

PREPARED STATEMENT

BY

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BEFORE THE

SUBCOMMITTEE ON PERSONNEL

COMMITTEE ON ARMED SERVICES

UNITED STATES SENATE

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Mr. Chairman, distinguished members of the committee, thank you for inviting me. Today, I will provide an update on the Military Health System (MHS) improvements in Psychological Health and Traumatic Brain Injury (TBI). You asked that I address implementation of the Mental Health Task Force recommendations, implementation of the Department of Defense Center of Excellence (DCoE) for Psychological Health and Traumatic Brain Injury (TBI), and information on suicide rates and risk factors.

The Psychological Health programs in the Military Health System continuum of care encompass:

- Resilience, prevention, and community support services;
- Early intervention to reduce the incidence of potential health concerns;
- Deployment-related clinical care before, during, and after deployment;
- Access to care coordination and transition within the Department of Defense (DoD)/Department of Veterans Affairs (VA) systems of care; and
- Robust epidemiological, clinical, and field research.

## **DoD Mental Health Task Force**

The Department is grateful for the hard work and dedication of the members of the DoD Mental Health Task Force, also referred to as the Mental Health Task Force (MHTF). In September of 2007, DoD responded to the Task Force's report accepting 94 of the 95 recommendations for implementation.

As of today we have completed five of the recommendations offered by the MHTF. We have initiated actions on all other recommendations. Some will be completed by May of this year and others will be completed at a later date, due to longer term implementation requirements. Finally, some will continue, based on the requirement of the recommendation. We will conduct a broad evaluation of our progress in May to gauge our status and reprioritize as needed to maintain our momentum.

The one recommendation that DoD did not accept recommended actions that are taking place through programs that are currently operating, such as Military OneSource. Further initiatives could serve to confuse our Warriors and their Families as well as duplicate successful programs.

## **Defense Center of Excellence**

Our approach in developing a culture of leadership and advocacy began with the creation of the DCoE. The Assistant Secretary of Defense for Health Affairs appointed me as the DCoE Director in September 2007 and the DCoE opened its doors on November 30, 2007. The Center serves as the Department's "front door" for all issues pertaining to Psychological Health and TBI.

This Center will lead clinical efforts toward developing excellence in practice standards, training, outreach, and direct care for our military community with Psychological Health and TBI concerns. It will also provide research planning and monitoring in these important areas of knowledge.

The DCoE will provide intensive outpatient care for wounded Warriors in the National Capital Region and importantly, it will instill that same quality of care across the country and around the world. We will accomplish this by establishing clinical standards, conducting clinical training, developing education and outreach resources for leaders, Families and communities, along with researching, refining and distributing lessons learned and best practices to our military treatment facilities (MTFs) and to the TRICARE provider networks. We will work together with our colleagues at the VA, National Institutes of Health (NIH) and elsewhere to create these clinical standards.

The DCoE staff will build and orchestrate a national network of research, training, and clinical expertise. It will leverage existing expertise by integrating functions currently housed within the Defense Veterans Brain Injury Center (DVBIC), the Center for Deployment Psychology (CDP), and Deployment Health Clinical Center (DHCC).

To date, the DCoE is engaged in multiple projects that respond to the recommendations of the MHTF, including:

- 1) Mounting an anti-stigma campaign projected to begin this spring using input from the Uniformed Services University of the Health Sciences, the National Institutes of Health (NIH), VA, the Substance Abuse and Mental Health Services Administration, our coalition partners, and others in the public and private sectors;
- 2) Establishing effective outreach and educational initiatives, including an Information Clearinghouse, a public Web site, a wide-reaching newsletter, and a 24/7 call center for Service members, Family members, and also for clinicians;
- 3) Promulgating a Telehealth Network for clinical care, monitoring, support, and follow-up;
- 4) Conducting an overarching program of research relevant to the needs of Service members in cooperation with other DoD organizations, VA, NIH, academic medical centers, and other partners – both national and international;
- 5) Providing training programs for providers, line leaders, Families and community leaders; and
- 6) Designing and planning for the National Intrepid Center of Excellence (anticipated completion in fall 2009), a building funded by the Intrepid Fallen Heroes Fund that will be located in Bethesda adjacent to the future Walter Reed National Military Medical Center.

The Department has allocated more than \$83M dollars toward DCoE functions. That total includes amounts allocated specifically to telehealth infrastructure, Automated Behavioral Health Clinic, Defense Suicide Event Registry and DVBIC functions. An additional \$45M was allocated to research and development projects.

A vital responsibility of the DCoE is quality of care. The Quality of Care initiative relies on developing and disseminating clinical guidance and standards, as well as training clinicians in clinical practice guidelines (CPGs) and effective evidence-based methods of care.

DCoE is moving forward on these projects, as it continues the relentless momentum to reach full operational capability in October of 2009. Each of the Services has initiated quality of care functions, including essential clinician training. For mental health, each Service is training mental health providers in CPGs and evidence-based treatment for Post Traumatic Stress Disorder (PTSD). The Services are training primary care

providers in mental health CPGs. Regarding TBI, we sponsored a TBI training course attended by more than 800 providers, including VA providers from over 30 disciplines. We will repeat this training in 2008 to provide a basic level of understanding of mild TBI to as many healthcare providers as possible. Over the coming months, the DCoE will consolidate and standardize these training efforts.

Severe TBI is easily observed. Similar to other severe trauma conditions, severe TBI is treated using well-established procedures. Usually, moderate TBI is clearly recognizable with an event-related period of loss of consciousness and observable neurocognitive, behavioral, or physical deficits. On the other hand, mild TBI, while more prevalent, is more difficult to identify and diagnose on the battlefield, just as it is in civilian scenarios. Our index of suspicion must be high to ensure that we appropriately evaluate, treat, and protect those who have suffered mild TBI. Military medicine has established a strategy to improve the entire continuum of care for TBI and published a DoD policy on the definition and reporting of TBI. This policy guidance serves as a foundation for shaping a more mature TBI program across the continuum of care and sets the stage for the mild TBI CPG to follow.

The Army Quality Management Office – the DoD executive agent for Clinical Practice Guidelines – is creating a formal CPG for mild TBI. Guidelines generally require two years to develop; however, we have expedited that process and will have the CPG completed in one year. The Department will collaborate with VA on the development of this CPG to assure a standard approach to identification and treatment of mild TBI.

Having standard guidelines and trained staff represent only part of the quality requirement. Equally important is proper equipment for the provision of care. Operations Iraqi Freedom and Enduring Freedom have placed our Service members at highest risk for potential brain trauma. Therefore, DoD acquired equipment to enhance screening, diagnosis, and recovery support for these Warriors.

## **Access**

Our ability to deliver quality care depends, in part, on timely access. Access, in turn, depends on the adequacy of staff to meet the demand in line with acceptable standards for appointment wait times. We also must

provide the services in a location or manner in which the Service or Family member can meet with the provider or interface with the system without undue hardship or long travel times and distances.

In October 2007, the Department issued a new policy stating that patients should have initial primary psychological evaluations scheduled within seven days of their request, with treatment to follow within normal access standards. Emergency evaluations are addressed right away.

In addition to this enhanced access, we have begun moving Psychological Health functions into primary care settings. The Services will hire Psychological Health personnel for both mental health clinics and primary care clinics. In the primary care setting, Psychological Health providers can consult with primary care providers to identify mental health conditions and to make appropriate referrals for treatment. Alternately, behavioral health providers can manage the patient's care in the primary care setting when appropriate. This arrangement also enables us to provide care for behavioral aspects of more traditionally physical health problems, such as pain and sleep problems that cause patients to seek care.

To ensure ready access to mental health and TBI care in our MTFs, we are increasing staff using a number of approaches.

- For TBI, we developed a standard capabilities model of multi-disciplinary staffing and management; capabilities we are now assessing for use across the military Services. This model offers the basis for a site certification pilot program that the Army has undertaken to ensure that soldiers with TBI receive care only at those facilities with established capability to care for them.
- Deployment-related healthcare has proven most effective when integrated with total healthcare. The Institute of Medicine advocated this position and the Department codified it in the DoD/VA Post-Deployment Health Evaluation and Management Clinical Practice Guideline. Telehealth technology will help to integrate this care particularly in the more remote locations. The DCoE will coordinate and integrate telehealth activities and capabilities across the Department; meanwhile, the Services have begun demonstration

projects to assess how best to leverage telehealth technology to increase care for TBI patients in remote or underserved locations.

- For mental health, we developed a population-based, risk-adjusted staffing model to more clearly inform us of the required number of mental health providers. The Department contracted with the Center for Naval Analysis to validate the model and expects results later this year. Using that validated model, the Department will adjust the requirements and disposition of mental health providers in the next fiscal year.
  - United States Public Health Service (USPHS). Mental health providers are in short supply across the country – complicated by hard-to-serve areas, such as remote rural locations. To increase providers in these areas, we have initiated a partnership with USPHS, which will provide uniformed mental health providers to the MHS. The USPHS has committed to sending us 200 mental health providers of all disciplines. The military Services will place those providers in locations with the greatest needs.
  - Civilian and contract. We will employ civilian and contract providers to increase our mental health staff by more than 750 providers and approximately 95 support personnel. Additionally, the MTF commanders have hiring authority and may increase their staffs to meet unique demands.
  - TRICARE network. In the past few months, our managed care support contractors have added more than 3,000 new mental health providers to our TRICARE network across the three regions. In addition, they have reached out to thousands of non-network providers to identify clinicians who would be available to take on new patients if a network provider could not be identified within the established access times.
  - Military. As always, we must recruit and retain military providers. These men and women serve critical missions as an integral part of our deploying force.

## Resilience

Our vision for building resilience incorporates psychological, physical, and spiritual fitness. When health concerns present, we must strive to break down the barriers so that those seeking care receive it at the earliest possible time and in the least restrictive setting, including non-medical settings, such as chaplains, first sergeants, and counselors.

I mentioned our anti-stigma campaign earlier. An important part of reducing stigma is education. The DCoE proposes a standardized curriculum for Psychological Health and TBI education for leaders, Service members, and Family members. In the interim, each Service will implement training across its leadership spectrum that adheres to our overarching principles and is adaptable to the culture of its own Service.

For Families, we have implemented and expanded a number of education and outreach initiatives.

- The Mental Health Self-Assessment Program is accessible at health fairs as well as in a Web-based format. We expanded this program to include our school-aged Family members.
- The Signs of Suicide Program, an evidence-based prevention and mental health education program in our DoD Educational Activity schools, will expand to public middle and high schools in areas with high concentrations of deployed forces.
- For our younger children, the proven-successful Sesame Street Workshop will expand with our cooperation to address the impact of having a deployed parent come home with an injury or illness. This program will be added to the original Workshop educational program and distributed widely across the Department. It is scheduled for completion and kickoff in April 2008 to coincide with the Month of the Military Child.

For our Service members, we have taken a number of steps to prevent and identify early psychological issues.

- We will incorporate baseline neurocognitive assessments into our lifecycle health assessment procedures from entering the service through retirement. As we progress in that objective, we will continue to provide pre-deployment baseline assessments.



- We added questions to both the Post-Deployment Health Assessment and Post-Deployment Health Reassessment to facilitate TBI screening. We also support initial identification teams at high-density deployment locations to ensure consistent screening and to further evaluate and treat those who screen positive.
- Screening and surveillance will promote the use of consistent and effective assessment practices along with accelerated development of electronic tracking, monitoring, and management of Psychological Health and TBI conditions and concerns. We will incorporate screening and surveillance into the lifecycle of all Service members.
- We must remember that our healthcare and community support caregivers may develop compassion fatigue. To help with that, the DCoE will develop a new curriculum of training or validate existing training to alleviate and mitigate compassion fatigue.

## **DoD-VA Transition**

We must effectively establish a patient- and Family-centered system that manages care and ensures a coordinated transition among phases of care and between healthcare systems. Transition and coordination of care programs help Wounded Warriors and their Families make the transition between clinical and other support resources in a single location, as well as across different medical systems, across geographic locations, and across functional support systems, which often can include non-medical systems.

In terms of transition, we seek better methods to ensure provider-to-provider referrals when patients move from one location to another or one healthcare system to another, such as between DoD and VA or the TRICARE network. This is relevant most especially for our Reserve Component members.

Care coordination is essential for TBI patients who may have multiple health concerns, multiple health providers, and various other support providers. Frequently, they are unsure of where to turn for help. Proactively, the DCoE Clearinghouse, Library, and Outreach staff will offer accurate and timely information on benefits and resources available. Meanwhile, Army and the Marines have established enhanced care coordination functions for their Warriors.

Newly hired care managers will support and improve transition activities. The Marine Corps created a comprehensive call center within its Wounded Warrior Regiment to follow up on Marines diagnosed with TBI and Psychological Health conditions to ensure they successfully maneuver the healthcare system until their full recovery or transition to the VA. The Navy is hiring Psychological Health coordinators to work with their returning reservists, and the National Guard is hiring Directors of Psychological Health for each State headquarters to help coordinate the care of Guardsmen who have TBI or Psychological Health injuries or illnesses related to their mobilization. The other Reserve Components are looking closely at these programs to obtain lessons learned as they set up their own programs.

Information sharing is a critical part of care coordination. DoD and VA Information Management Offices are working to ensure that information can be passed smoothly and quickly to facilitate effective transition and coordination of care.

## **Research**

Research and development provide a foundation upon which other programs are built. Our intent is to rely on evidence-based programs; our assessment identifies the need to develop a systematic program of research that will identify and remedy the gaps in Psychological Health and TBI knowledge. To that end, we have established integrated individual and multi-agency research efforts that will lead to improved prevention, detection, diagnosis, and treatment of deployment-related Psychological Health issues and TBI.

We will fund scientifically meritorious research to prevent, mitigate, and treat the effects of traumatic stress and TBI on function, wellness, and overall quality of life for Service members and their caregivers and Families. Our program strives to establish, fund, and integrate both individual and multi-agency research efforts that will lead to improved prevention, detection, diagnosis, and treatment of deployment-related Psychological Health and TBI.

## **Suicides**

Let me now offer you an update on our suicide rates and risk factors.

The DoD's confirmed and suspected suicide rates increased in 2006 and 2007. Even with these increases, the aggregate suicide rates for DoD remain comparable to the demographically-adjusted civilian population rates. Risk factors for suicide remain unchanged:

- Failing relationships
- Legal/occupational/financial problems
- Alcohol abuse

Early intervention and prevention programs include pre-deployment education and training, suicide prevention training, Military OneSource, the Mental Health Self Assessment Program, National Depression and Alcohol Day Screening, and health fairs. To increase the awareness of DoD's outreach and prevention programs available to the Reserve Component members, DoD formed a partnership with the VA and other federal agencies as well as professional advocacy groups.

DoD also provides a broad array of support systems and services to the military community. Services available at military installations include health and wellness programs, stress management, Family readiness and community support centers, Family readiness groups, ombudsmen, volunteer programs, legal and educational programs, and chaplains, among many other community programs.

## **Conclusion**

Mr. Chairman, distinguished members, thank you for caring and for understanding the needs of our Warriors and their Families. Thank you also for providing the resources and support to design and implement programs to meet these needs. I look forward to working with you as we continue to build the Center of Excellence and implement the MHTF recommendations for Psychological Health and TBI. I am honored to serve with you in support of our Warriors and Families. There simply is no greater privilege!