RECORD VERSION

STATEMENT BY
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THE SURGEON GENERAL
UNITED STATES ARMY

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Chairman Young, Chairman Rogers, Ranking Member Visclosky, and distinguished members of the subcommittee, thank you for the opportunity to tell the Army Medicine story and highlight the incredible work of the dedicated men and women I am honored to serve with. On behalf of the over 150,000 dedicated Soldiers and civilians that make up Army Medicine, I extend our appreciation to Congress for the support to military medicine faithfully given, which provides the resources we need to deliver leading edge health services to our Warriors, Families and Retirees.

I would like to start by acknowledging America's sons and daughters who are still in harm's way -- today we have nearly 80,000 Soldiers committed to operations around the world, doing the hard work of freedom. I have recently had the pleasure to talk with some of the men and women currently serving in the combat theater of operations during my trip with my fellow Surgeons General and Dr Karen Guice to Afghanistan. Despite austere conditions and separation from those they love, these courageous men and women are saving lives through teamwork in a joint environment.

Since 1775, America's medical personnel have stood shoulder to shoulder with our fighting troops, received them at home when they returned, and stand ready today when called upon to put their lives on the line to care for our wounded Soldiers. While the wounds of war have been ours to mend and heal during a period of persistent conflict, every day our Soldiers and their Families are kept from injuries, illnesses, and combat wounds through our health promotion and prevention efforts; are treated in state-of-the-art fashion when prevention fails; and are served by an extraordinarily talented medical Force.

Not Until I have Your Wounded

We are at our best when we operate as part of a Joint Team. It is our collective effort – Army, Air Force and Navy - that saves lives on the battlefield. It could be an Army MEDEVAC crew moving a wounded Service Member from the point of injury to a jointly staffed Role III field hospital. It is the Air Force provided aeromedical evacuation to Landstuhl Regional Medical Center where a triservice medical care team provides further definitive care. And then finally it is a joint team's capabilities at locations such as

Walter Reed National Military Medical Center and the San Antonio Military Medical Center that provide the critical care and rehabilitative medicine for this Service member, regardless if they are a Soldier, Sailor, Airman, or Marine. The AMEDD is focused on building upon these successes on the battlefield as we perform our mission at home and is further cementing our commitment to working as a combined team, anywhere, anytime.

On today's battlefield, military medicine continues to refine the way that we evacuate our critical casualties. Within the last year, we conducted a successful proof of concept study on administration of blood products onboard US Medical Evacuation (MEDEVAC) aircrafts. Originating in Regional Commands South and Southwest, we are now expanding this capability across all US MEDEVAC units in the Combined Joint Operations Area-Afghanistan (CJOA-A). The rapid replacement of blood volume during transport will undoubtedly prove to save even more lives in the future.

We have placed Critical Care Nurses on board combat MEDEVAC platforms to assist in the transport of critical casualties between our Role 2 and Role 3 medical facilities. This capability, known as the Enroute Critical Care Nursing (ECCN) program, is designed to enhance the outcomes for severely injured patients following initial lifesaving resuscitation and surgical treatment.

Our Army is charged with being prepared to face tomorrow's challenges, remaining relevant for the future ahead of us. As we continue to care for the needs of the current Force, we must also anticipate how our National Defense Strategic pivot to the Asia-Pacific could influence the medical requirements of our Military. Army Medicine acknowledges that this is both a time of challenges - and a time of great possibilities.

A Call to Action: Army Medicine 2020

The reality is that after more than a decade of war, our Military and our Nation face a time of significant changes and challenges. Army Medicine is impacted by both the National healthcare conversation and the direction of the Military Health System (MHS). As a part of the MHS, our strategy is aligned with the Army and the MHS.

The Army Medicine 2020 strategy is a Call to Action that contains the vision, strategic imperatives and way ahead for Army Medicine to move from a healthcare system to a System for Health. This strategy aligns with and supports the Army's vision for 2020, the Army's Ready and Resilient Campaign Plan and the MHS Quadruple Aim.

Health is a critical enabler of readiness, and Army Medicine is a valuable partner is making our Force 'Army Strong.' By moving from a disease model to a health model, we can impact health on a National level. The health of the military and the health of the Nation are not separate discussions. Our Nation's Warriors come from our citizens. During the last 20 years, there has been a dramatic increase in obesity among adults, children and adolescents in the US (according to the 2012 National Examination Survey for 2009-2010*).* Approximately nine million young adults in the prime recruitment ages of 17-24 are too overweight to serve as a member of our Nation's fighting Force. Nationally, only about 25 percent of young adults are eligible to serve. The remaining individuals are not eligible to enlist due to obesity or other disqualifying factors (health, educational, legal).

The United States Army and Armed Forces are not immune to the National health crisis, therefore Army Medicine cannot overlook the issues that affect the health of our population. The youth of today appear to be less prepared for entry-level military physical training than their predecessors, and poor physical conditioning is associated with higher injury risk in those that do qualify for military service. If large numbers of possible recruits are ineligible to serve, and poor activity and nutrition discipline impacts the readiness of those that do enter military service, then the issue is not just a matter of National health. It is a matter of National security.

Army Medicine is *"Strengthening the health of our Nation by improving the health of our Army*." We want to engage the Army Family (Soldiers, Retirees, Family Members and Civilians) in conversations about health in support of greater readiness and better living. This goal complements what we execute today – healthcare here in the states, around the world, and wherever the Army deploys – and does not change the mission to care for Soldiers, Families and Retirees in traditional healthcare settings.

This is a Call to Action – Healthcare in the United States is at a turning point, and the Military Health System has an opportunity to lead the Nation away from the status quo. The transformation of Army Medicine from a healthcare system to a System for Health begins now.

A Ready & Resilient Force: The Ready and Resilient Campaign Plan

In 2012, the Army lost 183 Soldiers to suicide. These tragic losses affect all those left behind, including fellow Soldiers, Families, and communities. Last summer, I was privileged to travel with the Vice Chief of Staff of the Army and my colleagues, the Assistant Chief of Staff for Installation Management (ACSIM) and the Deputy Chief of Staff for Personnel (G1) to six Army installations in order to conduct sensing sessions, collect data and evaluate suicide-prevention efforts and programs. It became clear that our mission extends far beyond suicide. The strain on our people after years of persistent conflict has manifested itself through high-risk behaviors, including acts of violence, excessive use of alcohol, drug abuse and reckless driving. Simply stated, we must find ways to improve the behavioral health and well-being of Soldiers and their Families – 365 days a year.

Secretary of the Army and Chief of Staff of the Army made the decision to synchronize and expand efforts to improve the resiliency of our Soldiers and their Families through the Army's Ready and Resilient Campaign (R2C) Plan. On February 4, 2013, the Secretary of the Army issued a directive calling for the Army to move forward with its R2C plan. The R2C addresses the challenges that stress the Force by synchronizing and integrating the current programs designed to improve the readiness and resilience of Soldiers (Active, Reserve and National Guard), Army Civilians and their Families.

Making resilience a part of Army culture is key to Soldier and unit readiness. By partnering with the line leadership and improving the Soldier health and resilience, Army Medicine improves the readiness and performance of our Nation's Army.

Today, we proactively work to identify, assess, and mitigate issues before they become significant concerns; educating Soldiers to ensure they are aware of, and have

access to, resources and support programs. For those individuals who require additional assistance and resources, Army Medicine stands ready to evaluate, treat, and manage those in need of help.

We must eliminate the perceived stigma of asking for help. This is not simply an issue isolated to the medical community to recognize and resolve. Commands play a critical role in establishing a supportive climate for those who come forward and seek assistance. We continue to partner with the line leadership to improve the overall resiliency, behavioral health and well-being of Soldiers, Families, and Civilians.

Our challenge regarding military suicides is to move forward in a coordinated, multifaceted, and National approach. It will take a team effort across all Army components, jurisdictions and commands, as well as in cooperation with the Department of Health, Congress, National Institute of Mental Health (NIMH) and other willing partners in civilian health-care and research institutes. I can assure the members of this subcommittee that this challenge remains a top priority for the United States Army and for Army Medicine.

A Fit and Healthy Force – The Performance Triad

As part of the Army's R2C efforts, Army Medicine is advocating a culture shift by encouraging every Professional Soldier to develop a mindset that drives them to optimize their own health in order to improve performance and resiliency. There must be an effective way to change mindsets, not just dictate behaviors. As Army Medicine continues to open the aperture, we must look at where health is truly influenced.

Long term success in Army Medicine lies in our ability to effectively impact the "Lifespace." It is in the Lifespace where the choices we make impact our lives and our health. We understand the patient healthcare encounter to be an average interaction of 20 minutes, approximately five times each year. Therefore, the average annual amount of time spent with each patient is 100 minutes; this represents a very small fraction of one's life. It is in between the appointments -- in the Lifespace -- where health really happens and where we desire a different relationship with Soldiers, Families and Retirees. We want to reach beyond the physical boundaries of our medical treatment

facilities. In other words, we want to partner with those entrusted to our care during the other 525,500 minutes of the year where people are living their lives and making their health choices. The connection between health and Army readiness is clear. The more we positively influence health, the better our Army is able to answer our Nation's call.

The Lifespace is where we make decisions on Activity, Nutrition and Sleep (ANS). Army Medicine's operational approach to these three key components of health –activity, nutrition, and sleep -- is the Performance Triad. We want to illustrate to our patients that they can positively impact their health by investing in this triad of factors. Getting back to the basics of Activity, Nutrition, and Sleep---as both Leaders and healthcare providers---will be key in optimizing personal and health, performance and resilience.

Physical activity encompasses more than just exercise at the gym. Regular activity throughout the day can improve health by reducing stress, strengthening the heart and lungs, increasing energy levels, and improving mood. Similarly, quality nutrition and sleep management can serve as key components in promoting health, preventing disease, and achieving or maintaining a healthy body weight. Chronic poor sleep may increase your risk for stroke, cardiovascular disease, diabetes, and obesity. We think better, feel better, and perform better when our bodies are well nourished, well rested, and healthy.

While the Army may have a more visible influence in the Lifespace and health of its Active Duty population, the challenges become greater with the Army Reserve and National Guard – the Reserve Components (RC). The RC provides strategic depth and flexibility to the capabilities of our Force and has a valuable connection to the broader US population. A significant percentage of Army capabilities are within the RC, therefore, when it pertains to readiness of the Force, the Performance Triad is just as important for the reserve component Warriors as it is for those who serve on active duty full-time. Finding innovative ways to extend our influence into the Lifespace of the Reserve and National Guard is an important avenue to pave, and may set the stage for Army Medicine to truly strengthen the health of our Nation by impacting those in uniform who work within our civilian communities.

Across all age groups and medical conditions, the impacts of restful sleep, regular physical activity, and good nutrition are visible in both the short- and long-term. While each component is independently important, optimal performance is achieved when all three are addressed simultaneously. Making lasting changes in health behaviors works best when approached through multiple channels. There will be a change in how we educate our medical providers to view activity, nutrition, and sleep – making the pillars of the Performance Triad a part of any medical encounter.

The Performance Triad is bringing together the US Army Public Health Command (PHC), US Army Medical Research and Materiel Command (MRMC), US Army Forces Command (FORSCOM), Army Medical Department Center and School, US Army Training and Doctrine Command (TRADOC), and the US Army Installation Management Command (IMCOM). The people who have the greatest impact on Soldier behaviors do not reside in military hospitals and clinics – they are the unit leaders, mentors, and Family in the Lifespace. Eventually, I want this to be a part of the DNA of the Army – sleep discipline, daily activity, and good nutritional decisions.

We will implement a Performance Triad pilot program in 2013 at three FORSCOM Battalion-sized units. The pilots will test the program with one element at each location for a total of about 2,200 Soldiers for 180 days. By leveraging public health initiatives, promoting Soldier education and involvement, and increasing leadership engagement, the lessons learned from the pilot program will inform the Performance Triad approach and allow for adjustments to the comprehensive plan before an Army-wide implementation.

Prevention – Public Health Command

The health of the Total Army is essential for readiness and prevention is the best way to health. Prevention—the early identification and mitigation of health risks through surveillance, education, training, and standardization of best public health practices—is crucial to building and sustaining health and resiliency in Army populations and is the foundation for military success.

Protecting Soldiers, Retirees, Family members and Department of Army Civilians from conditions that threaten their health is operationally sound, cost effective and better for individual well-being. Though medical care of our sick and injured will always be necessary, the demands for health care can be reduced through prevention. Army Medicine is continuing to shape this proactive, preventive vision. Our emphasis on fitness, surveillance and disease prevention in the combat theater has led to the lowest Disease Non-Battle Injury hospitalization rates (33 per 1000 Soldiers) in history.

Army Public Health Command protects and improves the health of Army communities and personnel by identifying, assessing and prioritizing community or population wide health issues. Army public health efforts include identifying infectious and chronic disease threats, assessing occupational and environmental health hazards from chemical exposures in deployed settings, evaluating injury risks during military training, identifying risk factors associated with military suicides and inspecting food and drinking water supplies on Army installations and operational base camps. New efforts include improving the overall health of Soldiers, Retirees, their Families and our DA Civilian employees by assessing their Activity, Nutrition and Sleep habits and providing them evidence-based tools to improve their behaviors in these areas. The Army Public Health Command plays a central role in the health of our Soldiers, Retirees, their Families and our DA Civilian employees whether they are deployed or at home

Women's Health

Women have been a part of America's military efforts since the Revolutionary War. As their roles continue to evolve, Army Medicine recognizes the impact on women's health and appreciates the unique challenges of being a woman in the military.

During World War I, Beatrice MacDonald was the first of three nurses to receive the Distinguished Service Cross after she volunteered to accompany a surgical team reinforcing a British Casualty Clearing Station on the front lines. While serving in that capacity, MacDonald received shrapnel wounds to her face which resulted in the loss of her right eye. Undeterred, MacDonald resumed her original duties at Evacuation

Hospital No. 2 following her convalescence and continued to serve there until January 1919.

Female Soldiers proudly serve in our Nation's military, health care must adapt to meet their needs in any environment. Women make up 15.8 percent of the Force today—including Active Duty, Reserve, and National Guard – and the percentage of women continues to grow, up about 4 percent from 20 years ago. During the past decade of persistent conflict, 275,000 women have deployed. This year the DoD announced the ban against women serving in combat roles will be lifted, a decision that reflects the reality of military operations. The increasing role that female Service Members play in defending our Nation requires Army Medicine stays on target to ensure that the unique health needs of women are being addressed—a matter that is critical for Army readiness.

The Army is the first military service to focus specifically on women's health issues, particularly related to deployed environments. As a part of the Health Service Support (HSS) assessment team that deployed to Afghanistan in 2011, I evaluated the issues and concerns that female Soldiers experience both in the theater of operation and in the garrison environment. Following the HSS white paper on the concerns of female Soldiers in the combat theater, the Women's Health Task Force (WHTF) was established in 2012.

The WHTF assesses the unique health needs and concerns of female Soldiers, reviews of the care currently being provided, identifies best practices and gaps, and informs the Army Surgeon General's women's health initiatives. Army Medicine is looking towards preventive practices through initiatives such as education and training of female Service Members and their leaders to prevent gynecological problems from occurring in the field setting, and early recognition and treatment if they occur. These efforts not only allow for synchronization of information related to women's health, but increase awareness among all Soldiers that Army Medicine is leaning forward to meet their unique needs of our Service Members.

The WHTF team coordinated with the Program Executive Office (PEO) Soldier for updates to the new female body armor with improved maneuverability and fit for the female body shape. The Warrior Readiness Guide (TG372) combines female the Soldier Readiness and Warrior Readiness guidelines. It is for use by all and increases the visibility of female specific concerns. The Army Public Health Command has created a Women's Health Portal for Service Members, providing links through various social media to information pertaining to women's health preventative practices/ self-care. The new body armor and updated guidelines will undoubtedly support the ongoing success of our female Warriors.

As part of the Army Medicine 2020 Campaign Plan, a Women's Health Service Line (WHSL) has been established. The WHSL will manage the unique needs of women's health as a population by building the fundamentals of sound, gender based programs and policies. The WHSL will recognize and adopt 'best practices' that will focus on women's health management in order to provide care to women that is coordinated, collaborative, and patient focused.

Army Medicine is creating and implementing Clinical Practice Guidelines (CPGs) for use by providers and designed to standardize diagnosis and treatment of common female conditions, such as urinary tract infections and vaginitis, and will ensure all female Soldiers are afforded the same counseling. Algorithms geared toward the Medics will aid in the triaging of these same conditions. The use of CPGs and algorithms will ensure diagnosis and treatment that provides women confidence in their provider and the care they receive.

Army Medicine is actively engaging issues, identifying solutions, and ensuring the future health and readiness of our female Soldiers.

Warrior Care

There is no greater honored than serving to help wounded, ill or injured (WII) Soldiers heal and transition successfully back to the Force or into private sector jobs and careers. Warrior Care is an enduring requirement for the Army. The Warrior Care and Transition Program (WCTP) fulfills our sacred obligation to our injured Soldiers,

their Families, and our Nation by providing the best health care possible and striving to return medically qualified Soldiers to Active Duty service. Its goal is to empower them with dignity, respect, and the self-determination to successfully reintegrate either back into the force or into the community. For those Soldiers not meeting retention criteria, we care for them through the transition out of military service to the Department of Veterans Affairs (VA).

I want to thank the Congress for your unwavering support of these efforts and for the warm embrace of our communities as we transition our Veterans back to hometown USA. Since the inception of Warrior Transition Units (WTU) in June 2007, nearly 61,600 WII Soldiers and their Families have either progressed through or are being cared for by dedicated caregivers and support personnel. Approximately 50% have returned to the Force.

Since 2004, the Army Wounded Warrior Program (AW2) has supported the most severely wounded, ill, and injured Soldiers. The program assigns an AW2 Advocate who provides personalized assistance with the daily issues that confront healing Warriors and their Families, including benefits counseling, educational opportunities, and financial and career counseling. AW2 Advocates help these wounded Warriors and their Families regain their independence; and the AW2 has provided this support to nearly 15,763 Soldiers and Veterans.

An all-volunteer military is skilled at taking our country's eligible civilians and transitioning them into Service Members. What cannot be overlooked is how we then transition those Soldiers out of the uniform and back into the civilian workforce. While there are those small numbers who are challenged by their reintegration into civilian life, the vast majority of our veterans take the lessons of leadership, discipline, and honor with them through the transition; bringing with them the intangibles gained through battle buddies, squad leaders, and mentors. Our communities need to continue supporting this reintegration, recognizing those unique skills that follow after selfless service to our Nation.

"Never Shall I leave a Fallen Comrade:"

The Integrated Disability Evaluation System (IDES)

A key element of our Warrior Ethos is that we never leave a Soldier behind on the battlefield. This commitment extends beyond the battlefield, and extends to the unwavering commitment of Army Medicine. In close partnership with the Department of Veterans Affairs, we continue to improve our processes, honoring that commitment to ensure Soldiers are not left behind or lost in a bureaucracy.

Assigning disability has long been a contentious issue. The present DoD disability system dates back to the Career Compensation Act of 1949. Since its creation, gaps in processes have been identified including long delays, duplication in DoD and VA processes, confusion among Service Members, and distrust of systems regarded as overly complex and adversarial. In response to these concerns, the joint Disability Evaluation System (DES) Pilot was implemented in 2007 in the National Capital Region. DoD, with VA assistance, revised the DoD disability evaluation system to streamline DoD processes, with the goal of also expediting the delivery of VA benefits to Service Members following discharge from service. We continue to strive for improvements with the physical disability evaluation system and seek ways to make it less antagonistic, more understandable for patients and Families, more equitable for Soldiers, and more user-friendly. In the past year, the Army has made some lasting improvements.

After a careful review of our overall behavioral health and IDES processes, I am proud to share that the strong response of Army and DoD leaders has ensured we truly are better today. The Secretary of the Army directed the establishment of an Army wide Task Force on Behavioral Health (ATFBH) which completed a comprehensive assessment of all Army behavioral health programs. One of the areas we looked at during our Army wide review of patient records was diagnostic variance. Following a review of 154,000 behavioral health records, we found our clinical diagnostic variance rate is lower than in the private sector.

For the first time since IDES was initiated, MEDCOM met the standard for Active Component Medical Evaluation Board (MEB) phase with an average processing time of

96 days. Reserve Component Soldiers were also within 3 days of meeting the standard with an average processing time of 143 days. Currently, 65 percent of all Soldiers complete the MEB phase within the standard. The greatest improvement has been in Narrative Summary (NARSUM) timeliness which improved from 58 days in July 2012 to a current 11 days. With the standardization of processes across all Army medical treatment facilities, currently 23 out of 32 IDES sites are meeting the standard for the MEB phase. While all MTFs have demonstrated improvements, the most dramatic change is at Fort Hood, TX, where the IDES team decreased MEB phase from 249 days in July 2012 down to their current 115 day average. Through our partnership with our VA counterparts and emphasis on effective standards, IDES teams decreased the number of Soldiers in the MEB phase from 9,283 in July 2012 to 5,801 currently.

Behavioral Health

The longest period of war in our Nation's history has undeniably led to physical, mental and emotional wounds to the men and women serving in the Army – and to their Families. The majority of our Soldiers have maintained resilience during this period. However, the stresses of increased operational tempo are evident in the increased demand for Behavioral Health Services and increased suicide rate. The Army is keenly aware of the unique stressors facing Soldiers and Families today and continues to address these issues on several fronts. Taking care of our own—mentally, emotionally, and physically—is the foundation of the Army's culture and ethos. The lessons learned from military medicine's experience over the last decade have informed the medical community, not just the Behavioral Health (BH) community, about the processes and characterization of trauma-related events.

While physical injuries may be easier to see, "invisible wounds" such as mild traumatic brain injury, depression, anxiety and post traumatic stress (PTS) also take a significant toll on our Service Members. And yet, to the individuals who suffer from these wounds, and those who care for them, they are anything but invisible. One of the most challenging areas of wartime medicine is PTS treatment. We have discovered that with the right treatment, most will go on to live productive, fulfilling lives. Military research shows that 15% of Operation Iraqi Freedom (OIF) and Operation Enduring

Freedom (OEF) veterans develop PTS. PTS is treatable; 80% of those with PTS have remained on Active Duty.

Army Medicine continues to move the model of behavioral healthcare delivery outside of the brick and mortar MTFs through behavioral health initiatives, such as Embedded Behavioral Health (EBH). We demonstrated success by looking at ways to bring healthcare and education to the foxhole, which allows us to increase accessibility, visibility, and ultimately trust, while decreasing the stigma and time spent away from the unit. Validation of this program by the Army Public Health Command has led to expansion. Currently, 26 Brigade Combat Teams (BCTs) and 8 other Brigade-sized units are supported by EBH Teams. Expansion to all operational units anticipated no later than FY16.

Program evaluation by Public Health Command of EBH found the following:

- 73% reduction in in-patient BH admissions
- Decreased number of off-post BH referrals
- 58% reduction in risk-taking behaviors, including suicide gestures and attempts, spousal abuse, and STIs.
- Reduction in non-deployable Soldiers for BH reasons

Behavioral health problems, mild traumatic brain injury, and suicide, while often described as “invisible wounds of war,” are not unique to a theater of combat or to the military population – they are National issues. As a Nation, there are opportunities for us to partner and to lead the way in breaking the silence – to encourage those who struggle with behavioral health issues to receive help. The Army and Army Medicine are actively engaged in reducing stigma and upholding our responsibility to raise national awareness regarding mild traumatic brain injury and mental health conditions including PTSD. We anticipate the need for mental health services will only increase in the coming years as the Nation deals with the effects of more than a decade of conflict.

Consistent with National and Military Health System goals, the Army seeks to further understand and improve the prevention, diagnosis and treatment of these signature wounds of war through clinical and scientific research - paving the way for

improved health, function and quality of life for those with PTSD, TBI, and co-occurring conditions, and to reduce the incidence of suicide. Army Medicine developed a service line to coordinate standardized BH delivery across the enterprise, and integrated BH staff at over 90% of our medical treatment facilities falling under one department head. This integration reflects the best-practices at leading civilian institutions and enhances multidisciplinary teamwork and efficient care delivery.

As a Nation, we have learned that combat stress and PTSD resulting from deployment are treatable and curable with proper care; and the majority of Service Members return to productive and engaging lives.

Accountable Care

The Warfighter does not stand alone. Army Medicine has a responsibility to all those who serve, to include Family members and our Retirees who have already answered the call to our Nation. Every day we must earn the trust of our beneficiaries – it is a trust we hold dear. Our healthcare is the product of a culture of accountable care, prominent medical training programs, and groundbreaking medical research. Our success also relies upon partnerships with Sister Services, other Federal and State agencies, and academic institutions and industry. It is the daily delivery of care that allows us to maintain critical skills that guarantee readiness capability and success. During each visit with a provider, it is our goal to show patients the extent of our care and to deliver the Army Medicine Promise - to provide the best care, with the best care experience, provided by the most talented and compassionate care providers.

The Joint Commission requires that there be a self-governing organized medical staff providing oversight of the quality of care, treatment and services delivered by the medical providers who are credentialed and privileged through the medical staff process. All military and civilian healthcare professionals who provide care in our facilities are held to the highest standards of training and conduct, and their peers and supervisors are held accountable for the review of their credentials by the executive committee of the medical staff. This includes all privileged providers, not just physicians.

We give our best care when we take care of our teammates. Realizing that Army Medicine Team works tirelessly, I have asked our leaders to make certain they are caring for those who care for others. Years of persistent conflict have placed great demands on our military and civilian work force. While uniformed members provided care in combat zones, it was our civilian teammates who were called upon to shoulder the responsibilities for care at the home front. For all in the Army Medicine team, we must help strike a balance between the high demands of the job, time for personal recovery and growth, and time for family. We must prepare a military healthcare team that understands the need to have balance in their lives – personally embracing the tenets of the Performance Triad that we remind our patients to observe.

The MEDCOM Care Provider Support Program was established in 2008 to mitigate provider fatigue and burnout. The program requires providers to complete annual provider fatigue and provider burnout assessments to self-monitor personal well-being. The program also offers classroom instruction and wellness activities to enhance individual resilience and work-life balance. MTF-based instructors and staff are professionally prepared and qualified by the Army Medical Department Center and School. Results from the annual provider fatigue assessments show that MEDCOM staff burnout and provider fatigue scores fall well-below civilian comparison groups and that overall rates of burnout and provider fatigue have dropped since program inception. Most recently, the CPSP program staff at Tripler Army Medical Center helped the facility win the American Psychological Association's 2013 Psychologically Healthy Workplace Award which recognized Tripler's focus on well-being, physical activity, work-life balance, health and safety and employee satisfaction.

The Most Important Unit in the Army

We must never lose sight of the fact that the most important unit in the Army is the Family unit. Our Families, including those outside of the nuclear family setting, have demonstrated unprecedented strength and resilience, quietly shouldering the burdens of our Nation's wars.

Back in January, I received a beautiful letter from an Army Family that dealt with a difficult theme -- suicide. While waiting to pick up a prescription with his mother, seven year old John Murray Jr. was taking the opportunity to work on his reading skills by reading the posters in the waiting room. In that pharmacy waiting room was a poster for Army Suicide Prevention. John Jr. did not know what the “s” word meant and he implored his mother for an explanation. At first she did not want to explain, but then she realized that the Army wants us to talk about it. Not just Soldiers, but everyone in the Army Family: spouses, leaders, coworkers.

After a very delicate explanation about how some Soldiers are hurt, and although you cannot see their injuries, they feel sad, Mrs.Murray carefully explained to her second grader what ‘suicide’ meant. Confused as to why people would not go to a doctor for their invisible injury, he echoed his father’s words and told his mother, “Daddy says that Army people are helpers and if you are a helper you don't laugh, you just help. Especially if you are an Army person you want to help other Army people.” The Murray family story illustrates how our military families have also taken ownership of the care and support of our Soldiers.

Army Medicine is currently setting the conditions to better understand the Army Family both within and outside of conventional patient care settings. Impacting the Lifespace of our Army Families will not only improve the strength, performance, and readiness of the Soldier, but also establish an example for our Nation on a way forward to improve the health of communities.

Across Army installations, there are numerous military Family programs that assist our beneficiaries with resiliency. The Community Health Promotion Council (CHPC) at each Army installation synchronizes programs between service providers (medical and garrison) and unit leaders. The Family Resilience Working Group (FRWG) of the CHPC assesses programs and services for families, and addresses issues and programs to build resilient families on an installation. Through one of our strongest Family Resilience Working Groups at Fort Campbell, KY, the Spouse Master Resiliency Training program was piloted as a way to increase saturation of resiliency

training to family members and communities. The volunteers who received the training are conducting monthly resiliency training within their units and communities.

Under the Behavioral Health Service Line, the Army continues to establish a network of behavioral health clinical services targeted to family member beneficiaries. Specifically, the Army is fielding School Behavioral Health programs (SBH) and continuing to design and pilot programs such as the Child and Family BH System (CAFBHS), which provides a full spectrum of services to enhance mental well-being of our Family Members. At present, CAFBHS pilots are operational at Joint Base Lewis-McCord, Schofield Barracks, and Forts Bliss, Carson and Wainwright, and in initial stages at Forts Bragg, Campbell, Drum, Hood and Polk.

The PHC Army Wellness Centers (AWC) provide integrated and standardized primary prevention programs and services that promote healthy lifestyles to improve the overall well-being of Soldiers and Family Members. Through educational programs in areas like stress management, nutrition, and tobacco cessation that are available to all Army personnel and Family Members, the AWC program supports the Ready and Resilient Campaign, as well as the Patient-Centered Medical Home initiatives.

Our military families – the children of our men and women in uniform – have a different story to tell compared to their peers outside of the military. I want the story of the military Family to resonate throughout our Nation's history as an example of resilience – demonstrating the powerful impact that can be felt when we invest not only in the Soldier, but in the individuals, old and young, who support our heroes.

Taking steps to capture that story, Army Medicine has invested in the RAND Corporation's Deployment Life Study (DLS). This is a 3-year longitudinal study that began in March 2009 to examine the impact of deployment on the health and well-being of military families. This project is funded by the offices of the Army Surgeon General and the Assistant Secretary of Defense for Health Affairs, and is unique because it follows multiple members of the military families—Service Member, spouse, and, if eligible, a child—at four month intervals over three years.

Patient Centered Medical Home

The Patient Centered Medical Home model for primary care is a key enabler of the Military Health System Quadruple Aim: readiness, population health, experience of care, and per capita cost. Much of the future of Army Medicine will be practiced at the Patient-Centered Medical Home (PCMH). It relies upon building enduring relationships between patient and their provider-doctor, nurse practitioner, physician assistant and others-and a comprehensive and coordinated approach to care between providers and community services. This means much greater continuity of care, with patients seeing the same physician or professional partner 95% of the time. The result is more effective healthcare for both the provider and the patient that is based on trust and rapport.

The PCMH integrates the patient into the healthcare team, offering evidence-based prevention and personalized intervention. Physicians will not just evaluate their patients for disease to provide treatment, but also to identify risk of disease, including genetic, behavioral, environmental, or occupational risk. The healthcare team encourages healthy lifestyle behaviors, and success will be measured by how healthy they keep their patients, rather than by how many treatments they provide. The goal is that people will live longer lives with less morbidity, disability and suffering.

By redesigning health care delivery around the patient, starting with a multi-disciplinary team that includes the patient, primary care truly becomes the foundation of health and readiness, and drives the strategic outcomes defined in the Quadruple Aim: ensuring a medically ready Force, delivering a consistently competitive care experience, reducing the causes of disease and illness through focus on prevention and encouragement of healthy behaviors, and creating value through improved health outcomes and elimination of waste and inefficiency in the care delivery process.

Across the services, mature Patient Centered Medical Homes have shown significant improvements from August 2011 to September 2012 in patient satisfaction (increasing from 91 to 94 percent), PCM continuity (increasing from 55 to 65 percent), and access to care (ER utilization decreasing from 53 to 45 percent).

“Medicine is the only victor in War”

History is replete with examples of war serving as a catalyst for medical innovation and of battlefield medicine producing advances in civilian healthcare. Plastic surgery was a result of treating the horrors of mustard gas and facial wounds during World War I. The specialty of infectious diseases evolved from efforts to combat debilitating infections in the trenches during World War I. Blood management and utilization were greatly improved during World War II. Civilian life flight came from advances in helicopters and air ambulance doctrine started in Korea and honed in Vietnam. These wars have also led to tremendous advances in delivery of life-saving medicine on the battlefield. One of the unique features of these wars has been the intense attention on invisible wounds of war, and for the first time research has led directly to changes in how mental health services are delivered in the military. Medical research conducted by the U.S. Army continues to lead to advancements that benefit civilian medical practice worldwide.

Medical Advances from a Decade of War

More than a decade of war has led to tremendous advances in knowledge and care of combat-related wounds, both physical and mental. The US Army Medical Research and Materiel Command (MRMC) is leading Army Medicine in scientific research, with ongoing efforts focused on establishing more effective methods for diagnosis, treatment, and long-term management of the health-related consequences of war, including TBI, behavioral health care, PTSD, burn and other disfiguring injuries, chronic pain, and limb loss.

Army Medicine is a learning organization; through continued validation and refinement of the tools used throughout the deployment cycle and in our medical treatment facilities, improvements in the training, education, and resources for our care team, and through synchronization of standardized approaches to care, we continue to advance how we deliver across the care continuum. We collaborate with subject matter experts to evaluate clinical guidelines that reflect the latest scientific research and best practices. MRMC has created a system to review and analyze the large number of research projects to identify promising findings that can be quickly translated into actionable policy or clinical practice. I would like to highlight a few areas that are

impacting health care of our Soldiers today which were guided by medical research efforts.

The past decade of research has guided health policy, clinical practice guidelines, preventions and treatment interventions. Multiple programs have been implemented in theater and post-deployment to enhance resiliency, address combat operational stress reactions and behavioral health concerns, and improve the quality of life of our military.

In the area of mild traumatic brain injury, research findings directly affected policy and changed the way the Military Acute Concussion Evaluation (MACE) is used and administered in the deployed environment. For example, the latest version of the MACE, released in 2012, now includes additional word lists to test memory as well as a component to test for balance deficits. Key neuro-imaging indications were incorporated within the concussion management algorithms from research published in the New England Journal of Medicine, and three Magnetic Resonance Imaging (MRI) machines are currently in use in Afghanistan to advance TBI science. Commanders throughout Afghanistan have implemented a mandatory screening for mild TBI and rest policy while medical providers and Concussion Care Centers facilitate provide proper treatment and recovery, resulting in a 98% return to duty rate.

We are working on a capability for medics in austere combat environments to administer a simple test to detect mild TBI. The Biomarker Assessment for Neurotrauma Diagnosis and Improved Triage System (BANDITS) program is developing a blood test for brain cell damage, which may aid in the clinical assessment of patients with mild TBI. BANDITS has completed pilot and feasibility studies and has launched its pivotal trial which will enroll up to 2000 patients with mild, moderate and severe TBI. This capability has applications beyond the military and could be used to detect concussions in civilian sports environments.

Advances in trauma surgery which have occurred during operations in Iraq and Afghanistan are manifold and encompass the diverse set of interventions which are deployed to stop hemorrhage, repair damage, restore physiology and maximize

functional recovery. One of the principal medical legacies of the current conflict will be the development and implementation of a formal battlefield trauma system. The Joint Theater Trauma System allowed the rapid identification of emergent battlefield medical problems, which are then addressed with focused research and development. The results fielded the medical providers with improved equipment and CPGs. This rapid cycle ensures validated innovations in trauma care reach the field rapidly to sustain life. This process proved so effective, that many of these advances have been adopted by civilian trauma centers where the innovations developed in the military are employed to save the lives of countless civilians. The improvements in bleeding control devices such as tourniquets, improved dressings and devices to stop hemorrhage from the large arteries of the trunk, improved treatment of bleeding will be a legacy of military medical innovation in the last 12 years of combat.

Since 2003, there have been more than 1,550 amputations as a result of OIF, OEF, and unaffiliated conflicts, half of which were caused by IEDs *(Armed Forces Health Surveillance Center Medical Surveillance Monthly Report, February 2013).* MRMC has provided $169 million for intramural and extramural research efforts in amputee care and prosthetic/orthotic technologies. MRMC funded iWalk to develop the BiOM ankle prosthesis, which replaces the function of the calf muscle by providing active push-off while walking. It became the first commercially available bionic ankle prosthesis.

The prosthetic advances funded by MRMC have brought dramatically improved functional abilities to Service Members with limb loss. Technological improvements allow prosthesis users to move more naturally and mimic able-bodied movements much better than prior to the OEF/OIF conflicts. Current and future work is focusing on improving the prosthesis-user interface, reducing secondary health effects after amputation, and optimizing the rehabilitation process after amputation.

Military medicine continues to work to reduce morbidity and mortality resulting from devastating injuries on the battlefield, achieving the historically high survivability rate of 91.3 percent in the current conflict. Following a spike in devastating blast injuries in 2010, the Army convened the Dismounted Complex Blast Injury Task Force to look at

opportunities to improve the spectrum of care, from point of injury through rehabilitation and reintegration back to the military or into the civilian community. The task force, comprised of clinical and operational medical experts from the DoD and VA, solicited input from the subject matter experts in both Federal and civilian sectors to determine the way forward. The severity of these injuries presents new challenges to the medical and military communities to prevent, protect, mitigate and treat.

Several initiatives have come out of this task force, from training our flight paramedics to increasing and enhancing the immediate pre-deployment training of physicians and nurses. We have fielded new physical protections for our Warriors, and are exploring new care and treatment modalities and techniques.

MRMC established the Armed Forces Institute of Regenerative Medicine (AFIRM) in 2008, a multi-institutional, interdisciplinary network with two academic consortia, one led by Wake Forest University, the other by Rutgers University, working to develop advanced treatment options for our severely wounded Service Members. The current 5-year, $100M AFIRM I effort will end this fiscal year (FY13), and the AFIRM II program, a 5-year, $75M award, will focus on extremity injury, cranio-maxillofacial injury, burns / scar-less wound healing, composite tissue transplantation, and genitourinary / lower abdominal reconstruction. AFIRM II is expected to be awarded by September 2013.

The management of combat trauma pain with medications and the introduction of battlefield anesthesia was a tremendous medical breakthrough for military medicine. The first American use of battlefield anesthesia is thought to have been in 1847 during the Mexican-American War. Military Medicine has worked very hard to manage our Service Members' pain from the point of injury through the evacuation process and continuum of care. The management of pain – both acute and chronic or long-standing pain – remains a challenge for military health care providers and for the Nation at large.

Military Medicine launched a major initiative through a multi-disciplinary, multi-service and DOD-VA Pain Management Task Force (PMTF) to improve our care of pain. Since 2006, the Defense and Veterans Center for Integrative Pain Management

(DVCIPM) has been coordinating a comprehensive portfolio of DoD-VHA pain management research projects. The approach to pain research is a direct result of the PMTF recommendations, and studies range from studying battlefield use of regional anesthesia to the use of yoga as a pain management modality. The use of medications is appropriate and often an effective way to treat pain when it is clinically required. The possible overreliance on medication-only pain management may lead to other unintended consequences. The goal is to achieve a comprehensive pain management strategy that is holistic, multi-disciplinary and multi-modal in its approach, uses state of the art modalities and technologies, and provides optimal quality of life for Soldiers and other patients with acute and chronic pain.

The military is developing regional pain consortiums that combine the pain expertise from DoD with local Veterans Health Administration and civilian academic medical centers. The first of many of these relationships has been established in Washington State between Madigan Army Medical Center, VA Puget Sound Health Care System, and University of Washington Center for Pain Relief. Some of the largest research projects dealing with Wounded Warrior pain have been facilitated through partnerships with VHA research leaders. Collaborations of this type will ensure the latest, evidence-based techniques and protocols are available to patients.

Accelerating Progress through Collaboration

Army Medicine does not work alone in this venture to care for our Nation's men and women in uniform. Leveraging the capabilities of executive leadership, inter-agency and international collaboration, and public-private partnerships can yield paradigm shifts in our understanding and management of complex injuries or illnesses. The DoD supports collaborative research efforts between the Services, Agencies and academic/public/Non-Government Organizations. The DoD, Veterans Affairs (VA), and National Institutes of Health (NIH), including: National Institute of Mental Health (NIMH), National Institute of Drug Abuse (NIDA), National Institute of National Institute on Alcohol Abuse and Alcoholism (NIAAA), National Institute of Neurological Disorders and Stroke (NINDS) work closely to coordinate and integrate research efforts.

In response to the White House Executive Order (EXORD) released on August 31, 2012, “Improving Access to Mental Health Services for Veterans, Service Members, and Military Families,” the Army, through MRMC, has the DoD lead on the interagency National Research Action Plan (NRAP) to coordinate ongoing and future planned efforts to synergistically address TBI and PTSD and suicide. The Army is proud to contribute to the efforts of the Departments of Defense, Veterans Affairs, Health and Human Services, and Education, to develop the NRAP. Improved data sharing between agencies, academic and industry researchers will accelerate progress and reduce redundant efforts without compromising privacy. Making better use of electronic health records will allow us to gain insight into the risk and mitigation of PTSD, TBI, and related injuries. The ongoing collaborative effort of the Millennium Cohort Study and the VA Million Veterans Program may also be leveraged to address the longitudinal study called for in the EXORD.

Collaborations with academic and public-private partnerships are mostly in the form of grants and cooperative agreements awarded to academic, private, and non-profit institutions. These efforts foster multidisciplinary and multi-institutional collaboration to accelerate advances in medicine, whether on the battlefield or during reintegration and rehabilitation. Public-Private Partnerships also include working with the National Football League (NFL) and the Center for Integration of Medicine and Innovative Technology (CIMIT). DoD also collaborates internationally through North Atlantic Treaty Organization (NATO) panels, The Technical Cooperation Program (TTCP), and its human factors workgroups.

During the current fighting season in Afghanistan, we are partnering with German Forces in Regional Command North, conducting proof of concept study for placement of German Emergency Medicine physicians on board US MEDEVAC aircraft in support of combat operations in the German controlled battle space.

A collaborative suite of aeromedical evacuation capabilities available for our future Force will ensure that we provide the right capability at the right time and the right joint synchronized platform to our US Forces and allies.

Training and Developing Leaders for Excellence

The Army calls upon each of us to be a leader, and Army Medicine requires no less. We will capitalize on our leadership experiences in full spectrum operations while continuing to invest in relevant training and education to build confident and competent leaders. Within this focus area, we have examined our leader development strategy to ensure that we have clearly identified the knowledge, skills, and talent required for leaders of Army Medicine. We will continue to develop adaptive, innovative, and decisive leaders who ensure delivery of highly-reliable, quality care that is both patient-centered and inherently trustworthy. Being good stewards of our Nation's most treasured resources, through agile, decisive, and accountable leadership, we will continue to build on the successes of those who have gone before us. Our recruitment, development and retention of medical professionals – physicians, dentists, nurses, ancillary professionals and administrators – remain high. With the support of Congress, through the use of flexible bonuses and special salary rates, we have been able to meet most of our recruiting goals. Yet we recognize that competition for medical professionals will grow in the coming years, amidst a growing shortage of primary care providers and nurses.

The Joint Program Committee-1 (JPC-1) is the Medical Research and Materiel Command's research area directorate responsible for programming research in two distinct areas: Medical Simulation & Training and Health Information Sciences. This committee works with the services and joint agencies to address gaps and requirements as indentified by the Military Health System. The JPC-1 is tasked with planning, coordinating, and overseeing a tri-service science and technology program focused on improving military medical training through medical simulation, educational gaming, and objective training metrics as well as improving health information sciences through increased interoperability, strategic planning, process development, and medical applications.

A significant advance of the JPC-1 includes improved synthetic materials in simulation systems that provide a capability to use real surgical instruments on material

that simulates not only skin, but deeper tissue structures as well. The Medical Simulation & Training portfolio of the JPC-1 is focused primarily on the following research objectives: Combat Casualty Training, Medical Practice Initiative, Patient Focused Initiative, and Developer Tools for Medical Education.

Army Medicine has harnessed lessons learned to improve upon how we train our medical team, preparing them to have an adaptability to assess, triage, and manage patient care under austere conditions or in environments of extreme conditions, such as heat or noise.

I am proud to command some of the brightest medical minds our country has to offer. The strength, skills, and attributes of the Army Medicine Team are a testament to that statement. The young men and women who choose to enter military service during a time of war exemplify what it means to provide selfless service to our country.

At the AMEDD Center and School in San Antonio, Texas, the flight paramedic training program was initiated in 2012 to develop a long-term Army institutional program to produce highly skilled national registry flight paramedics with critical care skills training. As a result of this endeavor, 52 Army medics from the Active component, Army National Guard and Army Reserves were trained and certified; some of whom are deployed to OEF today. The Army currently has 31 medics enrolled in a paramedic training course at Joint Base San Antonio and home stations with six more courses scheduled in 2013 and 2014. In addition, AMEDD Center and School recently initiated a program to enable units and Soldiers from all compos to enroll in paramedic certification training at home station in an effort to build capability as rapidly as possible throughout the Force.

Within our graduate medical education programs, we continue to attract and educate some of the best medical minds. We currently have 1,700 Health Professionals Scholarship Program students in medical, dental, veterinary, optometry, nurse anesthetist, clinical psychiatry and psychiatric nurse programs. We have the largest Graduate Medical Education (GME) program among the uniformed services, investing in 43 percent of total military trainees and 68 percent of training programs

(including joint programs). Our first-time board examination pass rate for our GME graduates is 93 to 95 percent, higher than what is seen in the civilian medical training programs.

As I look at this enterprise, I am excited about the potential that exists within our programs, people, and innovations of Army Medicine.

The Future of Military Health

In the fixed facility, as on the battlefield, we are at our best when we operate as a joint team. Together with Dr. Woodson, the Service Surgeons General are working to organize and lead the Military Health System (MHS) into the future by building a stronger, even more integrated team. Leaders at all levels are engaged in building accountable care organizations that ensure smooth, safe transitions between inpatient and emergency room settings, primary care, the subspecialist offices, home, and work. MHS governance changes will change the way we currently operate for everyone. These recommended changes will strengthen our system. In the delivery of military medicine, the Military Departments have more activities in common than not – together we will drive toward greater common approaches in all areas, except where legitimate uniqueness requires a service-specific approach. Our commitment is to achieve greater unity of effort, improve service to our members and beneficiaries, and achieve greater efficiency through a more rapid implementation of common services and joint purchasing, as well as other opportunities for more streamlined service delivery. We will continue the collective work of optimizing policies and processes across the MHS to advance our transformation to a System for Health.

The military health system is one of the most valued benefits our great Nation provides to its service members. The Defense Health Program, the appropriation that supports the MHS, is under mounting fiscal pressure, with military healthcare costs projected to exceed 10% of the overall Defense Department budget by 2015. The Army supports reasonable fee increases phased in over time as an effective means to protect the TRICARE program for current and future beneficiaries.

We understand that we cannot ask our beneficiaries to share more of the cost of healthcare without also looking within to streamline. The rising cost of healthcare coupled with the increasingly constrained defense budget presents a challenge to the MHS. In doing our part, Army Medicine must develop innovative and effective ways to deliver care in a resource constrained environment while integrating health and wellness into everything we do. I join our Army's Chief of Staff in supporting the budget the President has put forward for 2014. It represents a responsible path forward to sustaining the Military Health benefit in a changing world and recognizes that the fiscal health of the country is a vital element in our National security. We support the adjustments to the TRICARE cost sharing requirements as a means of ensuring the delivery of sustainable and equitable health care benefits. The subcommittee's strong consideration of full funding of the President's budget submission for fiscal year 2014 is greatly appreciated.

The budget we are putting forward reflects our commitment to the broad range of responsibilities of the military health care system; the medical readiness requirements needed for success on today's battlefield; the medical research and development necessary for success on tomorrow's; the patient-centered approach to care that is woven through the fabric of the military health care system; the transformative focus we have placed on the health of our population; the public health role we play in our military community and in the broader American community; the reliance we have on our private sector health-care partners who provide indispensable service to our service members and their families; and our responsibility to deliver all of those services with extraordinary quality and care. Given our commitment to readiness as a priority, constrained resources could force us to reduce the scope of services offered at some locations and potentially impose a financial burden on family members and retiree beneficiaries.

We have enduring obligations to the men and women of our Armed Forces, to their families who serve with them, and to the millions of retired personnel who have served us in the past. This obligation begins with the new recruit and ends with a lifetime commitment for those Service Members who honorably concluded their service

and retired. For those who have borne the greatest burden through injury or disease suffered in our Nation's conflicts, we have an even higher obligation to the wounded and to their families. They will need our care and support, as will their families, for a lifetime.

The Road Ahead

Military Medicine is at an important crossroad. From Soldiers with severe injuries to those whose injuries may not be visible to the naked eye, we owe it to this generation of Veterans to help them deal with the consequence of war, long after the last Soldier departs Afghanistan. As the size of our Army draws down, we must continue to support a high-quality, leading-edge healthcare system. Our decisions today must preserve the capability to defend a life in the future. Commitment to Wounded Warriors and their Families must never waiver, and our programs of support and hope must be built and sustained for the long road ahead - the rest of this century as the young Soldiers of today mature into our aging heroes in the years to come.

I would like to leave you today with a story which illuminates the miracles that can happen in healthcare when we operate as a national team. SGT Marrocco is the Army's first Soldier to survive after "giving" all four limbs in combat. Wounded by a road side bomb in Iraq in 2009, he was saved by a medic who had the training and courage to treat him. He was rapidly evacuated to Landstuhl Germany and onward to Walter Reed within 72 hours where a multi-disciplinary team continued providing him the care needed on his journey to recovery. A New York City native, Brendan said that he could get by without legs, but hated living without arms. He is one of only 60 patients worldwide to receive a double-arm transplant - and only the seventh double-hand or double-arm transplant in the U.S. His transplant operation took place this February at Johns Hopkins University Hospital in Baltimore, Maryland. The ground-breaking procedure was the most complicated to-date, taking more than 13 hours and involving 16 orthopedic and micro-vascular surgeons from five hospitals.

SGT Marrocco's story is the story of sacrifice, determination, and personal resiliency. His survival and recovery has involved countless medical professionals -- from the medic on the battlefield and the researchers, to the surgeons and rehabilitative

staff -- dedicated to improving care for our Wounded Warriors. I count myself fortunate to have met such a remarkable Soldier, thankful for those that have cared for him, and proud to serve in the same Army.

In closing, though we live in uncertain times, one thing is certain - a strong, decisive Army will be -- as it always has been -- the strength of our Nation. I am proud of Army medicine's proficient, professional and courageous performance of mission over the last 237 years - and especially over the last 12 months to help our Soldiers, Families and Veterans. In partnership with the Department of Defense, my colleagues here at the panel today, the Department of Veterans Affairs, and the Congress, we will be prepared for tomorrow's challenges.

Thank you for the opportunity to tell the Army Medicine story -- stories of our Army Family and Warriors like SGT Marrocco. Thank you for your continued support of our Soldiers, Families, Civilians and Veterans. The Army Medicine team is serving to heal -- and truly honored to serve.