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THE ARMY MEDICAL ACTION PLAN: IS IT WORKING?

HEARING

BEFORE THE

MILITARY PERSONNEL SUBCOMMITTEE

OF THE

COMMITTEE ON ARMED SERVICES
HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

SECOND SESSION

HEARING HELD
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THE ARMY MEDICAL ACTION PLAN: IS IT WORKING?

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ARMED SERVICES,
MILITARY PERSONNEL SUBCOMMITTEE,
Washington, DC, Tuesday, July 22, 2008.

The subcommittee met, pursuant to call, at 2:03 p.m., in room 2212, Rayburn House Office Building, Hon. Susan A. Davis (chairwoman of the subcommittee) presiding.

OPENING STATEMENT OF HON. SUSAN A. DAVIS, A REPRESENTATIVE FROM CALIFORNIA, CHAIRWOMAN, MILITARY PERSONNEL SUBCOMMITTEE

Mrs. DAVIS. Good afternoon, everybody. Thank you very much for being here, especially to our witnesses. Thank you very much for being with us today, and participating. I know it will be, I hope, a very fruitful discussion.

The purpose of today's hearing is to take a hard look at the current state of the Army Medical Action Plan (AMAP). This will be the third hearing this subcommittee has held on the Army Medical Action Plan, the Army's response to the revelations at Walter Reed Army Medical Center last year, since it was issued in June, 2007.

When the Army Medical Plan execution order was issued last summer, the Military Personnel Subcommittee believed that the Army had finally demonstrated a full understanding and acceptance of the organizational and systemic shortcomings that had led to the scandalous conditions at Walter Reed. We felt that the Army Medical Action Plan was a comprehensive and ambitious blueprint to tackle these issues head on. After years of frustration, many on this subcommittee believed that the Army was finally ready to take the necessary steps to solve these problems.

However, from our very first briefing on the Army Medical Action Plan, we had two significant concerns. The first was that the Army would be unable to initially dedicate and then maintain over the long haul the level of resources required by the Army Medical Action Plan. Specifically, we were worried that the Army would be unable to assign adequate numbers of personnel to the Warrior Transition Units (WTUs). Why? Because the core of the Warrior Transition Units were to be the same soldiers that make up the backbone of our brigade combat teams, midgrade noncommissioned officers, and these soldiers were already in short supply.

The second concern was that Army commanders would overwhelm the Warrior Transition Units by sending them all of their soldiers with medical issues rather than just those with complex injuries or conditions that required comprehensive case management. In truth, we do not feel that this was necessarily a bad

thing, especially if it helped units deploy at full strength, while injured or ill soldiers had the opportunity to fully recover. Of course, this would only work if Warrior Transition Units were properly resourced to take care of these soldiers.

From June, 2007, through February, 2008, the members and staff of this subcommittee made numerous visits to Warrior Transition Units throughout the Army. The overall trend we observed was positive. The Army Medical Action Plan was clearly providing better support for recovering soldiers than the previous Medical Holdover system. One wounded warrior commented, "Thank God for the Warrior Transition Unit. Things are so much better than they were before."

That was good to hear.

But despite the positive trends, we were frustrated at the slow progress of implementing the AMAP. We felt that things should have and could have been moving faster. We also felt that there was a disconnect between how quickly the Army leadership believed things were happening and what the facts on the ground seemed to indicate. Again, despite the challenges, we felt things were moving in an overall positive direction.

However, our concerns about Warrior Transition Unit staffing levels and the potential of line units, "dumping" soldiers on the Warrior Transition Unit, continued. We asked General Schoomaker about this repeatedly during our hearing in February to get an update on the AMAP. In response to a question asked by Mr. McHugh, the Army Surgeon General declared, "For all intents and purposes, we are entirely staffed at the point we need to be staffed." As the facts at Fort Hood demonstrate, that is clearly not the case now.

Gentlemen, the Army Medical Action Plan was designed by the Army. It is your plan. The Army senior leadership has publicly trumpeted your commitment to wounded soldiers at every opportunity, and we believe that that is true. The Secretary of Defense agrees; as Dr. Gates has made clear, Apart from the war itself, this Department and I have no higher priority.

Over the course of this hearing, we will review the following topics.

Resources: Why has the Army failed to properly resource the Warrior Transition Units?

Warrior Transition (WT) population growth: Why did the Army fail to predict the growth in the WT population? We were assured by the Army during our hearing in February that you had the processes and reviews in place to stay on top of the population; and clearly that is not the case today.

Priority: Is the Army Medical Action Plan truly the Army's number two priority? Our visits do not leave us with that impression.

Creativity: From the outset, the Army Medical Action Plan has been sold as a bold roadmap to overhaul outdated, inefficient, and detrimental policies and procedures; and in fact, when General Tucker was selected to lead this effort last year, he was introduced to us as the Army's premier bureaucracy buster, responsible for identifying outmoded practices and leading the effort to develop new, more effective ways of doing business.

Many of the problems that continue to hinder Warrior Transition Units seem to be an institutional insistence on doing things the old way.

Oversight: Finally, and perhaps most importantly, why did it take oversight visits from the subcommittee to identify and spur the Army to fix these issues, and what will it take to ensure that the Army follows its own plan and lives up to its own promises?

Gentlemen, aside from telling us you will work harder to implement—and know, we do believe that, and we know you are working very hard at this—what concrete steps are being taken to ensure better follow-through?

I also want to mention that this subcommittee has worked very hard to make this an open and collaborative process. Our staff readily and routinely shares all of the information they collect at the Warrior Transition Units they visit. This includes conducting an outbrief with the cadre hospital chain of command and, frequently, representatives from the senior mission commander before they leave an installation. They have also met regularly with the surgeon general in the warrior transition office.

There is nothing we have learned that we have not shared. There are no facts that we know that you do not.

So let me be clear that we understand that the Army Medical Action Plan remains a work in progress. We do not expect that it would immediately resolve all problems. None of us could have expected that; we were certain that it would require modification and update along the way. However, we are very concerned that the Army took its eye off that ball, that you are not living up to the goals you set and the promises you made when the Army Medical Action Plan was issued.

So we look forward to your testimony and to learn what steps you plan to take to ensure its success. We intend to make certain that our wounded warriors receive the care and the support they deserve by holding you to the standards you have yourselves set forth in the Army Medical Action Plan.

I want to turn now to Mr. McHugh for his comments.

[The prepared statement of Mrs. Davis can be found in the Appendix on page 45.]

STATEMENT OF HON. JOHN M. MCHUGH, A REPRESENTATIVE FROM NEW YORK, RANKING MEMBER, MILITARY PERSONNEL SUBCOMMITTEE

Mr. MCHUGH. Thank you very much, Madam Chair. I have a rather extensive statement that I am not going to read in its entirety. I would ask for its unanimous adoption into the record without objection.

Let me just make a few comments. First of all, Madam Chair, let me express my appreciation to you. As you noted, this is the third open hearing we have had. Both the Chair and other members and I have had the opportunity, as well, to visit Warrior Transition Units at various facilities and to meet with some of the command staff.

I think it is important to say at the outset that I certainly agreed at the time this approach was implemented that it is the correct path. And for all of the challenges that we have encountered, I con-

tinue to believe that the WTU concept is a very, very positive one, responding to a rather new dimension of challenge in terms of treating with respect and dignity—and in, hopefully, the greatest facility—these warriors that have given so much on behalf of their Nation. And in no discussion I have had, in no trip I have made, no visit I have taken part in have I in any way had cause to question any of the devotion or dedication that the Army and its personnel bring to this challenge.

That having been said, as the Chairlady I think very adequately and accurately outlined in her opening comments, there continue to be serious shortfalls; shortfalls that our staff did identify and that I know the Army continues to try to deal with. Serious questions, those of resources, of a mechanism that sufficiently anticipates the population growth that we have seen, an explosion in the cadre of these units and an expansion that we have every reasonable expectation will continue; the continued proliferation of rules and regulations, good old-fashioned bureaucracy that, for all of the efforts and, I think, successful attempts that have been made to identify them, far too often continue to frustrate those who are trying to do this very important challenge; and trying to ensure that we minimize the waits that are involved through, of course, the Medical Evaluation Board (MEB) process, and on and on and on.

This hearing, I would say to our distinguished panelists, is an attempt to more fully discuss those challenges, those shortfalls, to try to get from you your perspective in a process by which we can all learn and, hopefully sooner and as quickly as possible, begin to do the best job by these folks who have done such incredibly positive work for us.

So I want to add my words of welcome to our distinguished panelists that I know the Chair will introduce here, and I very much look forward to your testimony and, hopefully, to taking part in a process that can finally get this concept off paper and fully implemented in a way I know we all want to see it work.

Madam Chair, thank you very much. I would yield back.

[The prepared statement of Mr. McHugh can be found in the Appendix on page 48.]

Mrs. DAVIS. Thank you, Mr. McHugh.

I would turn to General Rochelle. I believe you are going to give the statement. Is that for everyone?

General ROCHELLE. Madam Chair, I believe we each have a statement, an oral statements, but I would like to submit our joint written statement for the record, with your permission.

Mrs. DAVIS. Absolutely.

General ROCHELLE. If I may proceed with my oral statement?

Mrs. DAVIS. Yes, please.

General ROCHELLE. If I may proceed with oral statement?

Mrs. DAVIS. Yes, please.

STATEMENT OF LT. GEN. MICHAEL ROCHELLE, USA, DEPUTY CHIEF OF STAFF FOR PERSONNEL, G–1, U.S. ARMY

General ROCHELLE. Madam Chair, thank you very much. Representative McHugh, distinguished members of the subcommittee, thank you so much for the opportunity to discuss the status of the

Army Medical Action Plan, in particular, the Warrior Transition Units.

I echo, first of all, the Chief of Staff of the Army and the Secretary's call to the Army to ensure our warriors in transition and their families receive the care and support they require in environments most conducive to their healing. We have accomplished much, but we are not mission-accomplished in this area. Our system of caring for and supporting warriors in transition and their families is vastly superior to the previous system. We acknowledge, however, that it absolutely needs to work better.

Over the past 18 months, the Army has made tremendous improvements in our ability to streamline the disability process, the Medical Evaluation Board process; and orders process are likewise streamlined, wasted time eliminated, and soldiers' rights preserved. However, improvements under the current statute still cannot fully address soldiers' concerns over quality of life, compensation, future income stream gaps, or family health care coverage for soldiers that are separated with medical disabilities.

Our wounded warriors deserve to have a physical disability evaluation system, PDES, if you will, which is uncomplicated, easily understood, but above all, fair. The Army has developed strategies, programs, and initiatives to improve the physical disability evaluation process. Additionally, a training certification program is now a part of the physical disability evaluation system, ensuring caregivers, care managers, and administrative personnel involved in each area of warrior care are certified annually. These courses are now an annual certification requirement in their respective disciplines. We still have room to improve this process as well.

We reduced the bureaucratic burdens on our wounded warriors through several initiatives, including casework forms reduction, increases in accessibility to lawyers, a physical disability evaluation handbook for wounded warriors and their families, a My MEB/My PEB—Medical Evaluation Board, Physical Evaluation Board—webpage on the Army Knowledge Online system for wounded warriors to track the status of their disability cases, and Department of Veterans Affairs counseling prior to discharge from the Army.

Last, case processing results across the three PEBs were reviewed, analyzed, and periodic samples taken. With the help of the Concepts Analysis Agency, we now have greater consistency in Physical Evaluation Board review process.

Manning the Warrior Transition Units is only second to manning those units preparing to deploy. Warrior Transition Units are filled with multicomponent soldiers to meet the needs of our total force. Human Resources Command, in conjunction with senior commanders, continue to fill these billets very quickly as the mission dictates, but not quickly enough, I will admit.

Senior commanders, as part of the triad of leadership, are critical to this effort. They are currently assigning qualified—and I emphasize "qualified"—permanent party cadre to meet mission needs while we focus on providing them backfills in the support.

We are changing our permanent change of station reporting timelines for our WTUs to better meet the intent of keeping soldiers who are fit for duty quickly to their next assignment. This change is eliminating the delay and backlog of soldiers remaining

in the Warrior Transition Units at many installations and so, very soon, all installations.

The orders process has also been streamlined further by reducing and redirecting communications between the Human Resources Command directly with the respective Warrior Transition Unit. Previously, soldier notifications were passing through multiple layers of command in order to be executed. No more.

In closing, Army dedication to our wounded warriors is unwavering—unwavering—and we are committed to continually seeking improvements in all aspects of wounded warrior care. We know we have come a long way, and we also know that we still have a long way to go. But we will not falter.

Thank you for holding this hearing and thank you for your continued support, both of the United States Army, our wounded warriors, and families that we are all honored to serve.

I look forward to your questions.

[The joint prepared statement of General Rochelle, General Wilson, General Rubenstein, and General Cheek can be found in the Appendix on page 51.]

Mrs. DAVIS. Thank you. Thank you, General.

General Wilson.

STATEMENT OF LT. GEN. ROBERT WILSON, USA, ASSISTANT CHIEF OF STAFF FOR INSTALLATION MANAGEMENT AND COMMANDER, U.S. ARMY INSTALLATION MANAGEMENT COMMAND

General WILSON. Madam Chair, Congressman McHugh, distinguished members of the subcommittee. Thank you for the opportunity to discuss the Army Medical Action Plan and Installation Management Command's recent initiatives on Warrior in Transition units. We, alongside the Surgeon General and the Army G–1, are working hard to provide Warriors in Transition and their families the care and support they need in an environment most conducive to their healing process.

I would like to highlight our transformed system of care and support. Additionally, I will present what we have done and what we are doing in facilities support.

The Army has revised its support structure for the wounded. Warrior Transition Units, or WTUs, have replaced legacy Medical Holdover Units and Medical Retention Processing Units with a robust command and control structure, administrative support, and managed care.

We currently have 35 Warrior Transition Units in modified existing facilities, consisting of barracks, soldier family assistance centers, and headquarters buildings. The needs of the Warriors in Transition and quality of the facilities are our primary considerations. We are building new 88 compliant facilities and locating them as close as possible to our medical treatment facilities to promote the healing process.

Congress has supported Warriors in Transition by passing the fiscal year 2008 supplemental, which includes WTU projects at seven locations, valued at $138 million, as highlighted in our written statement and for the record. The Army is working with the

Office of the Secretary of Defense to build complexes to meet WTU requirements in fiscal year 2009 and beyond.

Our support plan includes new construction to build a permanent mix of Americans with Disabilities Act (ADA)-compliant one-plus-one barracks and apartment-style facilities to best provide for our Warriors in Transition. Military construction for Warriors in Transition complexes are based on projected Army requirements and locations of the Army medical treatment facilities. This footprint considers the projected growths of our WTU populations, our Base Realignment and Closure (BRAC) realignments, and the Grow the Army initiatives.

Our Warriors in Transition consist of a 50–50 active duty or active component and Reserve component soldiers. A dramatic increase in wounded ill and injured soldiers continues to challenge us in providing timely and adequate facilities for those deserving soldiers and their families. We are confident that our efforts will have a significant and lasting positive impact on the way we care for our soldiers.

Warrior care is our highest priority, second only to the global war on terror. Our policy is to house Warriors in Transition in the best available facilities the Army can provide.

While we have made significant progress over the last year, we realize that we have much work to do to ensure the Warriors in Transition receive the world-class care and support they deserve. Support of Congress is critical and appreciated. The Installation Management Command pledges in uniting efforts to those challenges and to ensure the success of this critical program. Our soldiers and their families deserve nothing less.

Thank you very much.

[The joint prepared statement of General Wilson, General Rochelle, General Rubenstein, and General Cheek can be found in the Appendix on page 51.]

Mrs. DAVIS. Thank you.

General Rubenstein.

STATEMENT OF MAJ. GEN. DAVID RUBENSTEIN, USA, DEPUTY SURGEON GENERAL OF THE UNITED STATES ARMY

General RUBENSTEIN. Madam Chair, Representative McHugh, distinguished members of the subcommittee, I am Major General David Rubenstein, Deputy Surgeon General for the Army; and on behalf of Lieutenant General Schoomaker, I want to thank you for hosting this meeting today.

I am also very honored to represent the tens of thousands of dedicated men and women who provide health care, support, and supervision to our wounded, injured, and ill soldiers, our warriors, and their family members. In this regard, we have no higher priority, except for putting boots on the ground itself in Iraq and Afghanistan, and today we have 9,000 pair of medical boots on the ground in those two theaters of war.

This morning, there was an article in *USA Today* which I think is a bit of a success story. In this article, the author talks about the fact that soldiers can wait 2 to 12 months to be transitioned out of a Warrior Transition Unit. I think that is a good news story. We are giving our warriors the time they need to heal—the time

they need to heal and return as productive citizens of their community and the time they need to heal to return as productive soldiers to their units.

We have soldiers in Iraq fighting the war on a prosthetic leg because we gave them the time they needed to heal. We have soldiers jumping out of airplanes on a prosthetic leg because we gave them the time they needed to heal.

We have a soldier in graduate school today. When he finishes, he will go to West Point in uniform as an active duty instructor to new cadets. He is blind as a result of injuries in Iraq. He is in graduate school because we gave him the time he needs to heal.

Someone said we are a step slow. I have no argument with that complaint. Some say that we are not keeping up with the explosive growth of the population in our WTUs. I have no argument with that as well. We are doing phenomenal work at a very, very difficult mission, which is to keep pace with the growth of our WTUs, to ensure that we have trained and qualified cadre, to ensure that we have trained and qualified health care providers to provide the very best in health care, support, and supervision.

It is not unlike a story that I will share with you related to my deployment to Bosnia. When I left to go to Bosnia, I left behind a wife and two school-aged kids. The seven months that I was gone saw our son grow seven inches in those seven months. No matter how hard my wife tried, the shoes were always one size too small and the pants were always one size too short. But she never gave up.

I believe in my heart that you know that we will not give up. We are working diligently at executing an outstanding Army Medical Action Plan, but there are challenges in its execution, and I am very excited to spend some time today talking about our responses to those shortfalls and our responses to improving a system that is so good at supporting our warriors.

Thank you very much. And thank you all for your openness. I acknowledge, ma'am, that your staffers have been very open with all their findings, sharing them with myself, with General Cheek, with our staff, and our Surgeon General; and that has helped us between our committee testimonies to continue to work on the findings that you have and the findings that we ourselves come up with.

Thank you very much.

[The joint prepared statement of General Rubenstein, General Rochelle, General Wilson, and General Cheek can be found in the Appendix on page 51.]

Mrs. DAVIS. Thank you. We appreciate your support on our trip to Fort Drum as well.

General Cheek.

STATEMENT OF BRIG. GEN. GARY CHEEK, USA, ASSISTANT SURGEON GENERAL FOR WARRIOR CARE AND TRANSITION, AND DIRECTOR, WARRIOR CARE AND TRANSITION OFFICE, OFFICE OF THE CHIEF OF STAFF OF THE ARMY

General CHEEK. Madam Chair, Representative McHugh, and distinguished members of the committee, thank you for the opportunity to speak with you today about our Warrior Transition Units

and the care that we provide to our wounded, ill, and injured soldiers and their families. I would also like to thank Congress for the leadership and support you provide to the Army in the development and execution of this program.

After brigade command in Afghanistan, and then service on both the Joint and Army staffs, my selection as the Director for Warrior Care and Transition truly caught me by surprise. But I quickly told my assignment officer it would be my honor to do that job. And here's why.

Every senior leader in the Army has some kind of direct and personal experience with our wounded, ill, and injured soldiers and their families. Mine is personified in Lieutenant Colonel Greg Gadson, his wife Kim, and their children Gabriella and Jaelen. You know Greg Gadson as the wounded soldier who inspired the New York Giants to win the Super Bowl, but I know him from our service in combat together—a magnificent leader, trusted confidante, and a loyal friend. He and his family motivate me to do all I can for our wounded, ill, and injured soldiers, all volunteers to our Nation in a time of war.

When I assumed my duties from Brigadier General Mike Tucker on the 1st of May, he made it clear that this effort was a work in progress. But from my vantage point, the accomplishments of the Army and the leadership of Mike Tucker were remarkable. In contrast to what the Army had in place in February of 2007, not just Walter Reed, but across the Army, we made enormous progress: superb facilities, traditional military structure, dedicated cadre and medical care providers, centralized family assistance and appropriate prioritization, all underpinned by a deep care for the well-being of our soldiers and their families.

Now, certainly this program has been imperfect and execution uneven, but I believe we are well on our way to institutionalizing this as an enduring Army mission. We will continue to refine and improve the program, and to that end these are my marching orders as we move ahead:

First is to understand the dramatic growth in Warrior Transition Unit population and become proactive in meeting future demands.

Next, empower commanders with more options for managing our wounded, ill, and injured soldiers; refine our entry and exit criteria to better focus the Warrior Transition Units on those who truly require complex managed care; and then address the current issues that limit us from optimal performance and soldier satisfaction, such as maintaining our cadre strength, managing high-risk soldiers, streamlining our evaluation boards and also our assignment processes.

Again, let me say thank you for your leadership and support to this extremely important Army program. When I tell you I am committed to its enduring success, it is because of soldiers like Greg Gadson. During my promotion to General Officer, he stood on his prosthetic legs and administered my oath of office—a personal reminder to me to make this program the best in the world. And I am greatly honored to be a part of it.

Thank you.

[The joint prepared statement of General Cheek, General Rochelle, General Wilson, and General Rubenstein can be found in the Appendix on page 51.]

Mrs. DAVIS. Thank you.

Thank you very much to all of you.

Mrs. DAVIS. Perhaps we will start with resources and why it has been very difficult to properly resource the Warrior Transition Units. I wonder if you can take us through some of the bureaucratic constraints and how that has borne itself out not just among the military population, but also in recruiting civilians to be part of this effort.

Could you help us out with that?

Part of our purpose here obviously is to understand it and see is there a way we can help. Is there something that can be done that will really make it much easier to go through what sometimes is a very painful process of releasing people from one duty or another? Where have the problems been? What have you done since the spring to correct some of the issues that have come to light that perhaps were not anticipated to the extent that they were?

General ROCHELLE. Allow me to start if I may, Madam Chair.

First of all, because I think the most significant resource that concerns the subcommittee is people—and make no mistake about it, the Army is stretched; our chief has testified to that, the Secretary of the Army has also testified to the fact that we are stretched—that said, I want to reiterate that this is the number one priority for people resources right behind the war on terror and resourcing our deployers. We must field units fully manned, best equipped, and best led. That goes without amplification.

Your question is on the bureaucracy, primarily, the bureaucracy that we, one—I will state, we, first of all, a bit overwhelmed ourselves with the execution order—healing warriors. We overwhelmed ourselves. Having revisited the prior hearings on this subject, the four prior hearings on this subject, it is clear to me that this committee perhaps foresaw that a little better than we anticipated it.

But our heart was in the right place and remains in the right place, providing the very best care for our wounded warriors, those who have borne the battle.

But to the bureaucracy, we didn't anticipate that at the lowest level, the installation level, the execution order would be interpreted by the personnel clerk at Fort X and Fort Y as being no different than an order to reassign a soldier who is leaving a unit that is simply not deploying or a unit that is training at home station.

In other words, typically an order will be issued, assignment instructions will be issued, and the administrative individuals at a lower installation level would look at 90 days—30 days for leave, 90 days to prepare to transition that soldier out. We didn't anticipate that. That wasn't the intent. When it was discovered, we jumped on it.

To the larger issue, the only way to adequately resource a flexibly growing organization—and that is what our Warrior Transition Units are—we knew that going in is at the local level first. That was articulated, first, in April of 2008 by General Cody; it has been rearticulated in Fragmentary Order No. 3, and I think we will—

in fact, I am confident we will see a lot better execution at the lowest level and at the highest level.

Mrs. DAVIS. You mentioned the 90 days. How has that been shortened?

General ROCHELLE. Several ways.

First of all, very clear standards. Five days from the point at which an individual is identified to Human Resources Command as Return to Duty—healthy, fit, returnable to duty; 5 days for Human Resources Command to publish the order, 5 additional days—excuse me, not publish the order; issue the request for assignment and the request for orders, the orders are cut at the local installation level—5 additional days for that to occur; and then 60 days for an individual who is leaving the installation for the report date.

So 60 days from the date the order is cut, if you are leaving the installation, going to another installation, that is the report date. If you are staying on the installation, it is 10 days.

Mrs. DAVIS. Can we look to some figures as of June and beyond that demonstrate that that has changed significantly?

General ROCHELLE. It is too early, Madam Chairman, but it will not be too early by the 1st of October. I welcome the opportunity to share that data with you, yes.

I was going to mention something about the data we are keeping now, but it is irrelevant.

It is too early now, but by the 1st of October we will have a mountain of data that we will be happy to share with the committee.

Mrs. DAVIS. Thank you, General.

Perhaps later in the discussion we will talk a little bit about outreach to civilians also, who might be very, very helpful in welcoming this opportunity to serve in this way.

Mr. McHugh.

Mr. MCHUGH. Thank you, Madam Chair. To repeat myself, I said during my opening remarks that I found no reason to question anyone's motivation here. Certainly, at the installation level these people are working as hard as they possibly can, oftentimes outside areas of training and expertise to do what they feel is necessary.

That having been said, in many ways this challenge isn't being met, and I find the current circumstances unacceptable. Do you gentlemen agree with that? Anybody disagree with that?

So what I think frustrates us, what frustrates me, as we talk about the challenges, we talk about the shortfalls we have repeatedly heard is that while we have taken care of that problem, installation managers or installation commanders have been given the authority to take whatever personnel they need. We have done this.

The next thing, while that sounds good, there still seems to be a disconnect between what is being told as to the resolution and what is being experienced on the ground. Let's just use the growth as an example.

You did have huge, huge growth. From June of 2007, this program had 6,000 in the population in the various WTUs. By June of this year, a year later, it had doubled to 12,000; and it is projected by spring or late winter of next year to grow to another 20,000. The original program in the implementation initiative was

intended to have a 90-day review period by which this growth could be projected and thereby accommodated. Yet, for whatever reason, that hasn't worked.

What I am trying to understand is why have we not been able to catch up to this growth in terms of the personnel? Is it that the 90-day review period, the 90-day look, didn't occur; or that it did occur and we do see the growth, we just can't keep up with it? Where is the shortfall here? Is it an inability for the model to accurately project where these new warriors are going to come from and in what numbers, or is it an inability to react, to find the personnel to put on to reach our required ratios?

General RUBENSTEIN. I will start off, if I may, and pass off as required.

We have thousands, literally thousands of civilian open hiring actions that are on the books with valid job descriptions that we have put out, looking for hires, looking for civilians to step up and take those jobs. We have filled thousands as well. Some align toward the WTUs, others aligned to the other parts of the medical, surgical, and health care mission. So it is not a matter of not putting the actions out there and looking for civilian hires.

We have also transferred a huge number of military to this mission, both in the health care arena, which is my area, and in the more generic cadre—squad leaders, platoon leaders, and the like.

Mr. MCHUGH. I want to interrupt to ask a question there because what we have heard as we talk about the civilian hire process is that it is structured currently in a way that is very frustrating to those at the WTUs. By that I mean, they are certainly recruited at low Grade Scale (GS) levels. The level may not be where it should be to be competitive in the civilian sector to bring in those folks you are trying to hire; and even when you get them, because the GS is so low, they, within a year or so, go under a higher GS and you lose them all over again.

Have you experienced that, maybe plussing up and hiring at a higher GS level?

General RUBENSTEIN. Actually, we have gotten rid of the GS system altogether.

Mr. MCHUGH. I am archaic. But you understand what I am saying?

General RUBENSTEIN. We have the flexibility to offer pay within a band. We are very competitive. In fact, in some communities we are too competitive for the higher actions that we are applying.

Mr. MCHUGH. Why are you not able to hire these individuals if you are competitive? Because what you just told me is you are not getting them.

General RUBENSTEIN. We are offering recruiting bonuses, we are offering relocation bonuses. We are going overboard to make this financially lucrative, certainly not to be paying less than the local community. One thing that this committee can do is help us with the direct hire authority. This is a year-to-year program.

I was mowing the yard in Augusta, Georgia, as Deputy Commander of the Medical Center, and a new family had moved in next door. The wife was a nurse. I asked her, as we were talking, asked her to come apply for Eisenhower Medical Center. I talked to her a couple of months later, said, I haven't seen you around the hos-

pital. She said, I didn't get a job. They didn't hire me fast enough, and I needed a job and I couldn't wait for that system to make it through.

The direct hire authority allows us to hire very quickly, but it is a year-to-year program. And we can certainly use that as a permanent benefit, permanent right for us to go out and hire.

To the question of pay, I do not believe that we are paying less than the civilian sector, and in some communities we are paying more and we are taking from the civilian sector.

Mr. MCHUGH. I am not here to argue with you, but I am telling you that is not what we have been told. We have been told by folks who really ought to be in a position to know that that is a challenge, and the hiring bands that have been assigned to these hires, in fact, encourage folks to leave at a rather short order.

General RUBENSTEIN. We can't compete with a community that offers a nurse 40 hours of pay for two 12-hour shifts at a downtown emergency room.

Mr. MCHUGH. You told me you were overly competitive, General.

General RUBENSTEIN. I can't compete with that kind of offer.

But a medical surge nurse, the staff we are looking to staff our WTUs, I don't believe we are paying less than the local community.

Now, nurses are a shortage across our country, and in some communities, as we are competing against health care systems that are out there in a for-profit motive, we do have difficulty. I don't deny that.

General ROCHELLE. Allow me, if I may, sir, to amplify.

Two points: You asked a question about agility. I will tell you that heretofore we anticipated that our system was a bit more agile in responding to the changes in structure requirements at installation by installation by installation than it really has been.

In my comment I mentioned—in my earlier comment, I mentioned that the only way to respond to that is the way that that Fragmentary Order No. 3 calls us to respond to it, locally first and then we backfill from the higher level. If I may, to the civilian personnel issue. I want to amplify the fact, having spent a little bit of time trying to recruit nurses and testifying before this committee in that capacity, that it is a national crisis. I have said that before. When you see governors, if you will, poaching across State lines to hire nurses from a neighboring State because we simply can't grow enough and our Nation isn't growing enough, that becomes problematic.

The Army is seriously exploring ways in which we can grow our own. I am speaking of a United States Army Nursing School as an example.

Mr. MCHUGH. I certainly, Madam Chair, will yield back in a second.

I understand the nursing shortage. There is a challenge on these ratios that extend beyond nursing, however.

General Rubenstein, I don't mean to engage you in a debate per se, but my frustration here is what kind of things do we need as a Congress and do you need as a command structure to do to meet that ongoing challenge? That really is the point. What some of the installation folks are telling us is that the hiring levels—and they didn't mention specifically, I did not just mention, I should say,

nurses, but listed it in a broader array. But what can we do to try to fix that?

I want to come back when we can, Madam Chair. I mean, the disconnect between some of the fragmentary orders and such is frustrating as well. On semipermanent buildings, for example, there is a $750,000 cap on the bidding of those, and supposedly you have got a frag order that has listed that that has never been implemented. In the meantime, installations are still trying to deal with that $750,000 cap. When it is recognized it is a problem, the implementation or the waiver has been issued, but it has never been exercised.

So we have got some problems there.

Mrs. DAVIS. Thank you.

I think there does seem to be some confusion because a number of individuals that are very engaged in the system and on the ground working with it, I didn't get the sense that they saw that the GS system was no longer something that was at play here, and that you had some of the options that you have. Maybe we need to really understand that better.

We will come back to that, General. Thank you very much.

Mrs. Boyda.

Mrs. BOYDA. Thank you, Madam Chairwoman, for calling this. It is something that we obviously hear about a great deal.

I have the opportunity to represent Fort Riley and Fort Leavenworth. Of course, Fort Riley is where we have the WTU. I applaud. And I tell people when they ask a lot about Walter Reed, how are things going? For several months I said, "Wow, I think we have really got a handle on this," and we are out there working on behalf of these wounded soldiers. People were very happy to hear that.

At this point, I would say that I hear from constituents or just different people from time to time about a problem every now and then, and then you get to a point where you recognize that there is a problem and something has to be done.

I would, with all due respect, again say that there seems to me to be a disconnect, and I don't doubt at all your commitment and what is in your heart to do this, but I would offer that there seems to be a real disconnect about what is going on and perhaps your vision of what is going on and what is happening on the ground. There seems to be more of a disconnect than I am comfortable with.

I think—hopefully, we would like to make sure that that is connected, that that reality is connected, and we start doing some things about what is going on.

I think we are going to have time for a couple of rounds. In the interest of time, I have several questions.

But when just the whole thing about we were going from 6,000 to 12,000, now it is projected to 20,000—if you could answer the questions possibly as quickly as you can—but did we anticipate that? What happened with that?

I know the whole 90-day thing just was a good idea, but it didn't really come to pass the way we wanted. But how did we go from 6 to 12, and where did that happen?

General CHEEK. Ma'am, I am probably the best one to answer that.

One of the key reasons we saw such a dramatic growth in our Warrior Transition Units is, we put out a directive for our units to move soldiers that were in their Medical Evaluation Board process into WTUs, or at least allowed deploying commanders to do that. That, of course, had some benefit to them in helping them.

Mrs. BOYDA. Wasn't that originally—did we project that doubling then? It was my understanding that that was what we had projected to do in the first place.

General CHEEK. We did project growth, and in fact what we built our original structure for was about 8,000 growth in February of this year, which turned out to be pretty accurate.

But it continued to grow, which we also forecasted. As we have said, we just were not agile enough to respond to that.

As we look back on that, one of the things that we recognize was that we had not sufficiently empowered our commanders and that triad of leadership on the installations with enough options on how they could best manage this population. So our recent fragmentary order really gives them more discretion and some options in terms of who they bring into the Warrior Transition Units, as well as some opportunities for soldiers who may be just almost completing their care and ready to return to duty, to allow them to go back to their unit.

So we are trying to give more options to the commanders to manage that population better and then also some greater latitude for them in terms of assigning cadre members. We have made a lot of progress.

Some of the things we used like borrowed military manpower had a lot of second-order effects for special duty pay and other things that just did not work out well for us. So we have learned a lot of lessons over the past six months.

As we look forward from here, we are going to build a structure which we will not require a formal structure to build cadre. We are going to build cadre based on the size of the population. So that is what we are going for. We will build structure for 16,000 by January; and for 12,000, we will have the official structure built with our new ratios that were developed by our manpower agencies. So we have a lot of changes.

Mrs. BOYDA. One of the things I have heard about is administrative levels are coming in at the GS–4 and –5, and it is just unacceptable to ask anybody to try to do that sort of thing. So at these administrative levels are nurses and some of the—more medical providers; but I think, again, from what we are hearing, there is a real disconnect on just keeping people on the ground who keep these things going. They are coming in at GS–5, they are temporary; there are all kinds of problems associated with it. We need to know what we need to do to get that to be something that is just going to work a whole lot better.

One of the things that our staff has heard about—this is not a personal experience of mine—for warriors that are in transition that now have gone through, they are ready to serve, they want to go back into the cadre of the WTU, they are ready to do that, and they are told—let me get the exact words—Human Resources Com-

mand said that the Warrior Transition Unit was, "over strength" according to their personnel authorization document. That was the number one reason for not being able to go right back into a place where they could help the fastest.

Again, I am assuming we are going to be taking care of that.

General CHEEK. Yes, ma'am. We have changed that. So we will allow those soldiers to stay, and the commanders will have some discretion to move them into cadre.

Mrs. BOYDA. I would be happy to yield until my next round of questions. Thank you very much.

Mrs. DAVIS. Thank you.

Mr. Jones.

Mr. JONES. Madam Chair, thank you very much.

I sit here really in great appreciation, truthfully, for the task that you have been assigned. And I know that with anything, when you have numbers, it is just very difficult to put it together, especially when we have these absolutely wonderful young men and women who have served this Nation, and even as they recover from their wounds, they still want to give. They are God's gift, quite frankly. They are very special.

I am not going to be—I guess what I wanted to bring forward, knowing that you are in the process of trying to make this program an efficient, a beneficial program that would be in place, something that has bothered me for the last four or five years—and I am like anybody on this committee, I go to Walter Reed, I go to Bethesda, and I see those who are the severely wounded; they will not go back to any unit, their life is—from the standpoint of serving this Nation in uniform, is over.

What kind of program—General Rubenstein, I guess maybe I should ask you, or General Cheek, what type of program is the Army working on to have a continued contact, if you will, with that traumatic brain injury soldier, or Post-Traumatic Stress Disorder (PTSD), once they get past this part of their service and they are in the process of leaving the military? Are you developing a program so that when all of us are retired and the people that replace you, that replace us, will know where that soldier is in 10, 15 years?

General CHEEK. Sir, this program really belongs to General Rochelle. But we have our Army Wounded Warrior Program, which is designed for our most severely wounded and injured. For each of those soldiers, we maintain a case manager, if you will, who maintains contact with that soldier and his family to help them with any problems that they have.

I don't know, General Rochelle, if you want to add any more.

General ROCHELLE. I would be happy to.

The program we are discussing is the Army Wounded Warrior Program, and it is designed, and was designed in 2004, for our most severely wounded to ensure that we were giving them the special treatment, the special focused care.

Quite frankly, I would tell the committee that it is the precursor to the Wounded Warrior—excuse me, the precursor to the Warrior Transition Unit. It was built on that model, and it is a commitment for life for those severely wounded soldiers.

The second thing and final thing I would like to add is that for directed care, every single one of those soldiers, over 3,000 today, has—every single one has a case manager who is assigned to him or her that follows them throughout their recovery, follows them throughout their lifetime for any need whatsoever they may have.

The last point is, twice in the last two years we have hosted symposiums for our wounded warriors, inviting them to come back at the Army's expense; and there have been individuals who have come who could not represent themselves. They were physically present but they were represented by their loved ones.

We go through four days. This recently happened in June, four days in Indianapolis; I might add, four days of taking their issues and then bringing those issues back inside the Army to incorporate them into the overall family action plan that Lieutenant General Wilson oversees on behalf of the Vice Chief of Staff.

So I wish to assure the committee that the Army wounded warriors, our most severely wounded, and who deserve, rightfully so, our lifetime of commitment, are in fact receiving it.

General RUBENSTEIN. I would also like to point out, in addition to the Army Wounded Warrior Program, the Office of the Surgeon General has placed a colonel into the office of Dr. Jim Peake, the Secretary of Veterans Affairs; and he likewise has put an equal-rank civilian into the Office of the Surgeon General (OTSG) so we can go further down the road of building bridges and connections between the Department of Veterans Affairs (DVA) and the health services of the DVA and the Army to supplemental the Army Wounded Warrior Program (AW2) that General Rochelle has just described.

Mr. JONES. Thank you, Madam Chair.

Mrs. DAVIS. Thank you.

Ms. Tsongas.

Ms. TSONGAS. I want to thank you for holding this important hearing and for all the hard work you have done as we have become so aware of the great challenges this presents. We are hearing the questions and challenges we have about projecting the need that you might have to address and provide for, and we all know, and certainly in your testimony we have heard, how difficult that is.

But as we face a situation in which potentially, one, we will have a large influx into the system as the surge soldiers come home, if we do eventually engage in a timetable for the redeployment of our soldiers, so again you will be bringing back larger numbers at once—and particularly where the issue is PTSD, where you might not have to really deal with it until the soldiers do come home—can you envision what you would do in a situation where you simply become overwhelmed by the demand?

Do you look to other sources for help? How do you plan for that so that as you anticipate it you know what you are going to do, whether it is from within the service or looking outside?

I ask that to anyone of you who wants to answer.

General RUBENSTEIN. I will start the answer on that.

To the extent that we can, we certainly want to keep our wounded warriors—in the example you have given, the psychologically wounded warriors, as well as our physically wounded warriors—

but keep them in our system to put our arms around them and provide care.

We are doing a very good job at keeping as many as possible. We do occasionally send our warriors down to community health care providers and bring them back where we can provide all of the care or the specific piece of care in our facilities.

Where we can't and where we may not be able to meet the needs if the numbers are overwhelming, we fall to our civilian network providers, our partners in the TRICARE contracts with our three partners—South, East, and North—and use them to supplemental the care that we cannot provide.

Ms. TSONGAS. And is this a plan you have in place, or is it reacting to any given moment?

General RUBENSTEIN. It is in execution as we speak today.

In October at Fort Hood we sent about 350 of our warriors downtown—Killeen, Harker Heights, Copperas Cove—to receive health care. Those same soldiers, 6 months later in April of this year, had 1,900 separate appointments downtown. So we already use the system that is in place.

General ROCHELLE. May I add, Madam Tsongas, the two things you hinted at in your question was being proactive in looking at both the deployment of individual elements of Army units, brigades, and support elements and being proactive for those that are redeploying as well. That, we have come to learn, is one of our misconnects, disconnects at the senior levels of the Army, and we are going to do better at that.

We already have a very reliable, very reliable metric that proves itself time and again as the number of soldiers that are being sent to the Warrior Transition Unit prior to a brigade deploy. Our effort under Fragmentary Order (FRAGO) 3 is to implement that and get in front of it.

What I will add, though, is that we are seeing such a disparate statistical behavior pattern for redeploying brigades that we are still trying to arrive at a reliable one standard or two standard deviation, if you will, prediction for redeploying brigades. We are not quite there yet. The number is too erratic—the history is too erratic, excuse me. But that is our effort, that is our commitment.

Ms. TSONGAS. It seems to be an important one, because a lot of this problem has come about for failure to anticipate and really think long term and understand what the alternatives would be, sort of the worst case, start to realize it.

General CHEEK. And, ma'am, we are doing that; we are taking the redeploying brigades. We know, for example, at Fort Campbell between November and January that they will have four brigades and another brigade deploying. So we can see already a need to plus up their cadre and prepare potentially, as you mentioned, for increased mental health issues from those redeploying units. So we are moving in that direction.

Mrs. DAVIS. Dr. Snyder.

Dr. SNYDER. Thank you, Madam Chair. And I want to thank you Mrs. Davis and Mr. McHugh for not just this hearing, because this issue is one that you all have had an interest in for some time, and I think it is in the best spirit of congressional oversight that this hearing be conducted. And I also want to acknowledge—perhaps

you did during your earlier statements—the work that Dave Kildee and Jeanette James, our staff, have done. They really have put a lot of time in, and I think it has been helpful to you all and it has certainly been helpful to us.

I also appreciate the four of you. It is never fun to come before this committee having to acknowledge that there are problems. I would say it is actually less fun to come before this committee when everyone knows there are problems but you, and you can't acknowledge it. So I think you are ahead of the game here today by acknowledging that you have work to do; and I appreciate it.

I need a tutorial here, because I don't understand. We have the Wounded Warriors program, to which Mr. Jones referred, of about 3,000 personnel, correct? And that is not a group that we are discussing today. Is that a fair statement? What we are talking about is a separate program, the Warriors in Transition program, which we think is probably 12,300, or somewhere in that range.

Of those 12,300, General Cheek, maybe you are the person to sort this out for me the best, and we can either take it in totality, or we can take it as a hypothetical, Fort Somewhere, and take 500 or something.

How many of those are Iraq or Afghan War veterans?

General CHEEK. Sir, I think about 70 percent of our population has been deployed to Iraq or Afghan.

Dr. SNYDER. Seventy percent of the population?

General CHEEK. Yes, sir. And then probably about half the population are actually in the Warrior Transition Units for some deployment-related condition.

And as we continue to back off of that, about one-third were evacuated from theater, and currently about 12 or 13 percent were what we would call "wounded in action" in terms of a Purple Heart recipient. So that is sort of how that population breaks out.

Dr. SNYDER. You made mention that you have—one of the units is—about 300 are considered in a waiting list; is that correct? Is that your testimony?

General CHEEK. Well, I know, sir, when your staff visited Fort Hood, they were told there was a list of soldiers waiting to enter the WTU.

Dr. SNYDER. I don't understand that. What does it mean to be on a waiting list? This seems to be contrary to the whole point of this.

The whole point was to create a program which would say from day one you will have somebody on top of your problems, not to say, By the way, you are number 273; it takes about 6 weeks to get there before we will even begin to get started on your problem.

What does this concept of a waiting list come out to be in a Warrior Transition Unit?

General CHEEK. Sir, I probably owe you a better answer, but let me give you my best understanding of that.

When we gave guidance to commanders to be able to move their Medical Evaluation Board soldiers to the WTUs, I think that is principally where these waiting lists come from. So these are soldiers that have a permanent profile that needs completion of an evaluation to determine fitness to remain in the Army or not. In the past, we left those soldiers in their unit and they didn't go to

the Warrior Transition Unit. So I think that is principally where that list lies.

If you take a soldier, just as an example, who is very seriously injured, we are going to put him in the Warrior Transition Unit. He is not going to be left on a waiting list.

General RUBENSTEIN. Sir, to put a face on that example.

I don't know, and I don't know that we have been able to duplicate this 311, as an example, but a soldier who is lifting weights and blows out his shoulder and needs to be evaluated, whether he is going to be able to stay in the Army or not, and his unit commander says, I want to nominate this soldier to go to the WTU; that is the kind of soldier—if there is a soldier who has not come over, that is the kind of soldier who has not come over, not a soldier who has been wounded in combat and needs the services and the support structure that is available in a WTU—if that makes any sense.

Dr. SNYDER. It does. And it gets to part of what I want to talk about.

I think the original concept of this was that perhaps we would not try to differentiate between those that got, severely, a gunshot wound in a training accident in Kansas versus hurt overseas; that we would say they have got medical problems that need to be dealt with.

But when it gets so inclusive that we are now having problems keeping up, I want to hear you, General Cheek, talk about what are the categories of these 12,000-plus that we have now? You referred to some as being high risk.

General CHEEK. Yes, sir.

Dr. SNYDER. What are the other categories that you have delineated amongst those 12,000-plus people?

General CHEEK. We can categorize them in any number of ways. I think what I would point out is——

Dr. SNYDER. Are you saying that these are not formal categories? I had the impression that somewhere there is a list of, we have this number of people that we now label as high risk, and I could hit a computer button and pull up that list and see how they are doing.

Is this or is this not a formal classification?

General CHEEK. The high risk, yes, sir.

The waiting list that is——

Dr. SNYDER. That is the more formal. I moved on from that. But the way you see it—so you have some that are designated as high risk and you assign them additional resources. Of those others, are there other distinctions between them?

General CHEEK. I don't know that I know enough to give you the answer on the other categories. But for the high risk, yes, we have a very formal process for every single soldier in the Warrior Transition Units where his leadership, his squad leader, and his medical managers all take a look at this entire soldier—not just his medical condition, but his personal life and other issues that he may have—and they will make an assessment based on all of those factors. And these were formalized in a directive to the field that was put out in February of this year. So we will go through that and then we will rate that soldier as high risk.

Every one of those soldiers is an individual, and all of them are high risk for a unique reason. And so the strategy for coping with that is unique as well. Some might be assigned a buddy. Some might be limited in terms of how much liberty they have to go from place to place. Some might have increased contact with a squad leader, or additional counseling, for example, if it is a problem with their family life, et cetera. So all of this is very personalized.

One of the great features of this—and this, as usual, was an outgrowth of what we had at Fort Knox when we had a suicide there or an accidental death by taking too much medication—we completely relooked our policies. And even while we have had a doubling in the size of our Warrior Transition Unit population, we have actually cut in half the number of suicides and accidental deaths.

So we have had some good success with this program, even though 311 at one installation will sound like a large number, but it is actually helping us take care of these soldiers.

Dr. SNYDER. Thank you, Madam Chair.

Mrs. DAVIS. Thank you, Dr. Snyder.

I think we would certainly all agree that anyone who isn't in a critical status absolutely needs to be there. But I am also a little confused on your response, because it seems like the people who have been already cleared to be part of the WTU are still on the waiting list. And is there kind of a disconnect between their unit, their commanders, and the needs of the WTU in terms of whether or not they actually can go? That they have the space for them?

Because it sounds like in many cases it is not a matter of space anymore, it is not a matter of individuals. Some of them, obviously, are way over capacity.

General RUBENSTEIN. To help answer the question and to address also a bit about the categorization, it is irrelevant to us if the patient was wounded by a gunshot wound in Iraq, by an improvised explosive device (IED) in Afghanistan, a car wreck in Lampasas, Texas, on the way to Fort Hood, or a parachute accident at Fort Bragg having never deployed in his or her life.

What is important to us is the complexity of care that that young man or woman requires to return to duty or to return to his or her community as a civilian. And so I am a little concerned about the concept of a waiting list.

Our focus is getting into the WTU those patients, those soldiers who have complex medical needs that require the supervision and the support that is not available in their units. And it is okay if a soldier who has a bad shoulder and is being boarded, that is a soldier who can be supervised by his unit; and if we need to get them into the WTU, we certainly will. But that is not necessarily a requirement for every soldier going through a boarded process.

Mrs. DAVIS. So there are some soldiers who aren't essentially cleared to even go into the WTU, because their problem can be dealt with locally?

General RUBENSTEIN. That is correct, ma'am, yes.

Mrs. DAVIS. I wanted to just go, General Cheek, to an issue you raised.

You said that borrowed military manpower did not work well. And I know that when our staffs visited, they came to the same

conclusion in talking and working with everyone. But I wonder how you reconcile that fact with General Rochelle's assertion that Warrior Transition Unit personnel shortages need to be handled locally.

What is the difference in practical terms from being borrowed versus local?

General CHEEK. Yes, ma'am.

When a soldier is borrowed for duties elsewhere, he is still assigned to that unit. The problem this created was, we have special duty pay for those noncommissioned officers that are squad leaders and platoon sergeants. By leaving them assigned to their old unit, by our own regulations—and actually it is not within the authority to pay them that special duty pay.

So what we have told our commanders is, stop using this technique for bolstering the cadre. Assign the soldier—and they can do that on the installation. Assign the soldier to that unit. That makes them fully eligible for that special duty pay once they have completed the training requirements.

And so in many ways there is not a big difference, but we want to have a more formal process and eliminate the use of borrowed military manpower because of the problems that it created.

Mrs. DAVIS. Is there a disconnect, though, here?

I think you are talking about trying to handle it locally; and yet, when we talk about other needs that the military has, we are nationwide. So how does that relate?

General ROCHELLE. Make no mistake about it, Madam Chair, it does stretch us, but there is not a disconnect. There is not a disconnect, either, in terms of our ability to pay the special duty assignment pay, which we have recently increased to $375 for squad leaders and platoon sergeants. And we managed to work with the Office of the Secretary of Defense, I am pleased to say, to find an adequate work-around that allows us to pay every soldier assigned or in a designated military overstrength position in support of our Warrior Transition Units. That is point number one.

Is there a disconnect? You are asking a much larger question. Will we be able to sustain this level of manning? We will sustain it, because the Army's leadership has said this is our number one priority immediately behind resourcing our deploying formations. We will sustain it.

Mrs. DAVIS. Is there any difficulty? This special duty pay, I think we were understanding that there was a lot of problem in whether it was processing the special duty pay. Is that the problem?

General ROCHELLE. Let me see if I can reiterate what General Cheek very correctly stated.

For an individual who is not assigned to a position, the position is one that is authorized special duty assignment pay. If you are in a borrowed military manpower, you are on loan from a unit, you are not occupying a position; you don't occupy the position. Therefore, a quirk in the system causes you not to be able to receive the special duty assignment pay.

Again, one of my extraordinary senior executive service leaders inside the G–1 worked this very, very hard, and recently, within the last week, we put a worldwide message out to the field that explained, we have solved this forever, and here's how to execute it.

Mrs. DAVIS. Can we check up on that one?

General ROCHELLE. Please do, ma'am.

Mrs. DAVIS. And you feel confident that that is the case as we move forward?

General ROCHELLE. I am very confident.

General CHEEK. There were two issues. One was the borrowed military manpower; the other one was the previous policy mandated experience levels that some of our cadre didn't have, and that is unique to this assignment.

For example, if you are a drill sergeant, that was not a requirement.

So both of those were removed, and I am confident we have got this right for the way ahead.

Mrs. DAVIS. Thank you. And I understand that the training for the cadre, especially if it was in an area that the person had not experienced before, is a relatively short period of training, but most of it is really learning on the job. Is that correct?

General CHEEK. There is an online course, a 40-hour course that they take. And then we are also setting up a course at Fort Sam Houston that will be a resident course. We are going to improve our current one. But that is the only requirement for training for the special duty pay, taking the online course.

Mrs. DAVIS. Maybe we will talk about that in another minute.

Mr. McHugh.

Mr. MCHUGH. It is good to hear that that has been fixed.

My understanding—I am just curious for my own clarification—are actually going to pay retroactively for some of those assignments that were caught where they didn't receive the special pay, because they were excluded either as General Rochelle explained or they were temporary?

General ROCHELLE. Let me answer that, sir, because my understanding right now is that we will have to assist those individuals who are occupying those positions legitimately, under competent authority, with applying to the board for correction of military records for that.

We do not have the authority retroactively to do it. If I had the authority, it would be done.

Mr. MCHUGH. But you will support that?

General ROCHELLE. We will absolutely support that.

Mr. MCHUGH. I do think that will be a big help.

General Cheek, you said that the issue of the manning documents in Human Resources Command (HRC)—and I believe it was to Ms. Tsongas—that you fixed that problem where you would have the installation commander making the assignment, and then having the manning document not validate that assignment.

I am assuming, and I just want to make sure that I am assuming correctly, the fix is the recent FRAGO 3; is that correct?

General CHEEK. Yes, sir. And we have done a couple of things. One of them, as General Rochelle mentioned, if our population exceeds structure, we will use directed military overstrength and assign cadre against that to keep our cadre commensurate with the population.

But we are also—we are going to do 90-day reviews. And in October, we are building the structure for a 12,000 population, and then we will follow that in January. We are simultaneously rebuilding

these for 16,000. So we are going to build structures so that we can assign from HRC to those positions, but we will always have the provision to use directed military overstrength if the population exceeds that structure.

Mr. MCHUGH. So, in essence, that FRAGO said under those circumstances the manning documents are irrelevant? Or don't apply? Let's use that phrase.

General CHEEK. Well, what it does, it directs commanders to make sure that their cadre stays at 100 percent in support of the population. That is what it says, sir.

General RUBENSTEIN. To use General Cody's words in a worldwide video teleconference (VTC) about a month ago: Assign to population; the paperwork will follow up.

Mr. MCHUGH. Well—and General Cody is a great American and a great soldier, but there was a lag, at best, or a total disconnect between what he said and what was implemented. That is why I think the specifics of this are pretty important.

General CHEEK. Yes, sir.

And just as an example, tomorrow we have a video teleconference with United States Army Forces Command (FORSCOM) and our major commanders; and they will go line by line, and we are going to review this. So one of the points that you have made about disconnects between our senior leaders in the Army and the echelons between, all the way down to the Warrior Transition Unit, I will accept we have had our challenges there.

But we are really working hard to get full ownership, from the Secretary and the Chief, all the way down to the squad leader; and this is one of our steps to do that.

Mr. MCHUGH. And I think that process tomorrow is an invaluable one because, frankly, we are still getting anecdotally that problem of manning documents being used as kind of a shortstop against where the intent lies. And that is to fill these billets and to meet the challenge, so that is certainly a step in the right direction.

Talk to me—and maybe it would be General Rochelle—but the capacity, the structure within this process to judge growth, it seems to me, is critical. General Cheek just mentioned the 90-day review process. The implementation documents for this program called for 90-day look-backs to try to ensure that we are projecting growth, we are accommodating current needs, et cetera, et cetera, and yet there were shortcomings.

Was it an inadequate evaluation process? Was that 90-day period not sufficient? Or was it, we knew all about it, but for various reasons, including some that General Rubenstein mentioned about hiring out of the civilian community that kept us from doing it? Do we have an adequate enough internal process by which we can ensure in the future that, A, we understand where the growth is coming—there was talk about Fort Campbell, for example—and, B, are we in a position to make sure, when that growth occurs, we have met the need?

General ROCHELLE. Yes, sir. That is precisely what I was attempting to explain to the question from Ms. Tsongas.

Mr. MCHUGH. Try again, and I will listen even more carefully.

General ROCHELLE. I will be happy to, sir, because it bears repeating.

The shortfall that we had was in linking the movement of assets, military and civilian, in advance of predictable increases into the Warrior Transition Unit. We had the understanding, but we were relying on a process that, as I mentioned in my earlier statement, simply wasn't nimble enough. We thought it was sufficiently nimble that we could place assets, either local—from the local commanders assets or from the departmental level to meet the growth.

Mr. MCHUGH. Was that lack of nimbleness in part what we just talked about with General Cheek and the manning document issues? Is that kind of lack of?

General ROCHELLE. I think it is, sir.

Mr. MCHUGH. That is fair.

General ROCHELLE. And for military and civilian, going forward, the committee will see a much better synergistic relationship between the Department, the Warrior Transition Unit, and the Warrior Transition Office to predict: What are the requirements going to be at Fort Campbell? How close can we come, using modeling and sampling techniques, to get at the influx upon redeployment?

And my goal is to position those assets before the soldiers arrive.

Mr. MCHUGH. So we are as nimble as we need be and as flexible as required now; is that correct?

General ROCHELLE. I am sorry?

Mr. MCHUGH. We are as nimble and as flexible as we need be now, going forward?

General ROCHELLE. I believe so. I truly believe FRAGO 3 gives us the capability. First of all, it empowers the commander locally, to repeat what General Cheek said. And try as we might, there still were, at the lowest levels, commanders who felt, for whatever reason, hamstrung by the letter of the Executive Order (ExOrd) or the letter of the FRAGO 1 or FRAGO 2.

But in point of fact, it was very clear that going back as far as April and even before April, that the Vice's intent was—and it was communicated quite clearly from me—fill it from the local assets, and we will backfill. FRAGO 3 empowers commanders now to be able to do that without any equivocation.

Mr. MCHUGH. From your lips to God's ears. All right.

Madam Chair, I see my time has expired again. Thank you.

Mrs. DAVIS. Mrs. Boyda.

Mrs. BOYDA. Help me understand when FRAGO 3—what was the timing? What is the timing on FRAGO 3?

General CHEEK. The 1st of July, right before Fourth of July weekend, the 2nd of July when we issued that fragmentary order.

Mrs. BOYDA. Thank you.

When we had the pleasure, the honor of going with Mr. McHugh to Fort Drum, one of the things that we heard consistently was, I am just sitting here waiting for my MEB. Again, there was one person—and I don't remember her name, but it was one doctor—and everybody was just sitting there waiting for this one person to sign their papers and get going. They had been there for months. Two of them had pregnant wives. The wives—of course, they thought that they were going to be back home, so the wives, preg-

nant, were back home. As you can well imagine, this was not a very good thing.

How are we going on just getting the number of MEBs through? And I am going with a different, kind of the broader question here.

I heard you say that suicides and other really horrible events were decreasing. And I think, in and of itself, that is an honorable and worthy goal, and I am glad to hear about that. Are we also looking at just the time that it used to take us through the Medical Hold company (MedHold)—MedHold, whatever all those words were? Was there a time? Do we have metrics for how long it used to take us? And are all of these, is everything that we are doing actually moving the timetable up any more? Do we have metrics before, after, and talking about MEBs? Please.

General RUBENSTEIN. Ma'am, when I got through Eisenhower Medical Center in the late 1990's, I had a soldier, MEB, Medical Hold soldier who had been there for 6.5 years. We don't have those kinds of issues anymore.

Mrs. BOYDA. I appreciate that. Anecdotes are interesting. Do we have set goals? Generally, where are we? Is this speeding this up for us? Do we know that it is speeding it up? And do you have some metrics of where things were one and two years ago? And what do you expect to have?

General RUBENSTEIN. Yes, using the MEB as your starting point for that question, we do have metrics. Ninety days from the time the soldier is on profile until the MEB is in the mail to the next step, which is PEB, the Physical Evaluation Board. So the MEB is done at the local hospital level, and then mailed to the PEB, which then defaults to General Rochelle's G–1.

Mrs. BOYDA. I am actually understanding all this now. It is frightening.

General RUBENSTEIN. Our metric is and has been 90 days. And we can go back into data files; I can take you back to Fort Drum in 2002 and tell you what the numbers were, or 2006 or today, 2008. And we do track those very, very closely.

The MEB physician at Fort Drum, when she arrived, the kickback rate—when the MEB goes to the PEB, the kickback rate was 40 percent. She and the command elected to go for quality of the MEB process, not speed. And she was able to get the kickback rate down to zero percent in April and May.

Now, to do that, she had to learn her job. This is—as we heard earlier from the subcommittee, this is putting people into jobs that they had not done before. And this physician had not been an occupational kind of MEB doc; You have to learn how to be an MEB doc.

Now, we have put a second physician at Fort Drum doing MEBs along with this particular physician. We have fired a contracted doctor who was working with her, who was not doing a good job, and erased the backlog. Over 110 MEBs left or will have left Fort Drum by the end of this month, next Thursday.

Mrs. BOYDA. Let me say again, too, I think that is—I applaud that.

What metrics do you have or something? I don't mind saying, I was looking forward to going up to Fort Drum and being told that things were going well. And, in fact, they are going well much of

the time, but we had some really fundamental underlying problems. And what was a little concerning to me is it felt like the subcommittee was the one who was saying to you all, there is a real problem here, and we are hearing about it in living color.

I want you to know that I hear about that same sort of thing. I just dealt with a mother who was—and father, but a mother who was absolutely beside herself with an extremely sick son, extremely sick son, who could not get into a WTU to save his life—and I mean that almost literally.

And when we had to intervene to get that to happen—and this is something that should have happened. What I am looking for is where—I just want to know that those are, somewhere or another that you are following those metrics and you are able to pick those things out before we happen to show up at Fort Drum or Fort Riley or wherever we show up and do a sensing session.

General RUBENSTEIN. And, in fact, we do track MEBs at every one of our hospitals and every one of our large clinics that do MEBs. We track it every month. We track the number of patients who have been there 0 to 15, 16——

Mrs. BOYDA. Were you already then—and I am putting you on the spot.

Were you already, then, aware that this one woman who was doing the Lord's work there at Fort Drum was not able to keep up? Were you already in process doing something about that? Or was it our being there?

General RUBENSTEIN. No, ma'am. My e-mail to your staff on 20 June, I expressed that in fact we were aware that Fort Drum was having a problem. The Fort Drum chain of command, the commander of the hospital and his staff, were working on a Lean Six Sigma, a quality improvement process, which is a process designed to implement change that is permanent as opposed to fixing something very rapidly and it goes away. And so what I directed on 20 of June was to put the Lean Six Sigma project on hold, to go in and clean out the backlog, and then to resume the Lean Six Sigma project to develop permanent change. Then we will learn the lessons from that permanent change that we can apply to our other 25 hospitals and remaining large clinics that do MEBs.

We had an eye on it. We observe our MEBs across on all 26 hospitals on a monthly basis. We let local commanders make efforts to fix their issues, as opposed to using a 2000 model screwdriver to fix it for them. In this case, we did direct, with a 2000 screwdriver, to wait to fix the backlog—and as I mentioned, 110 MEBs will leave post this month—and then to go back to the Lean Six Sigma project for permanent change.

Mrs. BOYDA. I appreciate your helping us with the visit, too. So thank you for everything.

Mrs. DAVIS. Before I go to Ms. Tsongas, if we were to go to a sensing session today, at what base would you expect that we would hear the most complaints, that perhaps they haven't been able to move through this sensing session or the MEB process as swiftly as you have just been able to articulate?

General RUBENSTEIN. I couldn't answer that right now. I could get an answer to you, but I don't know.

Are you saying as far as bases that have slow MEB rates?

Mrs. DAVIS. Right.

General RUBENSTEIN. I can get that for you.

[The information referred to can be found in the Appendix on page 61.]

General CHEEK. Generally, what I could tell you is our installations where we have deploying units, a high number of brigade combat teams, are where we have the greatest challenges in our MEB timelines.

The best one is Fort Bliss, Texas, where they consistently process theirs under 50 days and they have none waiting over 90 days. So they do an excellent job. And one of the things that we will do this fall at our conference, we are going to bring in some of our best practices, Fort Bliss being one of them, and have them share just what it is that they are doing.

And what I will just tell you is, it is the cooperation across that installation. It is not all tied to medical processes, but it is the cooperation of unit commanders and others that make them so successful, and a really superb administrator that runs their program.

So we have some places where they are successful, and we have got to share that across the Army to try and improve everywhere. But those with dedicated people that you invest in to do that, you will have success.

General ROCHELLE. Madam Chair, may I comment on question, if I may?

I would like to come back to Mrs. Boyda's question about something fundamentally wrong. And I would offer two points. First of all, is a bright spot on the horizon. General Casey has asked retired General Fred Franks, Desert Storm hero and Vietnam era amputee, to lead a 90-day effort to blow into what General Casey refers to as the logjam of the MEB/PEB process. And it is a logjam.

General Rubenstein is absolutely correct. We monitor month by month across the entire Army where the Army stands against the Department of Defense standards for timeliness of Medical Evaluation Boards and Physical Evaluation Boards. And I daresay, across the entire Army, we are not meeting the standard.

To my critical point, though, to your question, ma'am. The fundamental problem is that the Medical Evaluation Board and the Physical Evaluation Board place the soldier and the service at adversarial relationships. It shouldn't; it should not, but it does. And until we get the service out of the disability rating process, it is going to continue to be that way.

Mrs. DAVIS. We will come back perhaps to that discussion.

Ms. Tsongas.

Ms. TSONGAS. I have a question more about, at the end of that cycle as warriors are transitioning out, what percentage go back into regular service? Do you know? As opposed to leaving the services?

General CHEEK. Yes, ma'am. For this last month, it was 42 percent. Historically, it is around 65 percent. And one of the reasons why we are seeing this drop right now is, I think, as we are beginning to see this population of soldiers that were in the Medical Evaluation Board process that we moved into the Warrior Transition Units. And traditionally, when you are in that process, less

than 10 percent will remain in the service when they enter that process.

So I believe we will see that come back up to the 50–65 percent range. But that is where we are right now, 42 percent.

Ms. TSONGAS. And do you have in place a process following those who get back out into regular duty to sort of see how they are doing, and to use the feedback, the data from their experiences, to refine what you are doing in the transition units?

General CHEEK. Ma'am, I don't know that we do. That is a great idea, though, and I think it is something that we ought to pursue.

One of the things that we do want to do for our soldiers returning to service—in fact, I was at Fort Bliss, and a soldier who was returning to duty remarked to me that there were a lot of programs in the WTU to help soldiers who were leaving the service, but not a whole lot to help the soldiers that were staying. And leave it to a soldier to give you that blinding flash of the obvious.

And General Rochelle is well involved in this as well. We are going to put retention noncommissioned officers (NCOs) in our Warrior Transition Units, and build a program around them to retain a lot more of these soldiers that are probably medically fit, maybe not in their original military specialty, but in another one, and also have a rigorous program to assist them as they go back in. And when we work this up, one of the things we want to do is bring some of those soldiers in to talk to us and their chain of command so that they can help us build that system.

Ms. TSONGAS. Thank you.

Mrs. DAVIS. Dr. Snyder.

Dr. SNYDER. Help me understand, if you would. When a unit decides to put a person into the Warrior Transition Unit—I guess I will address this to General Cheek—I assume there are orders cut, there is a formal transfer to that unit. Is that correct?

General CHEEK. Yes, sir. In fact, we just revised that process in our current Fragment Order 3 that we have referred to many times.

The commander in evaluation of the soldier will make a recommendation—and I am talking about the unit commander. He will write a memorandum saying, "I would like this soldier assigned to the Warrior Transition Unit." And then there are several forms that will go with that, the chain of command's assessment and his medical providers' assessment as to his medical condition.

That application will go to what we call the Triad of Leadership—the installation commander, medical treatment facility commander, and WTU commander—and because we have such variation across the Army in size and scope of Warrior Transition Units, that triad of leadership will determine what process they will use to review that, I will call it, "application." And that system that they design will make the decision whether to allow that soldier in or not.

Dr. SNYDER. And then that person is formally assigned to that unit?

General CHEEK. Yes, sir.

There are some instances where we will attach, but yes, assign them to the unit.

Dr. SNYDER. Let me put it another way.

Does that mean that for some of them, then, they actually have to pack up their bags and move to a different barracks, living quarters?

General CHEEK. Yes, sir.

Dr. SNYDER. It is a move. You had talked before about—you seem to be as adverse to this idea of a waiting list as probably we are, but as you have looked at the 12,000-plus people that are there now, do you look at some of them and say at this point, some of those should have stayed with their unit?

I don't know if the blown-out shoulder from weight lifting is a good example.

Or are there some people that should have—that you see, looking at your universe of these numbers that are going up, and you are looking at some of those and saying—I may have missed this in early testimony, but—these people really were not the kind of folks the Warrior Transition Unit was set up for? We want them to have good care, but they could have been staying on sick call, put on light duty, sitting in the office helping someone while they have got their ankle propped up or still keeping all their appointments?

Where are you all at with that evaluation?

General CHEEK. And, sir, when I go out and visit Warrior Transition Units, that is exactly a question I will ask, especially the cadre, not so much the soldiers themselves. And the response I get is typically, between 10 and 30 percent they feel—the cadre feels don't need the managed care that we have in a Warrior Transition Unit.

So I believe the answer to your question is, yes, we have some that—they are probably all benefiting from that focused healing environment, but some of them would do perhaps just as well in their units in the way we have done this in the past.

Dr. SNYDER. Ten to 30 percent is a high number.

General CHEEK. Yes, sir.

Dr. SNYDER. When you are talking about 12,000, you are talking up to 3,500–4,000 people that may not be. That would solve some of your manning issues.

General CHEEK. It would, sir.

And one thing, too. We want to be very careful about how we proceed on this, because one of the things we don't want to do is have our soldiers think that we are going to take the axe out and chop a bunch of folks out of the unit.

Dr. SNYDER. It just means they could get lost again.

General CHEEK. Yes, sir. We are going to be real careful. And what we have told the commanders is, based on the recommendation of the Triad of Care—that primary care physician, nurse case manager and squad leader, in consultation with the soldier—we will look to make a recommendation to move him on.

Dr. SNYDER. Of the 12,000 that are currently in the Warrior Transition Unit, how many of them during the day are going to a duty station and performing some kind of work duty?

General CHEEK. Yes, sir.

Dr. SNYDER. In line with their military occupational specialty (MOS)?

General CHEEK. Depending on the capabilities of the soldier, we mandate that they be enrolled in some kind of work or education

program. And we are probably at about 75 percent. There are probably some more that we can add to that. But a great many of the soldiers will go either on the installation and work, or back to their parent unit that they came from and do work. And we have a variety of other things that they do; some take college courses and other things like that.

But as part of our comprehensive transition plan, we want to have a plan for them to develop or to improve medically and heal, but also personally as well as professionally. And so we want to make this a very strong environment that prepares them for that transition back to the Army or as a veteran in the civilian community.

Dr. SNYDER. My last question is, when would be the recommended time, if you were sitting here, for this subcommittee for hold another hearing like this for you all to hear about how we are doing?

Three weeks after you retire?

General ROCHELLE. No, sir.

Again, I have reviewed the testimony on the four previous hearings all the way back to General Schoomaker, Chief of Staff, on this particular subject. And I know that somewhere along the way we declared very intentionally, and well-intentioned, true full operational capability. And we were in the spirit of the AMAP, but we didn't know in many cases what we didn't know. And I am referring to the bureaucracy at the lower levels and the bureaucracy at the higher levels—the special duty assignment pay as an example.

In my humble opinion, I think we will be—between October and January, we will, no kidding, be full up and running, as we have testified.

It takes time to kill bureaucracies. It takes time to make sure that in an organization as large as the Army, stretched as much as the Army is and moving in as many different directions as the Army is, to have something of this novel nature really operating the way we fully intended it to.

So, sir, respectfully, my answer to your question is between October and January of 2009.

Dr. SNYDER. Thank you. Thank you for your service.

Mrs. DAVIS. Thank you, Dr. Snyder.

And we certainly appreciate all of your responses, and we know that this is very important to you. It is obviously very important to our soldiers and their families. And I think, if anything, we came away from the Fort Drum experience sensing session there feeling that we needed to do better by all of those, that it was important to do that.

You mentioned, I think, General Cheek, a focused healing environment. And I went with the expectation that we would see that focused healing environment. Perhaps that was unrealistic, but I think that it was also frustrating to get the sense that people were sitting around, a level of boredom and anxiety, not feeling that things were happening for them.

And one of the concerns that we heard—and we went to Fort Drum partly to see how the community and the military facilities work together; and I know, as the staff has gone around to other facilities, to other bases, there seemed to be certainly a willing-

ness—and you mentioned, I think, General Rubenstein, the aggressive nature of trying to get appointments for soldiers downtown, wherever that might be, where there are other mental health providers, other providers who are there in the community.

And yet we are also hearing, the staff is hearing that there is kind of a reluctance on the part of the commanders in some cases to open up those opportunities, that they are having a hard time getting those appointments. And we certainly heard that at Fort Drum; they were waiting a long time.

They acknowledged that they didn't have the providers they wanted, either. A new clinic was opening up.

But I am wondering how you see that changing at all, that people are able to get the appointments that they need. No matter how many cadre you have, even with a low ratio, if the appointments aren't coming through, then that is going to be difficult for everyone to move that situation forward.

The other question I would have is just about the standards by which people are asked to see soldiers, whether the time frame, is it 30 minutes, is it 45 minutes, an hour? What kind of—what do we know about the appointments that are being made and the level of care they are being provided, the level of expertise, so that people can move from one point to another?

It is fine if people are getting their appointments, but if nothing is happening in those appointments, then that is, you know, not so helpful.

General RUBENSTEIN. To your first question, the availability or the reluctance on the part of commanders to send patients downtown, whether they are active duty in the WTU or not, there is no corporate, there is no organizational bias about sending patients downtown. Wherever you need to send a patient to receive care is where we send a patient to receive care.

Fort Drum in particular, in October of last year we sent 380 patients downtown. In April of this year, 6 months later, over 500, almost 550 went downtown. So it is a growing trend to send patients downtown if that is where the care is available for them.

As far as the type of appointments, we run a variety of types of appointments, from an initial appointment to a family practice doc to a psychiatric appointment with a psychologist or a psychiatric appointment with a psychiatrist. They are all at different lengths. The length of the appointment is appropriate to the needs of the patient.

Now, that is from the perspective of our health care providers. Not all patients think they get enough time when they see their doctor. That is true in the military, that is true in the civilian sector. The literature is replete with the patients who walk in with the latest advertisement for the drug or the application or the treatment which they have read about, which may or may not be appropriate for them. The same is true with getting the amount of time you think you need to get with your provider.

Mrs. DAVIS. Is there anyone who oversees that care so that there is some opportunity to talk professionally even about what people are seeing, what kind of resources they are accessing?

I am just wondering, is there anyone who organizes that to the extent that you are able to get the best utilization, the best profes-

sional care, and that there is dialogue about that, that there is some interface?

General RUBENSTEIN. There are actually a variety of mechanisms to do just that.

Within the WTU itself, you have the nurse case manager, the supervisory nurse case manager, the primary care provider, the squad leader, that triad with the supervisory nurse case manager looking at cases, discussing cases if it is a small, like Fort Leavenworth where there are 19 Warriors in Transition, or a large WTU, like Fort Hood with over 1,300.

So among themselves at the WTU level, they are discussing the needs of their patients.

Additionally, within the hospital or clinic, we have got the deputy commander for clinical service and the deputy commander for nursing who are talking among themselves, a variety of committees that all hospitals are required to have to meet Joint Commission accreditation, which all of our hospitals do. And so there are a variety of committees and work groups; and in the case of the WTU, the Triad of Care who are constantly talking about the health care needs of their patients.

Mrs. DAVIS. Thank you. I appreciate that, because I think that sometimes we assume that that is happening, and I want to be sure that the oversight is there so that we know that it is and that people are having the adequate kind of consultation time that is really required.

Earlier we talked, very briefly—and my time is up, but I wanted to just clarify. You talked about the one-year authority for hiring that you have.

Actually, in the authorization bill it is up to three years.

General RUBENSTEIN. Yes, ma'am. We are just waiting for Department implementation of that.

Mrs. DAVIS. Good. We are hoping that you can go forward with that anticipation.

General RUBENSTEIN. As are we. Thank you very much.

Mrs. DAVIS. Mr. McHugh.

Mr. MCHUGH. I mentioned earlier, I was happy when General Cheek said they were going to have a video teleconference and talk about the changes with respect to HRC and the manning documents. And perhaps I should make a suggestion for a second topic in that.

What our staff had heard repeatedly is that as folks within the WTUs went through their MEBs, they might find themselves in a circumstance where there was a tag on, for whatever reason, for a psychiatric evaluation. That psychiatric evaluation, of course, takes time, and the process of going through that, some of the prior findings, including the physical exams that were used to validate those findings, had expired and had to be redone.

Now, that was addressed in the 2007 implementation document in that, as I read it, the commanders were given the authority to waive that expiration in a case needs basis. But apparently that has either been forgotten, or they need to have a booster shot to be reminded of their authority there, because we are still hearing, General, from people within the WTU that they are encountering

that kind of frustration where they are almost through and a psychiatric exam will expire some of their previous physical exams.

So maybe you can——

General CHEEK. Yes, sir.

Mr. MCHUGH. Remind them of that so that we can get through there, because I think it is another example of this disconnect where a problem was recognized at a level, the authorities were implemented or documented out to circumvent it, and for whatever reason, the problem still exists.

General RUBENSTEIN. We will touch every one of our MEB facilities in the next few days and pulse that, sir. Thank you.

Mr. MCHUGH. Thank you.

Now, under the topic of unintended consequences, a couple of things that I think we ought to be concerned about and try to avoid a hearing in the future where we talk about these problems that could result out of our very laudable and necessary and ongoing efforts for the WTU; and I will use two examples.

We have heard anecdotally where, in an effort to meet the nursing shortages that go back to what you were talking about, General, about the recruiting problems of nursing across the country, reassignments are happening within the military health care units on the facilities, moving nurses, military nurses over to the WTUs to meet that need.

We are hearing anecdotally, for example, at Fort Hood where up to 50 percent of the military nurses have been assigned from the base's medical facilities to the WTU, and the result is, you are having to take another look at perhaps closing some beds because now you don't have the necessary nursing cadre at the facility.

I don't know, you are probably not in a position to comment on that specifically. But we sure don't want to see a cannibalization of necessary personnel into the WTUs—and that is all we have talked here about today; I think we have made it pretty clear, we want to see those ratios met, and I know you do, too, but—where we create another problem somewhere else.

General RUBENSTEIN. In fact, I can speak to that.

Mr. MCHUGH. Let me just give the other example so maybe you can handle both at once.

But the other thing that concerns me—and, General Cheek, you commented about, that is the way we used to handle folks who had a medical challenge, non-combat-related, that was, shall we say, less serious. We created Medical Holds for the distinct purpose of getting folks who had a need for time of recovery with the good intention of getting out of those base units, because apparently there was a lot of pressure to suck it up by the unit commander, suck it up and get out there. And you all know that phenomenon.

The WTUs came as a follow-on to the Medical Hold circumstances for a lot of different reasons, but that well-intended effort to create the Medical Hold still exists. So are we taking a step backwards when we pull these folks out who were not hurt in a combat, theater combat, and hurt more seriously, but do have medical challenges?

I just worry about back to the future.

General RUBENSTEIN. I will start and then pass it off to General Cheek.

I talked with Colonel Casper Jones, the commander at the Fort Hood Hospital Medical Center on Saturday, and he told me on Saturday that if he moves nurses from his hospital to the WTU, he would break the hospital. And I told him not to do that, that given the fact that of his 1,300 soldiers in the WTU, 166 are actually on leave, just ready to depart the unit and go to the next assignment, and given the fact that they have got things well in hand, I told him not to move and break the hospital itself.

So that is the answer to that first question.

Mr. MCHUGH. That is an example. I want to make sure that we are not somewhere else where perhaps the commander isn't——

General RUBENSTEIN. We directed all 26 hospital commanders to look at the potential of moving—and I am going to speak to the medical side, not the squad leaders and such.

We directed all 26 hospital commanders to look at their hospital, to move where they could, but not to break anything in the process.

In getting ready for tomorrow's VTC with General Cody, yesterday and today, each of the hospitals have briefed the Medical Command (MEDCOM) headquarters on what they did over the weekend, what risks they may have taken with their hospital, or where they made a decision not to move someone to the WTU because of the negative consequences—the second order effect you very rightly bring up.

Mr. MCHUGH. Thank you.

General CHEEK. Sir, I would just say I think it is a valid concern. And for the soldiers that remain in their unit to rehabilitate, we are going to have to keep a close eye on them.

But I would tell you, frankly, we have quite a number of those soldiers right now in the Army, all around our units, that are doing very well and rehabilitating from things like we said, like a torn cartilage in the knee or a shoulder injury.

We actually, in looking at this FRAGO, considered an enrollment program where we would enroll soldiers that remain in their units and track them and give them some priority. And actually in concert with and discussions with your staffers, as well as the Soldier and Family Assistance Centers (SFACs) and our commanders, they all really said, "Hey, not so fast," and really hold off on that.

So we have tabled that for now. We will keep it in consideration if we see an issue with it.

But I do think the Medical Hold, that is really a different category of soldier; those really matched closer to our really severely injured soldiers, rather than what we are talking about of a more routine nature.

In fact, as a commander, what I would tell you as an operational commander, I couldn't figure out how to get a guy into Medical Hold. It was too hard, literally. So we just took care of those soldiers under their leadership.

And I think that is important as well, that the Army's leaders be responsible for their soldiers, both personally, professionally, and medically, if necessary to get them to their proper care.

But we will watch that, and if we have bad consequences, then we will look to how we can improve that.

Mr. MCHUGH. Thank you, Madam Chair.

Mrs. BOYDA. Thank you very much.

A couple more questions. And, again, I appreciate the opportunity to keep going around on here. And you guys have been extremely patient, and I really appreciate your answers.

Let's talk military construction (MILCON) here. We have got some real MILCON struggles.

From what I understand, we still are looking forward to what the whole military construction is going to need to look like. And it is my understanding that when we asked for a list for this particular hearing, that the comptroller of the Department of Defense (DOD) said, No, we are not able to give that to you, or we are not going to give that to you.

Do we have—does this committee or does our Military Construction Subcommittee have an idea of what has to be done?

Clearly, the one that pops up is Fort Carson that, in fact, we are just asking for a highly improbable/impossible to be done there, and yet we don't see where we are headed with MILCON.

Can you address that, please.

General WILSON. Yes, ma'am. I will be glad to address that.

I think from the beginning, you know, kind of where we started with our modifying our existing facilities; and with the Congress' help, $162 million in 2007 and then $100 million in 2008, we have been able to almost complete that.

That is taking 35 WTUs, a combination of the three types of facilities, and modifying the existing ones to accommodate our Warriors in Transition. That was an intermediate step.

What we need is our permanent construction dollars to create this campus-like environment and place those where they need to be, close to a medical facility.

Mrs. BOYDA. Did I miss something? And it would be highly possible that I did.

Did I misunderstand? Does this committee have your projected needs for MILCON through whatever the Five-Year Defense Program (FYDP) is here?

General WILSON. You do not have that. I submitted that. The Army submitted that to the Office of the Secretary of Defense (OSD), a request for supplemental funds. It is down from the initial $1.4 billion we looked at. We have kind of sized that on what we think the 21 new construction for permanent facilities should be. The dollar amount for that is $981 million, and we have submitted those 21 installations to OSD.

And I would be glad to give that to Chairman Edwards and his committee, if you would like. They are looking at that and we are working together.

Mrs. BOYDA. At Fort Riley, where I represent, things are moving along in that direction; and it has been a huge benefit, and everybody is very happy. So if you could help us just get that so we are making sure that we are pretty even—nothing will be completely even, but we want to make sure we understand where we are going with that.

Then the final question that I have just comes back to the retention of as many of these soldiers into our military. A question that I get—just have had it a couple of times from people in my district; and these are not military—they would be a military family grandma, generally something like that.

What am I supposed to say to them when they say, "Are we training our young men who are suffering from some PTSD, to bring them back in as people who would be trained in the PTSD and stay in the military?" Realistically, how much of that are we able to accomplish, how much of that is going to be a good thing?

I don't want to oversell it if it is not a great thing. But I have actually gotten that question twice, and I would like to know how we do that. And is there a disconnect between veterans who have come back or active duty that have come back from Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) versus somebody who tore his cartilage? Does everybody have the same opportunity to stay in the military and serve their country?

General, if you could talk about retention. Are we asking people to do that?

General RUBENSTEIN. Our number one goal for every wounded warrior is to allow him or her to return to active duty. I gave some examples earlier of soldiers who were in combat, soldiers jumping out of airplanes; and there are many, many other examples of soldiers who are staying on active duty with injuries that heretofore would have just, blanket, have sent them home.

Mrs. BOYDA. Does every soldier get treated pretty similarly in that regard, or is there any preference given? I have a reason for asking that, but I won't go into it. Generally, is there any differentiation between soldiers in how they are encouraged to stay in? Or are they all out there looking for new MOSs, if that is necessary?

General RUBENSTEIN. There is no differentiation from a corporate, from an organizational perspective. If a soldier has an injury and wants to stay in the service, we are going to find a way, to the best of our abilities, to work it for that soldier to stay in the service.

It may require a change in career fields. It may not. It may take a long time to rehabilitate that soldier to allow them to return to duty. It may be a type of injury which happens very quickly. They may have been injured in combat. They may have been injured here in the United States, having never been deployed before.

But in every regard we are going to give the soldier the benefit of the doubt.

Mrs. BOYDA. Thank you for clarifying that.

What about the PTDS and bringing those men and women who—I can imagine that would be fraught with some real benefits and some real challenges—how do you balance that?

General RUBENSTEIN. We owe it to that soldier to work with them and treat them for their PTSD for that percent that do have PTSD.

Mrs. BOYDA. I am talking about to go into the care of other soldiers with PTSD. That is the question I have been asked a couple of times.

General RUBENSTEIN. To put soldiers in the care of other soldiers in the warrior transition unit?

Mrs. BOYDA. A soldier who has PTSD, to go back and spend the time to train that soldier, to send them to college, whatever, to come out two, three, four years later as somebody who is a licensed social worker or whatever, with PTSD. Do we ever do that?

General RUBENSTEIN. I don't know that we don't do that. You are asking for a specific example or anecdote.

Mrs. BOYDA. The first time I got it, I didn't have a really good answer. The second time I said, I will find out.

General RUBENSTEIN. We do send soldiers through our long-term health, education, and training program off for graduate degrees; especially in the health care fields, we do send folks out for training and for further education. There is an opportunity to use education and training through the Montgomery GI Bill and such.

PTSD in and of itself is not a disqualifying factor if we have the PTSD under control. There is no reason we wouldn't keep a soldier who is responding well and has PTSD under control, keep that soldier in the Army in whatever capacity he or she is able to serve.

Mrs. BOYDA. I think I am actually finished with my questions, Madam Chairwoman. Thank you very much. Thank you for your patience.

General WILSON. Congresswoman, if I may close out with you on your specific question at Fort Riley, those projects for Fort Riley were——

Mrs. BOYDA. We are good on Riley.

General WILSON. They are coming. It is a good news story for Fort Riley.

Mrs. BOYDA. Again, as I understand—Fort Carson, is that on schedule and where do we stand with that specifically? There were some temporary buildings that I think are scheduled—contracting problems.

General WILSON. Fort Carson, the billets and the battalion headquarters and company headquarters are in our 2009 supplemental request for these facilities. We need permanent facilities; we are in temporary facilities now.

But the permanent solution has not been—it is going to go forward with the 2009 supplemental, we hope.

Mrs. BOYDA. Thank you very much. I appreciate that.

Mrs. DAVIS. Thank you, Ms. Boyda.

Thank you for hanging in there over the course of the last few years, and we will conclude it in just a second. I want to just mention, because as part of the defense authorization we did include language that would incentivize us to capture essentially those men and women who have perhaps suffered from PTSD—or not—who would like to go into mental health provider fields to be able to really help out their peers. That is something that the language is there, and how exactly it is done, I think will proceed over a period of time.

But I do want to recognize that the first school of social work for the Army was just begun this month. So we are hoping that we will have a number of people who perhaps couldn't move on with their prior fields, but they recognize how important it is to move on and to help their fellow soldiers. We hope that they would be interested in those fields, having had a firsthand knowledge of how that can be affected during wartime.

So we will be doing that. I am very pleased that we are going to move on to it.

One question to just follow up with the military construction issue for a second. About what size WTU population will those

MILCON projects that you described support? How do they jibe with the population that we are seeing?

General WILSON. That MILCON was based on moving to the 12,000. We still have some work to do to go to the 16,000 or greater; we are working that. For example, I just got a request in from Fort Hood last Friday for additional military construction requirements.

So we are still working the growth. We have executed our requirements based on the current population we have with 100 percent growth over the last year. That is what is forward to OSD at this time.

General CHEEK. Sir, if I can add to that, that is true, but that also assumes a significant—well, about half of the population would be married and living off post. So we are not building barracks for 12,000 soldiers, but it reflects the demographics of our Army population.

General WILSON. We look at 30 percent basically as the population that would need facility support. That is what we base that on.

Mrs. DAVIS. As we continue to provide oversight on this issue and to move forward, will we be provided a list of all these requirements that you have?

General WILSON. We can certainly provide that to you.

Mrs. DAVIS. We would try and send that signal that we think it is appropriate that we have an opportunity to do that, so we can continue to work closely with you on that issue. I know the concern of when you might come back and have an opportunity to look at these issues again.

One of the difficulties, of course, that we are dealing with is, there is a congressional recess coming up by the end of September, and I am wondering whether you feel there would be sufficient movement by the end September to take a look at some of these issues and see if we are pretty much on track, where you would like to be, and if there is any way we can be of further help.

Is September too soon?

General ROCHELLE. My estimate would be September would be too soon. I don't believe we would have significant movement, to use your term, either in terms of personnel or in terms of facilities to show an appreciable—appreciable change worthy of a hearing.

General CHEEK. Ma'am, I will be glad to provide updates, as we move along, to your staffers. I think we have got a pretty strong relationship that we can continue to update them and share information.

General ROCHELLE. I will certainly commit to do likewise.

I would just like to commend the staff on their tremendous work and passion. It is noteworthy.

General RUBENSTEIN. It should be noted that there is movement every day.

On Friday of last week we had a job fair down in Round Rock, which is a small town just north of Austin, Texas. We walked away from that 12-hour job fair with 15 job applications for nurses for Fort Hood.

So there is movement every day. What you see today is not what you would have seen three weeks ago or three months ago.

Mrs. DAVIS. Is there anything else that you would like to say to the committee today to encourage us to help out in some other way, whether it is with the bureaucratic problems that you have encountered, or in any other way? Is there anything you would like to say that perhaps didn't get said?

General ROCHELLE. Clearly—and I won't try to speak for everyone—but we hope that we have communicated that we are absolutely committed to getting this right.

We did overwhelm ourselves a little bit. We are on track, and I am committed and truly believe that Frag 3 points us in the right direction. It unencumbers the local commander, it empowers him or her, and it also gives very clear standards to each of us on how we are going to take care of our most vulnerable, our wounded warriors.

We are committed to doing that.

Mrs. DAVIS. Thank you.

General RUBENSTEIN. I would highlight the relationship that we have built over time with Mr. Kildee and Ms. James. The openness of this committee and the openness of your staffers to come back to those of us who are working so hard to put the right programs and process in place is amazing, and that openness allows us to continue the work in between these opportunities to talk with the full committee.

We appreciate that opportunity.

General CHEEK. We look forward to working with you and appreciate the support that you and your staff have given us. It has been very helpful.

Mrs. DAVIS. Thank you. Thank you gentlemen. We appreciate your testimony today.

Thank you for thanking our staff. We appreciate them as well.

We will look forward to the next opportunity that we have. Thank you very much.

[Whereupon, at 4:15 p.m., the subcommittee was adjourned.]

A P P E N D I X

JULY 22, 2008

PREPARED STATEMENTS SUBMITTED FOR THE RECORD

JULY 22, 2008

Statement of Chairwoman Susan A. Davis
The Military Personnel Subcommittee
Hearing on the 'Army Medical Action Plan: Is it Working?'
July 22, 2008

The purpose of today's hearing is to take a hard look at the current state of the Army Medical Action Plan. This will be the third hearing this subcommittee has held on the Army Medical Action Plan, the Army's response to the revelations at Walter Reed Army Medical Center last year, since it was issued in June, 2007.

When the Army Medical Action Plan Execution Order was issued last summer, the Military Personnel subcommittee believed that the Army had finally demonstrated a full understanding and acceptance of the organizational and systemic shortcomings that had led to the scandalous conditions at Walter Reed. We felt that the Army Medical Action Plan was a comprehensive and ambitious blueprint to tackle these issues head-on. After years of frustration, many on this subcommittee believed that the Army was finally ready to take the necessary steps to fix these problems.

However, from our very first briefing on the Army Medical Action Plan, we had two significant concerns.

The first was that the Army would be unable to initially dedicate, and then maintain over the long haul, the level of resources required by the Army Medical Action Plan. Specifically, we were worried that the Army would be unable to assign adequate numbers of personnel to the Warrior Transition Units. Why? Because the core of the Warrior Transition Units were to be the same soldiers that make up the backbone our brigade combat teams: mid-grade non-commissioned officers. These soldiers were already in short supply.

The second was that Army commanders would overwhelm the Warrior Transition Units by sending them all of their soldiers with medical issues, rather than just those with complex injuries or conditions that required comprehensive case management. In truth, we did not feel that this was necessarily a bad thing, especially if it helped units deploy at full strength while injured or ill soldiers had the opportunity to fully recover. Of course, this would only work if Warrior Transition Units were properly resourced to take care of these soldiers.

From June 2007 through February 2008, the members and staff of this subcommittee made numerous visits to Warrior Transition Units throughout the Army. The overall trend we observed was positive. The Army Medical Action Plan

was clearly providing better support for recovering soldiers than the previous Medical Hold/Medical Holdover system. One wounded warrior commented, "Thank God for the Warrior Transition Unit! Things are so much better than they were before."

Despite the positive trends, we were frustrated at the slow progress of implementing the AMAP. We felt that things should have and could have been moving faster. We also felt that there was a disconnect between how quickly the Army leadership believed things were happening and what the facts on the ground seemed to indicate. Again, despite the challenges, we felt things were moving in an overall positive direction.

However, our concerns about Warrior Transition Unit staffing levels and the potential of line units "dumping" soldiers on the Warrior Transition Unit continued. We asked General Schoomaker about this repeatedly during our hearing in February to get an update on the AMAP. In response to a question asked by Mr. McHugh, the Army Surgeon General declared, "For all intents and purposes, we are entirely staffed at the point we need to be staffed."

As the facts at Fort Hood demonstrate, that is clearly not the case now.

Gentlemen, the Army Medical Action Plan was designed by the Army. It is **your** plan. The Army's senior leadership has publically trumpeted your commitment to wounded soldiers at every opportunity. The Secretary of Defense agrees, as Dr. Gates has made clear, "Apart from the war itself, this department and I have no higher priority."

Over the course of this hearing we will review the following topics:

- **RESOURCES**: Why has the Army failed to properly resource the Warrior Transition Units?

  WT POPULATION GROWTH: Why did the Army fail to predict the growth in the WT population? We were assured by the Army during our hearing in February that you had the processes and reviews in place to stay on top of the WT population. Clearly, you did not.

- **PRIORITY:** Is the Army Medical Action Plan truly the Army's number two priority? Our visits do not leave us with that impression.

- **CREATIVITY:** From the outset, the Army Medical Action Plan has been sold as bold roadmap to overhaul outdated, inefficient, and detrimental policies and procedures. In fact, when General Tucker was selected to lead this effort last year, he was introduced to us as the Army's premier "Bureaucracy Buster", responsible for identifying outmoded practices and leading the effort to develop new, more effective ways of doing business.

  Many of the problems that continue to hinder Warrior Transition Units seem to be an institutional insistence on doing things the old way.

- **OVERSIGHT:** Finally, and perhaps most importantly, why did it take oversight visits from this subcommittee to identify and spur the Army to fix these issues? What will it take to ensure that the Army follows its own plan and lives up to its own promises? Gentlemen, aside from telling us you will work harder to implement it, what concrete steps are being taken to ensure better follow-through?

I also want to mention that this subcommittee has worked very hard to make this an open and collaborative process. Our staff readily and routinely shares all of the information they collect at the Warrior Transition Units they visit. This includes conducting an outbrief with the cadre, hospital chain of command, and frequently representatives from the senior mission commander before they leave an installation. They have also met regularly with the Surgeon General and the Warrior Transition Office. Gentlemen, there is nothing we have learned that we have not shared. There are no facts that we know and you do not.

Let me be clear that we understand the Army Medical Action Plan remains a work in progress. We did not expect that is would immediately resolve all problems, and we were certain that it would require modification and update along the way. However, we are very concerned that the Army took its eye off that ball, that you are not living up to the goals you set and the promises you made when the Army Medical Action Plan was issued. We look forward to your testimony to learn what steps you plan to take to ensure its success.

We intend to make certain that our wounded warriors receive the care and support they deserve by holding you to the standards you yourselves set forth in the Army Medical Action Plan.

Mr. McHugh . . .

Opening Statement of Congressman John M. McHugh
Military Personnel Subcommittee
Hearing on the Army Medical Action Plan
July 22, 2008

"Thank you Madame Chair and thank you for holding this important hearing. I'd like to welcome our distinguished panel of Army leaders and thank them for appearing before us this afternoon.

"It has been just about a year since the Army unveiled the Army Medical Action Plan (AMAP) as the Army's service-wide solution prompted by conditions and problems uncovered at Walter Reed in February 2007. The AMAP was to be the way ahead to ensure that the problems would never be repeated.

"At that time I believed the AMAP to be the correct approach to solving the problems and I still believe that today. However, there are problems with the AMAP. I am disappointed and quite frankly frustrated that it was subcommittee oversight and not the Army that identified the shortcomings with the way the AMAP has been implemented.

"During recent committee staff visits to twelve of the 35 Warrior in Transition Units across the United States it became clear that although the AMAP is a good plan, the WTUs are struggling because the Army:

"Has not fully resourced these units;

"Failed to anticipate that the population in the WTUs would more than double within a year;

"Has not changed the rules and regulations that get in the way of caring for recovering soldiers and their families; and

"Is experiencing severe shortages in medical care resulting in soldiers waiting months for appointments with medical providers with the longest waits for mental health care.

"To illustrate how these problems have affected the WTUs, when our staff visited Fort Hood last month, the Fort Hood WTU had 1,342 warriors in transition with a staff that only supported 650. The same problem existed at other WTUs; Fort Stewart had 592 warriors in transition with staff to support 360; Fort Drum had

530 warriors in transition with staff to support 250; Fort Polk had 300 warriors in transition with staff to support 78 and the list goes on. These are the numbers from June.

"Of even greater concern is what may still come. Fort Campbell, although not currently experiencing severe staffing shortages will have five Brigade Combat Teams BCT) deploying or redeploying over the next several months. On average, each time a BCT leaves or returns 120 soldiers are added to the WTU. So, Fort Campbell can expect to have to care for 600 or more new warriors in transition. It was not clear during staff visits that Fort Campbell or the Army were preparing to accept this new surge of soldiers who would need care. Multiply the expected surges in new warriors in transition across the Army and the numbers are staggering.

"I understand why the WTU population exploded over the last year but what I can't understand is why the Army didn't see this coming.

"General Casey, the Army Chief of Staff, put it best during a recent meeting with the subcommittee when he said that the Army got overwhelmed en route to implementing AMAP in part because they didn't throw away the bureaucratic processes to get it done.

"Although the AMAP execution order, issued in June 2007, sought to streamline and expedite administrative processes like the MEB and PEB, it still takes on average six months to complete. This unstreamlined MEB/PEB process contributes to the bottleneck that delays soldiers and their families from transitioning either back to duty or to civilian life. To put it simply, there are large numbers of soldiers going into the WTUs but because of administrative holdups and resource shortages the numbers of soldiers leaving the WTU are small. Soldiers are unnecessarily just sitting around waiting.

"With that being said, I want to commend the Army for what I know has been a tremendous undertaking to stand up the Warrior in Transition Units and execute the AMAP to the extent it has so far. Despite the resource shortages, the WTU leadership and the men and women who serve as members of the WTU staff -- the commanders , sergeants major, first sergeants, platoon sergeants, squad leaders, case managers and primary care managers -- are all doing a remarkable job. They are the face of the AMAP. Their dedication and commitment to the soldiers and their families is why the AMAP works. But it is clear that it is a tough job and they need help.

"I believe the Army wants to get this right and I am still confident that the AMAP is the right plan, but it comes down to resources. We need to step forward as a committee and as a Congress to help you meet the needs of warriors in transition and to be part of the solution. We want to help.

"I understand that Secretary Geren and General Casey recently sent a letter to Army senior commanders to re-energize a process that has plateaued and provide focus in key areas.

"I want to hear from the panel what steps will be taken to:

"Anticipate population changes and required resource changes in the WTUs;

"Improve processes for identifying and moving resources to the WTUs;

"Streamline the MEB and PEB systems;

"Streamline the process for moving soldiers into and out of the WTU;

"Improve the availability of medical care, particularly mental health care; and

"Provide the right number of quality facilities and installation support to the WTUs

"Finally, I would like to know how we can help the Army either with resources or legislative authority to make the AMAP an enduring success. Again, I thank Chairwoman Davis for holding this hearing."

UNCLASSIFIED

JOINT STATEMENT BY

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DEPUTY SURGEON GENERAL OF THE UNITED STATES ARMY

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OF STAFF OF THE ARMY

COMMITTEE ON ARMED SERVICES
SUBCOMMITTEE ON MILITARY PERSONNEL
UNITED STATES HOUSE OF REPRESENTATIVES

SECOND SESSION, 110TH CONGRESS

ARMY MEDICAL ACTION PLAN: IS IT WORKING?

22 JULY 2008

NOT FOR PUBLICATION
UNTIL RELEASED BY THE
COMMITTEE ON ARMED SERVICES

Chairwoman Davis, Representative McHugh, and distinguished members of the Subcommittee, thank you for this opportunity to discuss the status of the Army Medical Action Plan and recent initiatives taken by the Army to ensure our Warriors in Transition and their Families receive the care and support they require in environments most conducive to their healing. In answer to the question posed in the title of this hearing, yes, we believe the Army Medical Action Plan (AMAP) is working. It absolutely needs to work better, but our system of caring for and supporting Warriors in Transition and their Families as codified in the AMAP is vastly superior to the previous system. Before we discuss some of the shortfalls and areas needing improvement, we would like to highlight how the Army has transformed Warrior Care over the last 18 months.

Wounded, ill, and injured Soldiers, Active, Guard and Reserve, have been organized into Brigades, Battalions, and separate companies at 35 sites under the command and control of the medical treatment facility commander. Unlike the previous command and control structure, the new Warrior Transition Units (WTU) focus solely on the care of their Soldiers. Every Soldier in a WTU, known as a Warrior in Transition, is supported by a Triad of Care--a primary care manager, a nurse case manager, and a squad leader. We've assigned one squad leader for every 12 Soldiers, one Primary Care Manager for every 200 Soldiers, and one nurse case manager for every 18 or 36 Soldiers depending on the unit's needs. Today we have approximately 2,800 trained personnel staffing our WTUs--a seven-fold increase in personnel over the previous system, but an even greater increase in capability due to formal training and the new policies and standards which have been put in place.

We've established Soldier and Family Assistance Centers (SFACs) to provide tailored, integrated support services to Warriors in Transition and their Families and act as a one-stop location for support at installations with WTUs. The SFACs provide a safe haven where Warriors in Transition and their Families can gather for mutual support and comradeship to aid physical, spiritual, and mental healing.

We created a 24/7 hotline that provides Warriors in Transition and their Families 24-hour access to information and assistance. The Army has responded to over 14,064

calls on the hotline since March 2007. Each unit also has a dedicated ombudsman who reaches out to Soldiers and Families as an extra resource and problem-solver. Ombudsmen have addressed over 5,900 concerns during the last twelve months. In addition to the hotline and ombudsman program, we have improved the ways we "listen" to the needs of our Wounded Soldiers and their Families and monitor the quality of care and support we provide to our Soldiers. We use third-party surveys and receive input from an array of internal and external sources.

We created a new Department of the Army office to focus on wounded warrior issues, the Warrior Care and Transition Office. Brigadier General Gary Cheek serves simultaneously as the Assistant Surgeon General for Warrior Care and Transition and as Director, Warrior Care and Transition Office reporting directly to the Director of the Army Staff. The role of this office is to be the single source on the Army Staff for all matters related to Warriors in Transition across all disciplines.

Since initiating the Army Medical Action Plan, the Army has made substantial progress in reducing the unnecessary bureaucratic processes. Some of the many substantive changes we have made since February of 2007 include:

- Continuing Combat-Related Injury Pay (CIP) while Soldiers are assigned to the Warrior Transition Unit or Community Based Health Care Organization. **Note:** "Pay Allocation Continuance" which will replace CIP is expected to be implemented by the end of FY 2008 (retroactive to May 15, 2008). This authority from FY08 NDAA will ensure that Servicemembers hospitalized for wounds, injury, or illness due to combat operations continue to receive all authorized special pays as well as their Traumatic Servicemembers Group Life Insurance (TSGLI) payments. Under CIP, TSGLI payments were suspended while receiving CIP.

- Creating a special duty pay for our WTU non-commissioned leaders (Squad Leaders and Platoon Sergeants).

- Adding an additional 17 military lawyers to provide more responsive legal counseling to Wounded Warriors in Physical Disability Evaluation System (PDES) processing;

- Establishing a My MEB/PEB web page on Army Knowledge Online so each Warrior can track the status of his or her PDES case.

o Considering Warrior in Transition preference for their location of care within the constraints of facility capabilities and medical necessity.

o Providing Warriors in Transition top priority in housing.

o Developing a Comprehensive Care Plan Process for each Soldier in the WTU that sets the conditions for the Soldiers to achieve a successful return to duty or a successful transition to civilian life.

o Authorizing Permanent Changes of Station for Warrior in Transition Families.

o Reducing paper work for PDES processing by eliminating 50% of the forms.

o Engaging the Center for Army Analysis to perform an in-depth review of case processing results across the three PEBs; as a result of this review, a robust quality control sampling program was implemented to ensure greater consistency in the board review process.

o Co-locating VA advisors at Army hospitals and facilities and initiating a leader exchange with the VA.

o Expanding VA access to Army Soldier medical records.

We've initiated a Post Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI) education program for every Soldier in the Army. This program is designed to not only educate and assist Soldiers in recognizing, preventing, and treating these conditions, but also to erase the stigma associated with these injuries. We also have similar training available to Family members. Over 900,000 Soldiers have received training since August 2007. We have also completed specialized PTSD/TBI training for social work personnel, nurse case managers, and psychiatric nurse practitioners.

Despite these tremendous successes over the past year, the Army will continue to improve in a number of areas in order to ensure our Warriors in Transition receive the best care and support possible. One significant shortfall relates to staffing of our WTUs. The dramatic increase in our population of Warriors in Transition challenges us to keep pace with sufficient WTU cadre, care providers, and facilities for these deserving Soldiers and their Families. The Army recently issued a fragmentary order aimed to improve this shortcoming and other areas where we've identified shortfalls. We are confident that these changes will further improve our system of care and support for these deserving Soldiers.

At the beginning of July, the Chief of Staff of the Army, General George Casey, issued Fragmentary Order (FRAGO) to the AMAP (Department of the Army Execution Order 118-7 [Healing Warrior] dated June 2, 2007). In FRAGO 3, the Army addresses WTU staffing shortfalls, TDA structure inadequacy, Triad of Care ratios, and PDES processing – four major areas identified for improvement. FRAGO 3 empowers commanders at the local level to use the resources at their disposal to ensure that all WTUs are staffed with sufficient personnel to meet the requirements of care and support required by all Warriors in Transition and Family members on their installations. To this end, Senior Commanders at these installations will form Triads of Leadership to include themselves, the Military Treatment Facility Commander, and the Warrior Transition Unit Commander to react quickly and decisively to ensure that WTUs have the personnel they need to successfully accomplish their mission. Accordingly, each installation's Triad of Leadership was directed to assign sufficient installation personnel to WTUs to fill all remaining staffing requirements no later than July 14, 2008.

The Triads of Leadership are charged with ensuring that the staffing of WTU cadre positions remains at 100 percent of required strength based on the number of Warriors in Transition assigned or attached to each installation's WTU. To ensure that WTUs are completely successful in their mission, the Triads of Leadership will fully involve their Command Sergeants Major and First Sergeants to monitor execution of the AMAP down to the individual position.

To address the shortcomings in the current WTU structure, FRAGO 3 directs the completion of an assessment and projection of the anticipated WTU Warrior in Transition population as of January 2009. The Deputy Chief of Staff for Operations (G-3/5/7) is directed to adjust WTU structure to reflect these projected requirements no later than July 28, 2008. The Chief of Staff of the Army further directs that these projections be based on the revised staffing ratios set forth in FRAGO 3 which U.S. Army Medical Command must put in place by October 16, 2008. These revised ratios include a reduction in the number of Warriors in Transition for which each Squad Leader is responsible from 1:12 to 1:10. Also, the ratio for Nurse Case Managers will be reduced from 1:36 to 1:20. These revised ratios are the result of the findings of a recent manpower analysis conducted for all WTU positions. We are confident that these

staffing ratios will better support our Warriors in Transition and ease the burden on our cadre. We will continue to monitor these staffing ratios and adjust them when necessary.

Senior Commanders are further directed to evaluate the effectiveness of installation execution of the PDES and provide their findings in writing to the Warrior Care and Transition Office no later than July 30, 2008. From these reports, an action plan will be developed to streamline the disability process, assist in meeting DoD established timeline metrics for Medical Evaluation Board (MEB) and Physical Evaluation Board (PEB) processing, and minimize the time required for PEB disposition by aggressively processing orders.

The Army has also established a comprehensive PDES training program. This program ensures that personnel who operate the PDES have the skills and knowledge needed to carry out their responsibilities. These courses are now required for annual certification in the respective disciplines. Through information technology, the Army has created a streamlined, efficient tracking and management environment. This allows us to provide detailed specific instructions to care givers, care managers, and administrative personnel involved in each area of Warrior Care. Despite these improvements to the PDES, the Army is continuing to consider, review, and analyze further modifications that will meet all the needs of our disabled Wounded Warriors whether they remain in the service or return to the civilian sector.

The Army will soon publish a new message for installations and the personnel community to cover the Return to Duty procedures for Wounded Warriors. Previous Army policy, which allocated Soldiers up to 90 days to work permanent change of station issues, was determined to be excessive. This policy was refined to allow 10 days for Soldiers reporting to units on the same installation and 60 days for new installation permanent change of station moves. This eliminated the delay in Soldiers found fit for duty remaining in the WTUs when they could have moved to their new units sooner.

The orders process is being streamlined further by better communications between the Army Human Resources Command (HRC) and the WTUs. Previously,

information concerning the WTs would move from the WTUs through Regional Medical Commands and Army Medical Command before reaching HRC, creating unnecessary delays in orders processing. Now HRC is directly linked to each WTU to issue orders. To the greatest extent possible, WTs are assigned back to their parent unit or installation upon release from the WTU. In certain situations, professional development courses, such as Drill Sergeant/Recruiter Duty or reenlistment requirements will place WTs in other units. This effort is important to our Soldiers and relieves an additional source of potential stress and anxiety.

We are restoring and modernizing existing facilities with available funds, improving accessibility, and co-locating facilities where practical. Operations and Maintenance funded contracts valued at $162 million were awarded in late Fiscal Year 2007 and an additional $100 million of projects is being executed in Fiscal Year 2008 to complete this effort.

The Army fully supports meeting the needs of our wounded, ill, and injured Warriors by co-locating WTU barracks and supporting facilities to promote a healing environment. These units will be stationed in complexes composed of Warrior in Transition Barracks, SFACs, and WTU administrative buildings, which provide robust command and control, administrative support, and a care management structure.

While the Army's Warriors in Transition are currently housed in quarters that meet DoD standards, we consider this to be an interim solution. Congress has supported our facility requirements by passing the Supplemental Appropriations Act, 2008, which includes $138 million in military construction funding for seven permanent WTU locations. Fort Riley will receive WTU barracks, SFAC, and headquarters; Fort Drum will receive WTU barracks and headquarters; Forts Campbell, Carson, Polk, and Stewart will receive WTU SFACs; and Fort Hood will receive a WTU SFAC. The Army will address additional emerging Warrior in Transition barracks and SFAC requirements in future budget requests.

The Army is also participating in DoD workgroup efforts to jointly identify, develop, and implement effective support for the care and management of Warriors in Transition and their Families. The focus of the DoD workgroup is to identify effective

practices and design a system to provide continuity of quality care and services delivery for Warriors in Transition and their Families from recovery to rehabilitation and reintegration, that is consistent across the Army. The Army is also providing the Families of both Warriors in Transition and Fallen Soldiers the highest priority for SFAC services and support.

In addition to care for Warriors in Transition and their Families, the Army has developed a holistic multi-agency and multi-component strategy to provide consistent and quality Survivor Outreach Support for survivors of the fallen. This initiative will centralize casualty case management and operations, decentralize programs and services, provide a quality assurance standard to evaluate the effectiveness and efficiencies of services delivery, provide program outcome measures, and improve financial services for survivors.

Thank you for holding this hearing and for your continued support of the Warriors and Families that we are honored to serve. We look forward to your questions.

WITNESS RESPONSES TO QUESTIONS ASKED DURING THE HEARING

JULY 22, 2008

RESPONSE TO QUESTION SUBMITTED BY MRS. DAVIS

General RUBENSTEIN. The Military Treatment Facilities experiencing the slowest average processing times for Medical Evaluation Boards in July 2008 were Fort Drum, New York; Fort Riley, Kansas; and Fort Hood, Texas. [See page 28.]

QUESTIONS SUBMITTED BY MEMBERS POST HEARING

JULY 22, 2008

QUESTIONS SUBMITTED BY MRS. DAVIS

Mrs. DAVIS. One of the problems identified at Walter Reed last year was that using wounded warriors as squad leaders and platoon sergeants was not a good idea. In fact, that would appear to be the philosophical underpinning of the entire Army Medical Action Plan. However, that seems to be happening at least two Warrior Transition Units that the staff visited, Fort Polk and Fort Drum. Feedback from both the warriors in transition and the cadre indicate that these soldiers are performing, but that the cost is too high. Perhaps the most telling quote was from a warrior in transition serving as a squad leader who said, "I'm an NCO, and a proud one at that, so I will accomplish my mission. But as a squad leader, my mission is to take care of my soldiers. My mission is no longer healing myself." How did this happen? What steps are being taken to fix this?

General ROCHELLE, General CHEEK, General RUBENSTEIN, and General WILSON. A thorough examination of current practice reveals that established guidance is being followed, and that there are no issues with regard to the manner in which Warriors in Transition are being allowed to participate in therapeutic work activities in Warrior Transition Units (WTUs).

No Warrior in Transition is required to assume the duties of a WTU cadre member. More importantly, the U.S. Army Medical Command (MEDCOM) established stringent criteria for Warrior in Transition participation in WTU cadre duties in Fragmentary Order 17 to MEDCOM Operation Order 07-55, which states:

> Warriors in Transition will only be assigned as duty drivers and fill WTU cadre positions while assigned to WTUs on a case-by-case basis with the approval of the local WTU Commander and or Command Sergeant Major/First Sergeant. The assignment of WTs as duty drivers and WTU cadre will be the exception and not the rule.

Further, preparing to transition back to the force or to a productive civilian and/or veteran status is an important element of the Warrior in Transition's mission to heal. Hence, functioning as a WTU cadre member can be part of the healing mission.

As of October 22, 2008, only 15 Warriors in Transition are performing duties as WTU cadre members (out of a population of 9,878 Warriors in Transition assigned or attached to WTUs and an additional 1,415 Warriors in Transition attached to Community Based WTUs (CBWTUs)). Of these 15, one was recently continued on Active Duty; two are currently transitioning to continued on Active Reserve status, effective November 1; one has healed and is awaiting transfer to an Active Component unit; one has recovered and will be assigned to an Active Component unit as Battalion Executive Officer, beginning in November; five are attached to a CBWTU and are functioning in CBWTU cadre positions as their regular duty due to a lack of other duty positions near their homes; and the remaining five have been determined by the Triad of Care to be sufficiently recovered to function in WTU Squad Leader (4 individuals) and Platoon Sergeant (1 individual) positions as part of their therapeutic work requirement as they continue to heal and prepare to transition back to the force. None of these 15 WTs are from Fort Polk or Fort Drum.

The current system of managing Warrior in Transition care is working well. As part of the process of assessing the ability of each of the previously mentioned Warriors in Transition to function in WTU cadre positions, the Triad of Care developed risk mitigation plans. These are carefully structured plans to determine if cadre duty is appropriate and it requires the approval of the WTU Commander. Additionally, the Triad of Care, with the input of other medical and health care professionals involved with the care of these Soldiers, develops a Comprehensive Transition Plan to guide the management of the therapeutic work activities of Warriors in Transition who are assigned WTU cadre duties to ensure they continue to contribute to the healing and transition process. The fact that only one tenth of one percent of Warriors in Transition are performing WTU cadre duties is an indication that the prescribed case-by-case approach is being applied judiciously.

Mrs. DAVIS. At just about every Warrior Transition Unit the staff has visited, they heard frustration from both the warriors in transition and the cadre that it was too

difficult to get soldiers transferred to a Community Based Healthcare Organization. Is there a backlog at the Community Based Healthcare Organizations? We have heard from senior Army leaders that they actually prefer the Community Based Healthcare Organizations to Warrior Transition Units. Do you gentlemen agree? If so, what can be done to facilitate the transfer of warriors in transition to these units?

General ROCHELLE, General CHEEK, General RUBENSTEIN, and General WILSON. The Army leadership is committed to the appropriate placement of Reserve Component (RC) Warriors in Transition in Community Based Warrior Transition Units (CBWTUs). This process does, in some cases, require significant examination of the environment of care. However, every effort is made to expedite this process to ensure that eligible RC Warriors in Transition can return to the familiar surroundings of home as quickly as possible, confident in the fact that they will receive the care they require.

A backlog does not exist at any of the nine CBWTUs. In fact, the Army prefers to return RC Warriors in Transition Soldiers to locations as near as possible to their homes to complete their healing, provided Military Treatment Facilities. Veterans Affairs Facilities, or community medical resources are available to provide the care the Warrior in Transition requires.

Army Medical Command policy stipulates that all RC Warriors in Transition be evaluated within 30 days of their arrival at the WTU for potential transfer to a CBWTU to complete their care. This evaluation is comprehensive and involves making several determinations. First, a determination is made regarding whether the RC Warrior in Transition's treatment plan indicates a requirement for at least 60 days of medical care. Second, a determination is made (which may require examination of the medical resources in a location not previously evaluated) regarding whether appropriate medical care is available within a reasonable distance from the RC Warrior in Transition's home. Third, since a key tenet of the Warrior Care and Transition Plan is to engage Warriors in Transition in meaningful work, a determination is made regarding whether an appropriate duty location exists within reasonable travel distance. Finally, a determination is made regarding whether a particular RC Warrior in Transition demonstrates the reliability and responsibility required for remote management (e.g., no Uniform Code of Military Justice actions pending, existing behavioral health requirements can be managed within the community, no drug or alcohol abuse issues are known to be present, etc.).

Once the above evaluation is complete and a RC Warrior in Transition is determined to be eligible for transfer to a CBWTU, the Human Resource Command mobilization office prepares orders attaching the Soldier (who is on Medical Retention Processing (MRP) orders) to the CBWTU. It is important to note that such orders are attachment orders only, and that all CBWTU Soldiers continue to be assigned to a WTU to ease their return should a change in their condition require the more structured management of such a unit. Considerable evaluation of this order generation process has been conducted to make certain it is timely.

Mrs. DAVIS. We understand that there are three different personnel systems in the Army, one each for the active Army, the Army Reserve, and the Army National Guard. When the Army Medical Action Plan was in development, there was some thought given to ensuring that each WTU had access to all three systems, with three personnel specialists (one from each component) assigned to make sure the WTU could properly manage all of the administrative requirements for the WTs. However, the decision was made not to do this, but to wait for the planned October 2008 roll-out of the Defense Integrated Military Human Resources System (DIEmers). The roll-out of that system has now been delayed until March 2009 at the earliest. As a result, most WTUs only have access to the active Army system, and have to rely on work-arounds for WTs from the Army Reserve and Army National Guard. How does the Army plan to address this in the short term?

General ROCHELLE, General CHEEK, General RUBENSTEIN, and General WILSON. The Active and Reserve components currently maintain unique human resource (HR) systems. Active component HR transactions are completed using the Electronic Military Personnel Office (eMILPO), the Total Officer Personnel Management Information System (TOPMIS), and the Enlisted Distribution Assignment System (EDAS); Army Reserve HR transactions are completed using the Regional Level Application Software (RLAS) and Army Reserve Personnel Center Orders and Resource System (AORS); and Army National Guard HR transactions are completed using the Standard Installation and Division Personnel Report System (SIDPERS). Because these systems do not interface readily with each other, the Department of Defense directed the development and implementation and of the Defense Integrated Military Human Resource System (DIMHRS) by March of 2009. Once implemented, this

system will facilitate tracking of all DOD personnel, regardless of component affiliation.

Warrior Transition Units (WTUs) currently use the interactive Personnel Electronic Records Management System (iPERMS) to track WTU orders, regardless of component. WTUs do not have direct access to RLAS and SIDPERS because both systems require a hard drop and have significant fire wall protections that preclude direct access to them. The cost to install these systems at each WTU is significant and would require months or years to complete. With the implementation of DIMHRS projected to occur in less than six months, the Army decided not to invest in the hard drops required for these systems.

During the 2008 Warrior Care and Transition Office (WCTO) Fall Conference, information was collected from all the HR participants that permitted the Army to forward access enrollment forms for the various HR systems to them. Currently, all WTUs that sent HR participants to the conference have access to all of the HR systems except RLAS and SIDPERS.

Although WTUs do not have direct access to SIDPERS and RLAS, they have coordinated with local installation support activities and state and National Guard Bureau headquarters to obtain the assistance. In response, the National Guard Bureau and the United States Army Reserve Command have identified direct points of contact that are available to assist WTUs in obtaining required information in order to satisfy their administrative HR processing requirements.

Mrs. DAVIS. I would like to ask about the practicality and desirability of voluntary retiree recalls addressing some of the Warrior Transition Unit staffing shortfalls. Mr. McHugh has repeatedly and rightly asked about this in the past. As the members and staff of this subcommittee have visited Warrior Transition Units, we are constantly struck by the number of retired military nurses, doctors, physician assistants, personnel specialists, and others who now work for Warrior Transition Units. We feel so fortunate that these patriots continue to serve our soldiers in retirement. It is hard to imagine a more qualified group to fill these roles. However, it begs the question, why is the Army not offering these same people the opportunity to come back on active duty to fill these positions? A quick look at the number of medical providers who have retired in just the past five years suggests that even enticing a tiny fraction back on to active duty would alleviate the Warrior Transition Unit shortfalls in Primary Care Managers and Nurse Case Managers.

General ROCHELLE, General CHEEK, General RUBENSTEIN, and General WILSON. The recall of retired Army Medical Department (AMEDD) personnel is governed by Title 10, United States Code, Sections 688 and 12301d; DoD Directive 1352.1, Management and Mobilization of Regular and Reserve Retired Military Members; Army Regulation 601-10, Management and Mobilization of Retired Soldiers of the Army; and the Department of the Army Personnel Policy Guidance for Contingency Operations in Support of GWOT. The Army Human Resources Command (HRC) in both Alexandria and St. Louis, the Army G-1, the Office of The Surgeon General, and the Assistant Secretary of the Army for Manpower and Reserve Affairs all play a role and have responsibilities in the retiree recall process, with HRC serving as the Army lead for processing requests.

The AMEDD solicits volunteers from the retirement community and has had great success. Since 2004, the AMEDD has recalled over 165 retired physicians, dentists, nurses, behavioral health and administrative personnel to fill valid vacancies. The AMEDD continues to receive a steady flow of retiree volunteers. Specific to the WTUs, the Chief, Army Nurse Corps and the Army G-1 jointly sent out a letter dated July 21, 2008 soliciting retired Army nurses to volunteer to serve as nurse case managers. Since this request, the AMEDD has recalled five Army case managers and has nine pending. The AMEDD has also used exceptions to policy to extend current active duty Soldiers beyond their mandatory retirement and release date in support of the AMEDD mission.

Mrs. DAVIS. We understand the process for a retiree to request a recall is unbelievably long and difficult. Just last week the staff heard from a chaplain who was willing to leave their civilian job specifically to go work for a Warrior Transition Unit, and the seemingly needless hoops that they were forced to go through. What is the Army doing to leverage your retiree population? Why are you not doing more?

General ROCHELLE, General CHEEK, General RUBENSTEIN, and General WILSON. The Army Medical Community continually seeks Retirees to fill cadre positions at Warrior Transition Units. The time taken to complete this process has been reduced from months to an average of 30 days. Retirees from special branches—Medical Corps, Chaplain Corps, Aviation, and Judge Advocate Corps—require more checks to ensure they have retained their skills and credentials, thus a slight increase in processing time.

The Army, beginning in July 07, has taken several steps to make processing retiree recalls more efficient and effective, such as conducting physical exams during in-processing, utilizing requirements-based requests to recall Retired Soldiers to Active Duty, simplification of endorsement requirements for Retiree packets, and approval of Colonel/Senior Executive Service endorsement of Category I, II Retirees. These changes to the policy have improved the processing time for by-name requests originating in units and Commands. Efforts are currently underway to automate the recall process thus allowing a Retiree to view online available positions, submit a request for recall, and receive confirmation and orders, which will further help streamline the volunteer process.

Mrs. DAVIS. We have heard stories by the Warrior Transition Unit cadre that part of the reason some WTUs are being overwhelmed is that they are being "abused" by reserve component mobilization sites. Specifically, the cadres have complained that at many installations, all reserve component personnel who are diagnosed with an illness or injury 25 days or later after mobilization are automatically assigned to the WTU. The cadres have described how many of these soldiers should never have been mobilized in the first place, that they were clearly not medically fit before they were mobilized. What steps are being taken to ensure that an adequate medical screening is taking place before reservists are mobilized?

General ROCHELLE, General CHEEK, General RUBENSTEIN, and General WILSON. The Army is ensuring that adequate medical screening is taking place before Reserve Component Soldiers are mobilized. All Army National Guard and Army Reserve Soldiers go through several levels of screening to identify non-deployable conditions prior to deployment.

The Periodic Health Assessment (PHA) has replaced the 5-year physical. This annual screening is highly focused on readiness and will improve identification of medical nondeployables throughout the ARFORGEN deployment cycle. Additionally, Soldiers are screened with a DD 2795 Pre-Deployment Health Assessment. The DD 2795 screening is conducted through a unit-level Soldier Readiness Process (SRP) event approximately 270 days prior to the Soldiers' mobilization station arrival date (MSAD) and is validated upon arrival at the mobilization site. All Soldiers are required to have an annual dental screening and correct significant dental problems prior to deployment.

All Reserve Component Soldiers also participate in a level II SRP as soon as possible after their unit is alerted, but no later than 30 to 90 days prior to MSAD. For the Army National Guard, the Soldier's State conducts the level II SRP. For the Army Reserve, the Soldier's Regional Readiness Command (RRC)/Regional Support Command (RSC) conducts the level II SRPs. During the level II SRP, medical/dental staff confirm that the Soldier has completed all required medical and dental readiness exams. Those identified with discrepancies are reported to the unit commander for follow up action. The Unit Commander utilizes the Reserve Health Readiness Proaram or contractors to eliminate readiness deficiencies.

In fiscal year 2008, the Army National Guard Directorate and the United States Army Reserve Command published guidance reemphasizing the level I and II SRP responsibilities for all Reserve Component Commanders.

A third screening takes place upon mobilization when the Soldier receives a Soldier Readiness Check (SRC) at the mobilization site prior to starting field training. The Soldier receives an additional SRC within 30 days of their actual deployment. If a Soldier is cleared at the SRC during mobilization and subsequently becomes ill, is injured, or aggravates a pre-existing condition, then the Soldier is eligible for assignment to the WTU.

Mrs. DAVIS. The phrase "the best barracks on post" was used in your opening statement, in the Army Medical Action Plan Execution Order, and in subsequent Fragmentary Orders. However, that does not always seem to be the case. For example, at Fort Bliss, the Warriors in Transition are in Tier II or transient barracks. At what other installations is this the case? What are you doing to meet your own standard of "the best barracks on post"?

General WILSON. In all cases at all installations, Warriors in Transition (WT) are located in the best available barracks on post. For WTs, the best barracks are those modified to meet their special needs. WT barracks have been modified, or are being modified, to improve accessibility. Modifications include wheelchair ramps, elevators, handicap crosswalks, lever latches on doors, lever faucets on sinks, keyless entries, widening doors, removing thresholds, improving bathroom accessibility, Americans with Disabilities Act (ADA) compliant furniture, and many other features.

The location of WT barracks on an installation is a critical factor in determining the best available barracks on post. The specific location is a decision jointly reached by the Senior Mission Commander, Medical Treatment Facility, and Garrison Com-

mander based on various factors, such as the needs of WTs, proximity to medical treatment facilities, the installation's transportation network, and an environment that promotes healing.

The Army is establishing dedicated standards and requesting new construction in supplemental appropriations. The Army standard for new WT barracks consists of two-bedroom with shared bath, and two-bedroom with private bath modules. The dimensions, in general, are greater than existing permanent party billeting standards to meet ADA circulation requirements.

QUESTIONS SUBMITTED BY MR. MCHUGH

Mr. MCHUGH. During the committee staff visits, case managers, squad leaders and warriors in transition told the staff that they often felt that the narrative summary included in the MEB packet did not accurately reflect the soldier's complete medical condition. This was particularly true when the soldier had a mental health diagnosis. What assurances can you provide us that any attempt to streamline or speed up the MED process will not negatively affect the accuracy of the MEB?

General WILSON. The U.S. Army Medical Command (MEDCOM) and the Physical Disability Agency (PDA) are developing a statement to be signed by the Soldier (or a Family Member in cases where the Soldier is identified with a behavioral health diagnosis) before the Soldier's Medical Evaluation Board (MEB) case is forwarded to the Physical Evaluation Board (PEB). This statement will require the Soldier to either confirm that there are no discrepancies between the Medical Evaluation Board Proceedings (DA Form 3947), the medical narrative summary (NARSUM), and the permanent profile (DA Form 3349) or identify the discrepancies. In addition, ongoing MEB streamlining initiatives have recommended process changes to ensure that Soldiers and Families are given sufficient time to obtain an independent NARSUM review and consult with an attorney regarding their case and any appeal. Finally, MEDCOM is evaluating a best business practice that requires the Soldier's presence during the generation of the NARSUM so that issue discussion and document generation occur simultaneously.

Mr. MCHUGH. Last year the Wounded Warrior Assistance Act of 2007 and the House version of the National Defense Authorization Act for Fiscal Year 2008 included a provision that established the requirement for case managers for wounded warriors at a ratio of not more than 17 soldiers per case manager. The Army disagreed with legislated ratios and on several occasions, including during testimony before the subcommittee, asked for latitude to use experience and lessons learned to determine appropriate ratios for Warrior in Transition and for Congress to not micromanage that process. We gave you that latitude and now our staff finds that the ratios for case managers and squad leaders at almost all of the WTUs they visited, far exceed the ratios set by the Amy. a. What happened? b. Were the ratios set by the Army incorrect? c. How will the new ratio of 1:20 for case managers included in the latest FRAGO improve the care of the soldiers? d. Given the resources constraints that already exist, how will you provide the additional case managers?

General WILSON. The Army has addressed staffing ratio issues with the publication and execution of FRAGO 3. Staffing ratios and position requirements for WTUs will continue to be reviewed on an ongoing basis.

a. The dramatic increase in our population of Warriors in Transition challenged us to keep pace with sufficient WTU cadre, care providers, and facilities for these deserving Soldiers and their Families. The Army had been using a peacetime process to build and staff Warrior Transition Units. This process was not responsive to the rapid population growth experienced in our WTUs as Soldiers undergoing Medical Evaluation Boards were being moved to the WTUs. FRAGO 3 specifically addressed this shortfall by: (1) establishing entry and exit criteria to the WTU; (2) directing new staffing ratios for cadre and care providers; and (3) authorizing the Triad of Leadership, which consists of the Senior Commander, the Military Treatment Facility Commander, and the WTU Commander, at each installation to fill WTU requirements on a priority basis.

b. The ratios originally established by the Army were not optimal in some cases. This was demonstrated during a thorough manpower analysis completed in early 2008 by the U.S. Army Manpower Analysis Agency (USAMAA). As a result of this analysis, USAMAA recommended we modify the staff to Warrior in Transition ratios in certain positions such as Nurse Case Manager (from 1:36 to 1:20), Squad Leader (from 1:12 to 1:10), and Platoon Sergeant (from 1:35 to 1:40). These changes were directed in FRAGO 3 to DA EXORD 118-07 and were effective October 17, 2008. Position requirements for WTUs continue to be reviewed on an ongoing basis and adjusted quarterly.

c. Our experience over the past 16 months has indicated that the Triad of Care is an extremely effective approach to managing the care of Warriors in Transition. The revised ratios will allow Nurse Case Managers and Squad Leaders to concentrate their attention on fewer Warriors in Transition, thereby enabling them to focus more effectively on the requirements of each Soldier and his/her Family. Coupled with the implementation of the Comprehensive Transition Plan that provides a detailed roadmap for recovery, rehabilitation, and reintegration for each Warrior in Transition, the Triad of Care will be able to manage more effectively the care and progress of each assigned Soldier.

d. In anticipation of the programmed TDA change directed in FRAGO 3, all WTUs have been staffed at or above 100% of requirements based on the Warrior in Transition population. As a result, much of the additional staffing requirement was in place prior to the October 17, 2008 effective date. Additionally, the Triad of Leadership has been authorized to fill any remaining requirements on a priority basis from existing installation resources or by hiring required personnel. This responsive approach is expected to ensure complete staffing of each WTU based on the Warrior in Transition census.

Mr. MCHUGH. In light of assurances from the Army leadership that the WTUs along with the Army Medical Action Plan will fix the problems uncovered last year at Walter Reed, I am concerned that some of the problems have continued in the WTUs. For example, in at least two WTUs, Fort Polk and Fort Drum, recovering warriors in transition are filling squad leader positions. In some cases, they are functioning as assistant squad leaders because there is no back up for a squad leader when they take leave or attend military schools. Why is this still happening? What additional positions will the Army provide to allow coverage for squad leaders and the other personnel in the triad?

General WILSON. No Warrior in Transition is required to assume the duties of a WTU cadre member. More importantly, the U.S. Army Medical Command (MEDCOM) established stringent criteria for Warrior in Transition participation in WTU cadre duties in Fragmentary Order 17 to MEDCOM Operation Order 07-55 which states:

> Warriors in Transition will only be assigned as duty drivers and fill WTU cadre positions while assigned to WTUs on a case by case basis with the approval of the local WTU Commander and or Command Sergeant Major/First Sergeant. The assignment of WTs as duty drivers and WTU cadre will be the exception and not the rule.

Further, preparing to transition back to the force or to a productive civilian and/or veteran status is an important element of the Warrior in Transition's mission to heal. Hence, functioning as a WTU cadre member can be part of the healing mission.

As of October 22, 2008, only 15 Warriors in Transition are performing duties as WTU cadre members (out of a population of 9,878 Warriors in Transition assigned or attached to WTUs and an additional 1,415 Warriors in Transition attached to Community Based WTUs (CBWTUs)). Of these 15, one was recently continued on Active Duty; two are currently transitioning to continued on Active Reserve status, effective November 1; one has healed and is awaiting transfer to an Active Component unit; one has recovered and will be assigned to an Active Component unit as Battalion Executive Officer, beginning in November; five are attached to a CBWTU and are functioning in CBWTU cadre positions as their regular duty due to a lack of other duty positions near their homes; and the remaining five have been determined by the Triad of Care to be sufficiently recovered to function in WTU Squad Leader (4 individuals) and Platoon Sergeant (1 individual) positions as part of their therapeutic work requirement as they continue to heal and prepare to transition back to the force. None of these 15 WTs are from Fort Polk or Fort Drum.

The current system of managing Warrior in Transition care is working well. As part of the process of assessing the ability of each of the previously mentioned 15 Warriors in Transition to function in WTU cadre positions, the Triad of Care developed risk mitigation plans. These are carefully structured plans to determine if cadre duty is appropriate and it requires the approval of the WTU Commander. Additionally, the Triad of Care, with the input of other medical and health care professionals involved with the care of these Soldiers, develops a Comprehensive Transition Plan to guide the management of the therapeutic work activities of Warriors in Transition who are assigned WTU cadre duties to ensure they continue to contribute to the healing and transition process. The fact that only one tenth of one percent of Warriors in Transition are performing WTU cadre duties is an indication that the prescribed case-by-case approach is being applied judiciously.

The Army has no plans to build additional positions to allow back-up coverage for squad leaders and the other personnel in the triad. The new ratio of cadre to Warriors in Transition was determined to be appropriate to manage Warriors in Transition. These ratios are based on a careful and thorough manpower analysis conducted by the U.S. Army Manpower Analysis Agency in May of 2008. Further assessments of WTU staffing will continue on a quarterly basis.

Mr. MCHUGH. For various reasons many warriors in transition require transportation beyond the normal shuttle bus service provided on most Army installations. Each WTU has a different system for providing this transportation. Some use contract drivers with government vehicles. Others reply on the squad leaders to drive the government vehicles and a few employ warriors in transition using government vehicles to drive their fellow warriors. Squad leaders have reported that due to shortages in government vehicles they are often required to use their private vehicles, sometimes driving over 25 miles per day at their own expense. It was my understanding that the practice of using recovering soldiers as drivers had stopped. I would like your thoughts on the best way to provide this transportation and your plans for any changes to the system.

General WILSON. The Army has re-evaluated the original vehicle support requirements for Warrior Transition Units (WTUs) and has identified the shortfalls that required WTU cadre to use their personal vehicles. The Army is addressing these shortfalls in a variety of ways at the local, regional, and Army levels including reallocating vehicles from existing Army inventories and/or entering into short-term local contracts to meet surges in WTU transportation requirements. We are resolving shortfalls in driver support requirements through a combination of hired civilian drivers, contract drivers, Military Treatment Facility personnel, WTU cadre, and in very limited cases, Warriors in Transition. WTUs also have the ability to request additional vehicle support from the installation when needed. WTU cadre members' personal vehicles are used only on an exceptional and reimbursable basis when available transportation assets are not sufficient to meet demand. WTU leaders know to request additional contracted vehicle support when cadre members are using their personal vehicles on more than an exceptional basis.

Mr. MCHUGH. The June 2008 AMAP execution order requires that warriors in transition live in billets, housing, or lodging, at or above Army billeting standards that accommodate the soldier's medical conditions or limitations. At Fort Bliss, WTU soldiers are living in Tier II or transient barracks that are not considered the best barracks on post. a. Why are the WTU soldiers living in Tier II barracks? b. What is the Army's plan for moving the soldiers into barracks that meet the required standards? c. When will the soldiers move?

General WILSON. The current WT facilities at Fort Bliss and across the Army are in overall good condition, with no life, health, or safety issues. Fort Bliss selected the best facilities to support WT medical and logistical needs based on suitable Soldier rooms; availability of administration and counseling space for case managers; proximity to dining facility, medical counseling, Army Community Service, interim Soldier Family Assistance Center (SFAC), key MWR facilities and other support services (PX, commissary, banks, post office, etc.), the Fort Bliss USO Center; and ability to execute ADA-compliant facility improvements. Other barracks, which may be better in terms of infrastructure and age, are not ADA compliant and do not meet specific WT needs.

Fort Bliss is committed to raising WT barracks to the highest possible standards by customizing these barracks through a series of renovation projects. The Army funded $8.8 million in August 2007 to renovate existing WTU facilities as an interim enhancement until permanent facilities are constructed. Three sets of barracks are currently under renovation, with a projected completion date of October 2008. Renovation includes ADA compliance upgrades (additional ramps, elevators, accessible rest rooms, and common areas) and other improvements such as individual room renovations. This is in addition to previous renovations, which included air conditioning upgrades completed last year.

The Army is requesting permanent WTU facilities for Fort Bliss in the fiscal year 2009 GWOT supplemental for $56 million, which will include a complete ADA compliant complex for barracks, headquarters, and a permanent SFAC. The Fort Bliss plan, when completed, will ensure that WT barracks are the best on post. The existing barracks will be used as overflow until the permanent WTU complex is constructed.

Mr. MCHUGH. WTUs soldiers and cadre consistently voice concern about their inability to get promoted or selected for school while they are in the WTU. This seems to be a particular problem for reserve component personnel and I would imagine it plays a part in an individual's decision to join the cadre of a WTU. Why are the warriors in transition and cadre having difficulty getting promoted or selected for

school? What are your plans for ensuring that WTU assignments do not become a hindrance to soldiers' careers?

General ROCHELLE. The Army has already taken numerous steps to ensure that Soldiers assigned as WTU cadre members and Warriors in Transition remain competitive for promotion. Promotion policy changes already implemented include the waiver of initial Professional Military Education (PME) requirements for promotion; the addition of specified promotion board guidance within the centralized promotion selection process for both WTU cadre members and Warriors in Transition; the authority to accelerate the advancement of Soldiers to the rank of SPC (E4) based on the total number of Soldiers qssigned as patients; and changes to the method of computing promotion points to SGT/SSG to ensure that Soldiers who have temporary or permanent physical profiles stemming from wounds or injuries directly related to combat operations are not disadvantaged by their inability to take a Army Physical.Fitness Test.

For Reserve Component (RC) WTU cadre members and Warriors in Transition, selection for promotion remains a vacancy-driven process that is tied to requirements in their parent RC unit. RCWTU cadre members and Warriors in Transition remain eligible for promotion selection while assigned to a WTU in the same manner as all mobilized RC Soldiers. If selected for promotion they are promoted against their RC parent unit of assignment requirements. Upon release from active duty, all RC Soldiers who were promoted while mobilized have one year from date of release from active duty to be assigned to a valid position to retain their promotion. Promotable RC WTU Soldiers who are separated from the military or retired for medical disability are promoted at that time.

The Army does not centrally select Soldiers for PME except for attendance at the United States Army Sergeants Major Academy. RC Soldiers assigned as cadre to a WTU and Warriors in Transition remain eligible for selection to attend PME. For RC cadre, selection for and attendance to PME does not normally present a challenge. However, there are occasions when multiple members of a WTU are scheduled to attend PME courses at the same or overlapping times. In such cases, the WTU chain of command may request select cadre members be rescheduled for alternate classes to ensure sufficient cadre are present for duty to accomplish the WTU mission. For Warriors in Transition, the Army's primary mission and concern is to ensure these Soldiers receive the best possible medical care to restore them to their maximum level of medical fitness.

Mr. MCHUGH. It appears that one of the biggest challenges for Army medicine right now is providing mental health care to the warriors in transition and their families. I understand that providing inpatient psychiatric care is particularly difficult since many Army hospitals do not currently have this capability. I am told that in some areas the nearest available inpatient psychiatric care may be in the next state. What is your plan for providing comprehensive and timely mental health care, to include appropriate inpatient and partial hospitalization, for the warriors in transition and their families?

General RUBENSTEIN. The Army currently relies on local or regional civilian inpatient facilities and Veterans Affairs inpatient facilities to provide most inpatient psychiatric services; however, the Army does have thirteen military treatment facilities that can also provide these services. These facilities are located at Fort Bliss, TX; Fort Hood, TX; Fort Leonard Wood, MO; Walter Reed Army Medical Center, Washington, DC; Fort Bragg, NC; Fort Gordon, GA; Fort Benning, GA; Fort Stewart, GA; Fort Jackson, SC; Madigan Army Medical Center, WA; Landstuhl Regional Medical Center, Germany; Tripler Army Medical Center, HI; and Korea. In addition, Brooke Army Medical Center uses dedicated bed space provided by the Air Force at Wilford Hall Hospital for inpatient psychiatric care.

The Army also has long-standing intensive outpatient programs (IOP) at Walter Reed Army Medical Center. Additionally, the Army is funding an IOP pilot at Tripler Army Medical Center and Eisenhower Army Medical Center, with the intent to standardize and execute intensive outpatient within each of our six Regional Medical Commands.

To increase behavioral health care to wounded warriors, the Army hired 115 Social Workers in WTUs to provide surveillance and direct services to wounded warriors and their Families. Priority of effort has been on comprehensive psychosocial assessments and risk management, completion of the Comprehensive Care Plan, and compliance with the Risk Assessment and Mitigation Policy.

The Army has likewise expanded the delivery of behavioral healthcare services for the total force. In FY08, the Army received over $120 million in supplemental funds to provide enhanced psychological health services. This funding has been used to hire over 285 behavioral health providers, including 42 marriage and family therapists, and to fund over 45 programs to improve access to care, resilience, quality

of care, and surveillance. The Army has also invested over $12 million in FY08 in facilities and inpatient renovations and expansion. Significant among these was the renovation of the Walter Reed Army Medical Center and Tripler Army Medical Center psychiatric inpatient wards and the expansion of the inpatient capability at the Dwight David Eisenhower Medical Center at Fort Gordon, GA, from 6 to 16 beds. In FY09, the Army plans to continue to assess the existing inpatient capabilities at installations and renovate or expand these capabilities as appropriate.

Finally, the Army is in the process of developing a Comprehensive Soldier Fitness Strategy which includes the six categories of wellness (social, spiritual, emotional, family/finance, career and physical). The strategy recognizes the need to enhance the current health of Soldiers and their Families, prevent future problems, and provide treatment when problems arise.

Warriors in Transition receive priority appointments and medical care, but the Army also provides inpatient and intensive outpatient psychiatric care to other eligible beneficiaries and the availability of such care varies from installation to installation.

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