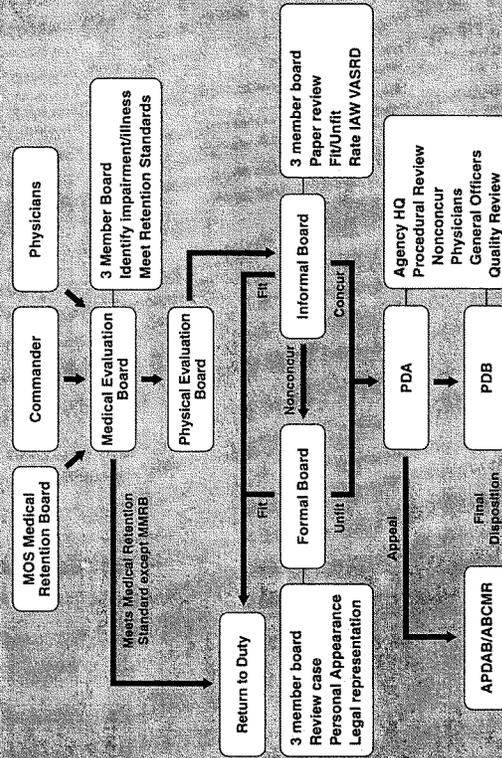
Source: GAO

Department of Defense: Medical Holdover Process



Source: Department of Defense

Department of Defense: Disability Evaluation System



Source: Department of Defense

MEDICAL EVALUATION BUARKU PAUNE I

FORM/DOCUMENT	FORM DESCRIPTION	PROFONENT AGENCY	WHO COMPLETES FORM
1 DA Form 5889-R	PEB Referral Transmittal Document	ARMY G-1	Medical Treatment Facility (MTF) PEBLO
2 DA Form 3947		OTSG	Physicians/Approving auth.
3 Narrative Summary		OTSG	Med Physician(s)
4 DA Form 4700	Med Record-Supplemental Medical Data	OTSG	Medical Records Division
5 Medication Profile		OTSG	Medical Treatment Facility (MTF)
6 MEB Physician Checklist		USAPDA	Guideline for Physicians
7 DD Form 2808	Report of Medical Exam	DoD	Soldier/Physician(s)
8 DD Form 2807-1	Report of Medical History	DoD	Soldier/Physician(s)
9 DA Form 3349	Physical Profile	OTSG	Profiling Officer/Unit CDR
10 DA Form 2173	Statement of Medical Exam & Duty Status	ARMY G-1	Physician/Pad/Unit CDR
11 DD Form 261	Report of Investigation Line of Duty	ARMY G-1	Inv Officer/BN CDR/APP OFF
12 DA Form 5893-R	PEBLO Counseling Checklist	ARMY G-1	MTF PEBLO
13 AR 635-40/MEMOs	Sample letters	USAPDA	Samples for use by all
14 DA Form 5891-R	Acknowledgement of Counseling	ARMY G-1	MTF PEBLO
15 DA Form 5892-R	PEBLO Estimated Disability Compensation Worksheet	ARMY G-1	MTF PEBLO
16 Commander's Example Letters		UNIT COMMAND	Unit Commander
17 DA Form 67-9	Officer Evaluation Report	ARMY G-1	Rater/In Rater/SR Rater
18 DA Form 2166-8	NCO Evaluation Report	ARMY G-1	Rater/SR Rater/Reviewer
19 DA Form 705	Army Phy. Fitness Test Scorecard	TRADOC	Soldier/NCOIC/OIC
20 DA Form 5501-R	Body Fat Content Worksheet	ARMY G-1	Unit NCOIC/OIC
21 Various Orders		Responsible Agency	Designated Agency
22 Memo Requesting DD Form 214		DoD	Requesting Agency
23 DA Form 1506	Statement of Service - For Computation	ASA (FM)	Technical/Reviewer
24 RPAS Summary Points Inquiry/Update		USAR/ARNG	SM/Responsible technician
25 DA Form 4037-E	Officer Record Brief	ARMY G-1	SM/Responsible technician
26 DA Form 2A (USAR)	Enlisted Personnel Record	ARMY G-1	SM/Responsible technician
27 Memo	Disciplinary Action Statement	UNIT COMMAND	Unit Commander
28 DEAS Form 702	Leave & Earning Statement	DEAS	Technician

*Data provided by United States Army Medical Command

ATTACHMENT 2

Kramer, Andrew. "Injured Oregon Soldiers Have Languished at Fort Lewis" *Seattle Times*, August 31, 2004

Geranios, Nicholas "The War in Iraq Washington's Wounded: Soldiers Return to Chronic Pain and Bureaucratic Headaches" *The Columbian*, September 6, 2004

Davey, Monica. "Part-Time Soldiers, Injured But Not Yet Home" *New York Times*, October 23, 2004

Kelley, Eileen. "Wounded Reservists in Limbo" *Denver Post*, November 10, 2004

Spencer, Jim. "No Soldier Should Be Left Behind" *Denver Post*, November 12, 2004

Austin, Marsha and Kelly, Eileen. "Soldiers in Medical Limbo: Members of Reserve, Guard, Stuck in 'Holdover'- Injured or Ill Soldiers Can Wait Months for Treatment in a System Where the Average Stay in 155 Days" *Denver Post*, December 5, 2004

"Soldiers in Medical Limbo at Fort Knox" *Associated Press*, January 3, 2005

Smith, Wes. "Red Tape Traps Injured Veterans" *Orlando Sentinel*, February 13, 2005

Seattle Times
August 31, 2004

Injured Oregon Soldiers Have Languished At Fort Lewis

By Andrew Kramer, Associated Press

FORT LEWIS — About a dozen Oregon National Guard soldiers say they have languished for months here because the Army lacked a protocol to allow them to return to Oregon to convalesce.

The soldiers also waited hours for doctor appointments, were forced to fill out confusing paperwork and faced months of delays with benefits, they told Brig. Gen. Raymond Byrne, acting adjutant general of the Oregon National Guard, yesterday.

"I feel that the system is lacking all common guidance," said Sgt. William Harris of Bend. "I don't have anything to fall back on. There's nothing for me here on the inside, and nothing on the outside."

Guard officials concede the soldiers, some of whom had only slight injuries, could have returned to their families, perhaps commuting to a base or a clinic for care.

The problem arose from an oversight in the Army's war planning, which failed to anticipate the large number of wounded soldiers returning from wars in Iraq and Afghanistan, said Col. Douglas Eliason, chief medical officer with the Oregon Guard.

He said a program introduced in Oregon two weeks ago will send more Guard members home to heal. Soldiers will be provided with a job suited to their injuries at a National Guard armory and given treatment options at a Veterans Administration clinic or with private doctors.

Around the country, close to 5,000 reserve and Guard soldiers are receiving medical care at active-duty bases, a consequence of the military's reliance on reserve soldiers in Iraq and Afghanistan.

From Oregon, 49 National Guard soldiers are convalescing from wounds at Army bases around the country — some because they need specialized care for severe injuries, but many because the Army had no system to allow them to return home.

Of the Oregon soldiers treated at active-duty bases, 39 were wounded in Iraq. Twenty-six of them are at Fort Lewis.

"They're on a remote post, with people they don't know and far from their support system of friends and family," Eliason said.

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Clark County/region

The War In Iraq Washington's Wounded ; Soldiers return home to chronic pain and bureaucratic headaches

NICHOLAS K. GERANIOS, Associated Press writer
 1,384 words
 6 September 2004
 The Columbian
 C2
 English
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SPOKANE - Lance Cpl. Ian Anderson of Spokane was a gung-ho Marine who was shot five times while serving his country in Iraq.

Now he is an embittered 23-year-old coping with his wounds, angry at his medical care and unsure what he will do with the rest of his life.

One of more than 130 Washington residents who have been wounded so far in Operation Iraqi Freedom, Anderson personifies a hard truth about war: Enthusiastic patriotism often gives way to shattered lives.

The number of Washington wounded ranks eighth among all states, reflecting the state's large military population. Nationally, 6,916 American troops have been wounded in Iraq, according to Pentagon figures published last week.

The military also estimates that an additional 57 military personnel from Washington have been wounded in Iraq, based on statistical analysis, because some soldiers' records are incomplete. The Washington state numbers are as of July 24, the most recent state-by-state breakdown by the federal government.

The wounds range from life-threatening brain injuries that left Army Chaplain Tim Vakoc in a coma, to Anderson's disabling injuries, to a blast that redistributed body fat in Sgt. Richard Peters of Yakima.

Even when the wounds are relatively minor, like the shrapnel injuries of 2nd Lt. Bryan Suits of Seattle, they cause disorientation and psychological trauma. In an e-mail to friends, Suits described the moments after the mortar attack that left him wounded.

"My bell is rung pretty hard. I don't know it yet, but I'll soon become easily distracted for 24 hours. A loud ringing is going to begin in about 20 minutes," he wrote.

Anderson was wounded near Baghdad on April 6, 2003, when his reconnaissance unit was ambushed. He was shot in both knees, a thigh and the right shoulder.

Despite his wounds, Anderson said he would choose the Marines again to turn around his life.

"It's been the best four years of my life," Anderson said. "I'm very glad I went to war."

After he was wounded, Anderson returned to Spokane to a hero's welcome, including a limousine ride to a free stay in the presidential suite of the Davenport Hotel.

But in a recent telephone interview, he was angry at the care he received at Bush Naval Hospital on the Marine base at Twentynine Palms, Calif. He feels wounded Marines are treated as an inconvenience by the military, which tries to limit the expense of caring for them.

Anderson contends he suffered needless pain as Navy doctors debated how to treat his wounds.

"Why did I suffer for 18 months?" Anderson wondered.

He recently found a private surgeon to perform arthroscopic surgery on his damaged knees. Scar tissue was removed and Anderson is hoping he will soon walk normally.

"I still run into walls," Anderson said.

Hospital spokesman Dan Barber declined to comment on Anderson's case for privacy reasons. Patient complaints are investigated by a customer relations officer at the hospital, he said.

"Sometimes patients are right and there is a procedure that needs to be changed," Barber said, adding such complaints are not common.

Before his wounds, Anderson often aced the Marine Corps' physical fitness exam by running three miles in under 18 minutes, doing 20 pull-ups, and completing 100 sit-ups.

"I don't have that anymore," he said.

Anderson's left knee still locks up, and it's tough to walk up or down stairs. He also had to beat an addiction to pain killers.

Anderson is no longer considered fit for combat, and left the Marines in August. He is back in Spokane with his wife and 2-year-old daughter, living with his parents and looking for a job. At heart, he remains a Marine.

"I swear to God if I had the knees I'd be a lifer," Anderson said.

It's not uncommon for wounded soldiers to replace battles in Iraq with battles against the military medical system.

The military's disability system mirrors workers' compensation and long-term disability in the private sector. It pays people when they have illnesses and injuries that are job-related. Many soldiers misunderstand that pain by itself won't win them compensation, because it is subjective and unmeasurable.

The Army said 56 percent of soldiers applying for long-term disability received a one-time lump-sum payment in 2003. Seventeen percent received nothing because they were declared fit for duty or suffered injuries unrelated to their service. Another 17 percent received temporary disability payments. Just 9.8 percent won long-term disability pay that lasts for life.

At Fort Lewis near Tacoma, there are 221 National Guard and Reserve soldiers who are recovering from wounds and assigned to a "**medical hold**" unit until they return to duty or are discharged from the military. A similar unit for regular Army soldiers is at nearby Madigan Army Medical Center.

The soldiers in the Fort Lewis unit come from all over, although they tend to be mostly from the western states, said Capt. Tealla Martin, executive officer of the unit.

The unit has had as many as 350 soldiers in the past year, staying an average of 91 days, she said.

Among those in the **medical hold** unit is Army Staff Sgt. Richard Peters of Yakima, who was wounded in late June when the truck he was driving was destroyed by a roadside bomb.

Peters suffered shrapnel wounds to his left thigh and calf and hip, and a broken front cranium that "filled my upper sinus cavity with body fat."

He has been living at home in Yakima with his wife and two young daughters since July 5. Once a week, he makes a three-hour drive to Madigan for treatment, a trip made more uncomfortable by his hip wound.

A guard at the Yakima County Jail in civilian life, the reservist won't be considered fit for duty again until September.

Peters loves bicycle riding, camping and other outdoor activities, but he doesn't get around much these days. His legs are covered with bandages. He still has some shrapnel in his body that will probably remain because removing it is too dangerous. He also has some head pain from the explosion.

"I can't do too much," Peters said. "I hobble around the house."

Some wounds barely take a soldier away from duty.

Suits is normally a radio talk-show host in Seattle, but has been serving as an information operations officer in Iraq. He gathers intelligence and tries to convince Iraqis that the U.S. occupation is to their benefit.

On July 1, he had just pulled into a base for lunch when a mortar round struck the ground near his vehicle. The steel casing

disintegrated into thousands of shards of steel and wire moving at 4,000 feet per second.

"I'm enveloped in a hot acrid cloud, like the inside of a tornado," Suits wrote. "I have the sensation of a fire hose shooting gravel at me."

He suffered numerous cuts on his wrist and a bruise from a rock.

Taken for medical care, Suits was informed by a nurse that his blood pressure of 129 over 90 was high. He realized the nurse didn't know why he was seeking medical attention.

"What happened?" she asked.

"We invaded Iraq," he replied.

Suits still suffers intense headaches after a day in the sun, but has returned to duty.

State By State

States with the greatest number of residents wounded in Operation Iraqi Freedom, according to the Department of Defense as of July 24.

1. Texas 436
2. California 432
3. Florida 234
4. Ohio 191
5. New York 186
6. Pennsylvania 155
7. Illinois 140
8. Washington 131
9. N. Carolina 130
10. Missouri 109

Caption: Former Marine Lance Cpl. Ian Anderson holds a Purple Heart he was awarded after being shot five times during combat operations in Iraq in 2003. Anderson, upset with the medical treatment he received at the Marine base hospital at Twentynine Palms, Calif., left the military in August after he was no longer considered fit for combat.

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New York Times
October 23, 2004
Pg. 1

Part-Time Soldiers, Injured But Not Yet Home

By Monica Davey

FORT LEWIS, Wash. - Staff Sgt. Jeffrey A. Elliott returned to this country with a back injury after his unarmored truck hit a roadside bomb in Iraq. Yet 15 months later, he still has not made it home for good.

A member of the Washington National Guard, Sergeant Elliott is hoping to finish whatever treatments may soothe the degenerating disk in his back and for the military to complete the paperwork for his case, now promised within weeks. He is living out of a suitcase in a barracks while his wife and children wait, 220 miles away.

Under a web of Army rules, Sergeant Elliott and thousands of other part-timers injured on duty are navigating a system suited to full-time soldiers. Most are required to stay on a military base to get government medical treatment, to collect their active-duty salaries and to finish military evaluations that will decide whether they return to duty or leave with severance or disability payments.

Full-time soldiers recuperating with Sergeant Elliott have to wait, too, but they have lives here - their spouses and children, their churches and their jobs. Long before Iraq, they lived on the base or just down the road.

The rules are affecting a growing number of part-time soldiers, as the military is deploying the National Guard and Reserves in Iraq, Afghanistan and elsewhere at rates unprecedented since World War II.

Many of the injured say they have grown embittered from being away from home so long. Some see the extended separations as one more indication that military leaders consider the needs of part-time soldiers - once taunted as weekend warriors - as less important than those of the full-time troops.

They view themselves as casualties not just of bombs and heart attacks and ankle twists, but also of poor planning for a war that is increasingly being fought by the nation's part-time military.

Sergeant Elliott's wife, Penny, is raising their three children, the youngest of whom thinks anyone on the other end of a telephone line must be her father, because Sergeant Elliott has been calling home for most of her two years of life.

"Having him in Iraq was hard enough," said Ms. Elliott, home in Moses Lake, Wash. "When he got hurt, I said, 'Well, at least he can come home now, and get better here with us.' But it's this strange thing. He came home, but he's not home at all."

In March, a year after the war began, after thousands of part-time soldiers had already returned home sick or wounded, and as complaints began emerging from homesick soldiers, the military said it would begin a test program to let some part-timers receive active-duty pay while being treated at hospitals and Veterans Affairs sites closer to their homes. But even now, only a few are actually receiving that service.

Since January 2003, more than 16,000 reservists and guardsmen have been placed on "medical

holdover" - waiting for treatment and the military to decide if they are fit for duty - either because of injuries overseas or because of medical problems found while they were training to be deployed. Of the 4,240 part-time soldiers now on such status, 904 are being treated in their own communities under the Army's Community Based Health Care Initiative. Many others, including residents of more than half the states across the country, cannot even apply.

Col. Barbara J. Scherb, who oversees the initiative for the Army Forces Command, was asked why military leaders had not planned a way for reservists and guardsmen to be treated near their homes before now. "No one really thought much about this before," she replied.

Colonel Scherb described the slim participation in the program. "I think a lot of it is because it's new," she said in a telephone interview, "and, quite candidly, because we're sort of making this up as we go along."

Some of the waiting soldiers, at Fort Lewis and at other bases, said that they had never heard of Colonel Scherb's program or had learned of only one or two soldiers who had been allowed to join it.

Many said they had become resigned to living apart from their families for unknown months more - even longer, in some cases, than their colleagues who served complete stints in Iraq.

Sergeant Elliott and his driving partner in Iraq were the first two Washington State guardsmen to be injured in combat there, and he received the Purple Heart. He has worked as a security guard, but said he had no idea whether he would ever be able to bear the weight of his utility belt and radio around his waist again. Recently, after The New York Times made inquiries about him, he learned that his discharge paperwork from the military had been completed and that he would be able to go home within weeks. He said he feared that if he left before then, his family could not survive without his active-duty pay.

Still, he said, the idea was oddly tempting, especially as strains at home mounted. He feels detached from decisions made in his own house, he said. His wife has come to rely on a girlfriend as her closest confidante.

"It feels not too much different than being deployed all over again," Sergeant Elliott said.

Cross-Country Recoveries

Most of the injured find themselves back on the base where their unit first assembled before going overseas. Others are flown to other bases because of a military hospital's medical specialty, and some have been delivered to bases closer - not always close, but closer - to home. Officials at Fort Lewis say many of their injured part-time soldiers live near the base, which is 45 miles from Seattle.

But data from the office of the Army's surgeon general show that some Oregon guardsmen, for example, are recovering in Fort Bliss, Tex.; some part-time soldiers from Wyoming and Florida are on medical holdover in Fort Dix, N.J.; and a handful of New Jersey troops are at Fort Riley, Kan.

"Unfortunately, the timetable of the soldier wanting to go home may not correspond with the treatment they need," said Jaime Cavazos, the spokesman for the Army Medical Command. "We're trying to provide them with the care they need."

Unlike the most gravely injured soldiers, receiving round-the-clock treatment at the finest military

hospitals, these are ordinary soldiers with more ordinary wounds. The loneliest and the impatient can elect to go home, even if they still need medical attention. But that can be an expensive trade-off; military rules dictate that they lose their active-duty salaries even though they may still be too injured or ill to return to their civilian jobs.

Someone who leaves active duty and seeks treatment from his own doctors qualifies for military medical insurance, known as Tricare, for only six months. Advocates for the National Guard say one in five guardsmen lacks medical insurance from his regular job, leaving no room for health problems that may linger.

Political and military leaders have pledged to make Veterans Affairs benefits, including access to the 157 V.A. hospitals and 845 clinics across the country, available to Iraq war veterans for two years, but most soldiers are not eligible until they are retired from military service or discharged from active duty.

There have been exceptions to the rule, V.A. officials said, but only in cases when the Department of Defense has chosen to refer a soldier to the V.A. for care.

Specialist Keith Bond, another guardsman waiting at Fort Lewis, whose family lives near Sergeant Elliott's in Moses Lake, said he had considered going home. "I did the war," he said. "I got the T-shirt, you know? I've had enough. My family's had enough."

Specialist Bond, 31, spent almost a year in Iraq before he came back to this country with pains in his foot and uncertainty about what they meant. Eventually, he said, military doctors found an unusual break in a bone at the top of his foot, a spot that had broken years ago.

Much as he wants to go home, Specialist Bond said he felt the Army was responsible for repairing his foot and worried that he could not handle his job mixing chemicals at General Dynamics while walking with a large medical boot that encases his leg.

He said he went home as often as he could slip away from Fort Lewis, but described the complications of cramming fatherhood into scattered weekend visits. His son, Dylan, 2, does not seem to recognize him. Specialist Bond's wife, Angelicque, described the look Dylan sometimes gives when seeing his father: "Who is this person? Why is he in my home?"

And their daughter, Alexa, 4, stopped eating after her father came home from Iraq but moved to Fort Lewis. "There was no explaining it to her why Dad was back, but living over there," Ms. Bond said. "She kept saying, 'No, the Army is going to keep him.'" Alexa had lost nine pounds by the time Ms. Bond took her to a doctor.

It seemed at first, Ms. Bond said, that some doctors at Fort Lewis did not take her husband's pain seriously. "Honestly, I think they thought he was malingering," she said.

Other soldiers complained of similar treatment.

"There are the few people out there who aren't injured, but who are just trying to get out of the service and get into the disability system," Ms. Bond said. That may make doctors doubt the legitimate cases, she continued, adding: "But there's another factor, too, that makes them want to doubt, and that's this: The Army does not like to pay."

Many Requirements to Meet

It is uncertain how much it would cost the Army to allow all part-time soldiers to receive their pay as well as their treatments at home. Some say the military would save in housing expenses, but would be unable to control health care costs. For now, military officials say they are unsure even what the medical costs will be for their current community-treatment program.

The requirements for that program are numerous. A soldier's home must be in one of 23 participating states; he must live near a private medical facility or a V.A. hospital suited to treat his particular problem and accepting Tricare; if he is capable of any work, which most of these soldiers are, he must live near an armory, recruiting station or another military facility for work, and the military must not have begun the process of determining whether he is no longer able to be a soldier - which can take months.

Military leaders began considering such a program, Colonel Scherb said, after they realized there might soon be overcrowding of part-time soldiers at military bases around the country. There is room for only 5,000 of these injured soldiers at bases, she said, and the numbers were mounting by late last year. Fort Lewis had also begun its own similar, smaller program for "remote care" late last year, a program Sergeant Elliott said he was allowed to join briefly.

In recent weeks, the numbers of those allowed to go home for treatment while still receiving active-duty pay has grown significantly, Colonel Scherb said, and she expects that to continue rising.

"Everybody is committed to making this work," she said.

But the future of the program seems uncertain. Announcing it in March, the Army described it as temporary, saying, "Once the number of soldiers needing care drops to a level that can be managed from Army posts, the program will be reduced or closed."

No final decisions have been made, Colonel Scherb said.

A Sense of Bias

Lingering just under the surface of these soldiers' complaints is a broader issue. They see a bias against part-timers, one that has seeped through everything over years of "weekend warrior" status.

The issue came into focus recently as reports emerged from Iraq of a group of 18 reservists who refused to make a fuel delivery because they considered it a suicide mission, saying that their vehicles were unreliable and that they felt unprotected without an armed escort along the planned convoy route.

Representative Darlene Hooley, Democrat of Oregon, has criticized the military over the past year for what she found when she visited Oregon guardsmen training to go overseas: mold-ridden barracks, faulty weapons and a lack of food, toilet paper, soap and hand-held radios.

"It is very different to be in the Guard or the Reserves and be called up," Ms. Hooley said. "And I think they just hadn't thought about it."

Even among the injured, some part-time soldiers insist there is a pecking order. When they go for appointments at the Fort Lewis medical center, they say, they are always asked which service they are in, Guard, Reserves or regular.

"Why would they need to know that? I thought we were an army of one," said Sgt. Jay Hemenway, a guardsman who went to Fort Lewis in March 2003 and whose family lives three hours away, in Salem,

Ore.

Sergeant Hemenway said he went to the orthopedic department not long ago, and watched as another soldier walked in, identified himself as a full-time soldier and got an appointment right away. "If you're the National Guard, you're on the back burner, forgotten," he said.

Officials at Fort Lewis vehemently deny that distinctions are made between part-time and full-time soldiers when it comes to priority or quality of medical care.

"There's a sincere effort here that all soldiers are treated the same," said Col. Mitchell Josh of Fort Lewis.

Clerks and receptionists at the hospital routinely request a soldier's status for paperwork purposes, nothing more, said Lynnda Henson, chief of patient affairs.

But Sergeant Hemenway sees himself at the bottom here as a guardsman - one of several - who said he was injured even before he could be deployed. He hurt his shoulder when his leg got stuck in a seat belt as he jumped from a vehicle. Later, while recovering, he hurt his back. At 38, he uses a walker.

Sergeant Hemenway is starting the process of being considered for discharge from the military. Before he was called up, he was a maintenance man in the apartment complex his wife manages, but he doubts he will ever be able to paint or plaster or move refrigerators again.

From her office in Salem, his wife, LoAnn D. Brandenberger-Hemenway, looked out at her gold Ford Mustang, its window papered with stickers: "Support Our Troops" and "Freedom Is Not Free." She said that she was proud of her husband when he was called to duty, but that was 19 months ago and he has lived at Fort Lewis ever since.

"This has gotten ridiculous," Ms. Brandenberger-Hemenway said.

When he visits home, she said, he sometimes seems impatient, frustrated, testy. "Don't they say a person heals better when they are surrounded by love?" she asked. "If anything, he's getting worse up there. By the time he comes to visit, we have to walk around on eggshells here."

When her husband left, Ms. Brandenberger-Hemenway decorated the outside of her office with yellow ribbons, but they grew dingy and frayed with passing months. Not long ago, she took them down.

Denver Post
November 10, 2004

Wounded Reservists In Limbo

Fort Carson 'medical hold'

By Eileen Kelley, Special to The Denver Post

Fort Carson - Their fellow soldiers are home with family or still in battle in Iraq, but 75 soldiers are stranded in medical limbo at Fort Carson - neither fit for duty nor allowed to go home for good.

On Tuesday, a pair of congressional staffers visited the post to talk with about 35 of those soldiers from the National Guard and Reserve. They heard a raft of complaints about the "medical hold" program that keeps citizen soldiers attached to the service but stuck far from families and jobs.

"They call us malingerers, and it is totally unfair," said Spec. Laurence Kiefer, 34, who returned from Iraq in May with post-traumatic stress disorder, knee and ankle injuries, and an intestinal ailment, but has been unable to get released to his civilian life as a chef in Montana.

"It's hard enough to wake up in the morning and start your day. I'm told they have exhausted all of their attempts to rehabilitate me, and they haven't even begun."

Congress has become interested after several complaints from soldiers attached to the Guard and Reserve. The two staffers, who did not comment on their visit, met with the soldiers Tuesday on part of a tour of several bases to hear concerns about "medical hold."

Soldiers and former soldiers such as Mike Lemke, 45, of Denver said they hope the staffers' visit results in congressional hearings.

Even after much of Lemke's unit returned to civilian life from Iraq, he remained stuck at Fort Carson for months while doctors, he said, took slow steps to help his post-traumatic stress disorder.

Eventually he was given a medical separation from the military and a lump sum of money.

"It's like fighting the war after the war," Lemke said. "Actually it is worse because you are totally depleted after fighting the war (in Iraq). It is demoralizing as hell, and you just have to wonder, 'Why did I fight that war when none of my rights as a soldier and citizen are being respected?'"

One soldier who attended Tuesday's inquiry has tried to kill herself three times since returning home from the war. She is one of several who Fort Carson leaders acknowledge have tried to kill themselves. The soldier's father sent a letter to Congress in October asking for help.

Officials at Fort Carson said they are doing the best they can for all soldiers and family members, and that there is more than enough adequate help available. Col. Brian Lein, commander of Evans Army Community Hospital at Fort Carson, said some will stay longer, but that on average most stay in medical hold for two months.

"You know as well as I do that there are going to be one or two soldiers who slip through the cracks or

who don't feel that they have been adequately cared for," Lein said Tuesday. "... We are absolutely committed to working with soldiers."

Congressional leaders called for reforms on treatment of National Guard and Army Reserve soldiers a year ago. Some progress has been made, but many are suffering, said Steve Robinson, a soldiers advocate from the Gulf War Resource Center.

"I have a gut feeling that what is going on at Fort Carson is a national issue. The House Armed Services Committee is going to see the same thing (at other posts), but the question is, what are they going to do about it? ... It's too soon to tell if there will be a congressional hearing, but they don't take on these tasks unless it is serious."

Staff writer Miles Moffeit contributed to this report.

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KY Injured Soldiers; Soldiers in medical limbo at Ft. Knox; Tennessean faces charges

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FORT KNOX, Ky. (AP) - Eighteen months after hurting his back while unloading a truck at Fort Campbell, Staff Sgt. Christopher Goodin is still assigned to medical holdover status at Fort Knox.

Sgt. Terry Underwood is still waiting for surgery to repair an Achilles' tendon he ruptured in 2003 while deployed to Bosnia by the National Guard.

They are among nearly 150 sick and injured soldiers at Fort Knox who are lingering in a medical limbo created when the military found itself unprepared for fallout from the war with Iraq.

Army officials have suggested a court-martial for a Tennessee soldier because he checked himself into a civilian mental hospital after being denied treatment at Fort Knox.

Members of Congress are investigating whether the soldier, 1st Lt. Jullian P. Goodrum, of Knoxville, Tenn., was placed in isolation at Walter Reed Army hospital because he complained to reporters about his treatment at Fort Knox. Army officials said that a "misunderstanding" caused Goodrum, suffering from post-traumatic stress syndrome, to be denied mental health treatment at Fort Knox.

Pentagon officials visited Fort Knox last month to monitor the conditions on the Army post for the soldiers who report to light duty while receiving medical treatment. A spokesman for Fort Knox says the situation is improving.

Problems at the medical holding facility first came to light in 2003 when, after returning from Iraq, some soldiers spent about eight weeks in dilapidated World War II-era barracks with leaking roofs, animal infestations and no air conditioning in the heat. The barracks were condemned and soldiers were moved.

Several ailing soldiers at Fort Knox agreed that conditions have improved but expressed frustrations over delays in their treatment.

Though Goodin, 52, is now allowed to stay with his family each night in Hodgenville, he faces an uncertain future once he gets a medical discharge and returns to civilian life.

"Who's going to hire me at my age?" Goodin said in an interview with the Lexington Herald-Leader. "I'm trying to get 30 percent of my salary for severance pay. It took me 179 days to get the right treatment. I guess somebody had to pave the way."

Sgt. Robert Dodge, a commander in a newly formed unit designed to improve conditions for the Fort Knox soldiers in **medical hold**, said an overhaul in accommodations and philosophy was needed. There are about 146 soldiers in the **medical hold** program, down from 400 in October 2003.

After the World War II barracks were condemned, an entire floor at Ireland Army Hospital was set aside for soldiers on medical holdover. But most soldiers have since been moved to separate barracks resembling a college dorm. In mid-December, the repairs continued.

"We've done the best we could," Fort Knox spokesman Jerry Meredith told the Lexington newspaper. "The conditions had to evolve. What we had was what we had. It's a tough time for the soldiers undergoing treatment."

The toughest part is being in limbo, several soldiers said.

Sgt. Todd Clites, 31, sustained two fractures in his back in Baghdad on Easter Sunday 2004 when a roadside bomb detonated. A

Pennsylvania native, he's been at Fort Knox in medical holdover for six months. He is eager to return to his unit in Iraq.

"At Fort Knox, I've had to pay somebody to buy me a special board for my bed because of my back," he said. "The paint was peeling, there were broken tiles in the ceiling. But I've slept in a lot worse. A lot of people who come here lose sight of the fact that it's better than sleeping in a humvee."

Nevertheless, Clites has concerns.

"Send me back to Iraq or send me home," he said. "The military needs a better system. The time span between appointments is too long."

The Pentagon is offering improvements for the holding facilities at Fort Knox and other bases.

Solutions include moving ill soldiers into nearby hotels, adding more doctors, and setting aside \$77 million to improve conditions.

Quality of life for soldiers in **medical hold** status is becoming a priority at Fort Knox, Meredith said. In addition to living in a renovated building within walking distance of recreational facilities, soldiers are offered a menu that includes eggs cooked to order, he said.

On weekends, many soldiers from the region drive home to see their families and some stay at home each night. Their work assignments are designed so as not to compromise medical conditions.

Another improvement, Meredith said, is a new program that offers soldiers medical care in their hometowns so they don't have to stay at posts like Fort Knox.

Information from: Lexington Herald-Leader, <http://www.kentucky.com>

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News

Soldiers in medical limbo Members of Reserve, Guard stuck in 'holdover' Injured or ill soldiers can wait months for treatment in a system where the average stay is 155 days.

Marsha Austin and Eileen Kelley Denver Post Staff Writers

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Army Pvt. Jessica Rich was medically evacuated from Iraq in January. Eleven months and two misdiagnoses later, she is still waiting to see a specialist who can treat the autoimmune disease hardening her muscles and attacking her joints.

Sgt. Michael Lemke spent two months after returning from combat dealing with flashbacks of a mass grave at Abu Ghraib prison and dodging phantom sniper fire. Finally, an Army nurse asked him if he might like to see a psychologist.

Sgt. Irene Cornett spent a year in treatment for a wrist injury that occurred when a tent rope snapped. After a bad infection, doctors fused the bone, leaving her with 10 percent movement and eligible for disability pay, according to her hand surgeon. But the officer who summarized Cornett's medical records to determine her eligibility for disability payments reported she had twice as much movement, ultimately disqualifying her from a lifetime pension.

All three, along with more than 13,000 others nationwide, have spent time in a 'medical holdover' unit, a system now under congressional scrutiny and the source of seemingly endless frustration to members of the Army Reserve and National Guard.

Critics inside and outside the Army say 'med hold' units are choked with reservists who should have been home much sooner with family or friends. Instead, they find themselves in a system that some Army officials acknowledge was unprepared to handle the thousands of soldiers wounded in combat overseas or injured while training or serving on U.S. military bases.

Shortly after the March 2003 Iraq invasion, when casualties started returning to the U.S., 'the system was immediately overloaded,' said Col. Lynn Denooyer, an Army Reserve nurse stationed at Fort Carson between March 2003 and August 2004.

Soldiers, veterans' advocates and some lawmakers say that despite recent efforts to beef up medical staffing and speed delivery of care, the Army still hasn't caught up, particularly when it comes to caring for National Guard and Reserve soldiers.

'Clearly, the unprecedented number of guardsmen and reservists mobilized in the war on terrorism has severely taxed the system and its resources,' said U.S. Rep. Tom Davis, R-Va.

Bias sensed by some

The med-hold program was set up in March 2003 to help injured soldiers keep full-time pay while under review.

Guard and Reserve soldiers can spend months in med-hold units, unable to return to their civilian lives, while the military decides whether they are fit to serve or must be discharged - and if so, how much pay they should receive.

Since November 2003, 13,542 men and women who volunteered to serve as Army National Guard and Reserve soldiers have been injured on military bases or returned wounded from combat in Iraq and been assigned to med-hold units. Currently, 4,326 soldiers are in the system, according to the Army surgeon general's office.

Past and present members of Fort Carson Army Base's **medical-hold** company, including Rich, Lemke and Cornett, say they've waited weeks, even months, for medical appointments, surgery or other treatments. Soldiers say military doctors routinely deny them consultations with specialists while prescribing dangerously large quantities of sleep aids and painkillers that only mask underlying medical issues.

Some argue that the delay and substandard care are a symptom of an Army that cares more for 'active' or 'regular' soldiers than for the Guard or Reserve.

'I'm National Guard - that's what happened,' said now-discharged and unemployed Sgt. Virgil Travecek, 45, who waited about a year on **medical hold** for treatment of an injured back at Fort Carson before he was finally given a lump-sum check and sent home to South Dakota.

'They screw you around,' he said. 'If you were National Guard, Reserve, you were not really a soldier. If you were regular Army, you were the best.'

The Army acknowledges that there remains a shortage of specialty doctors but insists that no preference in medical care is shown to active Army soldiers over those from the Guard and Reserve.

'Guard and Reserve are being treated differently than regular soldiers. They're being treated better,' said Col. Brian Lein, commander of Evans Army Community Hospital at Fort Carson. 'We don't treat them as second-class citizens. We take great care of all our soldiers here.'

Beyond the frustration of being cooped up in a barracks, with untreated mental and physical ailments, reservists and guardsmen say the system frustrates their efforts to be medically retired, a discharge that requires an Army judgment of 30 percent disability and comes with a lifetime monthly pension and access to military perks such as commissary stores.

Lemke described the whole process as a 'pressure cooker' designed to frustrate soldiers to the point where they stop fighting for medical care and retirement the Army can't afford.

He and others feel a deep sense of betrayal. These volunteer soldiers - waitresses, Wal-Mart managers, cooks and corrections officers - never expected to go to war.

Once they did, they expected to be taken care of when they came home to face broken marriages, unsalvageable careers, wasted minds and crippled bodies.

'Those who served are being kicked to the curb with little or nothing, and many of them will never fully regain their health,' said Lemke. 'I still find it totally incomprehensible that people wearing the same uniform I had on while fighting a war are the ones treating medical patients this way.'

'It makes me wonder, past all the flag-waving, what exactly it was I fought for.'

'Cultural change'

Col. Michael Deaton, Army deputy assistant surgeon general for force projection, acknowledged that the Army is having a difficult time getting injured soldiers to specific specialists such as orthopedic surgeons, neurologists and rheumatologists, mainly because of the remote locations of its bases.

'Are we stretched thin in areas? Absolutely,' he said. 'Are we providing safe and adequate care? I think we are.'

In November, congressional staffers visited Fort Carson to hear soldiers' concerns. The following week, the Army surgeon general's office dispatched a team of officers who held a similar series of meetings with many of the then-75 soldiers in **medical hold** at the base.

The Army has made 'significant strides' toward improving care for soldiers assigned to med-hold units, Deaton said. It has hired 762 new staffers to exclusively support **medical-hold** units and is expanding programs that will allow injured and ill Guard and Reserve soldiers to get care in their hometowns, Deaton said.

'We are making that cultural change that says we are here to take care of you, not to throw you out,' he said.

For soldiers who are injured or fall ill in Iraq or on their home bases, the system leading to **medical hold** begins with a diagnosis in the field.

Upon arrival at Fort Carson, they are initially screened. If they are not declared fit for duty within 60 days, they have the option of mustering out of active duty and going home to receive medical care through short-term reserve benefits.

'Part-time care'

Those who choose to seek more extensive care or disability pay enter **medical hold**. They are given treatment on the base,

while boards of soldiers and doctors at Fort Carson and Fort Lewis, Wash., determine how severe their disabilities are, and whether they are eligible for lifelong payments.

That process can take more than a year, though Army statistics show the average time spent in **medical hold** is 155 days.

Soldiers at Fort Carson say they don't see doctors as often as they need to. Additionally, they complain that reservists and members of the National Guard get less medical care and are less likely to receive a full medical retirement than their counterparts in the 'active Army.'

Reserve Sgt. Shelly Hays, 31, injured her back at Fort Carson last year while moving a 700-pound pump.

She said the doctor who saw her made it clear she would receive what she described as 'part-time care for part-time soldiers.'

'He said, 'I'm sick and tired of all you reservists coming in here and taking up all the (appointments) for the regular soldiers,' she said.

Army statistics show that reservists and members of the National Guard are less likely than active Army soldiers to receive full medical retirements.

From Oct. 1, 2003, through Sept. 30, 26 percent of injured active Army soldiers received a disability rating that resulted in a temporary or permanent retirement with all benefits.

Only 16 percent of Reserve or National Guard soldiers received a similar rating.

The Army says the discrepancy is partly explained by the different roles most reservists play in support compared to the large number of active Army soldiers in combat.

Dr. Gene Bolles, a Longmont neurosurgeon, spent two years as chief of neurosurgery for Landstuhl Regional Medical Center in Germany. He said he felt the Army's motivation in treating all soldiers was monetary, not medical.

He has seen herniated discs go untreated, causing severe neurological problems - loss of bladder control, loss of sexual function, atrophied extremities.

In his view, the Army needs to invest more in the care of soldiers, or Americans will face long-term costs for Veterans Affairs hospitalizations.

' 'This is one of the so-called 'hidden costs' of the war,' Bolles said. ' 'We are going to end up with a lot of young people with chronic pain.'

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Soldiers in medical limbo at Ft. Knox; Tennessean faces charges

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Solutions include moving ill soldiers into nearby hotels, adding more doctors, and setting aside \$77 million to improve conditions.

Quality of life for soldiers in **medical hold** status is becoming a priority at Fort Knox, Meredith said. In addition to living in a renovated building within walking distance of recreational facilities, soldiers are offered a menu that includes eggs cooked to order, he said.

On weekends, many soldiers from the region drive home to see their families and some stay at home each night. Their work assignments are designed so as not to compromise medical conditions.

Another improvement, Meredith said, is a new program that offers soldiers medical care in their hometowns so they don't have to stay at posts like Fort Knox.

Information from: Lexington Herald-Leader, <http://www.kentucky.com>

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Orlando Sentinel
February 13, 2005
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Red Tape Traps Injured Veterans

By Wes Smith, Sentinel National Correspondent

HINESVILLE, Ga. -- Staff Sgt. Howard LeRoy Hizer made it back from Iraq with a Bronze Star in November 2003, but he's still fighting to get healthy and get home.

More than a year after the rest of his Florida National Guard unit returned to civilian life, the St. Cloud reservist has a drawer full of medications, a Jeep with 265,000 miles on it and a bed in a 16-man trailer on a military base 300 miles from his family.

Hizer, 41, was called to active duty in December 2002 and served 11 months as an infantry-squad leader in the Persian Gulf before being sent to Fort Stewart, Ga., because of severe back and neck injuries. He was hurt when he fell from a truck on its way to help a military-police unit that had been attacked.

The staff sergeant, an Osceola County volunteer firefighter who works at St. Cloud's wastewater-treatment plant in civilian life, is now into his second year of what the military calls "medical holdover." He gets his military pay and free treatment for his injuries, but except for the time he spends on leave, he can't return to his wife and two young children.

"He's very frustrated, and I'm beyond frustration," said his wife, Lynette Hizer, a registered nurse. "He is back in the States, that's true, but he's not home."

Military bureaucracy

Col. Barbara Scherb of U.S. Army Forces Command in Atlanta acknowledged last week that at least 15 wounded or injured Iraq veterans who were among the first to arrive at Fort Stewart have been blocked from seeking treatment at home, even though other soldiers in similar circumstances have been allowed to do so.

The bureaucratic knot, which the colonel described as "very complex budgetary and statutory problem all wrapped up in legalese" should be untied by the end of February, the colonel said. She said efforts to untangle the red tape had been going on for a year.

The military spent millions to increase medical staff and to improve living conditions at Fort Stewart and other bases after injured Reserve and National Guard troops returning from Iraq complained to members of Congress and the media about unequal and poor treatment in fall 2002.

Last spring, the Army also unveiled a \$23 million Community-Based Health Care Organization to relieve overburdened bases by allowing soldiers such as Hizer to get medical treatment near their homes.

Care can be obtained either at nearby military hospitals or from local doctors and medical centers affiliated with the military's Tricare health-maintenance program.

Hizer, whose job is being held open for him by St. Cloud officials, has petitioned repeatedly to get into

the community-care program, but so far his requests have been denied.

"I just want to get fixed so I can go home and pursue my job," he said. "It's almost like they want to wait you out until you just say you want to quit and go home."

Currently, 1,455 active-duty Guard and Reserves -- of about 4,850 on medical-holdover status nationwide -- are in the community-care program, which has proved so successful that it is already close to capacity.

It is now being expanded to serve up to 4,000 soldiers in all 50 states and Puerto Rico, Scherb said.

The community-care headquarters for Florida, Georgia and North Carolina is in the National Guard Armory in Plant City. Since April, staff workers in Plant City have helped more than 280 Reserve and Guard soldiers on medical-holdover status find treatment closer to home, said the officer in charge, Lt. Col. Bruce Cornelison.

His unit of 31 medical and support staff soon will be increased by 10 so they can oversee the care of as many as 400 soldiers.

"It's been so popular, it has been a challenge, but we have not turned anybody down," Cornelison said.

Injured and wounded soldiers returning from Iraq and Afghanistan need to reconnect with their families and their support systems, so allowing them to get medical treatment while still working a military job but living at home allows for a smoother transition to civilian life, Scherb said.

"We have discovered that sending soldiers home works better just as a matter of policy and practice," she said.

Hizer and other medical holdovers at Fort Stewart agree, and they can't understand why they haven't been allowed to enter Scherb's program even as newer arrivals at the base are welcomed into it.

'Tearing my family apart'

There are still 157 National Guard or Reserve soldiers on medical holdover at Fort Stewart. Though living conditions and medical treatment there have improved considerably since the complaints surfaced three years ago, Hizer and others wounded or injured soldiers from Florida said they feel more like prisoners than patients.

"I fought for this country, but now I'm in a situation that is tearing my family apart. I've already done two years away from home, and I'm looking at another year now," said Guard member Hubert Aris, 38, of Fort Lauderdale, who has been on medical-holdover status at Fort Stewart since March.

Shortly after he returned a year ago from an 11-month tour in Iraq, National Guard Sgt. Bob Gipson, 44, of Tampa heard a presentation on the community-based health-care program that gave him hope of seeing more of his 3-year-old.

"The people who run the program were here, and they said, 'Everybody from Florida, pack your bags because you are coming home.' But I've tried to get into the program, and they say I can't go. It's crazy," said Gipson, a 23-year military veteran and former Army Ranger who injured his leg, back and neck when diving from a Humvee under fire in Iraq.

Soldiers are kept in medical-holdover status while doctors assess and treat them so they can be returned to duty, reassigned or discharged with disabilities.

Hizer and others at Fort Stewart said the methodical and labyrinthine process seems more designed to drive Guard and Reserve veterans out of the military system.

It took Hizer more than a year and more than 140 appointments to finally get an examination with a neurosurgeon -- and he had to travel more than three hours to a veterans hospital in Augusta, Ga., for that meeting.

"One of the neurosurgeon's first questions to me was, 'What have you been doing this past year?' It was like, 'Where have you been?' " he recalled.

Fort Stewart officials have also sent him to a pain clinic in Statesboro, Ga., about 50 miles from the base, and to a neurologist in Brunswick, Ga., 60 miles away, he noted.

Yet, one of the reasons given for keeping Hizer at Fort Stewart is that the base is the only place he can get the medical care he needs, he said.

Several tries for admission

The Guard member from St. Cloud has made repeated attempts to be assigned to the community-based care program in Plant City, but his supervisors have rejected his request each time, he said.

"The first time they said I was ineligible because I had missed medical appointments. So I got copies of my 148 appointments, and I hadn't missed any," he said.

His supervisors next said that he couldn't participate in the Plant City program because he had been uncooperative.

"I got a memorandum from the department head of behavioral health, which said I'd done what I was supposed to do," he said.

Next, Hizer was turned down because of claims that he hadn't been a model soldier.

"But they couldn't produce any documentation to support that -- and my own commanding officer in Iraq put me up for a Bronze Star. How do you become any more of a model than that?" he asked.

Former National Guard 1st Lt. Ted Pratchios, 33, of Jacksonville was Hizer's platoon leader in Iraq. Now a civilian, Pratchios recalled that he recommended Hizer for the Bronze Star based on his coolheaded leadership of his nine-man squad, often under fire.

Even after his injury, Hizer stayed with his men and rose above his pain and discomfort, according to Pratchios.

"The rest of us who did not get hurt have been demobilized and gone back to our civilian lives," said Hizer's former platoon leader.

"I can't believe he is still at Fort Stewart. It's like guys are being punished for being hurt," Pratchios said. "Certainly there is something not working the way it should be there."

'We appreciate feedback'

There are two primary reasons that medical-holdover soldiers are not allowed into the home-based program, Scherb said.

Some may be turned down if the medical care they need is not available where they live, or if their treatment is so far along that sending them home would delay their recovery, she said.

Hizer more likely has been forced to stay at Fort Stewart because he and 34 others in the first wave of medical holdovers voluntarily signed up for active-duty medical extensions. That was an earlier medical program that was funded differently, which might have prevented some of the otherwise qualified soldiers from being transferred to the community-care program, Scherb said.

The colonel said Army officials have worked for more than a year to untangle the red tape.

"We are really trying to fix that, and we appreciate the feedback from the individual soldiers," she said. "We keep trying to make things better."

ARMY IT INTEGRATION CHALLENGES

The Army has recently created a “Tiger Team” to look at approximately 29 IT systems to determine what needs to be done to pull all Soldier information into one Army system that can track the Soldier from in-processing into the Army, to discharge from the Army system.

It is believed that there are currently 29 databases that contain key pieces of information necessary for this to occur.

The Tiger Team is charged with researching the databases, determining what database feeds what system and whether modifications or creation of a new system would be the most appropriate course of action.

The Army provided the Committee the following information for the hearing:

Medical Occupational Data System MODS

The Medical Occupational Data System is designed to provide Commanders and AMEDD leadership with an interactive, worldwide operation system to manage the medical and AMEDD personnel readiness. MODS provides an integrated automation system that supports all phases of the Human Resources Life-Cycle management.

MODS currently has 33 operational modules in six functional areas, eight are in real time.

MODS maintains 27 system interfaces, which are updated on a daily, weekly, monthly and semi-annual basis.

Theses system interfaces provide more than 75% of the data used in the system.

The Medical Holdover/Active Duty Medical Extension module is one portion of this program.

It receives information from the following programs:

Total Army personnel Database(**TAPDB**) this program supplies demographic information

Medical Evaluation Board Individual Tracking Tools System(**MEBBITTS**) This information is hand loaded from the Patient Administration and Dispositions(**PAD**) providing information of the medical evaluation of the Soldier while in the MHO process.

Physical Disability Agency(**PDA**) is the program used by the Army PDA to track the process of Soldiers from the Physical Evaluation Board through the final disposition of

the Solder upon either release from Active Duty, retirement or separation from the Army system.

Defense Finance Accountability System (DFAS) is now using data through cross reference from MODS to track and respond to payroll issues of Soldiers.

Electronic Military Personnel Program (**e-milpo**) is now working to interface with the MHO/ADME module to be able to close records of Soldiers when they leave the MHO/ADME system.

The Joint Patient Tracking Application (JPTA)

JPTA is the Assistant Secretary of Defense (Health Affairs) proposed interim solution for achieving patient visibility in support of Operation Enduring Freedom/Operation Iraqi Freedom for the Department of the Army. JPTA captures patient movement from TRANSCOM's **TRAC2ES** system and some existing personnel and medical automated systems.

JPTA is used to facilitate requirements to collect, manage, analyze and report data generated by, and related to, patients arriving from OEF and OIF.

JPTA's future capabilities will include: patient's location, diagnosis, injury nature and medical status upon evaluation from theater until the patient is dispositioned to a Human Resources System or Physical Disability System. Ultimately, JPTA in conjunction with the **ASD/HA TMIP suite of systems** will provide patient tracking information from point of injury or time medical status changes from full duty.

Composite Health Care System (CHCS)

CHCS is a system through which military treatment facilities handle day to day business of health care-appointments, admissions, discharges, prescriptions, doctor's notes, email and more. The Army is in the process of converting to CHCS II to enhance capabilities.

PAD Tools

The **PAD Tool** was developed for deployed unties that do not have access to the Composite Health Care System. It is a easy to use database with which you gather information that satisfies the Patient Administration Reporting Real Time Tracking System(**PARRTS**) and the Standard Inpatient Data Record(**SIDR**) systems.

Hearing Date: 17 February 2005
Committee: HGRC
Member: Chairman Davis
Witness: LTG Hagenbeck, LTG
Kiley
Question #1

ADEQUATE STAFFING SUPPORT FOR MEDICAL HOLDOVER

Question: Do you have enough doctors and caseworkers or do you need more?

Answer: In December 2003 The Surgeon General of the Army (TSG) gave his Regional Medical Command (RMC) Commanding General the following guidance: assume that for the foreseeable future you will have a steady state population of approximately 5,000 Soldiers in medical holdover (MHO) status at any given time. Assume a utilization rate of four visits per month. Further assume that their diagnoses and demographics will remain constant. Determine how many and what types of people you need to take care of that population.

The RMC commanders provided an estimate of just over 1,000 personnel. That estimate was evaluated and revised by the Army Medical Command's (MEDCOM) manpower division using the Automated Staffing Assessment Model (ASAM). The final number was 967 required positions. As of 2 March 2005, there were 897 personnel in those positions.

Using a staffing ratio of one case manager per every 50 Soldiers, we have an adequate number of case managers. The requirements, however, include 62 orthopedic surgeons, 87 other physicians, and 31 operating room staff. Of those, the filled positions include 10 orthopedic surgeons, 67 other physicians, and 15 operating room staff.

MEDCOM compensates for these shortages largely by shifting workload to the TRICARE Network, and by extending work hours when necessary.

Hearing Date: 17 February 2005
Committee: HGRC
Member: Chairman Davis
Witness: LTG Hagenbeck, LTG
Kiley
Question #3

POLICY AND RESOURCES TO IMPROVE MEDICAL PROCESSING

Question: Can you tell us what specific support, in terms of policy or resources, that Office of the Secretary of Defense has given G-1 or Army Medical Command in your quests to improve the medical processing of Guard and Reserve?

Answer: The Office of the Secretary of Defense has provided policy guidance and financial resources to support medical processing of Guard and Reserve Soldiers. In October 2003, the Under Secretary of Defense (Personnel & Readiness) issued HA Policy 03-026, Subject: Personnel on Medical Hold. This policy emphasized TRICARE access standards as the minimum threshold for access to health care and established a medical hold specialty care access standard of within two weeks of identifying the need for a specialty appointment. In Fiscal Year 2004 the Office of the Assistant Secretary of Defense for Health Affairs provided the Army \$71.8 million to hire additional health care providers and to improve and expand clinic facilities supporting the medical processing of Guard and Reserve Soldiers.

Hearing Date: 17 February 2005
Committee: HGRC
Member: Congressman Davis
Witness: LTG Kiley and LTG
Hagenbeck
Question #4

WOUNDED ARMY GUARD AND RESERVE FORCES

Question: Chief Shuttleworth, after processing hundreds of records of Reserve Component Soldiers at Army Human Resources Command, suggested that a change should be made to Title 10, Subtitle E, Part II, Chapter 1223, Section 12731b. He stated that under current law Reserve Component Soldiers not injured in the line of duty are entitled to a retirement benefit that Soldiers who are injured in the line of duty are not entitled to. Can you tell us about this law and whether Chief Shuttleworth is correct in pointing out the unfairness of it? Do you recommend the law be changed?

Answer: Chief Shuttleworth is correct in pointing out that Title 10, Subtitle E, Part II, Chapter 1223, Section 1271b, as currently written, presents an inequity to the Reserve Component Soldier who incurs an in the line of duty medical condition. A Reserve Component Soldier with a non-line of duty may end up better off courtesy of Title 10, Section 1271b than a member who has an in the line of duty injury and thus has to be processed through the Physical Disability Evaluation System, which might result in a one time payment (severance pay) instead of an annuity (retirement pay). Recommend a review of the current law to determine what changes are necessary to correct the inequity within the Reserve Component.

Title 10, Section 12731b is intended for Reserve Component Soldiers who have between 15 – 20 qualifying years towards a Reserve Component retirement that become medically disqualified for retention due to a non-line of duty medically related condition. The law allows the Soldier to apply for a 15 year Reserve Component retirement letter making him or her eligible for a military retirement at age 60.

Title 10, Section 12731b does not apply to Reserve Component Soldiers who have acquired between 15 – 20 qualifying years towards a Reserve retirement who become medically disqualified due to a line of duty related medical condition to remain in the military. Reserve Component Soldiers who fall into this category are processed through the Physical Disability Evaluation System and if found non-retainable will receive disability compensation based on the percentage of their disability rating. A disability of 30% or higher gives the Soldier a temporary or permanent medical retirement, whereas, a disability rating of less than 30% gives the Soldier a severance pay based on the Physical Disability Evaluation System formula.

The Division of Military Personnel Management, G-1 will work with legislative liaisons at the Office Chief Army Reserve and National Guard Bureau to introduce a change in law to correct this inequity.

Hearing Date: 17 February 2005
Committee: HGRC
Member: Congressman Davis
Witness: General Kiley and General Hagenbeck
Question #2

SUBJECT OF QUESTION

Question: The GAO report cited a case where the Army lost track of an injured Reserve Component Soldier. How did this happen and what assurances can you give us that this will not happen again?

Answer: The Army has addressed this challenge and responsibility in two ways: First, MRP was established and, second, the Army is designing and implementing patient locator tracking software systems that we believe will eliminate the possibility of losing track of a Soldier. As background, the Active Duty Medical Extension Program (ADME) was established in July 2005 for Reserve Component Soldiers who incur or aggravate an injury, disease, or illness in the line of duty while performing weekend drill or annual training and is tied to the Soldier's ability to perform their normal military duties within the confines of a profile. It was not designed to handle large mobilizations of units or Soldiers that have occurred since 9/11.

The Medical Retention Processing (MRP) program was instituted on March 2004 specifically for Soldiers mobilized for GWOT contingency operations. These orders are for 179 days and are automatically renewed for another 179 days, if required. On February 15, 2005 a staff hand-off of the remaining ADME-GWOT MHO Soldiers took place from the Army G-1 to Human Resources Command (HRC). This involved 289 RC Soldiers. As of March 23, 2005 all ADME-GWOT MHO Soldiers have been converted to MRP orders.

Additionally, the Army is aware that the current means for patient tracking involves the use of non-integrated automation and manual systems. A study that just concluded provided recommendations to the Director of the Army Staff on how to fix this problem. The ASA, M&RA study group addressed the challenges raised in the question and recommended both a quick fix and a comprehensive long term solution which have been approved for implementation. A "Patient Locator" module will be added to the Medical Operational Data System (MODS) and will be available in approximately one (1) month. This web based module will provide near-real time location information on individual Soldiers and will be available for wide distribution. A more comprehensive "Patient Tracking" module will provide more detailed individual and aggregate information for case managers and senior leaders. This will be developed in parallel to the Patient Locator module. Both modules will draw data from current systems of record that provide information from theater, evacuation, medical treatment and human resources systems. Fields within both modules will be populated from these systems of record and will therefore not require duplicate data entry, the cause of most system errors. With the conversion of ADME -GWOT MHO Soldiers to MRP orders completed and the systems upgrade in the Army patient tracking system, these improvements will enhance future accountability and eliminate tracking incidents from occurring.

Hearing Date: 17 February 2005

Committee: HGRC

Witness: Mr. Denning, SAMR; LTG Hagenbeck, G1;

LTG Kiley, Surgeon General;

Mr. Sakowitz, Installation Management

Question #3

Average Stay in Medical Holdover

Question: Mrs. Embrey's second panel written testimony stated that the current average stay in medical hold for Guard and Reserve Soldiers is 67 days based on Army IT data programs.... General Byrne's written testimony provides a current list of 84 Soldiers in medical hold status. Of these 84 Soldiers, 73 have already been in these facilities for longer than 67 days.... How do you explain these facts? How do we know your record keeping is accurate?

Answer. Ms. Embrey's testimony states "From November 1, 2003 to February 2, 2005, a total of 15,485 Army Soldiers in Medical Hold have been medically evaluated for retention in the military. Of these 15,485 Soldiers, 65 percent were retained while 35 percent were released from the military. Army MEBS are currently taking up to 67 days to complete."

It is easy to see how this could be interpreted to mean that Soldiers only spend 67 days in medical holdover (MHO). What the statement is meant to convey is that medical evaluation board (MEB) processing was taking 67 days at the time the data were pulled for her testimony. Healing time was not included in those 67 days.

It is important to note that "Time in MHO" data varies from month to month based on factors that include patient load, complexity of cases, and operational tempo. For those Soldiers on whom final disposition was made in the months of January and February 2005, the average time in MHO was 182 days overall, 335 days if the Soldier required a MEB, 158 days if the Soldier healed and was released from active duty, and 90 days if the Soldier healed and was returned to duty.

The office of the Army's Assistant Surgeon General for Force Projection monitors the database weekly for errors and incomplete data. This office is responsible for educating case managers in the field on how to enter data properly and how to monitor their own performance. MHO data quality is part of a monthly briefing to The Surgeon General of the Army.

Hearing Date: 17 February 2005
Committee: HGRC
Member: Congressman Davis
Witness: Mr. Denning, LTG
Hagenbeck, and LTG Kiley
Question # 1

ADME, MRP, MEB and PEB PROCESSES

Question: Who in the Army is responsible for describing to an injured Guard or Reservist, the ADME, MRP, MEB and PEB processes? What can he or she expect during their treatment and recovery?

Answer: Several organizations are responsible. Once medical authorities determine that an injured Reserved Component (RC) Soldier will not be brought to full health within 60 days, then he or she becomes a Medical Holdover (MHO) Soldier. He or she is placed on Medical Retention Processing (MRP) orders and assigned to a Medical Retention Processing Unit (MRPU) or a Community Based Health Care Organization (CBHCO), if the Soldier meets the CBHCO assignment criteria. The leaders of the MRPU or CBHCO (Commander, First Sergeant and Platoon Sergeants) are responsible for describing the MRP, MEB and PEB processes (ADME does not apply to MRP Soldiers) to MHO Soldiers. To accomplish this they use counseling checklists, MHO pamphlets and brochures, job books, and town hall meetings to educate MHO Soldiers and ensure a baseline level of knowledge is attained. The Case Manager (CM) assigned to the MHO Soldier at the MRPU or CBHCO is also charged with helping the MHO Soldier to understand the MRP, MEB and PEB processes and to guide him or her through these processes as efficiently and expeditiously as possible. Finally, the Physical Evaluation Board Liaison Officer (PEBLO) at the installation Medical Treatment Facility (MTF) or the Patient Administrative Division (PAD) officer at the CBHCO is responsible for ensuring the MHO Soldier fully understands the MEB and PEB processes, if after receiving optimal care he or she has been determined to fall below medical retention standards.

MHO Soldiers can expect their treatment and recovery experience to meet or exceed that of the Active Component (AC) counterparts because the Army Surgeon General has made their care the MTFs' top priority.

Hearing Date: 17 February 2005
Committee: HG RC
Member: Chairman Davis
Witnesses: Mr. Denning, LTG
Hagenback, LTG Kiley
Question #2

TRAINING FOR MANAGEMENT OF MEDICAL HOLDOVER SOLDIERS

Question: Describe your responsibilities for training active duty installation personnel, caseworkers, reserve liaisons, and other caregivers that deal with injured Guard and Reserve? Do these personnel receive the same standardized training?

Answer: The Installation Management Agency is responsible to train our administrative support and command and control personnel. Administrative support personnel assist Soldiers and receive additional to support medical holdover Soldiers. Additionally, the Army is developing a training package related to Medical Readiness Processing Unit (MRPU) operations as well as medical holdover Soldier rights, responsibilities, and administrative requirements. The Army also conducts quarterly medical holdover conferences that address issues and disseminate lessons learned. On-the-job training, coaching, and installation-specific procedures are covered at the MRPU level by the chain of command in cooperation with the medical staff.

Hearing Date: 17 February 2005
Committee: HGRC
Member: Congressman Davis
Witnesses: Mr. Denning,
LTG Hagenbeck and LTG
Kiley
Question # 4

**WHAT IS THE ARMY DOING TO IMPROVE PATIENT AND FAMILY
INFORMATION**

Question: Mrs. Robinson, wife of Specialist Robinson has told the Committee that she spent hours on the phone being passed between Army office and Army office in the Pentagon seeking help for her husband. What is the Army going to do to improve patient and family information? Describe what steps the Army plans to take to improve the flow of information to patients and their families.

Answer: Since March 2004, the G-1 and the Army Human Resources Command were working on a "one-stop shopping" concept for the wounded Reserve Component Soldiers where they could call in/ e-mail/ fax questions and concerns and receive orders and other documents relating to their case. This organization has been established at HRC-A in the Reserve Components Personnel Support Services Branch. Since the concept's implementation, no Soldier has fallen off orders nor has any family member been denied services.

Hearing Date: 17 February 2005
Committee: HGRC
Member: Chairman Davis
Witness: Mr. Denning, LTG
Hagenbeck, LTG Kiley,
Question #5

CONGRESSIONAL CASEWORKERS SEEKING ASSISTANCE

Question: Congressional caseworkers report to this Committee extreme difficulty in getting timely and complete answers when trying to help Guard and Reserve who are stuck in these processes. Experiences include long waits for information, being passed around between Army staff in different offices, and receiving incomplete answers to questions. For example, after months of Committee staff seeking assistance for one reserve soldier, the reservist was not helped and never contacted by the Army. It begs the question of the difficulties a family member of an injured or wounded soldier might encounter with this bureaucracy.

Please explain why this is the case and what are you going to do to change this? As Chairman of the Committee, who should I call when I want to get answers for individual soldiers that seek help?

Answer: It is disheartening to hear that Congressional caseworkers are having difficulty getting timely and complete answers. The Secretary of the Army's Office of the Chief Legislative Liaison responds to tens of thousands of written and telephonic congressional requests for information each year. Depending on the type of inquiry, an Army Information Paper is provided to the member or staff member, or an OCLL telephonic or written response is prepared and conveyed. The House and Senate Liaison Divisions of OCLL are responsible for responding rapidly, tactfully, and factually to urgent telephonic constituent inquiries from members of Congress, committees, and their staff. The Congressional Inquiry Division of OCLL is responsible for the receipt of written inquiries as well as preparing and dispatching fully coordinated, timely and factual replies to members of Congress. When a congressional inquiry enters through one of these channels, it is tracked to completion and caseworkers have one point of contact.

To correct any potential problems with the congressional inquiry system, it is important that the Army educate all personnel involved in the process from congressional caseworkers to Army personnel. All participants need to be aware of the proper points of entry to the Army and proper procedures within the Army to handle those inquiries.

As Chairman of the Committee, you should call the Chief Legislative Liaison or his Principal Deputy with any urgent inquiries or concerns. The Army's continuing partnership with Congress is vital to our success. The perception of the Army by many members of Congress is directly related to the timeliness and quality of the information we provide. We will continue to strive to improve our systems and processes so that our responses to all congressional inquiries are timely, factual, and complete.

Hearing Date: 17 February
2005
Committee: HGRC
Member: Chairman Davis
Witness: Mr. Denning, LTG
Hagenbeck and LTG Kiley
Question #6

OFFICE OVERSIGHT AND RESPONSIBILITY

Question: The flip side of seeking more resources for addressing some of the issues we discussed at the hearing is that where there are no standards or oversight responsibility, there is also room for waste, fraud and abuse. What oversight responsibility does your office have and how do you know if overpayments or abuses are occurring? For instance, in the replacement MRP system, where Soldiers are given 179 days versus 30 days of active duty extensions for treatment, how do you know or track if 179 days might be too much. Chief Shuttleworth has told the Committee about serious gaps in oversight of incapacitation pay and cases of extensions being used for cosmetic reasons, not injury treatment. What systems are in place to stop this?

Answer: No MRP order will be published for less than 179 days and all MRP orders will be directly fed to the Army Finance personnel. HRC-Alexandria has developed an automated tracking system that notifies the MRPU and CBHCO Commanders 90 days out from the end of the 179 day order that the order is going to expire. HRC-Alexandria also tracks DJMS-RC (Pay System) through the REFRAD memos to ensure that the pay system is shut off for those Soldiers that leave prior to the 179 day end date. In addition HRC-A will rescind unexecuted portion of orders to match REFRAD memo. This ensures pay is terminated. Staff action is in progress to move incapacitation pay oversight from NGB and OCAR to DA (HRC-A). This will enhance compliance with DODI 1338.32 (Incapacitation Pay Guidance).

Hearing Date: 17 February 2005
Committee: HGRC
Member: Chairman Davis
Witnesses: Mr. Denning,
LTG Hagenbeck and LTG
Kiley
Question #7

ENFORCEMENT OF CURRENT ARMY POLICIES AND GUIDELINES

Question: How do you enforce current Army policies and guidelines effecting administrative treatment of injured Guard and Reserve Soldiers?

Answer: The chain of command provides enforcement of Army policy and guidelines. In most cases it would be the Medical Treatment Facility Commander through Medical Holdover Company Commanders. Command and Control cells are also in place to execute policy for Soldiers assigned to Community Based Health Care Organizations. HRC Alexandria (RC Branch- CW5 Shuttleworth) provides oversight for generating orders. When required, HRC Alexandria coordinates closely with Commanders and Transition Centers to ensure compliance.

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Hearing Date: 17 February 2005
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Witnesses: Mr. Denning, LTG
Hagenbeck and LTG Kiley
Question #8

MEDICAL EVALUATION BOARD PACKET

Question: The documents and proponents involved in a Medical Evaluation Board Packet chart gives this Committee a clear idea of how complicated this one process is. With so many agencies and people responsible for parts of one patient's packet, I can see where there would be room for errors and timing lags. It also begs the question of what one office in the Army is responsible for oversight of all these people.

Do any of you see any way to simplify this process? What is on paper and what is kept in computer programs? Why are so many entities involved? As we asked the first panel, where might there be stumbling blocks or choke points that add to the time it takes to get through this?

Who has oversight and responsibility over this process? What happens if the stated deadlines are not met? What Army office compels performance? How are Army policies enforced? What happens when they are not? Who is responsible for fixing errors and lapses in information?

Answer: The G-1 has overall Army Staff responsibility for the Army Physical Disability Evaluation System. Medical Evaluation Boards are the initial part of that process and their completion is a function of the US Army Medical Department. The Assistant Secretary for Manpower and Reserve Affairs exercises oversight of the Soldiers assigned as Medical Holdovers (MHOs).

In theory, the disability process is simplistic in nature, as a Medical Evaluation Board is convened to document a Soldier's medical status and duty limitations insofar as duty is affected by the Soldier's status. After the MEB packet is completed, it is forwarded to the Physical Evaluation Board, a fact finding board, which evaluates the physical condition of a Soldier against the physical requirements of his/her particular office, grade, rank, or rating. The two separate systems work hand in hand to accomplish one mission.

Through intense management and the integrating of three computer data bases, the Soldiers are tracked initially through their medical treatment and rehabilitation, then if required, the Disability Evaluation System (DES). The Director of the Army Staff receives bi-weekly briefings on the management metrics and the specific problem areas encountered in processing the MHO Soldiers.

Much of the complexity of the DES process is required to protect the rights of the Soldier, as the result usually is an involuntary release from Active Duty (either separation or retirement).

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Member: Oversight Committee
Witnesses: Mr. Denning, LTG
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Question #8

Through analysis of this process, and the application of significant resources, the Army has made significant improvements in eliminating many of the choke points that confronted the Soldiers who went through the DES in FY2003. Specifically, for the Reserve Component Soldier we changed the time allowed to transition for separation. Reserve Component liaison NCOs have been assigned to medical treatment facilities and transition centers to facilitate assembling key supporting documentation required in certain case files, as well as contributing to the coordination efforts between OCAR and the NGB. However, there are two periods of time that cannot be eliminated: (1) The time it takes a Soldier to heal, and (2) The time required for a Soldier to make his/her election and submit an appeal in response to the documents presented to them throughout the board process (The Medical Evaluation Board and the Physical Evaluation Board).

Only three agencies are involved in processing a Soldier through the DES: (1) The respective medical treatment facility during the Medical Evaluation Board phase, (2) The US Army Physical Disability Agency during the Physical Evaluation phase, and depending on the Soldier's component, either (3) Human Resources Command -- Alexandria or Human Resources Command-- St Louis, or the National Guard Bureau for separation actions for the active, Army Reserve or National Guard Soldiers. Each agency bears responsibility to insure the Soldier's case file reflects accurate and usable information (to include medical and administrative data).

As has been discussed in previous questions, (Mr. Denning Question 5) the ability to render accurate reports depends not only on the accuracy of the data, but the integration of these systems into a comprehensive reporting network. The ASM and RA Personnel and Medical Data Integration Tiger Team, has studied this situation, and made their recommendations. The Army is in the process of implementing those recommendations.

Hearing Date: 17 February 2005
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Member: Chairman Davis
Witnesses: Mr. Denning, LTG
Hagenback, LTG Kiley
Question #9

ABILITY TO SUPPORT INCREASE OF MEDICAL HOLDOVER SOLDIERS

Question: With the changing tides of war, and the increased mobilization of Guard and Reserve, is the current Army system ready to handle more injured Reserve Component? For example, with the OIF III mobilization, will the numbers grow? Are you equipped to handle them?

Answer: The Army's system of support is scalable to meet surges in the medical holdover population, and we can expand our command and control and transition processing capacity through the use of recalled retiree Soldiers, civilian hires, or contractors. Our medical holdover billeting capacity is more than adequate to meet current and projected requirements.

Hearing Date: 17 February 2005
Committee: HGRC
Member: Congressman Davis
Witness: Mr. Denning, LTG
Hagenbeck, and LTG Kiley
Question #10

IMPROVING TRACKING OF SYSTEMS

Question: Can someone tell us which systems you now rely on? What do each of them do and how are they integrated? With so many systems, and with so much input coming in from different Army personnel, how do you resolve conflicting entries? Whom within each command is responsible for their entering timely and accurate information?

Answer: Currently, patient tracking is performed using theater, evacuation, medical treatment and human resources systems, plus manual inquires (i.e. telephonic). The Medical Operational Data System (MODS) is the primary automation system used to derive patient location information from these multiple systems. MODS is an integration layer that interfaces with more than 40 separate medical and HR systems. To improve the accuracy and speed of patient tracking, the Army has approved the development of 2 new modules, within MODS, that will be dedicated to tracking soldier patients from evacuation from theater to return to duty or separation from the Army. MODS will provide both a quick fix and a comprehensive long term solution. A "Patient Locator" module will be added to the Medical Operational Data System (MODS) and will be available very shortly. This web based module will provide near-real time location information on individual soldiers and will be available for wide distribution. A more comprehensive "Patient Tracking" module will provide more detailed individual and aggregate information for case managers and senior leaders. This module will be developed in parallel to the Patient Locator module. Both modules will draw data from current systems of record and will interface with the Defense Integrated Military Human Resources System (DIMHRS) when available. Duplicate and potentially erroneous data will be avoided through the use of pre-populated fields provided by the systems of record.

Hearing Date: 17 February 2005
Committee: HGRC
Member: Congressman Davis
Witness: Mr. Denning, LTG Kiley
and LTG Hagenbeck
Question #11

WOUNDED ARMY GUARD AND RESERVE FORCES

Question: All the new processes and procedures coming from Army policy shops do not mean anything unless people are informed of the changes, trained to execute them, and monitored for performance. The Committee has found a number of people do not know the procedures or their responsibilities. What are each of you specifically going to do this year to ensure this is no longer the case?

Answer: Several actions and improvements are under way. The Assistant Secretary of the Army (Manpower and Reserve Affairs) (ASA(M&RA)), in its oversight role, is currently constructing Medical Holdover (MHO) operations checklists and associated criteria that establish MHO standard operating procedures (SOPs). These checklists and associated criteria will be distributed to all Medical Retention Processing Units (MRPUs) and Community Based Health Care Organizations (CBHCOs) by mid-April and these organizations will be expected to hone their operations to meet the established standards. In May 2005, the ASA (M&RA) led System Analysis and Review (SAR) team will begin its next round of visits to evaluate all MRPUs and CBHCOs against the established MHO SOPs. The SAR team, consisting of members from ASA(M&RA), Forces Command (FORSCOM), Office of The Surgeon General (OTSG), Installation Management Agency (IMA) and Human Resources Command (HRC) will evaluate each MRPUs and CBHCO.

ASA(M&RA) is developing a formalized MHO training program consisting of training modules for MHO leaders, cadre, and Soldiers. This program is intended for use by the MHO leaders, cadre, and Soldiers to enhance their knowledge of MHO operations and as a reference guide to answer questions. The training modules will be web based and at the conclusion of training will contain a certification portion that tests the level of knowledge attained by the participants. This training program will be available to the MHO Soldier in May 2005.

In January 2005, FORSCOM conducted the second five-day CBHCO cadre training program at Camp Robinson, Arkansas. This training program is designed to formally educate CBHCO staff of their responsibilities in caring for the MHO Soldier. The Army will continue to assess its MHO operations, train new cadre, and inform cadre of policy changes through their chain of command.

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Question #1

RECOMMENDATION FOR IMPROVEMENTS

Question: Where do we think we need to go next? What recommendations do you have for further improvements?

Answer: Several actions and improvements are underway. The Assistance Secretary of the Army, Manpower and Reserve Affairs (ASA (M&RA)) in its oversight role is currently constructing Medical Holdover (MHO) operations checklists and associated criteria that establish MHO standard operating procedures (SOPs). These checklists and associated criteria will be distributed to all Medical Retention Processing Units (MRPUs) and Community Based Health Care Organizations (CBHCOs) by late March and these organizations will be expected to hone their operations to meet the established standards. In May '05, the ASA (M&RA) led System Analysis and Review (SAR) team will begin its next round of visits to evaluate all MRPUs and CBHCOs against the established MHO SOPs. The SAR team, consisting of members from ASA (M&RA), Forces Command (FORSCOM), Office of The Surgeon General (OTSG), Installation Management Agency (IMA) and Human Resources Command (HRC), will evaluate the MRPUs or CBHCO during a structured 4-day visit and will write a formal report on the findings that will be distributed to the Army leadership.

Additionally, ASA (M&RA) is developing a formalized MHO training program consisting of training modules for MHO leaders, cadre and Soldiers. This program is intended to be used by the MHO leaders, cadre and Soldiers to enhance their knowledge of MHO operations and as a reference guide to answer questions. The training modules will be web based and at the conclusion of training will contain a certification portion that tests the level of knowledge attained by the participants. This training program will be available to the MHO Soldier in May '05.

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Question # 2

IMPROVEMENTS OF CONDITIONS/PROCESSES FOR INJURED RC SOLDIERS

Question: Since the start of the GWOT, what specifically has the ASA (M&RA) done to help improve the conditions and processes governing injured Guard and Reserve?

Answer: Over time, the GWOT surfaced several problems unique to injured Guard and Reserve Soldiers. In reaction, the ASA (M&RA) formed a Tiger Team and charged it with addressing and resolving these problems and associated issues. Through the efforts of this team, many new initiatives and programs have emanated:

- a. 25-Day Rule. Allows Army units to screen mobilized Soldiers and send home those who have pre-existing medical conditions that make them non-deployable. This rule has greatly reduced the number of Soldiers brought on active duty that are later to be found non-deployable.
- b. Upgrade of housing for MHO Soldiers. IMA ordered that all MHO Soldiers are to be housed in facilities equal to that of permanent party Soldiers and meets their medical needs and limitations. Further, these facilities must be climate controlled, have modern latrines located in the same building, and have no more than four Soldiers to a room.
- c. Enhanced medical access standards for MHO Soldiers at MTFs. The Army Surgeon General established standards that mandated no more than 72 hours for specialty referrals, one week for magnetic resonance imaging (MRI) and other diagnostic studies, and surgery within two weeks of the time the doctor says a patient is ready.
- d. Transfer of command and control of MHO Soldiers from MTF commanders to installation commanders. Allowed for more robust command and control of MHO Soldiers and lifted the burden from the MTFs which were in some cases overtaxed in trying to execute this function while providing for adequate medical care.
- e. Established the MRP program. Eliminated placing MHO Soldiers on ADME orders, a program that was never designed to handle the large number of Soldiers that became MHOs. The MRP program allows Soldiers to volunteer to remain on active duty for medical treatment and allows deployed units to request replacements for their Soldiers who become MHOs. This has served to significantly decrease the number of Soldiers falling off orders and subsequently losing pay and other benefits.
- f. Increased medical staffing to handle MHO Soldiers. U.S. Army Medical Command has hired approximately 800 doctors, nurses, technicians, and other staff to provide the level of care necessary for the MHO Soldier population.

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Question # 2

g. Community Based Health Care Initiative (CBHCI). With FORSCOM as the executive agent, the CBHCI was established. The key tenet of the CBHCI is to get the MHO Soldier at or near his or her home as they undergo treatment. The CBHCI through its CBHCOs provides command and control of MHO Soldiers while they receive treatment, finds them meaningful work compatible with their medical limitations, and leverages appropriate civilian healthcare for MHO Soldiers in or near their home towns.

h. Increased staff at the Physical Disability Agency (PDA). In order to provide better support to MHO Soldiers, increase throughput of cases, and overall decrease the amount of time a MHO Soldier spends in the PEB process, the PDA increased its medical, legal, and administrative staffs at the PEBs and Headquarters. In addition, it resourced an additional mobile PEB that travels between the three PEBs to work down any backlog of formal boards.

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Question # 3

OVERSIGHT & FINDINGS OF ADMINISTRATIVE PROCESSING

Question: Is your office responsible for the oversight of the administrative processing of injured Guard and Reserve? If so, how do you carry out this oversight and what are your findings?

Answer: An associated task of the ASA (M&RA) providing oversight of the MHO program is the oversight of the various administrative processes. It carries out this oversight through coordination and guidance to the organizations directly responsible for MHO administrative processes: OTSG, Army G-1, Human Resources Command (HRC), and IMA. Additionally, evaluation of administrative processes at MRPU and CBHCOs are key inspection areas of the ASA (M&RA) led Systems Analysis and Review (SAR) team (comprised of these organizations and FORSCOM) during its assistance visits to these units. To date, the SAR team has identified systemic administrative process issues associated with premature orders and pay termination, lack of Line of Duty (LOD) investigations, incomplete Medical Evaluation Board (MEB) packets, incorrect release from active duty (REFRAD) orders, and untimely transition point processing. Not all of these issues/problems have been resolved, but all are being actively addressed.

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Witness: Mr. Denning
Question #4

WHY FORSCOM IS RESPONSIBLE FOR CBHCI

Question: Why is Army Forces Command (FORSCOM) responsible for oversight for the new Community Based Health Care Initiative and not Army Medical Command? Why split the responsibility for the same services?

Answer: The three (3) components to MHO operations consist of the following: 1) Outpatient medical care; 2) Command and Control (C2); and 3) Administrative Support. As Medical Command (MEDCOM) is the proponent for outpatient medical care, they are not tasked organized for adequate C2 and Administrative Support operations. FORSCOM is responsible for the readiness of all Continental U.S. Army Forces to include Army National Guard (ARNG) and U.S. Army Reserve (USAR) units, which can provide adequate C2 and Administrative Support for MHO operations. CBHCI required the CBHCOs be manned by ARNG Soldiers with USAR liaison officers in support; the Army determined that FORSCOM is best suited to perform the key mission as the Executive Agent. In its Executive Agent role, FORSCOM coordinates and works hand-in-hand with OTSG and MEDCOM to ensure CBHCOs are manned sufficiently with qualified medical personnel and staff and that they are operating within prescribed medical standards.

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Witness: Mr. Denning
Question #5

OVERSIGHT AND CHECKS/BALANCES OF IT SYSTEMS

Question: You have a great deal of non-integrated IT systems, several sources of input and tracking, and no standardized training on entry or defined responsibilities. What oversight do you have in place to insure that all the information is accurate? What checks and balances do you have in place to check for accuracy? What are the responsibilities of your office to insure that improvements are made in IT integration and tracking and medical information?

Answer: The Army is aware that the current means for patient tracking involves both the use of non-integrated automation and manual systems. A study that just concluded provided recommendations to the Director of the Army Staff on how to fix this problem. The approved recommendations of this ASA, M&RA study group included both a quick fix and a comprehensive long term solution. A "Patient Locator" module will be added to the Medical Operational Data System (MODS) and will be available in approximately one (1) month. This web based module will provide near-real time location information on individual soldiers and will be available for wide distribution. A more comprehensive "Patient Tracking" module will provide more detailed individual and aggregate information for case managers and senior leaders. This module will be developed in parallel to the Patient Locator module. Both modules will draw data from current systems of record that provide information from theater, evacuation, medical treatment and human resources systems. Fields within both modules will be populated from these systems of record and will therefore not require duplicate data entry, the cause of most system errors. In addition, MODS has been identified as an interface system with the Defense Integrated Military Human Resources System (DIMHRS) and will therefore acquire record data from this system, when it is available.

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Witness: Mr. Denning
Question #6

ALTERNATIVES TO ARMY PROCESS OR PATIENT OUTREACH

Question: What contact or research have you done with your counterparts in other military services, for example the care of Marine Corps Reserve, in an effort to find alternatives to Army processes or patient outreach.

Answer: The Army, through OTSG, has coordinated with its Sister Services to leverage care in their MTFs for Soldiers located in their catchment areas. In addition, the Army has reviewed the Marine Corps and Air Force patient outreach program to understand how it can provide better outreach services to MHO Soldiers once they leave active duty. The Army, Navy & Air Force reports biweekly to the OSD on the status of Medical Hold and Medical Holdovers. In this venue, best practices are shared and implemented across DoD.

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Witnesses: Mr. Denning
Question #7

Enforcement of Current Army Policies and Guidelines

Question: What information or assistance have you provided Army Reserve Command, the National Guard Bureau or State Guard Headquarters on improving patient and family outreach for injured Guard and Reserve?

Answer: As a result of recommendations made at the hearing, Human Resources Command (HRC) has attended training sessions held by the National Guard Bureau (NGB) and the Office of the Chief Army Reserves (OCAR) and added both NGB and OCAR to its distribution lists. HRC, NGB, and OCAR participate in video-teleconferences and telephone conferences on a regular basis. The active and the reserve components are working more closely than ever before on many issues dealing with Reserve Component Soldiers, but especially on issues dealing with patient and family outreach.

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Witness: Mr. Sakowitz
Question #1

CARE AND SUPPORT OF MEDICAL HOLDOVER SOLDIERS

Question: Please tell us a little about improvements made in care of Guard and Reserve Soldiers at Fort Lewis, Fort Carson, Fort Bragg and Fort Knox.

Answer: We have made great strides toward improving the quality of life for our medical holdover (MHO) Soldiers. We are housing MHO Soldiers in billeting that is the same as Active Component Soldiers. We have renovated billeting to provide clean, comfortable surroundings and modified facilities to accommodate our Soldiers' medical requirements.

At Fort Lewis, Washington, the garrison commander initiated weekly meetings to monitor emergent situations before they become significant issues. Reviews of MHO Soldiers are conducted weekly between platoon sergeants, case managers, and MHO Soldiers. Counseling is provided to assistance in redeployment, family separation, chronic pain, long-term recovery, and ability to return to civilian jobs. Other steps to assist Soldiers' return to civilian life have been provided, such as locating Veterans Affairs satellite offices within barracks and implementing the Community Based Health Care Initiative to transition Army National Guard and Army Reserve Soldiers back to their communities within seven days of being qualified by their primary care physician.

At Fort Carson, Colorado, MHO Soldiers are housed in barracks that have undergone substantial renovations, including handicap accessible ramps, automated door openers, Americans with Disabilities Act bath and shower fixtures, and new paint and carpet. Two day rooms are equipped with new orthopedic furniture, big screen TVs, microwave ovens, vending machines, and billiard games. Soldiers are billeted at a 1+1 standard. Additionally, MHO the billeting facility is staffed 24 hours a day, 7 days a week to assist Soldiers with any special needs. The MHO barracks has three duty vans with permanently assigned drivers to provide transportation. An Internet cafe is available and located in a building adjacent to their billets. Fort Carson is currently renovating several other barracks in preparation for newly assigned Active Component units coming to the post. The MHO mission has been incorporated into the renovation master plan. The first completed barracks will be dedicated to our MHO Soldiers.

At Fort Knox, Kentucky, we have made renovations to provide handicap accessibility, e.g., ramps, wider doors, latrines, and showers. As at all installations, MHO Soldiers have first-in-line privileges for treatment and appointments. The medical treatment facility commander established a policy where all Soldiers being evacuated from the combat zone are seen by a physician upon their arrival. During normal duty hours, Soldiers report to a clinic and are assigned primary care physicians who provide referrals for follow-on care. The Soldiers then go

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Question # 1

to the hospital to meet case managers, who review records and check to ensure referrals are in the system. Soldiers arriving after duty hours are taken to the emergency room to be checked by a doctor. The next duty day, the Soldiers are taken to the clinic where the process of being assigned primary care physicians and meeting case managers is the same as above.

At Fort Bragg, North Carolina, all MHO Soldiers not living at home are residing in Army lodging on post. This affords them, at minimum, a semi-private room. If there is a situation where not enough adequate permanent party barracks are available, local hotels or motels are used to provide standards consistent with permanent party barracks. Case manager reviews are conducted periodically between the hospital and garrison staff to ensure medical providers and the chain of command have a complete picture as it relates to Soldier care. Town hall meetings are conducted regularly to ensure two-way communication is maintained between the garrison cadre and MHO Soldiers.

These best practices are briefed to Senior Army leaders and shared among all installation staffs to facilitate improvements in the MHO system.

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Question #2

CARE AND SUPPORT OF MEDICAL HOLDOVER SOLDIERS

Question. How do you rate the care of injured Guard and Reserve at your installations? What are the standards for these installations and how are you enforcing them?

Answer. Care of injured Army National Guard and Army Reserve Soldiers is excellent and improving. The Army continuously works to improve the facilities and the processes essential for conducting medical holdover (MHO) operations. One recent enhancement is the expansion of the Community Based Health Care Initiative into all 50 states. Medical treatment and support of our injured Guard and Reserve Soldiers remains a top priority for commanders and senior leaders throughout the Army. With respect to command and control and quality of life, we continue to invest considerable resources to provide the best possible accommodations for all MHO Soldiers. Also the Army recently improved the ratio of platoon sergeants to MHO Soldiers from 1:50 to 1:35 to allow for more individualized attention to our MHO Soldiers. The Army is working hard to provide additional personnel to meet this new command and control model.

We provide accommodations in accordance with DOD Instruction 4165.63-M, (Transient Billeting Standards), which includes no more than four MHO Soldiers to a room, climate controlled rooms, and inside latrines. We also work closely with the medical community to provide special accommodations for physical limitations if required.

Standards are enforced through a variety of means. For example, commanders hold weekly meetings to review the support to and the status of each MHO Soldier. Commanders also participate in monthly video teleconferences to brief the status of their MHO support missions. Each garrison provides a situation report at least three times a week to all concerned parties with information such as current and projected medical holdover population; staffing requirements; medical treatment facility capabilities; billeting and other quality of life requirements; status of medical and administrative processing; and commander's comments (other issues, challenges, requests for training support, command information efforts, recommendations).

This information is carefully reviewed and responded to by senior Army leaders to ensure compliance with standards and to provide resources in a timely manner. Commanders have direct lines to senior Army leaders should they need additional assistance on any facet of their MHO support missions.

The MHO commanders and staff are trained through an interagency effort between the Department of the Army, Forces Command, and the Installation Management Agency. Training is supplemented by garrison commanders with on-the-job training as new staff members arrive.

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The Army's MHO Tiger Team, led by representatives from the Assistant Secretary of the Army (Manpower & Reserve Affairs) visits all installations to assess MHO support and provide feedback to all stakeholders.

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Question #3

CARE AND SUPPORT OF MEDICAL HOLDOVER SOLDIERS

Question: How do you collect information from each facility on their needs for resources or training of staff to deal with Reserve Guard in med holdover status?

Answer: The Army works across command and organizational lines to gather timely and accurate information about what each garrison commander needs to support his or her medical holdover (MHO) population. We work with the Army Secretariat, Army Staff, Forces Command, Surgeon General, First and Fifth Continental U.S. Armies, installation senior mission commanders, and the Installation Management Agency regions to maintain a common assessment on the status of medical holdover Soldiers and the resources needed to fully support them.

Commanders hold weekly meetings to review the support to and the status of each MHO Soldier. Commanders also participate in monthly video teleconferences to brief the status of their MHO support missions. Each garrison provides a situation report at least three times a week to all concerned parties with information such as current and projected medical holdover population; staffing requirements; medical treatment facility capabilities; billeting and other quality of life requirements; status of medical and administrative processing; and commander's comments (other issues, challenges, requests for training support, command information efforts, recommendations).

This information is carefully reviewed and responded to by senior Army leaders to ensure compliance with standards and to provide resources in a timely manner. Commanders have direct lines to senior Army leaders should they need additional assistance on any facet of their MHO support missions.



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Washington, DC 20548

April 15, 2005

The Honorable Tom Davis
Chairman, Committee on Government Reform
House of Representatives

Subject: *Responses to Posthearing Questions Related to GAO's February 17, 2005, Testimony on the Gaps in Pay and Benefits Experienced by Injured Army Guard and Reserve Soldiers*

Dear Mr. Chairman:

On February 17, 2005, I testified before your committee at a hearing on the financial problems experienced by wounded reserve component soldiers. My testimony focused on gaps in pay and benefits that created hardships for injured reserve component soldiers and their families while on extended active duty service in the Active Duty Medical Extension (ADME) program or the Army's new Medical Retention Program (MRP).¹ This letter includes my response to questions for the record from Representative Ruppertsberger.

Questions from Congressman C.A. Dutch Ruppertsberger

- 1. In a perfect world, what would it take to really fix these problems and create a seamless Army system that was able to process active and reserve units with injured and disabled men and women at varying locations and stages in the process?**

First, the Department of the Army needs to develop and promulgate comprehensive, integrated policies and procedures for managing and treating injured reserve component soldiers. This would provide the framework for creating a seamless system. At a minimum, standard operating procedures and guidance should be developed that address (1) specific organizational responsibilities for managing programs that deal with injured or ill reserve component soldiers, including which officials have the ultimate responsibility for the success of these programs; (2) where orders that extend a soldier's active duty status are to be cut, how they are to be distributed and to whom they are to be distributed—for both command and control purposes and to update the Army's pay, personnel, and medical eligibility systems;

¹ GAO, *Military Pay: Gaps in Pay and Benefits Create Financial Hardships for Injured Army National Guard and Reserve Soldiers*, GAO-05-322T (Washington, D.C.: Feb. 17, 2005).

and (3) standards for being retained on active duty orders, including time frames and criteria for extension or retention beyond 1 year.

Second, with comprehensive policies and well-defined organizational responsibilities in place, adequate training and education programs are required to ensure that reserve component soldiers and Army officials responsible for administering the program are familiar with program requirements, benefits, and administrative processes.

Third, a seamless system for managing and treating injured reserve component soldiers should also include automated systems that provide visibility over injured and ill reserve component soldiers and ensure that the order writing system automatically updates the pay, personnel, and medical eligibility systems.

Finally, the Army should consider creating a patient advocate group, or an ombudsman, to further assist all injured or ill reserve component soldiers. These patient representatives could assist soldiers with any administrative difficulties that might arise while soldiers are receiving care.

a. Do we simply need to stop patching a broken process and create a state-of-the-art system that would best serve these soldiers and their families?

The Army's ad hoc or patchwork approach to addressing problems associated with managing and treating injured reserve component soldiers is the likely consequence of operating in an environment in which no one is accountable for the overall management and treatment of these soldiers. Many of the elements of the Army's new MRP program are clearly working and, therefore, should not be eliminated. For example, MRP has reduced many of the front-end processing delays experienced by soldiers applying for ADME by simplifying the application process, thereby reducing the risk of a soldier falling off active duty orders and missing associated pay and benefits. However, creating lasting, comprehensive solutions and a program that is responsive to the Army's changing requirements will require strong leadership; clearly defined organizational responsibilities; and integrated pay, personnel, and medical eligibility systems.

b. Is it just resources, priority status, and training that stop us from truly fixing this problem? Or is there a cultural problem within the Army as well that still separates active from reserve components in the rear?

The problems experienced by injured reserve component soldiers persisted for as long as they did for a variety of reasons. For example, at least initially there were not enough case managers to handle the patient workload. However, the primary reason the Army has not fixed the problem completely is that no one was accountable for the management and treatment of injured reserve component soldiers, and therefore, no one was responsible for providing a comprehensive solution to the problems

associated with the process. While some injured reserve component soldiers voiced concerns about a bias against reserve component soldiers, this issue was outside the scope of our work.

c. Are other military branches experiencing similar problems, such as Marines? If so, what? If not, why?

The scope of our engagement did not include an assessment of medical hold conditions at other branches of the military, such as the Navy, Air Force, or Marines. However because the Army accounts for nearly 65 percent of reserve component soldiers activated, it follows that there are significantly more Army reserve component soldiers who sustain injuries or illnesses while activated.

2. From the macro perspective, what is the greatest challenge in providing a seamless soldier support system for active and reserve Army soldiers?

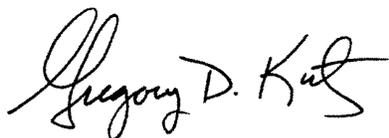
The greatest challenge to providing a seamless soldier support system for both active and reserve Army soldiers will be designing and implementing integrated pay, personnel, order-writing and medical eligibility automated systems that provide visibility over injured and ill reserve component soldiers. The current stovepiped, nonintegrated systems are labor-intensive and require extensive error-prone manual data entry and reentry.

a. Would you consider your recommendations to be patches to an old system or will these changes bring lasting systemic improvements that will prevent any soldier from experiencing what we have heard today?

We believe our recommendations, if implemented correctly, could bring about lasting improvements. The key is establishing integrated, comprehensive policies and procedures and designating organizational accountability for the success of programs and processes for managing and treating injured reserve component soldiers. Taken together, these measures provide a foundation on which an effective program can be created. In addition, as part of a longer-term strategy, the Army must design and implement integrated order-writing, pay, personnel, and medical eligibility systems that provide visibility over injured reserve component soldiers.

Thank you for the opportunity to testify on these important issues. Please contact me at (202) 512-9095 or kutzg@gao.gov if you or your staff have any additional questions.

Sincerely yours,

A handwritten signature in black ink that reads "Gregory D. Kutz". The signature is written in a cursive style with a large initial 'G' and 'K'.

Gregory D. Kutz
Director
Financial Management and Assurance

Enclosure

cc: The Honorable Henry Waxman, Ranking Member
The Honorable C.A. Dutch Ruppersberger