S. HRG. 110–212

HEARING TO RECEIVE TESTIMONY ON THE DEPARTMENTS OF DEFENSE AND VETERANS AFFAIRS DISABILITY RATING SYSTEMS AND THE TRANSITION OF SERVICEMEMBERS FROM THE DEPARTMENT OF DEFENSE TO THE DEPARTMENT OF VETERANS AFFAIRS

JOINT HEARING

BEFORE THE

COMMITTEE ON ARMED SERVICES AND COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

APRIL 12, 2007

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HEARING TO RECEIVE TESTIMONY ON THE DEPARTMENTS OF DEFENSE AND VETERANS AFFAIRS DISABILITY RATING SYSTEMS AND THE TRANSITION OF SERVICEMEMBERS FROM THE DEPARTMENT OF DEFENSE TO THE DEPARTMENT OF VETERANS AFFAIRS

THURSDAY, APRIL 12, 2007

U.S. SENATE,
COMMITTEE ON ARMED SERVICES AND
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committees met, pursuant to notice, at 9:30 a.m., in Room 216, Hart Senate Office Building, Hon. Carl Levin, Chairman of the Committee on Armed Services, presiding.

Present: Senators Levin, Akaka, Lieberman, Reed, Nelson of Florida, Nelson of Nebraska, Bayh, Clinton, Webb, McCaskill, Rockefeller, Murray, Obama, Brown, Tester, Sanders, McCain, Craig, Warner, Inhofe, Sessions, Collins, Ensign, Chambliss, Dole, Cornyn, Thune, Martinez, Specter, and Burr.

OPENING STATEMENT OF HON. CARL LEVIN, CHAIRMAN, COMMITTEE ON ARMED SERVICES, U.S. SENATOR FROM MICHIGAN

Chairman LEVIN. Good morning, everybody. The Armed Services and Veterans' Affairs Committees meet together this morning to consider the complex and inconsistent disability rating systems of the Department of Defense (DOD) and the Department of Veterans Affairs (VA) and the problems relative to transition of servicemembers from the military to the VA.

Our Nation has a moral obligation to provide quality health care to the men and women who put on our Nation's uniform and are injured and wounded fighting for our Nation in our wars. This obligation extends from the point of injury through evacuation from the battlefield, to medical facilities operated by the military services and the VA. Our responsibility ends only when the wounds are healed. Where the wounds will never heal, our obligation extends throughout the lifetime of the veteran. I am sad to say that we as a Nation are not meeting this obligation.

We have called this unusual joint hearing of the Veterans' Affairs and Armed Services Committees because there are gaps and inconsistencies between the VA and DOD systems that need to be

addressed jointly and because our Committees have a shared responsibility to authorize funding for the DOD and the VA and to oversee their efforts to provide proper care and treatment of servicemembers wounded in military service.

At present, when a servicemember is transitioned from the military to the VA, they face hurdles and roadblocks that no veteran should have to face. Disability ratings by the military services are inconsistent with disability ratings by the VA. Ratings for similar disabilities vary widely between the military services. And for some disabilities, the ratings do not accurately reflect the impact of the disability on the member's ability to function in an information-age society.

These programs are not only complex and difficult to navigate. Servicemembers often feel like they have to fight for a rating that accurately reflects their disability. In other words, the service they belong to, and put on the uniform of, acts as their adversary in their eyes. We simply have to do better than that. The cracks between the military and VA delivery systems must be filled. The transition must be smoothed out. The differences must be removed. The adversarial aspects must also be removed.

The military's disability rating is extremely important to the lives of our wounded warriors and their families. Those with disabilities rated at 30 percent or higher are medically retired, entitling them and their families to health care for life through the military's TRICARE health care program, a military pension, and access to commissary and post exchange benefits. Those whose disabilities are rated less than 30 percent are given a medical separation with severance pay. Although these servicemembers whose disabilities are rated at less than 30 percent are eligible to receive health care through the VA, their families are not. The VA disability rating is equally as important because the amount of VA disability compensation is based on the VA disability rating.

It takes too long to get a disability rating from the VA. Veterans report that they have to wait months and months to get a VA disability rating before they can start receiving compensation for their disabilities. Currently, the VA has a backlog of approximately 400,000 cases and it takes an average, they say, of 177 days to rate a claim. When I visited the VA hospital in Ann Arbor, Michigan, veterans told me that there are several thousand claims that have been pending for an average of a year. A few years ago, it was bad enough when the wait was 6 months.

Another problem reported by our servicemembers is the lack of a smooth or seamless transition from the military to the VA. Many say that their military medical records are often not available to VA doctors. One veteran said that there is too much red tape, so much red tape that it can take up to 22 documents with 8 different commands to exit the military medical system and enter the VA program. This exists even though there are numerous programs that are supposed to help the veterans as they leave active duty, such as the Transition Assistance Program and the Benefits Delivery at Discharge program. Despite those programs, the gaps and the chasms remain.

This is not a new issue. In 2003, the President's Task Force to Improve Health Care Delivery for our Nation's Veterans made a se-

ries of recommendations to ease the transition from servicemember to veteran status, most of which recommendations have not been implemented. For example, that Task Force 4 years ago recommended that the VA and the DOD implement by Fiscal Year 2005 a mandatory single separation physical as a prerequisite of promptly completing the military's separation process, expand the one-stop shopping process to include at a minimum a standard discharge exam, full outreach, claimant counseling, and when appropriate, referral for a VA compensation and pension examination and follow-up claims adjudication and rating. By Fiscal Year 2004, they recommended that we initiate a process of routine sharing of each servicemember's assignment history, exposures to occupational hazards, location and injuries information.

The disability rating issues and transition challenges are currently under review by at least five different entities. I am not going to enumerate them all, but they are all listed in my statement. A preliminary report of the Secretary of Defense's Independent Review Group, which proposed an acceleration of the closure of Walter Reed, describes in today's paper the current system for assessing soldiers' disabilities as "extremely cumbersome, inconsistent and confusing," and it calls for a complete overhaul of the process.

The findings and the recommendations of all of the groups may be useful as we seek solutions to the problems confronting our wounded servicemembers, but previous reports have been ignored and we can't wait until all of these studies and reviews are completed before we act.

The House of Representatives has already acted and passed the Wounded Warrior Assistance Act of 2007, which would impose a number of new requirements on DOD to improve medical care and other services for servicemembers and would require the DOD and VA to establish a single medical information system.

Several bills have been introduced in the Senate, including the Restoring Disability Benefits for Injured and Wounded Warrior Act of 2007, introduced by Senator Clinton; a Dignity for Wounded Warriors Act of 2007, which was introduced by Senators Obama, McCaskill, and others; the Effective Care for the Armed Forces and Veterans Act of 2007, by Senator Biden; and those are just some of the bills that have been introduced and those bills have been referred to the Senate Armed Services Committee, where we will address those bills soon.

The American people are deeply angry about the shortfalls in care for our wounded veterans. The war in Iraq has divided our Nation, but the cause of supporting our troops and our veterans unites us, unites us all as Americans and as Members of this Congress. We will do everything that we can do, not as Democrats or Republicans, but as grateful Americans, to care for those who have served our Nation with such honor and distinction. That is an obligation which all Americans accept and insist be met to the fullest.

[The prepared statement of Chairman Levin follows:]

PREPARED STATEMENT OF HON. CARL LEVIN, CHAIRMAN, COMMITTEE ON ARMED SERVICES, U.S. SENATOR FROM MICHIGAN

The Armed Services and Veterans' Affairs Committees meet together this morning to consider the complex and inconsistent disability rating systems of the Department of Defense and the Department of Veterans Affairs and the problems relative to transition of servicemembers from the military to the VA.

Our Nation has a moral obligation to provide quality health care to the men and women who put on our Nation's uniform and are injured and wounded fighting our Nation's wars. This obligation extends from the point of injury, through evacuation from the battlefield, to medical facilities operated by the military services and the VA. Our responsibility ends only when the wounds are healed. Where the wounds will never heal, our obligation extends throughout the lifetime of the veteran. I am sad to say that we as a Nation are not meeting this obligation.

I welcome our witnesses here today: Deputy Secretary of Defense Gordon England; Under Secretary of Defense for Personnel and Readiness, Dr. David Chu; VA Under Secretary for Benefits, Daniel Cooper; Acting Secretary of the Army, Pete Geren; Acting Principal Deputy Under Secretary for Health for VA, Dr. Gerald Cross; and Chairman of the Veterans' Disability Benefits Commission Lieutenant General James Scott.

We have called this unusual joint hearing of the Veterans Affairs and Armed Services Committees because there are gaps and inconsistencies between the VA and DOD systems that need to be addressed jointly, and because our Committees have a shared responsibility to authorize funding for the Department of Defense and the Department of Veterans Affairs and to oversee their efforts to provide proper care and treatment of servicemembers wounded in military service.

At present, as servicemembers transition from the military to the VA, they face hurdles and roadblocks that no veteran should face.

Disability ratings by the military services are inconsistent with disability ratings by the VA; ratings for similar disabilities vary widely between the military services; and for some disabilities, the ratings do not accurately reflect the impact of the disability on the member's ability to function in an information age society. These programs are not only complex and difficult to navigate, servicemembers often feel like they have to fight for a rating that accurately reflects their disability, i.e, the service they belong to, and put on the uniform of, acts as their adversary. We simply have to do better than that. The cracks between the military and VA delivery systems must be filled. The transition must be smoothed out. The differences must be removed. The adversarial aspects must also be removed.

The military's disability rating is extremely important to the lives of our wounded warriors and their families. Those with disabilities rated at 30 percent or higher are medically retired, entitling them and their families to healthcare for life through the military's TRICARE health care program, a military pension, and access to commissary and post exchange benefits. Those whose disabilities are rated less than 30 percent are given a medical separation with severance pay. Although these servicemembers whose disabilities are rated at less than 30 percent are eligible to receive health care through the VA, their families are not. The VA disability rating is equally as important because the amount of VA disability compensation is based on the VA disability rating.

I recently talked to a soldier at Walter Reed who had been injured by an IED blast while on his second tour of duty in Iraq. He understands that he is no longer physically fit for military duty because of the seriousness of his injuries. He receives care for his injuries in an outpatient status. He also is suffering from memory loss and believes that the Army's rating system will not take that problem into account. He told me that he is "scared to death" that the physical disability evaluation system will rate his disability at less than 30 percent and will "put me out on the street" without the ability to take care of his family, including his children. How can we, as a Nation, ask our young men and women to serve, and when they are wounded while serving, put them in a position where they are "scared to death" that we will not take proper care of them and their families? Surely we must change such a system.

It also takes too long to get a disability rating from the VA. Veterans report that they have to wait months and months to get a VA disability rating before they can start receiving compensation for their disabilities. Currently, the VA has a backlog of approximately 400,000 cases and it takes an average of 177 days to rate a claim. When I visited the VA hospital in Ann Arbor, Michigan, veterans told me that there are several thousand claims that have been pending for an average of a year—a few years ago it was bad enough—when the wait was 6 months.

Another problem reported by our servicemembers is the lack of a smooth or seamless transition from the military to the VA. Many say that their military medical records are often not available to VA doctors. One veteran said that there is so much red tape that it can take up to 22 documents with 8 different commands to exit the military medical system and enter the VA program. This exists even though there are numerous programs that are supposed to help the Veterans as they leave active duty, such as the Transition Assistance Program and the Benefits Delivery at Discharge Program. Despite these programs, the gaps and chasms remain.

This is not a new issue. In 2003, the President's Task Force to Improve Health Care For Our Nations Veterans made a series of recommendations to ease the transition from servicemember to veteran status, *most of which recommendations have not been implemented.* For example, this Task Force recommended that VA and DOD:

- Implement by Fiscal Year 2005 a mandatory single separation physical as a prerequisite of promptly completing the military separation process;
- Expand the "one-stop shopping" process to include, at a minimum, a standard discharge exam, full outreach, claimant counseling, and when appropriate, referral for a VA Compensation and Pension examination and follow-up claims adjudication and rating. Upon a servicemember's separation, DOD should transmit an electronic DD 214 to VA; and
- By Fiscal Year 2004, initiate a process for routine sharing of each servicemember's assignment history, exposures to occupational hazards, location, and injuries information.

The disability rating issues and the transition challenges are currently under review by at least 5 different entities. The Army Inspector General recently completed an inspection of the Army Physical Disability Evaluation System, identifying numerous shortfalls in the Army system. The Secretary of Defense has established an Independent Review Group to identify shortcomings and opportunities to improve rehabilitative care, administrative processes and the quality of life of outpatients at Walter Reed and Bethesda hospitals. The report of this independent review group is due on April 16th. The President established a bipartisan Presidential Commission on Care for America's Returning Wounded Warriors. This Commission is to provide independent advice and recommendations on care provided to wounded servicemen and women from the time they leave the battlefield through their return to civilian life. The Commission's report is due on June 30th, with an option for an extension to July 31st. The President also created an inter-agency cabinet level Task Force on Returning Global War on Terror Heroes to identify and examine Federal services provided to servicemembers who served in Afghanistan and Iraq, to identify gaps in the services, and to ensure cooperation between Federal agencies. The final report of this task force is due on June 30th. Finally, the Veterans' Disability Benefits Commission has been looking at these issues for some time. This Commission's report is due on October 1st. I'm confident that General Scott will give us some insight into this Commission's observations thus far. A preliminary report of the Secretary of Defense's Independent Review Group which proposed an acceleration of the closure of Walter Reed, describes the current system for assessing soldiers' disabilities "extremely cumbersome, inconsistent, and confusing," calling for a complete overhaul of the process. The findings and recommendations of all of these groups may be useful as we seek solutions to the problems confronting our wounded servicemembers, but previous reports have been ignored. We shouldn't wait until they are all completed before we act.

The House has already acted and passed the Wounded Warrior Assistance Act of 2007, which would impose a number of new requirements on the Department of Defense to improve medical care and other services for servicemembers and would require the Department of Defense and Veterans' Administration to establish a single medical information system. Several bills have also been introduced in the Senate, including the Restoring Disability Benefits for Injured and Wounded Warrior Act of 2007 introduced by Senator Clinton; the Dignity for Wounded Warriors Act of 2007 introduced by Senators Obama, McCaskill and others; and the Effective Care for the Armed Forces and Veterans Act of 2007 introduced by Senator Biden. All of these bills have been referred to the Senate Armed Services Committee where we will address these bills soon.

The American people are deeply angry about the shortfalls in care for our wounded veterans. The war in Iraq has divided our Nation, but the cause of supporting our troops and our veterans unites us all as Americans and as Members of Congress. We will do everything we possibly can do, not as Democrats or Republicans but as grateful Americans, to care for those who have served our Nation with such

honor and distinction. That is an obligation which all Americans accept and insist be met to the fullest.

Chairman LEVIN. Senator McCain?

STATEMENT OF HON. JOHN MCCAIN, RANKING MEMBER, COMMITTEE ON ARMED SERVICES, U.S. SENATOR FROM ARIZONA

Senator MCCAIN. Thank you very much, Senator Levin. I want to thank you and Senator Akaka for conducting this hearing. It is an important next step in determining how our Armed Services and Veterans' Affairs Committees will respond to the needs of the wounded and injured servicemembers and I join you in welcoming the witnesses today.

At our last hearing on the situation at Walter Reed, I described the conditions there as appalling. Perhaps even more appalling was the failure to appreciate the bureaucratic manner in which outpatients were being treated after they had received superb medical care and they and their families were attempting to transition to civilian life.

It took that situation and holding accountable those who were in charge to bring us to a point where we can all agree that change is needed. Information that was reported this morning on the recommendations of the Independent Review Group appointed by Secretary Gates confirms the need for significant and far-reaching change. There appears to be consensus, for example, that the current decentralized disability evaluation systems for the Army, Navy, Air Force, and Marines have received very little oversight from DOD and have produced questionable outcomes for many severely wounded soldiers.

I and others have drafted legislation that would address some of the problems that have already been identified. For example, it would provide independent review on request from any servicemember who has received less than a 30 percent rating, in response to accusations that junior enlisted have been systematically low-balled in the disability ratings they have been offered and been denied the benefits of a medical retirement. It would also authorize the most severely injured to retain their medical health benefits for up to 5 years in order to complete their care.

These and many other good ideas need to be included, and Mr. Chairman, I am confident that they will be included in this year's Defense Authorization Act. Bureaucracies at both agencies, the Department of Defense and the Department of Veterans Affairs, have caused many of our wounded to wait months for disability evaluations, benefits, or pay. Why is it that health care information still cannot be easily shared between the military and the Department of Veterans Affairs? Why do the disability evaluation and claims processes take so long? Is there an adequate safety net for victims of Traumatic Brain Injury and Post Traumatic Stress Disorder whose injuries and care needs cannot easily conform to standardized time lines and criteria?

I recognize, Mr. Chairman, that while several commissions and review boards are at work, important changes have already begun in DOD and the VA. I hope we will receive assurances from Secretary England and our other witnesses that the housing and lead-

ership problems not only at Walter Reed but throughout the military and VA systems have been corrected.

I challenge our witnesses to inform the Committees about other meaningful reforms to the military and veterans' systems that build on the strength of each and ensure that procedures for disability evaluation and transition assist and do not frustrate the recovery of wounded servicemen and women. The heroism and sacrifice of these brave men and women deserve no less.

President Kennedy, in speaking about our treatment of veterans, expressed what I consider to be our responsibility to our injured and wounded troops. He said, "As we express our gratitude, we must never forget that the highest appreciation is not to utter words but to live by them." Obviously, Mr. Chairman, we must live up to that responsibility.

I thank you, Mr. Chairman, and I thank Senator Akaka and Senator Craig.

Chairman LEVIN. Thank you very much, Senator McCain.

Senator Akaka, who has very aggressively joined in this mutual effort, this joining together in a very unprecedented way of these two Committees to address an issue which can only be addressed by these two Committees, working together here in the Senate and by our comparable Committees working together in the House. Senator Akaka?

OPENING STATEMENT OF HON. DANIEL K. AKAKA, CHAIRMAN, COMMITTEE ON VETERANS' AFFAIRS, U.S. SENATOR FROM HAWAII

Chairman AKAKA. Thank you very much, Mr. Chairman. I am really delighted to join you, the Armed Services Committee Chairman, and Senator McCain, the Ranking Member, and the Senate Veterans' Affairs Committee Ranking Member, Senator Craig, and all of our colleagues, Members of both Committees, in this really unprecedented joint hearing. Also, I want to welcome our guests and our witnesses who are here today and look forward to working with you for the good of our country.

It is my hope that through this hearing and our follow-up work, we will be able to identify solutions to the problems that first gained public attention in connection with the stories about Walter Reed Army Medical Center. Unfortunately, many of the problems that surfaced at Walter Reed, particularly concerns about how DOD works with those servicemembers who will be leaving the service due to injuries or illness, are not limited to Walter Reed but exist throughout the military services.

I am concerned that the government is not doing an adequate job in providing a smooth transition between DOD and VA. As Chairman of the Veterans' Affairs Committee and a Member of the Armed Services Committee, I am able to look at these issues from two different perspectives. However, in the end, it is clear that the problems facing DOD and VA are not separate. While there are two organizations, both of them deal with the same set of servicemembers.

It is vital that we address both DOD and VA responsibilities and concerns to ensure that servicemembers receive the benefits and services available to them. I know we all agree that we have an

obligation to provide our wounded and ill servicemembers with optimal care from both DOD and VA. That obligation also must ensure the transition between the two departments is as smooth as possible.

We have to realize that VA not only has a relationship with DOD, but an independent relationship with each of the military services. In this regard, we should not just be looking at DOD, but at each of the military services individually. Hopefully, our oversight will result in identifying best practices from the services that can be exported and implemented DOD-wide.

I intend for this hearing to identify workable solutions to the many problems that confront DOD, the military services, and VA. I look forward to hearing the testimony of the Departments. These are some of the most important issues of our time. We have a unique opportunity at this joint hearing to focus upon identifying solutions to problems that impact our servicemembers and veterans. We owe them no less.

Thank you, Mr. Chairman.

Chairman LEVIN. Thank you very much, Senator Akaka.

Senator Craig?

STATEMENT OF HON. LARRY E. CRAIG, RANKING MEMBER, COMMITTEE ON VETERANS' AFFAIRS, U.S. SENATOR FROM IDAHO

Senator CRAIG. Chairman Levin, thank you very much, Chairman Akaka, Senator McCain, for bringing together these two Committees of jurisdiction on this very important issue. To all of you who have assembled to give testimony, we appreciate an opportunity to visit with you and better understand a situation that is not new and has been addressed over a long period of time with relatively few solutions.

To say the least, it has been disheartening over the past few months to learn of severely injured servicemembers and their families who have experienced delays, frustrations, and disappointments while trying to get decisions about their military disability benefits. For the men and women who have given so much in service to this Nation, I think we can all agree that we must ensure they are swiftly and properly compensated for their service-related disabilities.

When I first became Chairman of the Veterans' Affairs Committee a few years ago, one of the first hearings we held was with survivors, spouses, predominantly women, who gave us testimony of the years it took sometimes to thread their way through the bureaucracy of the systems to get what was legally and rightfully theirs. And if they were not extremely sophisticated in their pursuit of those benefits that were rightfully theirs, oftentimes they did not receive them, or they would find out later or 3 or 5 years from the time they had lost their loved one that they were still owed and deserving of certain benefits.

To have two separate disability systems between the Department of Defense and the Department of Veterans Affairs seems to me to only multiply the bureaucracy by two. Unfortunately, that issue and others that we are going to discuss today, as I earlier mentioned, are not new. Five decades ago, a commission chaired by

General Omar Bradley—yes, let me repeat that, General Omar Bradley—found that the military disability program overlaps the system of disability compensation administered by the VA and recommended eliminating duplication of administrative functions. The Bradley Commission also found that there were great variances in rating assignments by DOD and VA and that the rating criteria needed to be revised to reflect up-to-date medical, economic, and social thinking with respect to ratings and compensation disability. That is exactly what we need today. After fifty years and ten Administrations, there are still concerns about variances between rating assignments in VA and DOD and how they are assigned.

In that regard, I am perplexed as to why the Army only rates conditions that would independently render a soldier unfit, even if the soldier has multiple disabilities caused by the same event. For a soldier who has a number of wounds caused by an IED blast, shouldn't we look at how those wounds in concert affect his or her fitness and rate the overall disability level accordingly? Otherwise, the policy seems akin to totaling a car and only being compensated by the insurance company for the tires that were flattened in the accident.

Well, Mr. Chairman, there is a good deal more I could say. Let me ask unanimous consent that the balance of my statement be a part of the record and again thank all three of you for recognizing the importance of bringing these two Committees together that have dual jurisdiction in a variety of areas oftentimes that overlap. Most importantly, it is time, I think, we look at whether we continue the bureaucracy and the system we have or if we get modern, like the modern military and the young men and women who serve in it.

Thank you, Mr. Chairman.

[The prepared statement of Senator Craig follows:]

PREPARED STATEMENT OF HON. LARRY E. CRAIG, RANKING MEMBER, COMMITTEE ON VETERANS' AFFAIRS, U.S. SENATOR FROM IDAHO

Good morning, and welcome to this joint hearing of the Senate Armed Services and Veterans' Affairs Committees. And thank you to Chairman Levin and Chairman Akaka for calling this very important hearing.

To say the least, it has been disheartening over the past few months to learn of severely injured servicemembers and their families who have experienced delays, frustrations, and disappointments while trying to get decisions about their military disability benefits. For the men and women who have given so much in service to their Nation, I think we can all agree that we *must* ensure they are swiftly and properly compensated for their service-related disabilities.

But many of us are probably wondering whether we need *two separate* disability systems to do that—one run by the Department of Defense and the other by the Department of Veterans Affairs—or whether that much bureaucracy only adds to the frustrations.

Unfortunately, that issue—and others that we will discuss today—are not new. In fact, five decades ago, a commission chaired by General Omar Bradley found that "the military program overlaps the system of disability compensation administered by [VA]" and recommended "eliminating duplication of administrative functions."

The Bradley Commission also found that there were "great variances" in ratings assigned by DOD and VA and that the rating criteria needed to be revised to "reflect up-to-date medical, economic, and social thinking with respect to rating and compensation of disability."

Yet today—after 50 years and 10 different Administrations—there are still concerns about variances between ratings assigned by VA and DOD; about rating criteria that are not sufficiently up to date; and about overlapping functions being per-

formed by DOD and VA. Also, serious concerns have been raised about whether DOD is providing adequate disability ratings to wounded servicemembers.

In that regard, I am perplexed as to why the Army only rates conditions that would *independently* render a soldier unfit, even if the soldier has multiple disabilities *caused by the same event*. For a soldier who has a number of wounds caused by an IED blast, shouldn't we look at how those wounds—in concert—affect his or her fitness and rate the overall disability level accordingly? Otherwise, the policy seems akin to totaling a car and only being compensated by the insurance company for the tires that went flat!

In my view, long-term solutions must start with a serious assessment of what purpose each system is intended to serve and whether either system—as currently structured—is capable of providing timely, accurate and consistent decisions.

Later this year, the Veterans' Disability Benefits Commission—chaired by General Scott—will provide Congress with a comprehensive assessment of veterans' disability benefits. And I hope that will provide the foundation for the types of *fundamental* changes that may be needed to ensure lasting improvement in how we compensate injured servicemembers.

But, in the meantime, I think it is clear that we need to take *immediate* steps to make these systems work better for our Nation's heroes. For starters, there needs to be a more efficient system for transferring records both between DOD and VA and within different facilities at each department. In this age of technology, it seems inexcusable that injured servicemembers are asked to fill out the same forms over and over again or to endure long waits while records from different facilities are located and transferred.

I know our witnesses will have other suggestions for how to improve these systems—both in the short-term and the long-term—and I look forward to hearing their recommendations.

Whether we pursue those options or others, I sincerely hope that we can all work together to streamline the systems and omit overlapping levels of bureaucracy that serve only to lengthen the process and frustrate our Nation's wounded warriors.

Thank you again Chairman Levin and Chairman Akaka for calling this hearing, and thank you to all of our witnesses for being here today.

Chairman LEVIN. Thank you. Your statement, of course, will be made part of the record. I want to also thank you and Senator McCain for all you have done to make this joint hearing possible.

Let me first note that there will be a vote at 10:30. It is our intent to work right through that vote, so some of us could leave, vote early, and come back, and so forth. We will, after the statements from our witnesses, proceed on an early bird basis, alternating between Democrats and Republicans, with only a 4-minute round, I am afraid, given the number of Senators, at least for the first round and then we will see how far that goes.

So now let me thank our witnesses for being here. We very much appreciate your all coming and I think we are going to start with you, Secretary England.

STATEMENT OF HON. GORDON R. ENGLAND, DEPUTY SECRETARY, DEPARTMENT OF DEFENSE; ACCOMPANIED BY HON. DAVID S.C. CHU, UNDER SECRETARY FOR PERSONNEL AND READINESS, DEPARTMENT OF DEFENSE

Mr. ENGLAND. Chairman Levin, thank you very much, Senator McCain and Members of the Senate Armed Services Committee, and Chairman Akaka and Senator Craig and Members of the Senate Veterans' Affairs Committee. I do thank you for the opportunity to be here today. This is indeed, as you have commented, a vitally important topic, not just for our men and women in uniform, but, frankly, for all the citizens of this great Nation. And we do have some experts here today that hopefully can add some light on this discussion.

Let me first assure you that the very top priority of the Department of Defense is taking care of our men and women in uniform and their families and, in particular, those who have made the greatest sacrifices for our Nation. The Administration and the Department are absolutely committed to fixing problems and resolving outstanding issues and we are ready to bring forward to the Congress proposed legislation if and as required to fix problems identified.

In the meantime, the Department is indeed being proactive. Where problems are identified and can be fixed, we are doing so. I can tell you Secretary Gates is personally and actively engaged in meeting regularly with OSD and service leaders on this topic.

Our goal is an uninterrupted, seamless continuum of care and support for servicemembers who are wounded or injured as a result of their service. The population of the greatest concern which requires the most urgent action includes those warriors with war-related injuries or conditions, who account for about 11 percent of the total workload of the Department's Disability Evaluation System.

Unfortunately, despite good faith efforts by the services and by our agencies, by a lot of really very, very good people, and despite many significant accomplishments, it is evident that some of our valued servicemen and women, and particularly those with war injuries, are not receiving the benefits they deserve, and some of them and their families are also caught up in unacceptable bureaucratic delays and frustrations.

Now, given, frankly, what is in place today, it is not a single system and those delays and frustrations are, therefore, not really surprising, because DOD itself is a system of internal systems under a broad umbrella. Then the Department of Veterans Affairs is another system, and then the DOD and the VA are linked by the all important transition system.

Now, for an individual servicemember looking in from the outside, the division of roles and responsibilities is far less important than a completely transparent process to provide timely adjudication and appropriate results, and that should be the end objective of our efforts. That is, we should look at this from the servicemember's view looking in and they should see a completely transparent system.

Now, this time of taking stock, I believe, is a good opportunity to consider the overall joint DOD–VA health care and disability apparatus, so I have two suggestions. The first is that we immediately concentrate on the wounded. Currently, with the transition from DOD to the Department of Veterans Affairs, the ratings process is a one-size-fits-all process. That is, the same basic procedures are followed inside the Department and during the transition to the VA for all individuals, so the 11 percent of cases that are those wounded or severely wounded are funneled through exactly the same system as the other 89 percent, the career members transitioning to retirement. Now, many of the wounded have combat injuries that are readily understood, so these should be the most straightforward in terms of disposition. The system should be able to process these individuals very expeditiously, and so my first recommendation is we should work on this particular immediate issue.

Secondly, we have a lot of studies, reviews, commissions, and panels underway and they will all be reading out before the end of the year. Using results of those efforts, in my judgment, it is time to step back and take a more holistic look at the system instead of just applying fixes to the system, and that was basically the complete overhaul that Senator McCain commented earlier for the commission that Secretary Gates put together. We do need an integrated systemic solution with the right mechanisms in place, a solution that makes sense from the soldier's perspective. So if we were designing the system today from scratch, what would that system look like, and then what administrative and possibly legislative steps would we need to take to get there?

Lastly, our people eventually go into other systems of the Federal Government and it may be useful to look at the military disability system in the context of the entire national system for disability determination and compensation. Today, our Nation has diverse approaches. In the public sector, the problems have much in common. We have Social Security Disability payments, Department of Labor Workers' Compensation, Department of Veterans Affairs, Department of Defense's disability evaluation system. They are all carried out in different ways against different standards to achieve different ends and the complexity and the variance and outcomes often confuse benefit recipients. So even when we solve this problem, I believe our people eventually get into an even more complex system, so it may be time to cast a wider net and look at this whole area of disability.

I do want to comment, in conclusion, that Secretary Gates has clearly stated that the Department of Defense will work with the commissions, the panels, the study groups we have in place, the Congress, and all the partner agencies to clearly identify problems and fix them, so you have our full absolute support and cooperation. And I do thank the Members of the Committees here for your care and concern for our heroes. This is an extraordinarily important topic, I know, to all of you and to all of us in the Department of Defense, because at the end of the day, this is about the brave men and women in uniform who serve our Nation. So I thank you. I also thank you for the opportunity to be here today.

[The prepared statement of Mr. England follows:]

PREPARED STATEMENT OF HON. GORDON R. ENGLAND,
DEPUTY SECRETARY, DEPARTMENT OF DEFENSE

Chairman Levin, Senator McCain, Members of the Senate Armed Service Committee, Chairman Akaka, Senator Craig, Members of the Senate Veterans' Affairs Committee, thank you for your strong support for the brave men and women in uniform of the Department of Defense, and their families, who so courageously serve the Nation. And thank you for the opportunity to meet with you this morning to discuss two practical issues that directly and profoundly affect their well-being: disability ratings, and the transition of responsibility for servicemembers from the Department of Defense to the Department of Veterans Affairs. These are important issues that merit thoughtful consideration. Dialogue and discussion are helpful and appreciated.

It is a pleasure to appear with colleagues from the Department of Veterans Affairs—Under Secretary Dan Cooper and Dr. Gerald Cross—and with LTG (ret.) Terry Scott, Chairman of the Veterans' Disability Benefits Commission, since the complex challenges under discussion require efforts from multiple agencies. With me this morning from the Department of Defense are Acting Secretary of the Army Pete Geren, and Under Secretary of Defense for Personnel and Readiness Dr. David Chu.

Let me assure you that the top priority of the Department of Defense is taking care of our men and women in uniform and their families, and in particular those who have made the greatest sacrifices for the Nation. The Administration and the Department are absolutely committed to fixing problems and resolving outstanding issues, and are ready to bring forward to the Congress proposed legislation, if and as required to fix the problems.

The goal is an uninterrupted, seamless continuum of care and support, for servicemembers who are wounded or injured as a result of their service. The population of greatest concern—which requires the most urgent attention—includes those warriors with war-related injuries or conditions, who account for about 11 percent of the total workload of the Department's Disability Evaluation System.

Unfortunately, despite good faith efforts by the Services and by our agencies, and despite many significant accomplishments, it is evident that some of our valued servicemen and women, particularly those with war injuries, are not receiving the level of care they deserve. Some of them and their families are caught up in unacceptable bureaucratic delays and frustrations.

To address these issues, a number of efforts have already been initiated. On March 1, 2007, Secretary Gates appointed an independent panel—the Independent Review Group (IRG), co-chaired by the Honorable Togo West, Jr., and the Honorable Jack Marsh—to take a broad look at rehabilitative care, administrative processes, and quality of life, at Walter Reed Army Medical Center and Bethesda National Navy Medical Center. The Group's report is expected very soon.

The President also appointed an independent panel—the Commission on Care for America's Returning Wounded Warriors, co-chaired by Senator Bob Dole and Secretary Donna Shalala—to take a comprehensive look at the full lifecycle of treatment for wounded veterans returning from the battlefield. And the President directed the Department of Veterans Affairs to establish an Interagency Task Force on Returning Global War on Terror Heroes, in which the Department participates.

The results of these efforts will add to the ongoing work by the Veterans' Disability Benefits Commission, chaired by LTG (ret.) Terry Scott, and chartered by the National Defense Authorization Act of 2004 to study veterans' benefits, which is due to report out later this year.

As Secretary Gates has clearly stated, the Department will work with the Commissions, the Congress, and partner agencies to clearly identify the problems and fix them.

Meanwhile, the Department has taken a proactive approach. For example, a major internal review of care for our wounded servicemembers was launched immediately after the issues at Walter Reed came to light.

As Acting Secretary of the Army Pete Geren can better attest, the Army is evaluating the installation's infrastructure, upgrading information technology, improving clothing and food services, and creating the Warrior Transition Brigade, to provide wounded Soldiers with a full chain of command.

Where problems are evident and can be fixed immediately, the Department is doing so. The Department requested an adjustment to the Fiscal Year 2007 Emergency Supplemental request, to provide $50 million to create a Medical Support Fund to implement any findings or recommendations in which the Department can take action before Fiscal Year 2008.

This time of taking stock is a good opportunity to consider the overall joint DOD/DVA disability and health care system. In fact, what is in place today is not a single "system," but rather several: (1) DOD, itself a system of internal Service systems under a broad umbrella; (2) DVA; and (3) the all-important transition process that links the two departments. For an individual servicemember looking in from the outside, the division of roles and responsibilities is far less important than a completely transparent process that provides timely adjudication and appropriate results. This should be the end objective of our efforts.

Within the Department, the Disability Evaluation System is run primarily by the Secretaries of the Military Departments. Since the "fitness to serve" standard must and does vary by Service, military specialty, and grade, there is variance among the approaches. In a system that processes 20,000 cases annually, there are also real, and likely unwarranted, variances in execution.

In the transition from the Department of Defense to the DVA, our agencies do benefit from a strong basis for partnership. DOD and DVA share the mission of taking care of those who serve, and making sure cooperation is as seamless as possible. Our agencies have put in place a responsive organizational structure—the VA/DOD Joint Executive Council, co-chaired by DVA Deputy Secretary Gordon Mansfield and Under Secretary of Defense David Chu, which provides guidance and establishes policy for the full spectrum of collaborative initiatives. To provide broad vision for ongoing collaboration, DOD and the VA developed a Joint Strategic Plan, which will

be updated over time. Secretary Nicholson and I do meet and confer, when issues need to be addressed at our level. However, there are still challenges in meeting our shared goal of seamless transition between DOD and the VA.

However, seams between our agencies remain.

A fundamental challenge is that the Department of Defense and the Department of Veterans Affairs use two different disability ratings systems, which both produce end products expressed in terms of "percentages"—but the percentages refer to different things. DOD's Military Departments rate fitness, at a fixed point in time, for continued military service, while the DVA rates civilian employability, based on any changes in health status that can be linked to time in service—and the DVA's ratings may change over time, if the medical condition changes. This imperfect integration produces undue confusion for servicemembers and their families.

Another problem with the transition from DOD to the DVA is that the disability ratings process is "one size fits all"—the same basic procedures are followed inside the Department and during the transition to the DVA, for all individuals. The 11 percent of cases that are those wounded or severely wounded in war are funneled through exactly the same system as the other 89 percent, the career Servicemembers transitioning to retirement.

Many of the wounded have combat injuries that are readily understood. These should be the most straightforward cases in terms of disposition. The system should be able to process these individuals very expeditiously.

Other wounded warriors have conditions—particularly those resulting from new forms of warfare—that present new challenges to the medical profession, and stretch the abilities of the current system. For example, one of the most difficult conditions a Servicemember can struggle through is Traumatic Brain Injury (TBI), and much more needs to be done to leverage national capabilities, both civilian and military, to apply the most advanced technology and medicine to this condition. And while the Department is working to improve its ability to identify and treat mental health issues, including Post Traumatic Stress Disorder, this is another war-related challenge that needs further attention.

Another serious challenge is that DOD and DVA still operate largely on the basis of two different sets of information, based on two different vocabularies, without a single, accessible electronic database of information. While this is being addressed, a full solution is still several years away.

In the transition from DOD to the DVA, even when the system "works," it still fails in the eyes of too many servicemembers, due to bureaucracy and delays, and the anxiety, confusion and frustration they cause, even for those who pass "successfully" through the system. Because the process is complex and lengthy, and its results have such profound effects on servicemembers, it is understandably viewed by some as "adversarial." The system needs to be timely, and at the same time deliberate enough to produce fair, accurate and consistent results. Despite its complexities, it must be clear and transparent to its customers.

There is no single silver-bullet solution, but it might make sense to consider the following:

- As a first step, focus on and seek innovative solutions for the wounded and severely wounded cases, and then turn to the general population of servicemembers.
- Move beyond stovepiped data-storage systems to create a central database of information to expedite full electronic information exchange.
- Make existing benefits more accessible through common terminologies and a fully integrated process.

Lastly, it may be useful to re-evaluate the entire national system for disability determination and compensation. The Nation has diverse approaches in the public sector to problems that have much in common. Social Security's disability payments, the Department of Labor, Workmen's Compensation, the Department of Veterans Affairs' and the Department of Defense's Disability Evaluation Systems are carried out in different ways, against different standards, to achieve different ends. The complexity and variance in outcomes and numerous program offsets and tax exempt statuses often confuse benefit recipients. The purposes of the various programs also vary widely. These diverse approaches regarding compensation for disabled workers suggest the need for a new paradigm for the Nation.

The Department remains committed to working in closest partnership with the Department of Veterans Affairs, with the Commissions and Task Forces, and with the Congress, as we go forward.

I do thank the Members for your care and concern for our heroes—the brave men and women in uniform who serve the Nation.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. CARL LEVIN TO HON. GORDON ENGLAND, DEPUTY SECRETARY, DEPARTMENT OF DEFENSE

Question 1. What does DOD think of suggestion that the fitness for duty determination be made by the DOD and then there be one comprehensive physical examination by the VA that determines the rating?

Response. The Department of Defense (DOD) supports the suggestion of keeping the fitness determination in the Department of Defense. We also support a collaborative DOD and the Department of Veterans Affairs (DVA) single agency determination of disability ratings. A future system should also integrate the efforts of DOD and DVA, where reasonable, by eliminating redundancies. A DOD determination of fit/unfit allows decisions critical to maintaining a fit and ready force to reside appropriately in the Department. Deferring the disability determination to a collaborative body of DOD and DVA authorities more expert in utilization of the disability schedules would eliminate much of the tension associated with the adversarial burden of proof board process by placing the determination of permanent or temporary retirement, concurrent receipt, and disability percentage to the single entity that is most skilled at disability determinations. We believe that a demonstration authority is needed to adequately evaluate this concept. In this demonstration project, DOD and DVA would jointly define the framework and focus initially on those with a combat-related condition(s). DOD and DVA would report successes and findings of the demonstration to Congress on a regular basis. A major issue would be funding of retirements and disability ratings.

Note: It is assumed that the question on "one comprehensive physical examination . . . " is in reference to one disability determination and not to the medical examinations required to diagnosis severity of conditions accomplished by the DOD and DVA.

Question 2. What is the DOD timeline for electronic transfer of medical records?

Response. Department of Defense (DOD) and the Department of Veterans Affairs (VA) share health information today. Beginning with our electronic sharing in 2001, the Departments continue to pursue incremental enhancements to information management and technology initiatives to significantly improve the secure sharing of appropriate health information. Under the VA/DOD Joint Strategic Plan, these health information technology data sharing initiatives are prioritized by DOD and VA leadership.

CURRENTLY SHARED ELECTRONIC MEDICAL RECORD DATA

- Inpatient and outpatient laboratory and radiology results, allergy data, outpatient pharmacy data, and demographic data are viewable by DOD and VA providers on shared patients through Bidirectional Health Information Exchange (BHIE) from 15 DOD medical centers, 18 hospitals, and over 190 clinics and all VA facilities.
- Electronic digital radiographic images are being electronically transmitted from Walter Reed Army Medical Center (WRAMC) and National Naval Medical Center (NNMC) Bethesda to the Tampa and Richmond VA Polytrauma Centers for inpatients being transferred there for care.
- Electronic transmission of scanned medical records on severely injured patients transferred as inpatients from WRAMC to the Tampa VA Polytrauma Center.
- Pre- and Post-Deployment Health Assessments and Post Deployment Health Re-assessments for separated Servicemembers and demobilized Reserve and National Guard members who have deployed.
- When Servicemembers end their terms in service, DOD transmits to VA laboratory results, radiology results, outpatient pharmacy data, allergy information, consult reports, admission, disposition and transfer information, elements of the standard ambulatory data record, and demographic data.
- Discharge Summaries from 5 of the 13 DOD medical centers and hospitals using the Clinical Information System (CIS) to document inpatient care.

ENHANCEMENT PLANS FOR FISCAL YEAR 2007

- Expanding the electronic digital radiographic images transfer capability to Brooke Army Medical Center (BAMC) and from WRAMC, NNMC, and BAMC to all four VA Polytrauma Centers.
- Expanding the electronic transmission of scanned medical records on severely injured patients from WRAMC, NNMC, and BAMC to all 4 VA Polytrauma Centers.
- Making available discharge summaries, operative reports, inpatient consults, and histories and physicals for viewing by all DOD and VA providers from inpatient data at all 13 DOD medical centers and hospitals using CIS.

• Expanding availability of inpatient and outpatient laboratory and radiology results, allergy data, outpatient pharmacy data, and demographic data viewable by DOD and VA providers on shared patients through BHIE to all DOD and VA facilities.

• Making available theater outpatient encounters, laboratory and radiology results, and pharmacy data for VA providers to view through BHIE.

• Beginning collaboration efforts on a DOD and VA joint solution for documentation of inpatient care.

ENHANCEMENT PLANS FOR FISCAL YEAR 2008

• Making available encounters/clinical notes, procedures, and problem lists to DOD and VA providers through BHIE.

• Making available vital sign data, family history, social history, other history, and questionnaires/forms to DOD and VA providers through BHIE.

• Making available theater inpatient encounters, to include clinical notes, discharge summaries and operative reports; laboratory and radiology results; and pharmacy data to all DOD and VA providers via BHIE through a specific interface to the Theater Medical Data Store, designated the BHIE-Theater.

• Expanding CIS deployment to Landstuhl Regional Medical Center, Germany. Once CIS is installed at Landstuhl, the discharge summaries, operative reports, inpatient consults and histories and physicals will be available to VA on shared patients.

Question 3. There was a GAO report in March 2006 which criticized the Department and the Services for failing to systematically determine the consistency of disability decisionmaking. The Department has issued timeliness goals for processing disability cases, but there's no collection of information to determine compliance. The consistency and timeliness of decisions depend in part on the training that disability staff receives. However, the GAO found that the DOD is not exercising oversight over training for staff in the disability system. Are you familiar with that GAO report? I think the question is, are you familiar with the report and what are you doing about the findings?

Response. The Department has been working hard on remedying the problems identified in the GAO report. The GAO report conclusions stemmed partially from dated Department issuances and lack of an active Disability Advisory Council (DAC)—a consortium of advisors from the Military Departments, Department of Defense (DOD) agencies, and the Department of Veterans Affairs. In response:

• The Department has revitalized the DAC so that it plays an active and strengthened role in managing Department disability policy.

• The DAC is working to update the set of DOD issuances that promulgate disability policies and is charged with strengthening oversight processes and making recommendations on program effectiveness measures, future policy, and changes to title 10.

• A Directive-Type Memorandum (DTM), which is an interim policy, is in coordination that will implement policy consistent with the Department's overall efforts to address the recommendations of the GAO report and those directed by Section 597 of the Fiscal Year (FY) 2007 National Defense Authorization Act, which establishes procedural requirements for Physical Evaluation Boards (PEBs), including conveying PEB findings in an orderly and itemized fashion, assigning and training of PEB Liaison Officers and PEB staff, and establishing PEB operating procedures and timeliness goals. Section 597 also directs a comprehensive review of compliance every 3 years. The guidance in the DTM creates annual and quarterly reporting and verification mechanisms, clarifies timeliness goals, establishes sampling of disposition determinations and other performance measures, and formally elevates program awareness and issues to senior leadership levels.

• Additionally, the interim policies, incorporating these and other additions will, in due course, be formally coordinated and published. The current DOD Directive 1332.18, "Separation or Retirement for Physical Disability," and DOD Instruction 1332.38, "Physical Disability Evaluation," will be combined into one issuance. Until such time, the Department will issue regular directive-type memoranda every couple of months, which will allow consideration of findings and recommendations from the various commissions, task forces, and study groups. This process of continuous process improvement will help develop solutions to resolve many statutory and systemic issues associated with the Disability Evaluation System and the transition of those separated to the care of the Department of Veterans Affairs.

• The entire disability process and oversight by the Office of the Secretary of Defense have been strengthened by the utilization of outside assistance to assist in analyzing data and recording process for use in policy formulation, promulgation,

and management. We are pursuing permanent manpower dedicated to disability management oversight.

RESPONSE TO WRITTEN QUESTION SUBMITTED BY HON. LARRY CRAIG TO HON. GORDON ENGLAND, DEPUTY SECRETARY, DEPARTMENT OF DEFENSE

Question 1. What is the status of the Department of Defense (DOD) report regarding the implementation of a uniform policy of casualty assistance for survivors, pursuant to section 562 of Public Law 109–163? How exactly have the problems identified in the Government Accountability Office report filed pursuant to that same law been remedied?

Response. The report to Congress on Improvement of Casualty Assistance Programs was forwarded on April 20, 2007. The GAO made two recommendations. First, that the Department develop an oversight framework that includes measurable DOD-wide objectives for casualty assistance programs as well as DOD-wide outcome measures to evaluate aspects of its program, such as survivors' satisfaction with assistance they received from casualty assistance officers, and clearly link program performance with these objectives requiring the Services to report on these outcome measures so that DOD can use the reports to monitor the casualty assistance program's performance and make fact-based decisions about program operations and resources. Second, that the Department incorporate standards, such as a comprehensive checklist of duties for casualty assistance officers, when revising its casualty assistance policy.

The DOD's Instruction has been revised, incorporating the policy elements required by section 562, and is in the final stages of formal coordination. The Military Services, including the United States Coast Guard, are revising their policies and procedures, as necessary, to ensure a uniform application of services across the Military Departments.

Two standardized evaluation mechanisms are being developed to measure the effectiveness of the Department's casualty assistance program as well as measure the quality of the assistance provided.

Question 2. There is a wide array of benefits and services provided by both the Department of Veterans Affairs (VA) and DOD, yet there are discrepancies between benefits available for those on active duty versus those who are medically retired and in veteran status. This discrepancy may lead to confusion among family members who do not understand why legal distinctions exist for benefits meant to help those wounded in combat, irrespective of their status. The Wounded Warrior Project has recommended legislation to authorize a blanket overlap of DOD and VA benefits for a period of two years following the medical retirement of an injured servicemember or for the length of time a servicemember is held on Temporary Disability Retirement List (TDRL), whichever is greater. What are your views on this idea?

Response. Such a step would only create more confusion, would upend the principle precluding compensation for the same purpose, and is opposed by the Department.

Changes in compensation should be structured to resolve specific problems. In this case, the problem is that the veteran may need more financial support during the transition to civilian employment. The VA could possibly rate the Servicemember as individually unemployable (100 percent) until the member is gainfully employed, providing an economic bridge. DOD and VA should be provided the opportunity to study this concept.

Question 3. There exists a VA Office of Seamless Transition (OST) with a mission to facilitate the transition of servicemembers from active duty to civilian lives by coordinating VA benefits and services with those provided by DOD. Yet the OST reports only to the Under Secretary of Health. Within DOD, the Military OneSource Center is designed to augment and support transition services, yet problems with coordination with the support services provided by the military services persist. Is there a need for an organizational restructuring within VA so that the transition office has authority over ALL VA benefits and services and reports directly to the Deputy Secretary of VA? To increase interagency transition coordination, should DOD establish a mirror transition office that reports directly to the Under Secretary for Personnel and Readiness?

Response. We defer to the Secretary of VA on VA organizational issues. The several DOD offices that deal with various policies, benefits, programs, and information for transitioning Servicemembers, including the National Guard and Reserves, come under the Under Secretary of Defense for Personnel and Readiness. The Depart-

ment believes this facilitates coordination while drawing on the expertise of functional specialists.

Question 4. If we were to start from scratch and design a new system of compensation for those who are severely injured in service, what should that system look like?

Response. The existing compensation system for severely injured members under the Department's responsibility before separation continues all pays and allowances normally payable to the Servicemember. Additionally, the Department augments this normal compensation with certain travel benefits and traumatic injury insurance payments that contribute to the supporting family expenses while the member is undergoing active duty hospitalization, recuperation, and medical evaluation for potential continuation of active service.

The very term "compensation" might be challenged, with its connections post-discharge to a 1940s-world of conscripts that linked physical issues with the ability to perform manual tasks on an assembly line. Instead, we might focus on the national responsibility to enable the former Servicemember to pursue a satisfying career and lifestyle. That implies investment vice compensation, and emphasizes outcomes vice annuity calculations.

Question 5. What do you think should be the purpose of a modern compensation program and how should we regularly determine whether the program, as designed, is meeting its intended purpose?

Response. A modern compensation program should focus on career and lifestyle outcomes, vice income replacement per se. This would emphasize investment in the individual (education, accommodations, placement, coaching, etc.), instead of awarding a stipend, which may prove inadequate in any event.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. JOHN MCCAIN TO HON. GORDON ENGLAND, DEPUTY SECRETARY, DEPARTMENT OF DEFENSE

QUALITY AND ACCURACY ASSURANCE

Question 1. One requirement I see as essential is that the Office of the Secretary of Defense (OSD) establish a dedicated review process independent of the Services that will critically examine the performance of the Services' Physical Evaluation Boards (PEBs) and provide timely appellate review for individual members who perceive they have been unfairly treated. While changes surely are coming, it is no longer acceptable that the Department of Veterans Affairs (VA), in effect, be the safety net for poor DOD decision making. How are you going to ensure that the performance of the Services' PEBs is evaluated critically in the future?

Response. The Service Secretaries are charged with operating their respective disability evaluation systems consistent with Service roles and missions—this does not constitute poor decisionmaking. To improve oversight, the Department recently issued instructions on addressing the performance of PEBs. On May 3, 2007, the Department published interim oversight guidance in a directive-type memorandum entitled, "Policy Guidance for the Disability Evaluation System and Establishment of Recurring Directive-Type Memorandum." The guidance in this memorandum formally establishes the Disability Advisory Council, creates annual and quarterly PEB reporting and verification mechanisms, clarifies timeliness goals and other performance measures, formally elevates program awareness to senior leadership levels, and issues policy to comport with Section 597 of the John Warner National Defense Authorization Act for Fiscal Year 2007 (Public Law 109–364), which is codified at 10 United States Code § 1222.

Question 2. Would you support establishment of an OSD-level review panel that would examine cases in which members with severe injuries received low ratings from the PEB and that would be empowered to change those ratings?

Response. I would consider it as an option, but we are looking at wholesale redesign of the complex and arcane Disability Evaluation System (DES), which dates back to constructs from 1949. The Department of Defense (DOD) needs empowerment to revolutionize DES, rather than a new set of compliance standards that only serve to reinforce the present, much-criticized system. A demonstration authority would empower the Department of Veterans Affairs (VA) and DOD to operate a combined activity that transcends present law, and allow for rapid proof of new concepts and a quick response to the needs of the disabled. In the interim, DOD, in compliance with the April 19, 2007 report from the President's Task Force on Returning Global War on Terror Heroes, is working with VA toward developing an approach within current policies for VA and DOD collaboration on the DES.

DOD AND VA JOINT INPATIENT MEDICAL RECORD

Question 3. In January of this year, DOD and VA announced that the two departments would develop a joint inpatient medical record. But in his February report to Congress, the former Assistant Secretary of Defense for Health announced that the two departments were merely embarking on "a six-month assessment" of a strategy for achieving this important transition milestone. How many more years must we wait for complete medical records that can be easily shared between DOD and VA?

Response. DOD is fully committed to working with VA to implement a joint inpatient electronic health record (EHR) system. Mr. Mansfield, Deputy Secretary for Veterans Affairs, and Dr. Chu, Under Secretary of Defense for Personnel and Readiness, identified the joint acquisition/development of a new common inpatient EHR system as one of their top priorities for DOD and VA sharing.

The full scope of the Armed Forces Health Longitudinal Technology Application (AHLTA), the DOD EHR, will support both outpatient and inpatient care. Support for outpatient care was the first priority for AHLTA. The inpatient component for AHLTA is targeted for a future version. The VA is undertaking a modernization of VistA, their EHR, which encompasses both outpatient and inpatient. While current VA and DOD health information sharing is significant, the information shared is primarily outpatient data with limited inpatient data. Given that DOD and VA are both in the process of developing and/or acquiring an inpatient EHR component, it was to our mutual advantage to explore the potential for working jointly.

The joint DOD–VA inpatient EHR project includes a 6-month assessment of clinical processes and functional requirements that must be met by a joint DOD–VA inpatient EHR. There is clearly much commonality in the delivery of inpatient health care for DOD and VA, but there are also unique mission requirements that must be addressed. In addition, many existing information systems must provide data to or obtain data from the inpatient EHR. Therefore, it is critical that a solid assessment of requirements, business processes, and the existing technical environment be conducted in order to take the appropriate next steps to select the best approach to a joint inpatient EHR. Business process analysis and requirements definition is required under United States Code, title 40 (formally known as the Clinger-Cohen Act), prior to system acquisition and is consistent with best industry business practices for a project of this size and complexity.

Question 4. Is there a plan to achieve a real goal, not just a study?

Response. The Department of Defense (DOD) is fully committed to working with the Department of Veterans Affairs (VA) to implement a joint inpatient electronic health record (EHR) system. Mr. Mansfield, Deputy Secretary for Veterans Affairs, and Dr. Chu, Under Secretary of Defense for Personnel and Readiness, identified the joint acquisition/development of a new common inpatient EHR system as one of their top priorities for DOD and VA sharing.

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The plan, including milestones for achieving a joint inpatient EHR, will be developed after the analysis of alternatives and agreement on the approach.

Question 5. Are resources included in the President's budget request, or are we just buying time until the next commission comes to a similar conclusion: that DOD

and the VA need to be able to share medical information electronically in order to facilitate the transition of patients from one system to the other?

Response. The Joint Electronic Health Record Interoperability (JEHRI) program is funded across the Future Years Defense Program. The JEHRI program is the roadmap for the way the VA and DOD will share electronic health information to achieve health data interoperability and support the seamless transition from active duty status to veteran status.

With regard to the DOD and VA joint inpatient medical record, as each department was planning a new inpatient electronic record acquisition or modernization, DOD and VA have initiated this joint assessment project. We anticipate a contract award to a study support contractor in May 2007. A 6-month study will produce an initial recommendation for a joint acquisition/development strategy. The DOD and VA will then evaluate alternatives for funding which will be incorporated into future President's Budget requests.

PROJECTION OF FUTURE HEALTH CARE NEEDS
BY AMERICA'S VETERANS

Question 6. A column by Harvard researcher Linda Bilmes asserts that "the seeds of the Walter Reed Army Medical Center scandal were sown in . . . a failure to foresee the sheer number and severity of casualties." Do you agree with that statement?

Response. Not exactly. It is true that the volume of Medical Evaluation Board (MEB) cases for the Army significantly increased from 6,560 cases in FY 2002 to approximately 11,000 cases in each of the last two FYs (2005 and 2006). In addition, the number of Physical Evaluation Board (PEB) cases rose from just over 9,000 cases in calendar year (CY) 2001 to a peak of over 15,000 cases in CY 2005. The increased volume resulted in the Army augmenting the Medical Treatment Facility staffs conducting the MEB process. The Army also doubled the number of adjudicators in their existing PEBs and established a mobile PEB to accommodate the increased volume. The severity of the cases is well known and is a result of improvements in treatment that allowed Servicemembers to survive injuries that previously would not have been possible. In approximately 70 percent of all cases, the Military Departments are meeting the processing MEB and PEB timeline goals.

Question 7. What joint planning or analytical process exists today between DOD and the VA that did not exist in the past which will ensure a more complete understanding of the near- and long-term needs of our returning servicemembers?

Response. The DOD and VA developed the VA/DOD Joint Strategic Plan (JSP) in 2003. The JSP contains a number of specific targets and actions under each performance goal. The Fiscal Year (FY) 2007–2009 JSP was approved and signed by the co-chairs of Joint Executive Council (JEC) in January 2007. Each goal, objective, and strategy was reviewed to reflect the current climate of DOD/VA joint collaboration. Roles and responsibilities of the entities under the JEC structure were clarified, specific performance metrics were developed, and VA/DOD JSP goals and objectives were linked to departmental strategic plans. JSP objectives and measures are tracked monthly by the Health Executive Council and Benefits Executive Council work groups and reported to the JEC. It is reviewed and updated annually. JSP progress is reported in the annual report to the Secretaries and Congress.

The guiding principles of the JSP are:

- Collaboration—to achieve shared goals through mutual support of both our common and unique mission requirements.
- Stewardship—to provide the best value for our beneficiaries and the taxpayer.
- Leadership—to establish clear policies and guidelines for VA/DOD partnership, promote active decision-making, and ensure accountability for results.

JSP Mission—To improve the quality, efficiency, and effectiveness of the delivery of benefits and services to veterans, Servicemembers, military retirees, and their families through an enhanced VA and DOD partnership.

JSP Vision—A world-class partnership that delivers seamless, cost-effective, quality services for beneficiaries and value to our nation.

The strategic goals of the JSP are:

- Goal 1: Leadership Commitment and Accountability—Promote accountability, commitment, performance measurement, and enhanced internal and external communication through a joint leadership framework.
- Goal 2: High Quality Health Care—Improve the access, quality, effectiveness, and efficiency of health care for beneficiaries through collaborative activities.
- Goal 3: Seamless Coordination of Benefits—Improve understanding of, and access to, services and benefits that uniformed Servicemembers and veterans are eligi-

ble for through each stage of their life, with a special focus on ensuring a smooth transition from active duty to veteran status.

• Goal 4: Integrated Information Sharing—Ensure that appropriate beneficiary and medical data is visible, accessible, and understandable through secure and interoperable information management systems.

• Goal 5: Efficiency of Operations—Improve management of capital assets, procurement, logistics, financial transactions, and human resources.

• Goal 6: Joint Contingency/Readiness Capabilities—Ensure the active participation of both agencies in Federal and local incident and consequence response through joint contingency planning, training, and conduct of related exercises.

MANDATORY SEPARATION PHYSICALS FOR MILITARY SERVICEMEMBERS

Question 8. The President's Task Force to Improve Health Care Delivery for Our Nation's Veterans recommended in May 2003 that the DOD and VA should implement a mandatory single separation physical to accelerate determinations of benefits and increase access to care for those veterans eligible for VA benefits. What is the status of DOD's implementation of this important one-stop shopping concept to ease transition for military servicemembers?

Response. The VA and DOD signed a Memorandum of Agreement (MOA) on November 17, 2004, establishing a cooperative separation process/examination. This initiative was established to provide transition assistance and continuity of care to Servicemembers who are separating from active duty. Under this MOA, Servicemembers can begin the claims process with VA up to 180 days prior to separation through VA's Benefits Delivery at Discharge (BDD) program. The MOA also stipulates that only one examination is to be conducted which meets the needs of the VA and the military using VA's examination protocols. This MOA builds upon the prior successes of the BDD program over the past several years. VA has implemented the BDD program at 140 BDD sites in the United States plus two overseas sites. 130 of the 140 are VA/DOD sites and all of these targeted sites have signed Memoranda of Understanding between DOD and VA related to the BDD. Not all Servicemembers receive a physical examination when receiving transition assistance at a BDD site, and not all Servicemembers' physical examinations or transition assistance are received at a BDD site. The BDD program is expanding to the Navy in San Diego, California. BDD can commence 180 days before discharge, and is briefed to Servicemembers within the transition assistance program. The examinations must take place no more than 6 months before discharge in order to ensure that the exam is timely and has currency relative to the date of discharge. This has extra importance if the claim ever goes to appeal. In Fiscal Year 2006, approximately 40,000 BDD claims were completed, averaging 68 days of completion time. DOD has created a stretch goal of reaching 100 percent BDD use for Servicemembers receiving their separation/retirement physical at one of the 140 BDD sites.

Question 9. What is the impediment or objection to full implementation of this policy by the two departments?

Response. Department of Defense (DOD) memorandum, dated October 14, 2005, Subject: "Policy Guidance for Separation Physicals Exams," states "Compliance with this statutory requirement is a priority and will require a concerted effort by Military Treatment Facilities (MTFs) and commands and commanders at all levels."

DOD works closely with the Department of Veterans Affairs (VA) on a daily basis to expand awareness and use of the coordinated separation process that meets the needs of the VA disability compensation evaluation and the DOD separation retirement assessment. Currently, Memoranda of Understanding between local MTFs, Veterans Health Administration medical centers, and Veterans Benefits Administration regional offices are in place at 130 sites across the country. Under the auspices of these memoranda, VA representatives begin assisting Servicemembers in filing disability claims as early as 6 months before discharge. Not all Servicemembers receive a physical examination when receiving transition assistance at a Benefits Delivery at Discharge (BDD) site, and not all Servicemembers' physical examinations or transition assistance are received at a BDD site. DOD has created a stretch goal of 100 percent of Servicemembers departing due to routine separation or retirement at one of the 140 BDD sites receive a separation/retirement physical.

VA is participating in the reinvigorated DOD Disability Advisory Council. A key objective of this collaboration is to develop a process in which VA is a part as early in the DOD disability evaluation process as possible. This objective is consistent with the suggestions and recommendations for improvement contained in the Global War on Terror Heroes Task Force Report to the President and the Final Report of the Independent Review Group, submitted to the Secretary of Defense.

PRIVACY RULES AND THE SHARING OF DOD AND VA MEDICAL INFORMATION

Question 10. Congress enacted the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (Public Law 104–191) to prevent the disclosure of certain personal medical information, but permits DOD and VA to share information on individuals being treated in both systems. Yet HIPAA is often cited as a barrier to easy sharing of health data between DOD and VA. In 2003 a Presidential task force recommended that the two departments be declared a single health care system for the purposes of implementing HIPAA—in order to smooth transition of servicemembers from DOD to the VA, and to accelerate the development of shared health care information technology. What did the two departments do, if anything, in response to this recommendation?

Question 11. Why is HIPAA still cited as a barrier to information sharing?

Response. Certainly, the Department of Defense (DOD) and the Department of Veterans Affairs (VA) must ensure that they comply with the requirements of the Department of Health and Human Services (HHS) HIPAA privacy final rule whenever they use or disclose the protected health information of patients. For this reason, whenever new information sharing initiatives are proposed, how compliance with the HHS HIPAA Privacy Final Rule will be achieved is among the matters discussed and documented. DOD has not cited the HHS HIPAA privacy final rule as a barrier to sharing that protected health information with the VA when it makes sense to do so. The DOD and VA, by making maximum use of the authority provided in the HHS HIPAA privacy final rule to share protected health information for purposes of treatment at time of separation and between covered government entities providing public benefits, are currently sharing protected health information at unprecedented levels and continue to implement new initiatives in this regard.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. JOHN D. ROCKEFELLER IV TO HON. GORDON ENGLAND, DEPUTY SECRETARY, DEPARTMENT OF DEFENSE

Question 1. Given the recent GAO report's finding that policies and guidance for military disability determinations differ between services, Secretary Gordon England, do you consider this a problem? What have you done to address this disparity? And what is the difference between military retirement and temporary military retirement? How long can temporary retirement and those benefits last? What is the median time for temporary retirement benefits? Why hasn't disability decision making process been examined for its consistency across DOD and within individual services? Who should review the consistency of this process? How does it compare with VA's process?

Response. We are addressing perceived disparities among the Military Departments. Training on application of the rating schedule, centralized rating decisions, and continuous review of disposition data will all improve consistency. We are working to improve in all these areas.

I should note, however, that the GAO's detailed statistical analysis concluded that for a given condition, ratings were consistent between active and Reserve members. That may indicate there is more consistency than is perceived.

According to title l0, United States Code, chapter 61, Servicemembers are placed on the Temporary Disability Retirement List (TDRL) when they would be qualified for permanent disability retirement, but for the fact that the Servicemember's disability is not determined to be of a permanent nature and stable. Servicemembers are reevaluated every 18 months to ascertain permanency and stability of the disqualifying medical condition; members may be retained on the TDRL for 5 years, after which time the conditions are automatically considered permanent and stable and the Secretary must make final disposition of the case. Department analysis reflects that approximately 55 percent of the Servicemembers separated with severance from the TDRL served less than 4 years. Temporary retirement provides the Servicemember the benefits of normal retirement with the exception that the monthly retirement pay can be no less than 50 percent of the high three base pay average and no more than 75 percent.

To deal with the several issues you raise, the Department formally established the Disability Advisory Council, created annual and quarterly Physical Evaluation Board reporting and verification mechanisms, clarified timeliness goals and other performance measures, and formally elevated program awareness to senior leadership levels.

Question 2. The Health Executive Council established a VA/DOD Mental Health Working Group (MHWB) to focus on increasing the collaboration between VA and

DOD on mental health services to both VA and DOD beneficiaries. An assessment of opportunities for greater collaboration on mental health issues were in education, administration and transition of care. What has been done with these recommendations? Can you walk me through the process and provide a time frame from recommendations to implementation?

Response. The VA/DOD MHWB has collaborated on a number of initiatives in the areas of education, administration, and seamless transition. In education, the work group supported a training event utilizing the VA's Electronic Education System (EES). The topic evolved from the knowledge that Reserve component Servicemembers are being followed for significant mental health conditions in the VA. Many of these members are subject to deploying again. On March 29, 2006, DOD and VA mental health providers explored the ethical dimensions of sharing mental health records across departments. This generated high interest and utilized the full capacity of the EES. The new role of the VA taking care of Servicemembers who would return to active duty was explored.

The work group is also collaborating to disseminate evidence-based psychotherapeutic techniques across the VA and DOD. Subject matter experts will conduct train-the-trainer seminars for both VA and DOD mental health providers. Three mental health providers will receive additional specialized training from the Air Force, Navy, and Marine Corps. Six Army mental health providers will be the trainers of other providers in these techniques. Implementation of this shared program will begin the last quarter of Fiscal Year (FY) 2007 and carry over into FY 2008. This is in addition to other training programs available to providers in other venues and those sponsored by Service branches.

Administratively, the VA/DOD MHWB explored a number of areas of mutual concern. VA clinicians did not have clear direction from DOD on what mental health diagnoses/treatment regimens were identified as deployment-limiting conditions. DOD published policy guidance for deployment-limiting psychiatric conditions and medications internally and posted this information on its Internet site on November 7, 2006. VA/DOD MHWB collaboration facilitated coordination of this policy and additional internal guidance to ensure that VA clinicians who may be treating National Guard or Reserve members can utilize this DOD guidance to ensure the best care for the subject individuals in the face of their military career concerns.

In addition, there was not a clear understanding about the degree to which DOD Servicemember information was available in the Bilateral Health Information Exchange (BHIE) system. DOD Pre- and Post-deployment Health Assessment and Reassessment (PPDHA) data for over 680,000 Servicemembers have been sent to the VA with ongoing input of subsequent PPDHAs, and Post-deployment Health Reassessments. Work group communication resulted in the VA publishing an internal information note ("Hey VA Have You Heard") to advise VA clinicians of the information available in the BHIE and how to access it as needed for treatment of Operation Iraqi Freedom/Operation Enduring Freedom veterans. It is anticipated that, in October 2007, medical and mental health electronic encounter notes will be visible throughout both departments via the BHIE.

Also administratively, it was unclear on web sites whether VA clinical practice guidelines for various mental health conditions also applied to DOD. As these clinical practice guidelines are co-developed by both departments, sites were modified to clearly indicate they are shared VA–DOD clinical practice guidelines, reinforcing common practices.

Regarding seamless transition issues, the VA/DOD MHWB is committed to improve methods and strategies to ensure appropriate care for Reserve component members who are released from active duty with an ongoing health care requirement or need to maintain continuity of care across the VA and DOD health care systems. Areas of concern include leveraging community care resources to ensure a comprehensive safety net for behavioral health care and improving strategies to include methods to identify, track, and provide access for treatment for behavioral health issues. This requires active VA collaboration with existing Guard and Reserve, and State and regional coalitions to address the mental health and readjustment needs of Operation Iraqi Freedom and Operation Enduring Freedom veterans. The work group recommended a target of 90 percent or greater of existing Guard and Reserve or regional coalitions to include both Veterans Health Administration mental health and Vet Center staff as members by September 30, 2007.

Currently, members of the VA/DOD MHWB are identifying Reserve component best post-deployment practices with the intent to disseminate such information and make policy recommendations based upon findings.

Question 3. At an earlier hearing this year, VA testified that disability claims for PTSD more than double since 2000, from 130,000 to nearly 270,000 VA claims. Such claims are hard to process, and even harder to ensure consistency. What efforts are

underway to help Guard and Reserves get screened for PTSD, and get the care and benefits they deserve during their 2-year window of eligibility? And I believe that this should be extended to at least 5 years. Is DOD and/or VA studying how delays in care and disability benefits affects soldiers who are struggling with mental health issues, particularly PTSD? How can such stress be minimized?

Response. Currently, there are multiple efforts to ensure that PTSD is recognized and identified early before it becomes a chronic health condition. All Servicemembers receive global health assessments at least three times post-deployment. All assessment procedures include a review of possible PTSD and other deployment-related mental health condition and concerns. Servicemembers participate in the Post-deployment Health Assessment immediately at the end of deployment, the Post-deployment Health Reassessment at three to six months after they return home, and the Periodic Health Assessment annually, which includes the Reserve Components as specified in DOD Policy in DOD Instruction 6025.19, paragraph 6.1, as part of their Individual Medical Readiness requirement.

In addition, there are repeated education and outreach efforts to increase awareness of the signs and symptoms associated with PTSD and the sources of care available. This public education campaign is assisting veterans who are now recognizing their mental health symptoms and seeking both treatment and disability, when appropriate. One of DOD's efforts is the Mental Health Self Assessment Program, which is a voluntary and anonymous method for Servicemembers, veterans, and their family members to learn more about signs and symptoms associated with PTSD and where to go for counseling or treatment. This program is available 24 hours a day on the Internet and by telephone, in addition to health fairs held throughout the year to provide in-person screening and assessment. For Servicemembers and families who may need counseling on readjustment after deployment or need further assistance in locating sources of care, Military OneSource provides 24-hour access to a counselor. In addition, each veteran who enters the VA health care system completes a PTSD screening questionnaire to determine if there are signs and symptoms that have not been otherwise identified. The Managed Care Support Contractors are also enhancing mental health support. As an example, in a recent press release, TRIWEST announced they have set up a Behavioral Health Center for Service Members' Families.

DOD and VA are studying mental health issues both jointly and separately. The Mental Health Task Force (MHTF) report sets forth recommendations to continue the longitudinal Millenium Cohort Study that addresses these issues, and notes the need for greater collaboration between DOD and VA on future longitudinal studies. The report also recommended more emphasis and priority on family issues. The DOD/VA Joint Executive Council Workgroup on Mental Health serves as a forum to address these issues. DOD is convening a Psychological Health Summit to incorporate the MHTF recommendations.

We are not aware of any studies on the impact of delays in care or disability determination. DOD and VA are working to minimize stress on Servicemembers by minimizing delays while maximizing psychotherapy and medical treatments in a supportive psychosocial environment.

Question 4. How are DOD and VA treating our National Guards and Reserves as well as their families? What special outreach is underway? And isn't it odd the less Guards and Reservists are seeking service than active duty? One would intuitively think that active duty soldiers have more training and support? Could it be that Guard and Reservists just unaware of the options and benefits?

Response. DOD and the National Guard and Reserve family programs prepare, support, and sustain families when their military members are activated and/or deployed. Support is facilitated through education, outreach services, and partnerships by leveraging resources, training, and constantly capitalizing on new capabilities, concepts, and technological advances.

The National Guard has a strong joint service family support network, organized in each State and territory by the National Guard State Family Program Director, and reinforced by a Wing Family Program Coordinator at each Air National Guard Wing. While limited full-time support staff at headquarters and some other locations around the country lead the day-to-day activities for providing family readiness support to commanders, Servicemembers and families, volunteers, and the Family Readiness Network are the heart of this program, and the unit level Family Readiness Group volunteers provide vitality to the program.

Approximately 330 Family Assistance Centers (FACs) are regionally based and are the primary entry point for all services and assistance that any military family member, regardless of Service or component may need during the deployment process. This process includes the preparation (pre-deployment), sustainment (actual deployment), and reunion phases (reintegration). The primary services provided by the

FACs are information, referral, outreach, and follow-up to ensure a satisfactory result.

Joint Force Headquarters Commands (JFHCs) within each State, territory, and the District of Columbia are responsible for coordinating family assistance for all military dependents, regardless of Service and component, within the State and in the geographically dispersed areas beyond the support capability of military facilities. To coordinate family assistance, each JFHC is authorized one State Family Support Director.

Military OneSource (*www.militaryonesource.com*) is a key resource available to National Guard and Reserve members and their families. OneSource supplements existing family programs with a 24-hour, 7 days a week, toll-free information and confidential referral telephone and Internet/web-based service. It is available at no cost to Guard and Reserve members and their families, regardless of their activation status. OneSource provides information ranging from everyday practical advice to deployments/reintegration issues and will provide referrals to professional civilian counselors for assistance.

Military Family Life Consultants (MFLCs) are another resource available to National Guard and Reserve families. The goal of the MFLC is to prevent family distress by providing education and information on family dynamics, parent education, available support services, and the effects of stress and positive coping mechanisms.

A Regional Joint Family Support Model is being designed per direction in the Fiscal Year 2007 National Defense Authorization Act. Critical components of the model involve building coalitions and connecting Federal, State, and local resources and nonprofit organizations to support Guard and Reserve families. Best practices learned from more than 22 inter-Service Family Assistance Committees and the Joint Service Family Support Network will guide the planning process. Minnesota will serve as a model.

The VA Office of Seamless Transition has implemented a robust outreach program for all separating Servicemembers/veterans. These interactions with new veterans include the offering of Transition Assistance Program (TAP) and TAP for Disabled Veterans briefings at the demobilization stations, and, when they return home, National Guard and Reserve units request VA participation at family day events, Post-deployment Health Reassessments (PDHRAs), Freedom Salute, and family reunions. These new veterans are Guard/Reserve members who now return to Reserve status and live in rural areas of the State. VA also partnered with the National Guard for their hiring/VA training for Transition Assistance Advisors (TAA) to be the point of contact for returning veterans in the State and to enhance access to VA services and community organizations in rural areas. VA has collaborated with National Guard and DOD family programs. These partnerships have granted VA access to Soldiers/Sailors/Marines/Airmen and Coast Guard veterans as well as family members to educate them on VA services and benefits that are available to them in rural areas. Due to this partnership, TAAs are energizing the formation of State VA/National Guard coalitions to ensure any returning veteran in need will have access to VA and/or community resources. VA is also participating in PDHRA events at the unit level with VA eligibility staff, Vet Center staff, and TAAs who discuss VA health care services and benefits that they are eligible to receive. To track effectiveness of outreach activities to this population, rates for utilization of Veterans Health Administration services are monitored quarterly to identify those on active duty, National Guard, and all other Reserves who use VA health care. Outreach staff members continue to brief the senior leadership in the Guard/Reserve and family program directors on VA services and benefits by providing monthly conference calls to the TAAs, national conferences, booth displays, and close ties with family programs.

VA/DOD JOINT EXECUTIVE COUNCIL FY 2006 ANNUAL REPORT PUBLISHED FEBRUARY 2007

Question 5. The Joint Executive Council (JEC) was established by Congress and has been meeting for 4 years. However, it has taken 4 years to produce broad recommendations and the group proposed additional working groups to examine the issues further. In July 2006, the JEC approved a proposal to establish a VA/DOD Joint Coordination Transition Working Group that will be focused on achieving an even greater integrated approach to coordinated transition for injured and ill servicemembers and their families. Why did the JEC feel a group needed to be developed in order to achieve this approach? Who has been chosen/assigned to this working group? Have they met yet? If so, what have they developed so far? Why has it taken so long to acknowledge this problem needed another group to address transition issues for injured and ill servicemembers? The JEC has been meeting for 4 years and was established by Congress. However, it has taken 4 years to produce

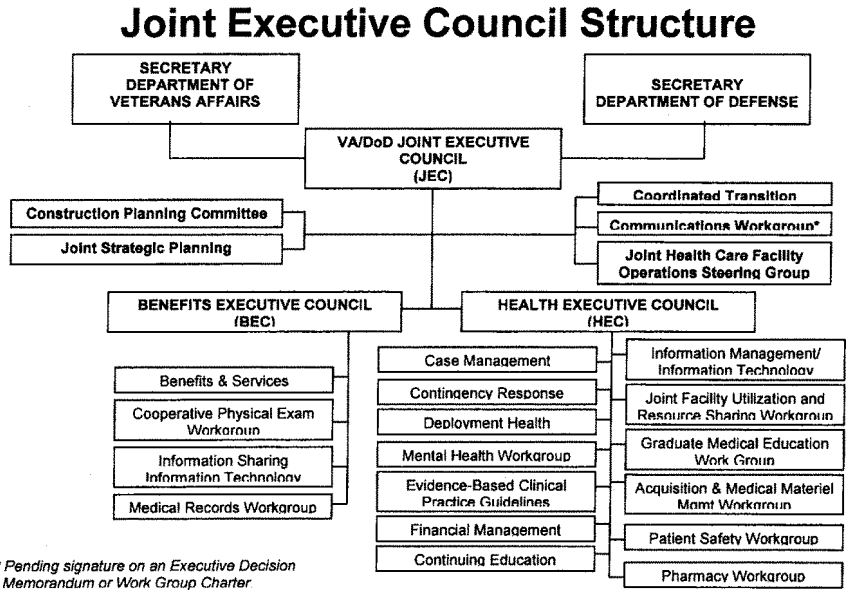
broad recommendations and proposed additional working groups to examine the issue further. I would request a breakdown of each council, working group, members of each, and dates of meetings. This information would be helpful in determining their level of commitment to the joint project(s).

Response. First, I should note that the Joint Executive Council was originally established by the two cabinet departments, and later sanctioned by the Congress in statute.

The VA created an Office of Seamless Transition in the VA central office in January 2005. Its mission is to improve coordination between the Veterans Health Administration, the Veterans Benefits Administration, and the DOD, and to ensure appropriate VA policies and procedures are in place to enhance seamless transition of health care and disability services. This VA office began interacting with individual Military Treatment Facilities to place VA social workers and benefits counselors to assist severely injured Servicemembers and their families during the transition to the VA.

The VA/DOD JEC approved the establishment of a VA/DOD Coordinated Transition Working Group. The JEC decided this working group would be an excellent solution to integrate the various DOD and VA support services, which are needed by all Servicemembers who are transitioning their medical care and benefits from DOD to VA.

Attached, please find information on the DOD/VA Executive Councils as well as the Fiscal Year 2006 JEC Annual Report to Congress that describes the collaborative efforts of DOD and VA.



JEC Charter

- Oversee development and implementation of VA/DOD Joint Strategic Plan (JSP)
- Oversee Health and Benefits Executive Councils
- Identify opportunities (policy, operations, and capital planning) to enhance mutually beneficial coordination
- Submit Annual Report to Secretaries on progress to-date on JSP

JEC Membership

DOD

- Under Secretary of Defense (Personnel and Readiness)—Co-Chair
- Principal Deputy Under Secretary of Defense (Personnel and Readiness)
- Assistant Secretary of Defense (Health Affairs)
- Principal Deputy Assistant Secretary of Defense (Health Affairs)

- Deputy Chief Information Officer
- Assistant Secretary of the Air Force (Manpower and Reserve Affairs)
- Assistant Secretary of the Army (Manpower and Reserve Affairs)
- Assistant Secretary of the Navy (Manpower and Reserve Affairs)
- Deputy Director of Contract Policy and Administration

VA

- Deputy Secretary, Veterans Affairs—Co-Chair
- Under Secretary for Health
- Under Secretary for Benefits
- Assistant Secretary for Policy, Planning and Preparedness
- Assistant Secretary for Management
- Assistant Secretary for Information and Technology
- Counselor to the Secretary of Veterans Affairs

JEC Committees, Steering Groups and Workgroups

Joint Strategic Planning Committee

- To improve the quality, efficiency and effectiveness of the delivery of benefits and services to veterans, servicemembers, military retirees and their families through an enhanced VA and DOD partnership

Construction Planning Committee

- Provide an integrated approach to the oversight and coordination of joint capital asset planning and investment to ensure maximum benefit

Joint Health Care Facility Operations Steering Group

- Provide direct oversight of all HEC approved joint facility initiatives, including submission to the HEC of recommended courses of action to reach early issue resolution and problem solutions

Coordinated Transition Workgroup

- Foster an integrated approach and common understanding of coordinated transition as it pertains to injured and/or ill servicemembers and their families who are eligible for VA benefits and services

Communications Workgroup

- Oversee and implement the joint communications efforts outlined in the VA/DOD JSP
- Improve information flow between the two departments and ensure coordinated messages and statistics are communicated
- Maintain and comply with the approved joint communications plan

BEC Charter

- Examine ways to expand and improve information sharing
- Refine process of records retrieval and identify procedures to improve benefits claims process
- Streamline the transition process from active duty to veterans status including the standardization of the cooperative physical examination protocol, interoperability and data sharing

BEC Membership

DOD

- Principal Deputy Under Secretary of Defense (Military Community and Family Policy)
- Deputy Under Secretary of Defense (Military Personnel Policy)
- Deputy Under Secretary of Defense (Civilian Personnel Policy)
- Deputy Under Secretary of Defense (Program Integration)
- Assistant Secretary of Defense (Health Affairs)
- Assistant Secretary of Defense (Reserve Affairs)

VA

- Under Secretary for Benefits (USB)
- Associate Deputy Under Secretary for Policy and Program Management (VBA)
- Deputy Chief Information Officer for Benefits (VBA)

BEC Workgroups

Benefits and Services

• Enhance collaborative efforts to educate active duty, Reserve, and National Guard personnel on VA and DOD benefits programs, eligibility criteria and application processes

Cooperative Physical Exam

• Review laws, policies, and procedures pertaining to separation in order to develop a DOD/VA cooperative physical assessment protocol

Information Sharing/Information Technology

• Develop interoperable date repositories that will form the backbone for all sharing electronic military personnel information; interoperable software applications; and the adoption and identification of common data, architecture, communications, security and software standards

Medical Records

• Address Health Treatment Record (HTR) issues and facilitate resolution and review the paper HTR business process within the Departments as required

HEC Charter

• Oversee development and implementation of VA/DOD JSP
• Oversee Workgroups
• Identify opportunities (policy, operations, and capital planning) to enhance mutually beneficial coordination
• Submit Annual Report to JEC on progress to-date on JSP

HEC Membership

DOD

• Assistant Secretary of Defense (Health Affairs)—Co-Chair
• Principal Deputy Assistant Secretary of Defense (Health Affairs)
• Surgeon General of the Army
• Surgeon General of the Navy
• Surgeon General of the Air Force
• Deputy Assistant Secretary of Defense (Health Budgets and Financial Policy)
• Deputy Assistant Secretary of Defense (Force Health Protection and Readiness)
• Deputy Assistant Secretary of Defense (Clinical and Program Policy)
• Chief Operating Officer, TRICARE Management Activity
• Chief Information Officer, Military Health System

VA

• Under Secretary for Health
• Deputy Under Secretary for Health
• Deputy Under Secretary for Operations and Management
• Chief of Staff, VHA
• Chief, DOD Coordination Officer
• Chief Financial Officer
• Chief Information Officer
• Chief Patient Care Services Officer
• Chief Public Health and Environmental Hazards Officer

HEC Workgroups

Acquisition and Medical Materiel Management Workgroup

• Combine medical supply requirements to leverage volume and negotiate better pricing
• Eliminate duplication of contracting and contract administration effort
• Allow customers to select products and pricing
• Identify new business practices

Case Management Workgroup

• Define and utilize a clinical case management model to address the transition issues of our servicemembers and veterans
• Support the delivery of comprehensive healthcare regardless of the care delivery setting

Continuing Education Workgroup

• Enhance the open and ongoing dialogue between the departments on continuing education and training infrastructure and operations issues

• Identify opportunities for joint educational contracts and co-development of training programs of mutual interest and benefit
• Design and develop a strategy to facilitate sharing of education and training opportunities particularly those that take advantage of distributed learning architectures

Contingency Planning Workgroup

• Enhance collaborative efforts in support of the VA/DOD Contingency Plan and the National Disaster Medical System
• Review and update the VA/DOD Contingency Memorandum of Understanding and Plan to reflect current and future DOD requirements

Deployment Health Workgroup

• Establish an open dialogue between Departments on issues of deployment health
• Collaborate on review of VA's Congressionally mandated report on Gulf War illnesses, and other related reports
• Identify and foster opportunities for sharing information and research between VA, DOD, and Health and Human Services

Evidence-Based Practice Workgroup

• Identify CPGs requiring clarification/modification to remove barriers and enhance sharing
• Develop recommendations for streamlining CPGs for specified clinical areas
• Develop tools to facilitate implementation of CPGs
• Monitor and evaluate published CPGs to identify strengths and resolve problems

Financial Management Workgroup

• Inter-departmental communication on resource management issues
• Review reimbursement policies and identify policies requiring modification/clarification
• Develop recommendations for improving financial processes and practices (create incentives)
• Resolve billing and reimbursement problems
• Joint incentive fund implementation guidelines

Graduate Medical Education (GME) Workgroup

• Review current state of GME between both departments
• Develop joint pilot program for GME
• Develop agreement for departments to implement and finance program

Information Management/Information Technology Workgroup

• Oversee the development and implementation of VA/DOD health IM/IT initiatives

Joint Facility Utilization and Resource Sharing Workgroup

• Identify areas for improved resource utilization
• Oversight of joint assessment study and demonstration projects

Mental Health Workgroup

• Increase collaboration between VA and DOD on the provision of mental health services to both VA and DOD beneficiaries

Patient Safety

• Improve continuity of care/patient safety
• Identify and implement best practices in patient safety

Pharmacy

• Joint evaluation of high dollar/volume pharmaceuticals
• Increase uniformity and improve clinical and economical outcomes of drug therapies
• Eliminate redundancies in class reviews, contracting prescribing guidelines, and utilization management

DOD MILITARY SEVERELY INJURED CENTER (MSIC)

Question 6. Prior to the Walter Reed incident, the Army requested the MSIC to remove its caseworkers from monitoring Army soldiers. Has this decision by the Army been reversed, and if not how has the MSIC role with the Army been recreated?

Response. The Department of Defense (DOD) established the MSIC in December 2004 to augment support provided by the Military Services to severely injured Servicemembers and their families. Counselor-advocates were assigned to military installations and Department of Veterans Affairs medical facilities to provide non-medical support as needed.

As part of a routine program assessment, staff from the Military Community and Family Policy office consulted with each of the Military Services to evaluate the support provided by the counselor-advocates. Leadership from the Army Wounded Warrior Program indicated a readiness and desire to accept total responsibility for delivery of services. As a result, on January 16, 2007, cases supported by the counselor-advocates at Fort Campbell, Kentucky; Fort Carson, Colorado; Fort Drum, New York; Fort Hood, Texas; Fort Lewis, Washington; Fort Riley, Kansas; and Fort Stewart, Georgia, were transferred to soldier family life consultants with the Army Wounded Warrior program. The Army has increased the number of soldier family life consultants to 46 staff to support this mission.

Counselor-advocates have continued to support Sailors and Marines receiving care at Brooke Army Medical Center, Texas; Camp Lejeune, North Carolina; Camp Pendleton, California; Palo Alto, California; San Diego, California; Tripler Army Medical Center, Hawaii; and Redstone Arsenal, Alabama.

RESPONE TO WRITTEN QUESTIONS SUBMITTED BY HON. EVAN BAYH TO HON. GORDON ENGLAND, DEPUTY SECRETARY, DEPARTMENT OF DEFENSE

Question 1. My understanding is that active duty personnel, who suffer from TBI, have access to private facilities that contain the latest cognitive therapies but that care is not available to retirees in the VA system. Is that true? If so, why?

Response. Rehabilitation therapy is covered under the TRICARE program. It is therapy to improve, restore, or maintain function, or to minimize or prevent deterioration of a function, of a patient when prescribed by a physician. The rehabilitation therapy must be medically necessary and appropriate care rendered by an authorized provider, necessary to the establishment of a safe and effective maintenance program, and must not be custodial, or otherwise excluded from coverage.

Under the TRICARE Basic Program, the law requires all medical services to be medically necessary, that is, appropriate medical care which is in keeping with generally accepted norms for medical practice in the United States. Covered rehabilitation services for TBI patients may include physical, speech, occupational, and behavioral services. Under the TRICARE Basic Program, cognitive rehabilitation defined as "services that are prescribed specifically and uniquely to teach compensatory methods to accomplish tasks which rely upon cognitive processes" are considered unproven and are not covered when separately billed as distinct and defined services. Coverage of "a systematic, goal-oriented rehabilitation treatment program designed to improve cognitive functions and functional abilities to increase levels of self management and independence following neurologic damage to the central nervous system" is excluded. Community and work integration training, and vocational rehabilitation are also excluded.

Cognitive rehabilitation strategies can be integrated into these components of a rehabilitation program and may be covered when cognitive rehabilitation is not billed as a distinct and separate service. Beneficiaries, including active duty Servicemembers, may receive rehabilitation services in direct or purchased care facilities. Active duty Servicemembers may also receive TBI rehabilitation in specialized Veterans Affairs treatment centers.

Some forms of Traumatic Brain Injury (TBI) rehabilitation (including cognitive rehabilitation) excluded from coverage under the TRICARE Basic benefit may be extended to active duty Servicemembers under the Supplemental Health Care Program (SHCP). Under the SHCP, active duty Servicemembers may receive care that is excluded under the TRICARE benefit if those services are potentially contributory to keeping or making the active duty patient fit to remain on active duty.

The Department of Defense recognizes that change in coverage during transition from active duty to retired status can create disruptions of care for combat-wounded Servicemembers and is exploring the feasibility of testing strategies for mitigating this disruption using demonstration authority. The Department of Defense has commissioned a formal Technical Assessment of the current scientific evidence supporting cognitive rehabilitation intervention for TBI. This evaluation will be completed in August 2007. The Department will reevaluate its coverage policy for cognitive rehabilitation under the basic TRICARE benefit at that time.

MEDICAL COVERAGE FOR TRAUMATIC BRAIN INJURY

Question 2. As you mentioned during the hearing, Active Duty servicemembers who have incurred Traumatic Brain Injury (TBI) are able to access private rehabilitation facilities at the expense of the Department of Defense (DOD). Contrary to your testimony, however, once retired, I understand that TRICARE no longer covers such therapy. In fact, I have heard several personal stories from servicemembers and their families indicating that they were medically retired before learning of the apparent discrepancy in benefits, and, therefore, were precluded from accessing private facilities. Conversely, I have also heard from families of TBI patients fighting to stay on Active Duty for fear of losing their TRICARE eligibility for cognitive therapy in a private facility. Are medically retired servicemembers with TBI eligible to receive cognitive therapy in a private rehabilitation facility under TRICARE? If so, how are they informed of such an option, and why have the families with whom I have spoken asked for and been denied private care? If not, do you agree that such a discrepancy should be addressed to ensure that these severely injured warriors have options available to them?

Response. Rehabilitation therapy covered under the TRICARE basic program is available to both active duty Servicemembers and retirees, and includes physician-prescribed therapy to improve, restore, or maintain function, or to minimize or prevent deterioration of patient function. Rehabilitation therapy under the TRICARE basic program must be medically necessary and appropriate care keeping with accepted norms for medical practice in the United States, rendered by an authorized provider, necessary to the establishment of a safe and effective maintenance program, and must not be custodial, or otherwise excluded from coverage.

Covered rehabilitation services for TBI patients may include physical, speech, occupational, and behavioral services. Cognitive rehabilitation strategies may be integrated into these components of a rehabilitation program and may be covered under the TRICARE basic program when cognitive rehabilitation is not billed as a distinct and separate service. Beneficiaries, including active duty Servicemembers, may receive rehabilitation services in direct or purchased care facilities. Active duty Servicemembers and veterans may also receive TBI rehabilitation in specialized Department of Veterans Affairs' treatment centers.

Under the TRICARE basic program, cognitive rehabilitation, defined as "services that are prescribed specifically and uniquely to teach compensatory methods to accomplish tasks which rely upon cognitive processes," are considered unproven, therefore, not appropriate care keeping with accepted norms for medical practice in the United States and are not covered when separately billed as distinct and defined services. Post-acute, community reentry programs, work integration training, and vocational rehabilitation are also excluded. TBI rehabilitation excluded from coverage under the TRICARE basic benefit for retirees and dependents may be extended to active duty Servicemembers under the supplemental health care program (SHCP), if those services may potentially keep or make the active duty patient fit to remain on active duty.

Coverage of cognitive rehabilitation by major health insurers is mixed. For example, Cigna, Aetna, and UniCare cover cognitive rehabilitation for TBI, when it is determined to be medically necessary. Cigna excludes coverage of cognitive rehabilitation for mild TBI. Regence and Blue Cross/Blue Shield consider cognitive rehabilitation to be investigational and do not provide coverage for it. There is no Medicare national coverage determination for cognitive rehabilitation for TBI. In determining whether a medical treatment has moved from unproven to proven, TRICARE reviews reliable evidence, as defined in 32 Code of Federal Regulations (CFR), Part 199. Research study of cognitive rehabilitation in neurological conditions, including TBI, is limited by differences between patients, and by variation in the type, frequency, duration, and focus of cognitive rehabilitation interventions. The TRICARE determination that cognitive rehabilitation for TBI is unproven is supported by a 2002 technical assessment performed by Blue Cross/Blue Shield (updated in 2006), and by a 2004 technical assessment by Hayes, Inc. (also updated in 2006).

Medical evidence is dynamic and evolving, however. We know that, in the future, some care considered unproven today will achieve the required evidence threshold and become covered under the TRICARE basic program. Care that is likely to become proven is periodically reevaluated to ensure that TRICARE coverage is current and consistent with the latest evidence. DOD therefore commissioned a formal technical assessment of the current scientific evidence supporting cognitive rehabilitation intervention for TBI. This evaluation will be completed in August 2007. DOD will reevaluate its coverage policy for cognitive rehabilitation under the TRICARE basic program at that time.

DOD recognizes that, as a determination is made that an active duty patient will not be able to return to active duty service, and the transition is made from active duty to retired status, changes in coverage may result in discontinuity in care for combat-wounded Servicemembers. DOD is exploring the feasibility of testing strategies for mitigating potential disruption in care using demonstration authority.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. BARACK OBAMA TO HON. GORDON ENGLAND, DEPUTY SECRETARY, DEPARTMENT OF DEFENSE

Question 1. Secretary Gates announced yesterday that tours would be extended from 1 year to 15 months for our active duty soldiers. Leading up to this decision, could you describe what additional steps the DOD took to plan for the impact of these extended tours on servicemembers and their families at home?

Response. The Department recognizes that extended deployments place a heavy burden on Servicemembers and their families. In response, the Department established the Military and Family Life Consultant (MFLC) program to provide non-medical, short-term counseling to active duty Servicemembers and their families and to the National Guard and Reserve component Servicemembers and their families. The program augments existing military and civilian support services by providing as needed, short-term, situational, problem-solving counseling services when and where they are needed. The MFLC program assists individuals and families in dealing with the stress of deployment, family separations, reunions, and reintegration due to deployments, parent-child communications, anger management, school/academic issues, and more.

Question 2. Is the DOD tracking who is serving in this war, and the potential impact on different groups of servicemembers? For example: how many single mothers are currently deployed in Iraq and Afghanistan? Do you have a sense of how many American children have one or more parents deployed?

Response. Yes, we do track Servicemembers serving in the Global War on Terror (GWOT). Regarding the specific questions, on March 31, 2007, 2,978 single mothers were currently deployed for GWOT and 205,629 children had one or more parents currently deployed.

Question 3. Last year's Defense Authorization Act required that servicemembers be screened for Traumatic Brain Injury and that all servicemembers receive postdeployment mental health screenings with clear criteria for follow-up referrals. Are these screenings occurring yet, and are they being conducted face-to-face?

Response. The Department of Defense (DOD) implemented Post-deployment Health Assessments (PDHAs) in the late 1990s. These assessments occur at the end of each operational deployment. The process consists of the Servicemember answering a series of questions on DD Form 2796 and then completing a face-to-face interview with a health care provider. The provider then clarifies all of the Servicemember's concerns, whether physical, mental, or environmental. To address health problems or concerns that emerge after returning home, the DOD implemented the Post-deployment Health Reassessment (PDHRA) program in 2005. This process is very similar to that described for the PDHA and includes a self-reporting tool (DD Form 2900). However, because the PDHRA is accomplished three to six months after returning, it is not possible to provide a face-to-face encounter in all cases because many of the Reserve component Servicemembers live far from active duty military installations and some Servicemembers have separated from military service. To ensure everyone has an opportunity to voice concerns and receive additional evaluation as clinically indicated, the DOD established roving onsite teams and a national call center.

The PDHA and PDHRA self-reporting questionnaires have always contained questions about several general symptoms that are often associated with TBI or post-concussive syndrome and validated screening scales for several common mental health conditions, including Post Traumatic Stress Disorder, depression, relationship problems, and the potential for self-harm or loss of control. The PDHRA questionnaire specifically asks if the Servicemember was exposed to a blast or explosion during deployment. On March 8, 2007, the Assistant Secretary of Defense for Health Affairs issued direction to modify the DD Form 2796 and DD Form 2900 to include additional TBI-specific screening questions with an effective date of June 1, 2007. These new questions follow the methodology recently developed by the Department of Veterans Affairs (VA) and reflect the decision of the DOD–VA Health Executive and Joint Executive Councils to use the same approach to TBI screening.

Question 4. How many servicemembers have been diagnosed with Traumatic Brain Injury since the start of the war? How is the DOD tracking this information?

Response. Approximately 2,700 Servicemembers injured since the start of the war have been found to have a TBI. Individuals identified as having TBI are tracked in databases at the Defense Veterans Brain Injury Center and at the National Naval Medical Center.

Question 5. You spoke about the need for an improved disability rating system. It's great that we fix things going forward, but what should we do to address the cases that may have received a low rating previously? What kind of fair process should we put in place to reassess those cases where it appears the Army low-balled the rating for a given servicemember?

Response. As we move forward with an improved system, we will maintain data to compare previous disability decisions with those of the new system or pilot. If the data indicate a need to review past decisions, then we will. In addition, in any case where there is evidence of improper application of statute, policy, or the disability-rating schedule, the case will be referred to the respective Military Department's Board for Correction of Military Records.

RESPONSE TO WRITTEN QUESTION SUBMITTED BY HON. JOHN WARNER TO HON. GORDON ENGLAND, DEPUTY SECRETARY, DEPARTMENT OF DEFENSE

Question. Regarding closing WRAMC as soon as possible and constructing a larger Army hospital at Fort Belvoir. What steps are you taking to accelerate the funding profile to initiate an earlier start at these two institutions?

Response. Thank you for your interest in this critical issue. The Department is evaluating options and costs to accelerate the Bethesda and Fort Belvoir Base Realignment and Closure construction projects. We will keep Congress informed of our progress and recommendations.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. SAXBY CHAMBLISS TO HON. GORDON ENGLAND, DEPUTY SECRETARY, DEPARTMENT OF DEFENSE

RATIO OF CASE MANAGERS

Question 1. I understand that the only DOD regulation related to the number of case managers required to manage personnel in a medical hold status is a 1 to 35 ratio of case managers to Guard/Reserve personnel in a medical holdover unit. By implication, there are no regulations for the ratio of case managers to personnel for Active Duty personnel in a medical hold status. Do you believe that the 1 to 35 ratio for medical holdover personnel is adequate and do you think that DOD should establish a requirement standard for case managers for Active Duty personnel in medical hold?

Response. The ratio for case management to personnel is not a "one size fits all" answer, including Servicemembers in the medical hold status. The Department of Defense (DOD) Medical Management Guide, dated January 2006, outlines a suggested caseload for case managers. The ratio is determined on several factors, including the experience of the case manager, Military Treatment Facility and community-based resources, and other variables. Currently, DOD supports the Case Management Society of America's recommendations that are based on acuity of the patient as illustrated in the following table:

Level	Amount	Type
Acute	8–10 cases	Early injury/illness stages (case manager performs all coordination).
Mixed	25–35 cases	Acute and chronic cases (some requiring semi-annual or annual follow-up, some needed full-time case manager coordination).
Chronic	35–50 cases	Cases requiring 1–2 hours follow-up/month.

Question 2. One focus of complaints related to DOD's rehabilitation process has been the role of case managers in the process. To what extent are there prescribed regulations related to the duties and responsibilities of DOD case managers of medical hold and holdover personnel?

Response. DOD Instruction 6025.20, Medical Management Programs in the Direct Care System and Remote Areas, gives specific guidance on responsibilities for case management. Specific guidance regarding medical holdover personnel is addressed in Section II–17 of the DOD Medical Management Guide, dated January 2006. Coordination of care from the Military Health System to the Department of Veterans Affairs is also addressed in the Medical Management Guide.

Question 3. Is there a required training program for case managers and regulations that govern their specific responsibilities on behalf of servicemembers or do those regulations vary from installation to installation and Service to Service?

Response. There is a required training program for case managers, and the TRICARE Management Activity (TMA) provides medical management training which includes case management. The medical management training is typically held annually in each of TRICARE's three regions. Participants include Military Treatment Facility providers, case managers, utilization managers, and disease management managers.

Additionally, Department of Defense Instruction 6025.20, Medical Management Programs in the Direct Care System and Remote Areas, gives specific guidance on responsibilities for not only case management, but also disease and utilization management. Additionally, there are Web-based modules available for case management training through the TMA.

The Assistant Secretary of Defense for Health Affairs is convening the Military Healthcare System Case Management Summit on 15-16 May. An action plan will be developed at the multi-agency, multi-disciplinary meeting that focuses on the way forward for addressing policy, training, and information sharing issues/challenges for injured, ill, and wounded warriors.

Question 4. One of the responsibilities of case managers should be to better educate soldiers on the medical evaluation and disability process. Is that in fact one of their responsibilities?

Response. The Department of Defense is bringing all of the involved members together for a Case Management Conference on May 15–16, 2007, to outline all requirements and assign responsibilities. The role of educating Servicemembers on the Physical Evaluation Board (PEB) process has traditionally been the role of the PEB Liaison Officer and not the case manager. We have to be careful we do not "medicalize" command and personnel responsibilities. While it is true that the case managers can assist with the education of Servicemembers on the medical evaluation and disability process, their major role will be to provide care coordination; ensuring that the Servicemember gets the right care at the right place and at the right time.

EVALUATION BOARDS

Question 5. One complaint I have heard regarding the MEB/PEB process is that it was established in the 1970s, is outdated, and is extremely bureaucratic. For an Active Duty servicemember, the process requires between 22 and 27 pieces of paper, and even more for a Guard/Reserve member. Some would argue that given the numerous opportunities for appeals during the process, that it is overly biased toward the servicemember, and maybe that is the way it should be. We want to give our servicemembers every opportunity to get well and, if they desire, continue their service in the military. I would appreciate your comments on the MEB/PEB process, and your thoughts regarding—if you had to do a "lean event" to streamline and remove the excess time and steps in the process—what would you change to make it more efficient and cause it to better serve our men and women in uniform?

Response. The Disability Evaluation System (DES), which consists of the MEB and PEB processes, is complex, sometimes adversarial, and burdensome. Much of that is related to the statutory imperative for a fair and impartial system that affords due process protections (boards, legal representation, witnesses, an appellate process, etc.). The DES, as set forth in statute, allows the Department to provide additional guidance, but ultimately, the Secretaries of the Military Departments operate their DES consistent with their roles and missions, and apply ratings in accordance with how they interpret application of the Veterans Affairs (VA) Rating Schedule for Disabilities (VASRD).

The complex and adversarial nature of the DES is partially a result of the magnitude of the benefits associated with the decisions on the rating. The disability rating determines whether the individual will separate with severance or with retirement benefits. For many, there is strong motivation to be declared fit to remain in uniform, despite injuries that would suggest otherwise.

There are concerns that the VASRD has not kept current with the knowledge and service job environment, especially for brain injuries and pain as compared to other more physical injuries.

We are looking at wholesale redesign of the complex and arcane DES, which dates back to constructs from 1949, but we need authority to waive current laws in fielding a new system. There is substantial precedent for this. It is highly effective and it points the way to legislative changes that could be enacted next year, as needed. DOD needs empowerment to revolutionize DES, rather than a new set of compliance

standards that only serve to reinforce the present, failed system. A demonstration authority would empower VA and DOD to operate a combined activity for rating those judged unfit by DOD. It would also authorize the establishment of benefits under programs that transcend present law, and allow rapid proof of new concepts and quick response to the needs of the disabled. VA and DOD jointly would define the framework for conducting the demonstration. The Secretaries of VA and DOD would partner in making determinations with regard to waiving existing statutes and in managing congressional reporting.

MEDICAL HOLDOVER PERSONNEL

Question 6. One key to effectively handling medical holdover personnel is by having active and engaged case managers. The Army has three medical holdover units in Georgia, at Fort Gordon, Fort Benning, and Fort Stewart. The Fort Benning medical holdover unit relies in part on contract case managers. I am not fundamentally opposed to contractors performing this function, but I do think it can put the mission at risk if the contract expires and new case managers cannot be recruited and hired in time to replace the old ones. Do you think there should be a regulation requiring a certain percentage of case managers to be DOD civilians or military personnel?

Response. Military personnel do not provide all health care in the DOD Military Health System. Federal civilians and contract staff supplement the military medical professionals in virtually all settings. Similarly, case management is not conducted using only military providers. Contract personnel are required to accomplish an activity of such scope and volume. However, it would not be good practice to mandate specific percentages for the mix of case managers. Instead, the mix at any particular medical care facility should be determined by the workload, budget, and other operational factors for that location.

Question 7. In the event that contractors are utilized, what are you doing to ensure the medical holdover mission is not compromised and that our soldiers receive the necessary advocacy when they are in a medical holdover unit?

Response. Supervision of all Servicemembers and the personnel supporting them takes an active and engaged command. Each Military Service will stay actively engaged in the care of all of its Servicemembers to ensure there are no lapses.

SHORTAGE OF MEDICAL PERSONNEL

Question 8. My staff traveled across the State of Georgia last week and visited three DOD hospitals, and one comment that surfaced at every installation related to the Army's inability to offer attractive enough incentives to hire the doctors and nurses they need to execute their mission, as well as an overly burdensome bureaucratic hiring and contracting process that prevents military bases from getting the military, civilian, and contract health care providers that they need when they need them. I think you will agree that this is a problem across DOD. In my mind, we ought to be able to do whatever we need to streamline this process and give you the authorities you need to get the personnel you need in this area because it is one of the most critical areas facing our military. What, in your opinion, needs to be done here and how can Congress help?

Response. While conducting the most recent Quadrennial Defense Review (QDR), the DOD identified a requirement to transform the process by which the Military Services acquire contracted medical professionals to work in MTFs. The QDR Roadmap for Medical Transformation includes an initiative titled "Contracting for Professional Services," that will enable the Military Health System (MHS) to more effectively and efficiently employ contract medical personnel by providing an acquisition process that is consistent throughout the system and makes health care more accessible to beneficiaries.

DOD is establishing a Strategic Sourcing Council for the acquisition of medical professional services. The council will oversee a collaborative and structured process by the Military Services to critically analyze the MHS spending for contracted medical personnel in order to optimize performance, minimize price, increase achievement of socio-economic acquisition goals, improve vendor access to business opportunities, and otherwise increase the value of each dollar spent. This transformed acquisition process will be first applied to establishing a common, standing contracting vehicle that all of the Military Services can use to quickly fill medical professional staffing needs as they arise in the MTFs. Congress has already provided the statutory authority needed to accomplish this.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. MARK PRYOR TO HON. GORDON ENGLAND, DEPUTY SECRETARY, DEPARTMENT OF DEFENSE

Question 1. When our soldiers deployed in combat fall victim to IEDs, it is many times the concussion impact, and not shrapnel that causes the most significant "injury." These head traumas consequently require a lengthy and specialized rehabilitation to return a cognitive thought process and speech capability. What initiatives does the military's "seamless transition" address toward the significant lack of psychologists, psychiatrists, counselors and social workers available to treat these men and women?

Response. As of January 2007, the Department of Defense (DOD) uniformed mental health clinical staffing levels were as follows: psychiatrists = 85 percent; clinical psychologists = 78 percent; social workers = 75 percent; psychiatric nurses = 129 percent; and psychiatric techs = 98 percent. These statistics do not include contracted services within our Medical Treatment Facilities, they do not reflect the role of the managed care support contractor network providers, nor do they include other counseling services through Military OneSource, family support, chaplain, and family advocacy systems.

A variety of incentives are currently authorized (e.g., board certification pay, critical skills retention bonuses, educational loan repayment programs, incentive special pay, and multiyear specialty pay) to enhance recruitment and retention of mental health providers. These incentives have increased substantially in the last year. They will continue and likely expand. In addition, the DOD Mental Health Task Force has been exploring mental health staffing issues and will report to the Secretary by June 15, 2007. The report should provide some recommendations for improving mental health provider staffing issues.

Question 2. The responsibility for assigning a disability rating originates from the services' Medical Evaluation Board (MEB) and Physical Exam Boards (PEB). On average the Department of Defense (DOD) and Veterans Affairs (VA) evaluation systems yield a significantly different distribution of disability ratings, with the VA rating at a statistically higher percentage and rate than that of the DOD. How do we address this disparity? What is the "fitness to serve" standard? Should we create a common, shared database between the DOD and VA?

Response. The DOD Disability Evaluation System (DES) ratings cannot be compared directly to those from the VA. While both the DOD and the VA use the Veterans Administration Schedule for Rating Disabilities, the DOD ratings focus on conditions determined to be physically unfitting—compensating for a military career cut short. The VA may rate any service-connected impairment (not merely the condition rendering the member unfit for further service). In addition, the DOD's ratings are permanent upon final disposition, while VA ratings change (most often an increase) as conditions worsen with age.

The "fitness to serve" standard, based on statutory direction, is what the Military Departments use to determine whether an injured or ill Servicemember can physically perform the duties of their office, grade, rank, or rating. Only the unfitting conditions are assigned disability ratings, as required by title 10, United States Code, chapter 61.

The Department supports a common, shared database between DOD and VA for the purposes of health care and disability evaluation.

RESPONSE TO WRITTEN QUESTION SUBMITTED BY HON. JOHN MCCAIN TO HON. DAVID S.C. CHU, UNDER SECRETARY FOR PERSONNEL AND READINESS, DEPARTMENT OF DEFENSE

UNIFORMITY AMONG THE SERVICES

Question 1. There are many complaints about the operation of the disability evaluations systems, and one of those most consistently heard is that each of the Services has been permitted to interpret law and DOD regulations differently. The Army Inspector General (IG), for example, found that the Army had devised its own processing timelines despite DOD guidelines. Do you agree that each of the Services has gone its own way in interpreting controlling law and DOD regulations regarding the disability evaluation system?

Response. As legislated in title 10, United States Code, chapter 61, and set forth in DOD policy and Directives, the Secretaries of the Military Departments are charged to operate their respective Disability Evaluation Systems (DES) consistent with the roles and missions of their Military Department. The Department, however, can do a better job when interpreting the inconsistent DES statutes and the Veterans' Administration Schedule of Rating Disabilities. To this end, we recently

published the first of many DES-related clarifying issuances and have reinvigorated the Department's Disability Advisory Council.

Question 2. What does OSD intend to do now to provide oversight and to ensure uniformity in the manner in which the Services conduct disability evaluation?

Response. The Department reinstituted and maintains an aggressive schedule of Disability Advisory Council (DAC) meetings. These meetings are conducted quarterly and have had intense agendas, which focus on oversight and revisions to policy and process to ensure the consistency and accuracy of the Disability Evaluation System (DES). A recently published charter for the DAC guides our efforts and authorizes the formation of work groups to address specific issues.

The Department also issued a directive-type memorandum providing policy for the overall management of the DES. The guidance addressed the issues of the Government Accountability Office report and statutory changes from National Defense Authorization Act for Fiscal Year 2007. The directive-type memorandum, in addition to other policies, included a comprehensive review of compliance every three years and the establishment of reporting requirements. These will include sampling of decisions on disability ratings of medical conditions for Department-wide analyses. The memorandum also established the DES Annual Report and the Quarterly DES Performance Measures Report to the Under Secretary of Defense for Personnel and Readiness.

DOD AND VA HEALTH INFORMATION SHARING

Question 3. Shared health care information technology has been identified by congressional and Presidential task forces for nearly a decade as a key enabler of transition for servicemembers from DOD to the VA. In spite of years of joint committees and joint programs, we continue to hear that when wounded soldiers transition from DOD to VA for their health care, they carry with them a conglomeration of health records on paper—often incomplete. Why are VA and DOD hospitals faxing important laboratory and inpatient data?

Response. The DOD and VA share a significant amount of health information today (itemized below). By the end of 2007, DOD will be sharing electronically with VA nearly every health record data element identified in our VA/DOD Joint Strategic Plan (JSP) for health information transfer. By 2008, we will be sharing the remaining electronic health record data elements identified in the VA/DOD JSP. However, a significant number of Servicemembers have their historical medical data on paper records that were generated prior to the full implementation of DOD's electronic outpatient medical record system, Armed Forces Health Longitudinal Technology Application.

Currently shared electronic medical record data

- Inpatient and outpatient laboratory and radiology results, allergy data, outpatient pharmacy data, and demographic data are viewable by DOD and VA providers on shared patients through Bidirectional Health Information Exchange (BHIE) from 15 DOD medical centers, 18 hospitals, and over 190 clinics and all VA facilities.
- Digital radiology images are electronically transmitted from Walter Reed Army Medical Center (WRAMC) and National Naval Medical Center (NNMC) Bethesda to the Tampa and Richmond VA Polytrauma Centers for inpatients being transferred there for care.
- Electronic transmission of scanned medical records on severely injured patients transferred as inpatients from WRAMC to the Tampa and Richmond VA Polytrauma Centers.
- Pre- and Post-deployment Health Assessments and Post-deployment Health Reassessments for separated Servicemembers and demobilized Reserve and National Guard members who have deployed.
- When a Servicemember ends their term in service, DOD transmits to VA laboratory results, radiology results, outpatient pharmacy data, allergy information, consult reports, admission, disposition and transfer information, elements of the standard ambulatory data record and demographic data.
- Discharge summaries from 5 of the 13 DOD medical centers and hospitals using the Clinical Information System to document inpatient care are available to VA on shared patients.

Enhancement plans for 2007

- Expanding the electronic digital radiology image transfer capability to include images from WRAMC, NNMC, and Brooke Army Medical Center (BAMC) to all four VA Polytrauma Centers.

• Expanding the electronic transmission of scanned medical records on severely injured patients from WRAMC, NNMC, and BAMC to all four VA Polytrauma Centers.

• Making discharge summaries, operative reports, inpatient consults, and histories and physicals available for viewing by all DOD and VA providers from inpatient data at all 13 DOD medical centers and hospitals using CIS.

• Expanding BHIE to include all DOD facilities.

• Making encounters/clinical notes, procedures and problem lists available to DOD and VA providers through BHIE.

• Making theater outpatient encounters, inpatient and outpatient laboratory and radiology results, pharmacy data, inpatient encounters to include clinical notes, discharge summaries and operative reports available to all DOD and VA providers via BHIE.

• Beginning collaboration efforts on a DOD and VA joint solution for documentation of inpatient care.

Enhancement plans for 2008

• Making vital sign data, family history, social history, other history, and questionnaires/forms available to DOD and VA providers through BHIE.

• Making discharge summaries, operative reports, inpatient consults and histories, and physicals at Landstuhl Regional Medical Center, Germany available to VA on shared patients.

Question 4. Why are medical records still being lost?

Response. Past reliance on paper records accounts for an important part of the lost record problem. The Department of Defense (DOD) and Department of Veterans Affairs (VA) now share a significant amount of health information electronically (itemized below). By the end of 2007, DOD will be sharing electronically with VA nearly every health record data element identified in our VA/DOD Joint Strategic Plan (JSP) for health information transfer. By 2008, we will be sharing the remaining electronic health record data elements identified in the VA/DOD JSP. However, a significant number of Servicemembers have their historical medical data on paper records that were generated prior to the full implementation of DOD's electronic outpatient medical record system, Armed Forces Health Longitudinal Technology Application.

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• Electronic transmission of scanned medical records on severely injured patients transferred as inpatients from WRAMC to the Tampa and Richmond VA Polytrauma Centers.

• Pre- and Post-deployment Health Assessments and Post-deployment Health Reassessments for separated Servicemembers and demobilized Reserve and National Guard members who have deployed.

• When a Servicemember ends their term in service, DOD transmits to VA laboratory results, radiology results, outpatient pharmacy data, allergy information, consult reports, admission, disposition and transfer information, elements of the standard ambulatory data record and demographic data.

• Discharge summaries from 5 of the 13 DOD medical centers and hospitals using the Clinical Information System to document inpatient care are available to VA on shared patients.

Enhancement plans for 2007:

• Expanding the electronic digital radiology image transfer capability to include images from WRAMC, NNMC, and Brooke Army Medical Center (BAMC) to all four VA Polytrauma Centers.

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• Making discharge summaries, operative reports, inpatient consults, and histories and physicals available for viewing by all DOD and VA providers from inpatient data at all 13 DOD medical centers and hospitals using CIS.

• Expanding BHIE to include all DOD facilities.

• Making encounters/clinical notes, procedures and problem lists available to DOD and VA providers through BHIE.

• Making theater outpatient encounters, inpatient and outpatient laboratory and radiology results, pharmacy data, inpatient encounters to include clinical notes, discharge summaries and operative reports available to all DOD and VA providers via BHIE.

• Beginning collaboration efforts on a DOD and VA joint solution for documentation of inpatient care.

Enhancement plans for 2008

• Making vital sign data, family history, social history, other history, and questionnaires/forms available to DOD and VA providers through BHIE.

• Making discharge summaries, operative reports, inpatient consults and histories, and physicals at Landstuhl Regional Medical Center, Germany available to VA on shared patients.

Question 5. Why are these still problems for our servicemembers?

Response. They shouldn't be much longer. The Department of Defense (DOD) and Department of Veterans Affairs (VA) now share a significant amount of health information electronically (itemized below). By the end of 2007, DOD will be sharing electronically with VA nearly every health record data element identified in our VA/DOD Joint Strategic Plan (JSP) for health information transfer. By 2008, we will be sharing the remaining electronic health record data elements identified in the VA/DOD JSP. However, a significant number of Servicemembers have their historical medical data on paper records that were generated prior to the full implementation of DOD's electronic outpatient medical record system, Armed Forces Health Longitudinal Technology Application.

Currently shared electronic medical record data

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• Electronic transmission of scanned medical records on severely injured patients transferred as inpatients from WRAMC to the Tampa and Richmond VA Polytrauma Centers.

• Pre- and Post-deployment Health Assessments and Post-deployment Health Reassessments for separated Servicemembers and demobilized Reserve and National Guard members who have deployed.

• When a Servicemember ends their term in service, DOD transmits to VA laboratory results, radiology results, outpatient pharmacy data, allergy information, consult reports, admission, disposition and transfer information, elements of the standard ambulatory data record and demographic data.

• Discharge summaries from 5 of the 13 DOD medical centers and hospitals using the Clinical Information System to document inpatient care are available to VA on shared patients.

Enhancement plans for 2007

• Expanding the electronic digital radiology image transfer capability to include images from WRAMC, NNMC, and Brooke Army Medical Center (BAMC) to all four VA Polytrauma Centers.

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charge summaries and operative reports available to all DOD and VA providers via BHIE.

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Enhancement plans for 2008

• Making vital sign data, family history, social history, other history, and questionnaires/forms available to DOD and VA providers through BHIE.

• Making discharge summaries, operative reports, inpatient consults and histories, and physicals at Landstuhl Regional Medical Center, Germany available to VA on shared patients.

RESPONSE TO WRITTEN QUESTION SUBMITTED BY HON. PATTY MURRAY TO HON. DAVID S.C. CHU, UNDER SECRETARY FOR PERSONNEL AND READINESS, DEPARTMENT OF DEFENSE

Question. I do want to make sure that those people who have already been discharged and are now finding that they have TBI, that they aren't lost. So I'd like to hear back from you as to your recommendation on that.

Response. Servicemembers who served in Operations Iraqi Freedom or Enduring Freedom who, after leaving active service, find they have symptoms compatible with having suffered a Traumatic Brain Injury (TBI), may go to a Veterans Affairs medical facility where they will be screened for TBI. When a veteran screens positive for possible TBI, the findings are discussed with the patient by an appropriate clinical staff member and further evaluation is offered. Consults for further evaluation must be submitted, but only after discussion with and agreement by the patient.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. EVAN BAYH TO HON. DAVID S.C. CHU, UNDER SECRETARY FOR PERSONNEL AND READINESS, DEPARTMENT OF DEFENSE

MEDICAL COVERAGE FOR TRAUMATIC BRAIN INJURY

Question 1. As you mentioned during the hearing, Active Duty servicemembers who have incurred Traumatic Brain Injury (TBI) are able to access private rehabilitation facilities at the expense of the Department of Defense (DOD). Contrary to your testimony, however, once retired, I understand that TRICARE no longer covers such therapy. In fact, I have heard several personal stories from servicemembers and their families indicating that they were medically retired before learning of the apparent discrepancy in benefits, and, therefore, were precluded from accessing private facilities. Conversely, I have also heard from families of TBI patients fighting to stay on Active Duty for fear of losing their TRICARE eligibility for cognitive therapy in a private facility. Are medically retired servicemembers with TBI eligible to receive cognitive therapy in a private rehabilitation facility under TRICARE? If so, how are they informed of such an option, and why have the families with whom I have spoken asked for and been denied private care? If not, do you agree that such a discrepancy should be addressed to ensure that these severely injured warriors have options available to them?

Response. Rehabilitation therapy covered under the TRICARE basic program is available to both active duty Servicemembers and retirees, and includes physician-prescribed therapy to improve, restore, or maintain function, or to minimize or prevent deterioration of patient function. Rehabilitation therapy under the TRICARE basic program must be medically necessary and appropriate care keeping with accepted norms for medical practice in the United States, rendered by an authorized provider, necessary to the establishment of a safe and effective maintenance program, and must not be custodial, or otherwise excluded from coverage.

Covered rehabilitation services for TBI patients may include physical, speech, occupational, and behavioral services. Cognitive rehabilitation strategies may be integrated into these components of a rehabilitation program and may be covered under the TRICARE basic program when cognitive rehabilitation is not billed as a distinct and separate service. Beneficiaries, including active duty Servicemembers, may receive rehabilitation services in direct or purchased care facilities. Active duty Servicemembers and veterans may also receive TBI rehabilitation in specialized Department of Veterans Affairs' treatment centers.

Under the TRICARE basic program, cognitive rehabilitation, defined as "services that are prescribed specifically and uniquely to teach compensatory methods to accomplish tasks which rely upon cognitive processes," are considered unproven,

therefore, not appropriate care keeping with accepted norms for medical practice in the United States and are not covered when separately billed as distinct and defined services. Post-acute, community reentry programs, work integration training, and vocational rehabilitation are also excluded. TBI rehabilitation excluded from coverage under the TRICARE basic benefit for retirees and dependents may be extended to active duty Servicemembers under the supplemental health care program (SHCP), if those services may potentially keep or make the active duty patient fit to remain on active duty.

Coverage of cognitive rehabilitation by major health insurers is mixed. For example, Cigna, Aetna, and UniCare cover cognitive rehabilitation for TBI, when it is determined to be medically necessary. Cigna excludes coverage of cognitive rehabilitation for mild TBI. Regence and Blue Cross/Blue Shield consider cognitive rehabilitation to be investigational and do not provide coverage for it. There is no Medicare national coverage determination for cognitive rehabilitation for TBI. In determining whether a medical treatment has moved from unproven to proven, TRICARE reviews reliable evidence, as defined in 32 Code of Federal Regulations (CFR), Part 199. Research study of cognitive rehabilitation in neurological conditions, including TBI, is limited by differences between patients, and by variation in the type, frequency, duration, and focus of cognitive rehabilitation interventions. The TRICARE determination that cognitive rehabilitation for TBI is unproven is supported by a 2002 technical assessment performed by Blue Cross/Blue Shield (updated in 2006), and by a 2004 technical assessment by Hayes, Inc. (also updated in 2006).

Medical evidence is dynamic and evolving, however. We know that, in the future, some care considered unproven today will achieve the required evidence threshold and become covered under the TRICARE basic program. Care that is likely to become proven is periodically reevaluated to ensure that TRICARE coverage is current and consistent with the latest evidence. DOD therefore commissioned a formal technical assessment of the current scientific evidence supporting cognitive rehabilitation intervention for TBI. This evaluation will be completed in August 2007. DOD will reevaluate its coverage policy for cognitive rehabilitation under the TRICARE basic program at that time.

DOD recognizes that, as a determination is made that an active duty patient will not be able to return to active duty service, and the transition is made from active duty to retired status, changes in coverage may result in discontinuity in care for combat-wounded Servicemembers. DOD is exploring the feasibility of testing strategies for mitigating potential disruption in care using demonstration authority.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. HILLARY RODHAM CLINTON TO HON. DAVID S.C. CHU, UNDER SECRETARY FOR PERSONNEL AND READINESS, DEPARTMENT OF DEFENSE

MILITARY DISABILITY BENEFITS SYSTEM

Question 1. In March 2006, the Government Accountability Office released GAO Report #06–362: Military Disability System: Improved Oversight Needed to Ensure Consistent and Timely Outcomes for Reserve and Active Duty Servicemembers. According to the report the Department of Defense regulations and policies allows each service to set up their own processes for certain aspects of the disability evaluation system. As a result, each service implements its system somewhat differently. Additional issues identified by the report include: Failure to monitor compliance of disability benefits evaluation system policies and guidance; Lack of oversight of the disability benefits evaluation system by the Disability Advisory Council; Ineffective protocols for processing disability benefit claims; Faulty disability benefits data entry system with high error rates exist; Lack of effective U.S. Army data processor training programs; Lack of oversight for disability system staff training; A need exists to improve the access and availability of each service's Physical Evaluation Board Liaison Officers; A need exists to improve service awareness and use of Line of Duty determinations for Active Duty and Reserve servicemembers; A need exists to improve the quality of care and services provided to reservists that are in a medical holdover status and receiving medical treatment away from their homes and families; and A need to improve each service's quality assurance mechanisms in an effort to ensure that disability determinations are consistent.

Will this report be used as a basis to improve the Department of Defense Disability System? What compliance checks are in place to address this year old report? What can this Committee do to assist the Department to address these problems?

Response. The Department issued a directive-type memorandum providing policy for the overall management of the DES. The guidance addressed the issues of GAO

Report #06–362 and statutory changes from the Fiscal Year 2007 National Defense Authorization Act. The directive-type memorandum, in addition to other policies, included a comprehensive review of compliance every 3 years and the establishment of reporting requirements. These would include sampling of decisions on disability ratings of medical conditions for Department-wide analyses. The directive also established the DES Annual Report and the Quarterly DES Performance Measures Report to the Under Secretary of Defense for Personnel and Readiness.

In addition, other efforts inform our work, such as the current and future reports of the Veterans Affairs' (VAs) Disability Benefits Commission: the President's Commission on Care for America's Returning Wounded Warriors, DOD's Independent Review Group, and internal DOD and Military Department Inspector General review/audits.

DOD needs authority to revolutionize DES rather than a new set of compliance standards that only serve to reinforce the present, failed system. A demonstration authority would empower the VA and DOD to operate a combined activity for rating those judged unfit by DOD and establish benefits under programs that transcend present law. The Committee's support of a demonstration effort would be appreciated.

Question 2. The Department of Defense's Disability Advisory Council (DODDAC) provides recommendations for amending and adjusting the Department of Veterans Affairs Schedule for Ratings which is used for disability rating determinations by each service. The DODDAC was faulted by the GAO for a lack of oversight and participation in the process to determine fair and consistent disability ratings. Has this lack of oversight and participation been corrected since the March 2006 GAO report was issued? What new compliance checks and procedures have been implemented to ensure DODDAC is more involved in the process?

Response. The Department reinstituted and maintains an aggressive schedule of Disability Advisory Council meetings. These meetings are conducted quarterly and have intense agendas focused on oversight and revisions to policy and process to ensure consistency and accuracy of the Disability Evaluation System (DES).

To improve oversight, the Department also issued a directive-type memorandum providing policy for the overall management of the DES. The guidance addressed the issues of the GAO report and statutory changes from the National Defense Authorization Act for Fiscal Year 2007. The directive-type memorandum included a comprehensive review of compliance every 3 years and established reporting requirements, to include sampling of decisions on disability ratings of medical conditions for Department-wide analyses. The directive also established the DES Annual Report and the Quarterly DES Performance Measures Report to the Under Secretary of Defense for Personnel and Readiness.

Question 3. The April 12, 2007 Joint Armed Services-Veterans Affairs hearing testimony indicated that the current rating scheme does not accurately or fairly address the nature of wounds suffered during the Global War on Terror to include: Traumatic Brain Injuries, Amputations, Spinal injuries, Post-traumatic Stress Disorder, Hearing loss, and Diseases. Does the current rating scheme fairly compensate disabilities related to Traumatic Brain Injuries, Amputations, Spinal injuries, Post-traumatic Stress Disorder, Hearing loss, and Diseases?

Response. By law, the Department of Veterans Affairs (VA) determines the rating scheme for disabilities through the VA Schedule of Rating Disabilities (VASRD). The VASRD considers loss of earnings capacity, and is governed by title 38. There are problematic conditions in the VASRD where the Department believes it should be updated. We are awaiting the Task Force results on Post Traumatic Stress Disorder and the VA Commission's review before we can adequately advise VA on the construct of the schedule.

TRAUMATIC BRAIN INJURIES

Question 4. Traumatic Brain Injuries have been called the "signature wound" of the Global War on Terror—TBI includes severe injuries as well as invisible wounds that result in trouble remembering appointments, holding down a job, and returning to civilian life. Additionally, the number of Post Traumatic Stress Disorder cases being diagnosed amongst returning OIF and OEF veterans is increasing with the number of repeated deployments and the stressful OPTEMPO. Distinguishing between mild TBI and Post Traumatic Stress Disorder is difficult because both conditions share common symptoms, such as irritability, anxiety and depression. Has DOD researched and developed any computer-based tests that would assess different basic functions (or domains) of cognition—such as memory, concentration, attention, and reaction time—that could be used to detect brain injury and distinguish TBI from Post Traumatic Stress Disorder?" What updated methods and tests have

been incorporated in pre-deployment screening for PTSD and TBI during pre-deployment activities?

Response. While there is some overlap in symptoms associated with PTSD and with mild TBI, clinicians are able to distinguish between the two and establish a diagnosis using standard clinical procedures. There is no medically validated computer-based testing that can differentiate these two very dissimilar conditions. A clinical evaluation, history of exposure, and review of all symptoms are required. It is also possible for both TBI and PTSD to exist in the same individual at the same time, since the events that cause one can also cause the other, and they are not mutually exclusive. There is a procedure to assess for non-deployable conditions during pre-deployment activities, but treated PTSD or previous TBI are not necessarily non-deployable conditions.

Because TBI is a significant health concern for the Department, we are working to develop a comprehensive DOD program to identify, treat, document, and follow up on those who have suffered a TBI while either deployed or in garrison. This program will establish common TBI tools and clinical practice guidelines for screening, assessment, treatment, and follow-up. A preliminary conference of DOD experts met in May and another will convene June 25 and 26, where the Department of Veterans Affairs, leading universities, and civilian institutions will send experts. At that conference, we will discuss the medical and scientific validity of a computerized test mechanism to differentiate PTSD from TBI with these national experts, as well as other important issues related to this injury.

Question 5. Servicemembers who have incurred severe TBI may never fully recover, and any chance of recovering the ability to perform daily tasks is dependent on access to intensive, specialized rehabilitation, including cognitive therapy. Active duty servicemembers can access a range of health care options including cognitive therapy—which is necessary for TBI rehabilitation—under their TRICARE plan. However, once troops are medically retired, their TRICARE coverage doesn't provide access to cognitive therapies provided at private facilities. Are you aware of the discrepancy in medical treatment options available to active duty and medically retired servicemembers who have incurred a Traumatic Brain Injury (TBI)?

Response. Rehabilitation therapy covered under the TRICARE basic program is available to both active duty Servicemembers and retirees, and includes physician-prescribed therapy to improve, restore, or maintain function, or to minimize or prevent deterioration of patient function. Rehabilitation therapy under the TRICARE basic program must be medically necessary and appropriate care keeping with accepted norms for medical practice in the United States, rendered by an authorized provider, necessary to the establishment of a safe and effective maintenance program, and must not be custodial or otherwise excluded from coverage.

Covered rehabilitation services for TBI patients may include physical, speech, occupational, and behavioral services. Cognitive rehabilitation strategies may be integrated into these components of a rehabilitation program and may be covered under the TRICARE basic program when cognitive rehabilitation is not billed as a distinct and separate service. Beneficiaries, including active duty Servicemembers, may receive rehabilitation services in direct or purchased care facilities. Active duty Servicemembers and veterans may also receive TBI rehabilitation in specialized Department of Veterans Affairs (VA) treatment centers.

Under the TRICARE basic program, cognitive rehabilitation, defined as "services that are prescribed specifically and uniquely to teach compensatory methods to accomplish tasks which rely upon cognitive processes," are considered unproven, therefore, not appropriate care keeping with accepted norms for medical practice in the United States and are not covered when separately billed as distinct and defined services. Post-acute community reentry programs, work integration training, and vocational rehabilitation are also excluded. TBI rehabilitation excluded from coverage under the TRICARE basic benefit for retirees and dependents may be extended to active duty Servicemembers under the supplemental health care program (SHCP) if those services may potentially keep or make the active duty patient fit to remain on active duty.

Coverage of cognitive rehabilitation by major health insurers is mixed. For example, Cigna, Aetna, and UniCare cover cognitive rehabilitation for TBI when it is determined to be medically necessary. Cigna excludes coverage of cognitive rehabilitation for mild TBI. Regence and Blue Cross/Blue Shield consider cognitive rehabilitation to be investigational and do not provide coverage for it. There is no Medicare national coverage determination for cognitive rehabilitation for TBI. In determining whether a medical treatment has moved from unproven to proven, TRICARE reviews reliable evidence, as defined in 32 Code of Federal Regulations, Part 199. Research study of cognitive rehabilitation in neurological conditions, including TBI, is limited by differences between patients, and by variation in the type, frequency, du-

ration, and focus of cognitive rehabilitation interventions. The TRICARE determination that cognitive rehabilitation for TBI is unproven is supported by a 2002 technical assessment performed by Blue Cross/Blue Shield (updated in 2006), and by a 2004 technical assessment by Hayes, Inc. (also updated in 2006). Medical evidence is dynamic and evolving. We know that, in the future, some care considered unproven today will achieve the required evidence threshold and become covered under the TRICARE basic program. Care that is likely to become proven is periodically reevaluated to ensure that TRICARE coverage is current and consistent with the latest evidence. The Department of Defense (DOD) commissioned a formal technical assessment of the current scientific evidence supporting cognitive rehabilitation intervention for TBI. This evaluation will be completed in August 2007. DOD will reevaluate its coverage policy for cognitive rehabilitation under the TRICARE basic program at that time.

DOD recognizes that as a determination is made, an active duty patient will not be able to return to active duty service, and transition is made from active duty to retired status changes in coverage may result in discontinuity in care for combat-wounded Servicemembers. DOD is exploring the feasibility of testing strategies for mitigating potential disruption in care using demonstration authority.

Question 6. Many servicemembers who have incurred serious traumatic brain injuries are fortunate to have family members or loved ones act as caregivers. However, family members of returning soldiers with TBI are often ill-equipped to handle the demands of caring for their loved one, which in some bases can become a full-time responsibility. Does the VA have any data on the number of family caregivers who have relocated or quit their job in order to provide care for a traumatic brain injured servicemember?

Response. We defer to the VA for the answer. The Department of Defense does not collect data related to this question.

TRAUMATIC INJURY SERVICEMEMBERS' GROUP LIFE INSURANCE

Question 7. On August 25, 2006, Director Thomas M. Lastowka, Veterans Affairs Regional Office and Insurance Center testified before the Senate Veterans' Affairs Committee on the Traumatic Injury Servicemembers' Group Life Insurance program. Director Lastowka testified that the TSGLI Program has denied 1,601 retroactive claims and 248 post-December 1 claims; approximately 40 percent of every claim. What quality control procedures have been implemented to improve the dismal approval rate for submitted claims? Has the Department of Veterans Affairs or the Department of Defense reviewed the denied claims and determined if they warrant a retroactive TSGLI award?

Response. TSGLI legislation followed commercial Accidental Death and Dismemberment policies and enumerated a list of specific losses for which a TSGLI payment would be made. The VA, in coordination with DOD, created a schedule of losses against which the injuries are evaluated. Members are encouraged to submit the certification forms even if they may not qualify for payment, to ensure that the injuries are considered under the program. As a result, more claims are filed in which the medical evidence does not support the claimed loss. While this leads to increased disapprovals, we believe it is better for the branch of Service to deny more claims than to have perhaps eligible members fail to file a claim due to self-screening.

The following are the quality control procedures used: If a claims examiner would like a second review, the claim is sent to a physician. The physician reviews the claim and provides a final recommendation. If a claim is disapproved, the member can request reconsideration. The claims examiner again reviews the claim. A physician is available to provide a final recommendation. If the claim is disapproved after reconsideration, the member may file an appeal. The claim is then reviewed at a higher level of authority. A history of the claim and all medical documentation are provided to officials, who make an appeal decision.

The VA and the Office of Servicemembers' Group Life Insurance recently conducted a detailed review of approximately 230 completed claims, and confirmed that the claims were adjudicated correctly under current law and regulations.

ELECTRONIC MEDICAL RECORDS

Question 8. Progress is being made by the Department of Veterans Affairs in utilizing electronic medical records. However, wounded soldiers continue to report that their paper medical records are being lost throughout the process. Why hasn't more progress been made in developing a seamless system whereby DOD and VA medical records systems would be able to integrate with one another? What is the current

status of efforts to fix the medical records process in DOD so that we will not have wounded soldiers complaining of lost records?

Response. The Department of Defense's (DOD) electronic medical record, Armed Forces Health Longitudinal Technology Application (AHLTA), is used worldwide to document approximately 112,000 outpatient encounters per day. DOD and VA share a significant amount of health information today (itemized below). By the end of 2007, DOD will be electronically sharing with VA nearly every health record data element identified in our VA/DOD joint strategic plan (JSP) for health information transfer. By 2008, we will be sharing the remaining electronic health record data elements identified in the VA/DOD JSP. However, a significant number of Servicemembers have their historical medical data on paper records that were generated prior to the full implementation of AHLTA.

Currently shared electronic medical record data

• Inpatient and outpatient laboratory and radiology results, allergy data, outpatient pharmacy data, and demographic data are viewable by DOD and VA providers on shared patients through bidirectional health information exchange (BHIE) from 15 DOD medical centers, 18 hospitals, and over 190 clinics and all VA facilities.

• Digital radiology images are being electronically transmitted from Walter Reed Army Medical Center (WRAMC) and National Naval Medical Center (NNMC) Bethesda to the Tampa and Richmond VA Polytrauma Centers for inpatients being transferred there for care.

• Electronic transmission of scanned medical records on severely injured patients transferred as inpatients from WRAMC to the Tampa and Richmond VA Polytrauma Centers.

• Pre- and Post-deployment Health Assessments and Post-deployment Health Reassessments for separated Servicemembers and demobilized Reserve and National Guard members who have deployed.

• When a Servicemember ends their term in Service, DOD transmits laboratory results, radiology results, outpatient pharmacy data, allergy information, consult reports, admission, disposition and transfer information, elements of the standard ambulatory data record, and demographic data to the VA.

• Discharge summaries from 5 of the 13 DOD medical centers and hospitals using the Clinical Information System (CIS) to document inpatient care are available to the VA on shared patients.

Enhancement plans for 2007

• Expanding the electronic digital radiology image transfer capability to include images from WRAMC, NNMC, and Brooke Army Medical Center (BAMC) to all four VA Polytrauma Centers.

• Expanding the electronic transmission of scanned medical records on severely injured patients from WRAMC, NNMC, and BAMC to all four VA Polytrauma Centers.

• Making discharge summaries, operative reports, inpatient consults, and histories and physicals available for viewing by all DOD and VA providers from inpatient data at all 13 DOD medical centers and hospitals using CIS.

• Expanding BHIE to include all DOD facilities.

• Making encounters/clinical notes, procedures, and problem lists available to DOD and VA providers through BHIE.

• Making theater outpatient encounters, inpatient and outpatient laboratory and radiology results, pharmacy data, inpatient encounters, to include clinical notes, discharge summaries, and operative reports available to all DOD and VA providers via BHIE.

• Beginning collaboration efforts on a DOD and VA joint solution for documentation of inpatient care.

Enhancement plans for 2008

• Making vital sign data, family history, social history, other history, and questionnaires/forms available to DOD and VA providers through BHIE.

• Making discharge summaries, operative reports, inpatient consults and histories, and physicals available to VA on shared patients at Landstuhl Regional Medical Center, Germany.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. JOHNNY ISAKSON TO HON. DAVID S.C. CHU, UNDER SECRETARY FOR PERSONNEL AND READINESS, DEPARTMENT OF DEFENSE

Question 1. Should a VA representative be embedded in the Medical Evaluation Board process from the beginning? If not, should a VA representative at least be present for the Physical Evaluation Board process?

Response. The primary focus of the MEB is to return a member to service, provide limited duty, or a protective profile. The primary focus of the PEB is to determine if a member is fit for continued military service. This function does not involve VA. Clearly, for those members who are unfit for further military service, the issue of rating the disability or disabilities is one that involves both departments. The two departments are now working on joint procedures to adjudicate more effectively disability system determinations in both departments.

Question 2. Do the questions on the DD Form 2900 adequately address mental health, specifically related to Post-Traumatic Stress Syndrome and Traumatic Brain Injury?

Response. The Post-deployment Health Reassessment (PDHRA) uses DD Form 2900 as a self-reporting tool. Similarly, the Post-deployment Health Assessment (PDHA) uses DD Form 2796. In both instances, the health assessment process does not rely solely on a form or questionnaire. The questionnaire is intended only to provide some structured information to aid the health care provider during an interview. The provider follows up on all concerns, whether physical, mental, or environmental, reported by the Servicemember during the interview.

Both the PDHA and the PDHRA include the Primary Care PTSD scale, a scale validated in a primary care clinical setting and recommended by the Clinical Practice Guideline for Acute Stress Disorder and PTSD.

The current version of the DD Form 2900 includes a question where the individual can indicate that he or she was in a situation that might have resulted in a TBI. The Department of Defense is currently in the process of adding additional TBI screening questions to both the DD Form 2900 and the DD Form 2796. These new questions are modeled after those used by the Department of Veterans Affairs. This approach is in keeping with current clinical practices and expert recommendations.

RESPONSE TO WRITTEN QUESTION SUBMITTED BY HON. SAXBY CHAMBLISS TO HON. DAVID S.C. CHU, UNDER SECRETARY FOR PERSONNEL AND READINESS, DEPARTMENT OF DEFENSE

RATIO OF CASE MANAGERS

Question 1. I understand that the only DOD regulation related to the number of case managers required to manage personnel in a medical hold status is a 1 to 35 ratio of case managers to Guard/Reserve personnel in a medical holdover unit. By implication, there are no regulations for the ratio of case managers to personnel for Active Duty personnel in a medical hold status. Do you believe that the 1 to 35 ratio for medical holdover personnel is adequate and do you think that DOD should establish a requirement standard for case managers for Active Duty personnel in medical hold?

Response. The ratio for case management to personnel is not a "one size fits all" answer, including Servicemembers in the medical hold status. The Department of Defense (DOD) Medical Management Guide, dated January 2006, outlines a suggested caseload for case managers. The ratio is determined on several factors, including the experience of the case manager, Military Treatment Facility and community-based resources, and other variables. Currently, DOD supports the Case Management Society of America's recommendations that are based on acuity of the patient as illustrated in the following table:

Level	Amount	Type
Acute	8–10 cases	Early injury/illness stages (case manager performs all coordination).
Mixed	25–35 cases	Acute and chronic cases (some requiring semi-annual or annual follow-up, some needed full-time case manager coordination).
Chronic	35–50 cases	Cases requiring 1–2 hours follow-up/month.

Question 2. One focus of complaints related to DOD's rehabilitation process has been the role of case managers in the process. To what extent are there prescribed

regulations related to the duties and responsibilities of DOD case managers of medical hold and holdover personnel?

Response. DOD Instruction 6025.20, Medical Management Programs in the Direct Care System and Remote Areas, gives specific guidance on responsibilities for case management. Specific guidance regarding medical holdover personnel is addressed in Section II–17 of the DOD Medical Management Guide, dated January 2006. Coordination of care from the Military Health System to the Department of Veterans Affairs is also addressed in the Medical Management Guide.

Question 3. Is there a required training program for case managers and regulations that govern their specific responsibilities on behalf of servicemembers or do those regulations vary from installation to installation and Service to Service?

Response. There is a required training program for case managers, and the TRICARE Management Activity (TMA) provides medical management training which includes case management. The medical management training is typically held annually in each of TRICARE's three regions. Participants include Military Treatment Facility providers, case managers, utilization managers, and disease management managers.

Additionally, Department of Defense Instruction 6025.20, Medical Management Programs in the Direct Care System and Remote Areas, gives specific guidance on responsibilities for not only case management, but also disease and utilization management. Additionally, there are Web-based modules available for case management training through the TMA.

The Assistant Secretary of Defense for Health Affairs is convening the Military Healthcare System Case Management Summit on 15-16 May. An action plan will be developed at the multi-agency, multi-disciplinary meeting that focuses on the way forward for addressing policy, training, and information sharing issues/challenges for injured, ill, and wounded warriors.

Question 4. One of the responsibilities of case managers should be to better educate soldiers on the medical evaluation and disability process. Is that in fact one of their responsibilities?

Response. The Department of Defense is bringing all of the involved members together for a Case Management Conference on May 15–16, 2007, to outline all requirements and assign responsibilities. The role of educating Servicemembers on the Physical Evaluation Board (PEB) process has traditionally been the role of the PEB Liaison Officer and not the case manager. We have to be careful we do not "medicalize" command and personnel responsibilities. While it is true that the case managers can assist with the education of Servicemembers on the medical evaluation and disability process, their major role will be to provide care coordination; ensuring that the Servicemember gets the right care at the right place and at the right time.

EVALUATION BOARDS

Question 5. One complaint I have heard regarding the MEB/PEB process is that it was established in the 1970s, is outdated, and is extremely bureaucratic. For an Active Duty servicemember, the process requires between 22 and 27 pieces of paper, and even more for a Guard/Reserve member. Some would argue that given the numerous opportunities for appeals during the process, that it is overly biased toward the servicemember, and maybe that is the way it should be. We want to give our servicemembers every opportunity to get well and, if they desire, continue their service in the military. I would appreciate your comments on the MEB/PEB process, and your thoughts regarding—if you had to do a "lean event" to streamline and remove the excess time and steps in the process—what would you change to make it more efficient and cause it to better serve our men and women in uniform?

Response. The Disability Evaluation System (DES), which consists of the MEB and PEB processes, is complex, sometimes adversarial, and burdensome. Much of that is related to the statutory imperative for a fair and impartial system that affords due process protections (boards, legal representation, witnesses, an appellate process, etc.). The DES, as set forth in statute, allows the Department to provide additional guidance, but ultimately, the Secretaries of the Military Departments operate their DES consistent with their roles and missions, and apply ratings in accordance with how they interpret application of the Veterans Affairs (VA) Rating Schedule for Disabilities (VASRD).

The complex and adversarial nature of the DES is partially a result of the magnitude of the benefits associated with the decisions on the rating. The disability rating determines whether the individual will separate with severance or with retirement benefits. For many, there is strong motivation to be declared fit to remain in uniform, despite injuries that would suggest otherwise.

There are concerns that the VASRD has not kept current with the knowledge and service job environment, especially for brain injuries and pain as compared to other more physical injuries.

We are looking at wholesale redesign of the complex and arcane DES, which dates back to constructs from 1949, but we need authority to waive current laws in fielding a new system. There is substantial precedent for this. It is highly effective and it points the way to legislative changes that could be enacted next year, as needed. DOD needs empowerment to revolutionize DES, rather than a new set of compliance standards that only serve to reinforce the present, failed system. A demonstration authority would empower VA and DOD to operate a combined activity for rating those judged unfit by DOD. It would also authorize the establishment of benefits under programs that transcend present law, and allow rapid proof of new concepts and quick response to the needs of the disabled. VA and DOD jointly would define the framework for conducting the demonstration. The Secretaries of VA and DOD would partner in making determinations with regard to waiving existing statutes and in managing congressional reporting.

Question 6. One suggestion I have heard regarding how to speed up the MEB/PEB process within DOD and make it more efficient and easier for our servicemembers is to embed more VA personnel within DOD to help with the transition process. Specifically, VA personnel could begin working with soldiers and possibly take charge of their paperwork and medical requirements once it is clear that a servicemember cannot be retained in the Service. Can you comment on how embedding VA personnel might affect the MEB/PEB process and if you think, from our servicemembers' perspective, that this would be a good idea?

Response. Yes, VA participation in the process could be helpful, and we are working with the VA to increase their involvement. We are looking at increasing VA liaison personnel in our Military Treatment Facilities, involving the VA in the process to determine a single disability rating, and more VA visibility in case management and tracking. We are also reviewing the Navy's recently released Severely Injured Marines and Sailors Pilot Program, which examined the pros and cons of an accelerated disability retirement program in order to maximize compensation and benefits to the most severely injured. The Navy conducted this pilot program in collaboration with the VA.

MEDICAL HOLDOVER PERSONNEL

Question 7. One key to effectively handling medical holdover personnel is by having active and engaged case managers. The Army has three medical holdover units in Georgia, at Fort Gordon, Fort Benning, and Fort Stewart. The Fort Benning medical holdover unit relies in part on contract case managers. I am not fundamentally opposed to contractors performing this function, but I do think it can put the mission at risk if the contract expires and new case managers cannot be recruited and hired in time to replace the old ones. Do you think there should be a regulation requiring a certain percentage of case managers to be DOD civilians or military personnel?

Response. Military personnel do not provide all health care in the DOD Military Health System. Federal civilians and contract staff supplement the military medical professionals in virtually all settings. Similarly, case management is not conducted using only military providers. Contract personnel are required to accomplish an activity of such scope and volume. However, it would not be good practice to mandate specific percentages for the mix of case managers. Instead, the mix at any particular medical care facility should be determined by the workload, budget, and other operational factors for that location.

Question 8. In the event that contractors are utilized, what are you doing to ensure the medical holdover mission is not compromised and that our soldiers receive the necessary advocacy when they are in a medical holdover unit?

Response. Supervision of all Servicemembers and the personnel supporting them takes an active and engaged command. Each Military Service will stay actively engaged in the care of all of its Servicemembers to ensure there are no lapses.

SHORTAGE OF MEDICAL PERSONNEL

Question 9. My staff traveled across the State of Georgia last week and visited three DOD hospitals, and one comment that surfaced at every installation related to the Army's inability to offer attractive enough incentives to hire the doctors and nurses they need to execute their mission, as well as an overly burdensome bureaucratic hiring and contracting process that prevents military bases from getting the military, civilian, and contract health care providers that they need when they need them. I think you will agree that this is a problem across DOD. In my mind, we

ought to be able to do whatever we need to streamline this process and give you the authorities you need to get the personnel you need in this area because it is one of the most critical areas facing our military. What, in your opinion, needs to be done here and how can Congress help?

Response. While conducting the most recent Quadrennial Defense Review (QDR), the DOD identified a requirement to transform the process by which the Military Services acquire contracted medical professionals to work in MTFs. The QDR Roadmap for Medical Transformation includes an initiative titled "Contracting for Professional Services," that will enable the Military Health System (MHS) to more effectively and efficiently employ contract medical personnel by providing an acquisition process that is consistent throughout the system and makes health care more accessible to beneficiaries.

DOD is establishing a Strategic Sourcing Council for the acquisition of medical professional services. The council will oversee a collaborative and structured process by the Military Services to critically analyze the MHS spending for contracted medical personnel in order to optimize performance, minimize price, increase achievement of socio-economic acquisition goals, improve vendor access to business opportunities, and otherwise increase the value of each dollar spent. This transformed acquisition process will be first applied to establishing a common, standing contracting vehicle that all of the Military Services can use to quickly fill medical professional staffing needs as they arise in the MTFs. Congress has already provided the statutory authority needed to accomplish this.

POST-DEPLOYMENT HEALTH ASSESSMENT

Question 10. I understand that the Army requires each soldier who redeploys from theater to undergo a post-deployment health reassessment 90 to 180 days after their return. This is obviously a good idea since many conditions may not show up until several months after a deployment. However, I understand that these health assessments are not always done in person but can be done over the phone and by contractors versus military personnel. In my mind this is not ideal and allows for many conditions to be overlooked and go unreported which might then surface months or years later. Specifically, related to some of the most common conditions such as PTSD and TBI, I believe that it would be particularly hard if not impossible to diagnose these conditions over the phone. Regarding the post-deployment health assessment process, do you believe it would be wise for DOD and the Army to require these assessments to be conducted in person by military personnel?

Response. The PDHRA is a DOD-wide requirement for every Servicemember who returns from an operational deployment. The PDHRA is a process that includes completion of an interview with a health care provider. A PDHRA does not result in a diagnosis, rather it allows the Servicemember to raise any concerns so that the health care provider, when interviewing the individual, can provide education and offer a referral for more detailed evaluation, as clinically appropriate. These assessments can be accomplished in person, or through a contract-operated national call center.

The call center follows established and well-accepted telehealth procedures to allow increased access to Servicemembers who are remotely located. It is not the standard for all members, but an option that makes the PDHRA more convenient for our Guard and Reserve members who may not drill with their unit. Call centers, nurse triage lines, and various other types of "hot lines" are widely used, accepted, and effective methods for various health screening programs. It is important to provide options to Servicemembers because not everyone communicates in the same way. Some people perceive a degree of anonymity over the telephone and are more comfortable answering personal questions under those conditions. Others are more open and honest during a face-to-face interview. While keeping both options available, we have initiated a program evaluation study to determine if there is any difference in effectiveness between these two approaches.

Military personnel do not provide all health care in the DOD Military Health System. Federal civilians and contract staff supplement the military medical professionals in virtually all settings. Similarly, PDHRAs are not conducted using only military providers, even for active duty members. Contract personnel are required to accomplish an activity of such scope and volume. However, past military experience is preferred when hiring the contract staff and standardized training and guidelines help facilitate consistent processes and decisions.

Question 11. How do DOD and the Army ensure that soldiers actually complete these health assessments?

Response. The DOD has a well-established Post-deployment Health Assessment (PDHA) process. As required by current DOD policy and Joint Staff guidance, the

assessments are accomplished by Servicemembers before leaving the theater. The completed forms are sent to the Defense Medical Surveillance System (DMSS) and are made available to military health care providers through TRICARE Online. The Services also check to ensure that Servicemembers returning from deployment complete a PDHA at their home station if they did not complete one in theater. All of the Services monitor their own compliance and Health Affairs measures PDHA compliance across the DOD as part of the overall force health protection quality assurance program. Health Affairs teams perform onsite visits and review physical medical records, and compare the findings with information contained in the DMSS. Generally, PDHA compliance rates have exceeded 90 percent.

Chairman LEVIN. Thank you, Secretary England.

I understand, Secretary Chu, that you do not have an opening statement, is that correct?

DR. CHU. No, sir. I couldn't say it better than Secretary England.

Chairman LEVIN. Thank you. Secretary Cooper?

STATEMENT OF HON. DANIEL L. COOPER, UNDER SECRETARY FOR BENEFITS, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY GERALD CROSS M.D., ACTING PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS

Mr. COOPER. Chairman Akaka, Senator Craig, and Members of the Veterans' Affairs Committee, Senator Levin, Senator McCain, Members of the Armed Services Committee, first, I respectfully request that my written statement be entered into the record.

Chairman LEVIN. It will be made a part of the record.

Mr. COOPER. It is my pleasure to be here today to discuss the transition of servicemembers from the Department of Defense to the Department of Veterans Affairs. I am pleased to be accompanied by Dr. Gerald Cross, Acting Principal Deputy Under Secretary for Health.

The focus of my remarks will be the Seamless Transition Program for the seriously injured veterans of Operations Iraqi and Enduring Freedom. I will also discuss our joint efforts with DOD in data and information sharing as well as the VA's disability rating system.

Seamless Transition is a jointly sponsored VA and DOD initiative for the most seriously injured OIF/OEF servicemembers and it is our highest priority. We must ensure that these courageous men and women transition seamlessly from DOD to VA, that they continue to receive the best care available, and are quickly awarded the benefits they have earned through their service and their sacrifice.

VA has social workers and benefits counselors assigned to ten military treatment facilities, including Walter Reed. These social workers and counselors are the first VA representatives to meet with the injured servicemembers and their families. They provide information about health care, disability compensation and rehabilitation benefits, the Traumatic Servicemember's Group Life Insurance benefit, as well as educational and housing benefits. Our benefits counselors assist servicemembers and their families in completing the benefits claims and in gathering the supporting evidence. Our social workers assist in coordinating the future course of treatment for their injuries after they leave the service.

Since last September, a VA Certified Rehabilitation Registered Nurse has been assigned to Walter Reed to provide patient updates

to our Polytrauma Centers and to prepare servicemembers and their families for the transition to VA and the rehabilitation phase of their recovery.

Secretary Nicholson recently announced an important new initiative. The VA will hire 100 new Transition Patient Advocates for the severely injured servicemembers. These Patient Advocates will travel to the MTFs to initiate contact with the servicemembers and their families and will work with them throughout the transition process to resolve problems and concerns.

As servicemembers are transferred from the MTFs to other DOD facilities or to VA care, the benefits counselors notify the appropriate Regional Benefits Office of the transfer. All regional offices have established points of contact with the military and the VA hospitals and all regional offices have designated case managers who maintain regular contact with these seriously injured veterans to ensure that their needs are met. Each disability claim from a seriously injured OIF/OEF veteran is case managed to try to ensure expeditious processing.

One important aspect of coordination between DOD and VA is access to clinical information, including a pre-transfer review of electronic medical information via remote access. The VA Polytrauma Centers have been granted direct access into inpatient clinical information systems at Walter Reed and Bethesda. Additionally, a new application known as the Veterans Tracking Application will enable VA to track servicemembers from the battlefield through Landstuhl, the MTFs, and to the VA medical facility. VTA is a modified version of DOD's Joint Patient Tracking application and will have all medically evaluated OIF/OEF servicemembers in the database. The application is also designed to identify where servicemembers have filed claims for disability and which VBA counselor assisted in the claims process. Full deployment of this process is scheduled to be completed by the end of April.

The VA's schedule for rating disabilities is the guide that we use in the evaluation of disabilities resulting from diseases and injuries encountered as a result and during military service. By law, VA must evaluate all diseases and injuries claimed by the veteran, but also any inferred, secondary, or unclaimed problems or conditions for which service connection could potentially be granted. The ratings VA assigns under the schedule represent the average impairment in earning capacity resulting from such diseases or injuries in civil occupations. The disability medical examination by the VA is highly structured and includes examination worksheets to ensure that all elements of the rating schedule are addressed. The ratings assigned are in 10 percent increments.

Servicemembers who are retiring or leaving the service and are not seriously wounded can apply for VA disability compensation under the Benefits Delivery at Discharge program. They then undergo a single medical examination while on active duty that is adequate for both VA and DOD purposes. Under the BDD program, servicemembers can complete an application for VA disability compensation up to 180 days prior to their discharge. Servicemembers are given one physical examination instead of both a separation exam from the military and a disability exam for the VA.

VA has worked hard to improve the transition process for our deserving servicemen and women. We are not satisfied that we have achieved all that is possible or can be done. As you know, a Presidential Interagency Task Force and other commissions are working to improve the services provided to our wounded Global War on Terrorism servicemembers as well as for all veterans. VA is committed to assisting their work and continuing to work internally to ensure all is being done for those who have so admirably served their Nation.

Mr. Chairman, this concludes my testimony. I would be pleased to answer any questions.

[The prepared statement of Mr. Cooper follows:]

PREPARED STATEMENT OF HON. DANIEL L. COOPER, UNDER SECRETARY FOR BENEFITS, DEPARTMENT OF VETERANS AFFAIRS

Chairman Akaka, Senator Craig, and Members of the Veterans Affairs Committee; Chairman Levin, Senator McCain, and Members of the Armed Services Committee: It is my pleasure to be here today to discuss the transition of servicemembers from the Department of Defense (DOD) to the Department of Veterans Affairs (VA) and the DOD and VA rating systems. I am also pleased to be accompanied today by Dr. Gerald Cross, Acting Principal Deputy Under Secretary for Health.

The focus of my remarks will be the seamless transition program, especially as it relates to the care of seriously injured veterans of service in Operations Iraqi and Enduring Freedom (OIF/OEF). I will also discuss our joint efforts with DOD in the area of electronic records transfer and data and information sharing, as well as the disability rating systems used by DOD and VA.

SEAMLESS TRANSITION

Seamless Transition is a jointly sponsored VA and DOD initiative that provides transition assistance to seriously injured servicemembers. In partnership with DOD, VA has implemented a number of strategies to provide timely, appropriate, and seamless transition services to the most seriously injured OIF/OEF active duty servicemembers and veterans. Our highest priority is to ensure that those returning from the Global War on Terror transition seamlessly from DOD military treatment facilities (MTFs) to VA Medical Centers (VAMCs), continue to receive the best possible care available anywhere, and receive all the benefits they have earned through their service and sacrifice in a timely manner. Toward that end, we continually strive to improve the delivery of our care and benefits.

Veterans Health Administration (VHA) social worker liaisons and Veterans Benefits Administration (VBA) counselors are located at ten military treatment facilities (MTFs) that receive the most severely wounded patients, including Walter Reed Army Medical Center. These social workers and counselors are a critical part of the seamless transition process, assisting active duty servicemembers in their transition to VA medical facilities and the VA benefits system.

The counselors and social workers assigned to the MTFs are usually the first VA representatives to meet with servicemembers and their families. They provide information about the full range of VA benefits and services, which include: health care and readjustment programs, disability compensation and related benefits, the traumatic injury benefit provided under the Servicemembers Group Life Insurance Program, as well as educational and housing benefits.

VBA benefits counselors assist servicemembers in completing benefits claims and in gathering supporting evidence. While servicemembers are hospitalized, they are kept informed of the status of their pending claims and given their counselor's name and contact information should they have questions or concerns.

VHA social worker liaisons play a very crucial role in the seamless transition of seriously injured servicemembers from MTFs to VA medical centers, where they receive the best possible care. Our social workers assist these servicemembers and their families in coordinating the future course of treatment for their injuries after they return home.

VA's Seamless Transition Program also includes two Outreach Coordinators—a peer-support volunteer and a veteran of the Vietnam War—who regularly visit seriously injured servicemembers at Walter Reed and Bethesda National Navy Medical Center. Their visits enable them to establish a personal and trusted connection with

patients and their families. They encourage patients to consider participating in VA's National Rehabilitation Special Events or to attend weekly dinners held in Washington, DC, for injured OIF/OEF returnees. In short, they are key to enhancing and advancing the successful transition of our servicemembers.

VA has coordinated the transfer of over 6,800 OIF/OEF severely injured or ill active duty servicemembers and veterans from DOD to VA care and services. Since September 2006, a VA Certified Rehabilitation Registered Nurse (CRRN) has been assigned to Walter Reed to assess and provide regular updates to our Polytrauma Rehabilitation Centers (PRC) regarding the medical condition of incoming patients. The CRRN advises and assists families and prepares active duty servicemembers for transition to VA and the rehabilitation phase of their recovery.

VA's social worker liaisons and the CRRN strive to fully coordinate care and information prior to a patient's transfer to our Department. Social worker liaisons meet with patients and their families to advise and "talk them through" the transition process. They register servicemembers or enroll recently discharged veterans in the VA health care system, and coordinate their transfer to the most appropriate VA facility for the medical services needed, or to the facility closest to their home.

In transferring seriously injured patients, both the CRRN and the social worker liaison are an integral part of the MTF treatment team. They simultaneously provide input into the VA health care treatment plan and collaborate with both the patient and his or her family throughout the entire health care transition process. Video teleconference calls are routinely conducted between DOD MTF treatment teams and receiving VA polytrauma center teams. When feasible, the patient and family attend these video teleconferences to participate in discussions and to "meet" the VA PRC team.

As servicemembers are transferred from the MTFs to other DOD treatment facilities or VA care, the VBA benefits counselors notify the appropriate regional office of the servicemember's transfer. All VA regional offices have established points of contact with all military hospitals and VA medical centers in their jurisdiction to ensure prompt notification of arrival, transfer, and discharge of seriously injured servicemembers. In addition to the established points of contact for medical facilities within their jurisdiction, all regional offices have designated OIF/OEF coordinators and case managers who maintain regular contact with injured veterans to ensure their needs are being met.

Servicemembers are given VA contact information for their regional office OIF/OEF coordinator and case manager when they are being transferred to another medical facility, released to home, or awaiting discharge/retirement orders.

Each claim from a seriously disabled OIF/OEF veteran is case-managed to ensure seamless and expeditious processing. All claims are immediately placed under computer control in VBA's benefits delivery system and carefully tracked through all stages of processing. The regional office directors immediately call returning seriously disabled servicemembers and veterans when they first arrive in their jurisdiction to welcome them home and advise them that the OEF/OIF coordinator or a case manager will contact them and assist them through the claims process. The director ensures a case manager is assigned for each compensation claim received from a seriously disabled OIF/OEF veteran. The case manager becomes the primary VBA point of contact for the veteran.

OIF/OEF case managers maintain a case history on each injured veteran throughout the claims process. All regional offices are also required to update a spreadsheet used to identify and track services provided to seriously injured OIF/OEF veterans on a national basis and monitored by VBA's Office of Field Operations.

TRANSITION PATIENT ADVOCATES

Secretary Nicholson recently announced that VHA is hiring 100 new transition patient advocates who will serve as ombudsmen for severely injured OEF/OIF sevicemembers and veterans. These transition patient advocates will initiate contact with assigned servicemembers and their families while the servicemembers are still at the MTF. They will assist servicemembers and their families with any concerns, help resolve problems and work with case managers as well. The transition patient advocates travel to the MTF for the initial meeting with patients and their families.

VA AND DOD INFORMATION SHARING

VA and DOD have made significant progress in the development of interoperable health technologies that support seamless transition from active duty to veteran status. Advances include the successful one-way and two-way transmission of electronic medical records between DOD and VA, and the adoption and implementation of data standards that support interoperability.

One important aspect of coordination between DOD and VA prior to a patient's transfer to VA is access to clinical information, including a pre-transfer review of electronic medical information via remote access. The VA polytrauma centers have been granted direct access into inpatient clinical information systems at Walter Reed and Bethesda. This remote inpatient access is in addition to the existing bidirectional data sharing of pertinent outpatient data. VA and DOD are working together to ensure that appropriate users are adequately trained and connectivity exists for all four polytrauma centers.

As stated above, in addition to sharing inpatient data, VA and DOD share outpatient data through the Bidirectional Health Information Exchange (BHIE). BHIE allows VA and DOD clinicians to share text-based outpatient clinical data between VA and select DOD military treatment facilities, including Walter Reed and Bethesda, and 18 hospitals, and more than 190 outlying clinics.

VA and DOD information sharing successes have resulted directly from implementation of the DOD/VA Joint Electronic Health Records Interoperability (JEHRI) Plan. JEHRI is a comprehensive strategy to develop collaborative technologies and interoperable data repositories, as well as adoption of common data standards. VA and DOD have made significant progress with the implementation of JEHRI. Most recently, the departments have agreed to enhance sharing through JEHRI to collaborate on the feasibility, identification and development of a common inpatient electronic health record. Initial work on this project will begin this fiscal year.

Additionally, a new application very near deployment will provide VA with the ability to track servicemembers from the battlefield through Landstuhl, Germany, the MTFs, and on to the VA medical facility. The new application, known as the Veterans Tracking Application (VTA), is a modified version of DOD's Joint Patient Tracking Application—a Web-based patient tracking and management tool that collects, manages, and reports on patients arriving at MTFs from forward-deployed locations.

The VTA Web-based system allows approved VA users to access this real-time information about the servicemembers we serve and track injured active duty servicemembers while they transition to veteran status. VTA will have all medically evaluated OIF/OEF servicemembers in the database as necessary to provide VA care and benefit claims support. This application was developed for VA to coordinate care from an MTF to a VAMC to ensure that VA will know where the servicemember is currently located, where the patient came from, and who has seen the patient. The application is also designed to identify where servicemembers filed claims and which VBA counselor assisted the servicemember in the claims process. The application has an historic record feature to ensure we preserve all status changes. Deployment in VBA is underway. Full deployment in both VBA and VHA is scheduled to be completed by the end of April.

The two departments are also working to expand VA access to DOD inpatient documentation, particularly for severely wounded and injured servicemembers being transferred to VA for care. An early version of this electronic capability is currently in use between Madigan Army Medical Center and the VA Puget Sound Health Care System, where inpatient discharge summaries are exchanged. Tripler Army Medical Center, Womack Army Medical Center, and Brooke Army Medical Center have also implemented this capability.

VA AND DOD DISABILITY RATING SYSTEMS

Disability ratings and evaluations completed by VA are in accordance with Title 38 Code of Federal Regulations, Parts 3 and 4.

Part 4, the VA Schedule for Rating Disabilities, is primarily a guide in the evaluation of disability resulting from all types of diseases and injuries encountered as a result of, or incident to, military service. The percentage ratings represent, as far as can practicably be determined, the average impairment in earning capacity resulting from such diseases and injuries and their residual conditions in civil occupations.

The military service branches also use the VA Schedule for Rating Disabilities in determining disability ratings, although they have instituted an appendix that differs from the VA schedule.

Although both VA and DOD use the VA Schedule for Rating Disabilities as the primary tool in the evaluation of disability resulting from disease or injury, there are a number of reasons why the resulting ratings might vary.

The evaluation of disability is a process that involves the objective standards listed in the VA Schedule for Rating Disabilities, but also involves the evaluation of evidence. This is important from two perspectives. First, the medical evidence gen-

erated for the evaluation is derived differently by the two agencies. In VA, the compensation and pension disability examination process is highly structured with examination worksheets that ensure that all elements of the rating schedule dealing with a specific disability are addressed. Further, most VA examinations are performed solely to support the disability evaluation process. In DOD, we understand that treating physicians produce the medical evidence. Second, disability raters evaluate a unique fact pattern for each servicemember or veteran. This uniquely human analytical process will produce some variability within and across organizations, which is why both agencies employ appeals processes to ensure the claimant receives the most accurate rating.

Currently, servicemembers who apply for disability compensation benefits under the Benefits Delivery at Discharge (BDD) program undergo a medical examination while still on active duty that is adequate for VA purposes. The BDD Program is a jointly sponsored VA and DOD initiative to provide transition assistance to separating servicemembers who have disabilities related to their military service.

The BDD Program helps servicemembers file for VA service-connected disability compensation and related benefits prior to separation from service, so that payment of benefits can begin as soon as possible after discharge. Timely decisions on servicemembers' disability compensation claims also help to ensure continuity of medical care for their service-connected disabilities.

Under the BDD Program, servicemembers can complete an application for VA disability compensation benefits up to 180 days prior to separation. VA and DOD have agreed to a cooperative separation examination process for servicemembers filing a VA claim for benefits. Servicemembers attend one physical examination, instead of both a separation exam for the military and a VA exam for the disability claim. VA fully develops the claim, and the single VA/DOD medical examination meets the military's needs for a separation physical and also fulfills VA's examination requirements for processing the disability claim.

CLAIMS PROCESSING ACCURACY AND CONSISTENCY

To increase the accuracy and consistency of our benefit decisions, we have established an aggressive and comprehensive program of quality assurance and oversight to assess compliance with VBA claims processing policy and procedures and assure consistent application.

The Systematic Technical Accuracy Review (STAR) program includes review of work in three areas: rating accuracy, authorization accuracy, and fiduciary program accuracy. Overall station accuracy averages for these three areas are included in the regional office director's performance standard and the station's performance measures. STAR results are readily available to facilitate analysis and to allow for the delivery of targeted training at the regional office level. The Compensation and Pension (C&P) Service conducts satellite broadcast training sessions based on an analysis of national STAR error trends. Over the last 4 years, our rating decision quality has risen significantly from 81 percent to 89 percent.

In addition to the STAR program, the C&P Service is identifying unusual patterns of variance in claims adjudication by diagnostic code, and then reviewing selected disabilities to assess the level of decision consistency among and between regional offices. These studies will be used to identify where additional guidance and training are needed to improve consistency and accuracy, as well as to drive procedural or regulatory changes.

Site surveys of regional offices address compliance with procedures, both from a management perspective in the operation of the service center and from a program administration perspective, with particular emphasis on current consistency issues. Training is provided, when appropriate, to address gaps identified as part of the site survey.

It is critical that our employees receive the essential guidance, materials, and tools to meet the ever-changing and increasingly complex demands of their decisionmaking responsibilities. To that end VBA has deployed new training tools and centralized training programs that support accurate and consistent decisionmaking.

New hires receive comprehensive training and a consistent foundation in claims processing principles through a national centralized training program called "Challenge." After the initial centralized training, employees follow a national standardized training curriculum (full lesson plans, handouts, student guides, instructor guides, and slides for classroom instruction) available to all regional offices. Standardized computer-based tools have been developed for training decisionmakers (69 modules completed and an additional eight in development). Training letters and satellite broadcasts on the proper approach to rating complex issues are provided to the field stations. In addition, a mandatory cycle of training for all Veterans Serv-

ice Center employees has been developed consisting of an 80-hour annual curriculum.

VA has worked hard to improve the transition process for our deserving servicemen and women. Yet, we are not satisfied that we have achieved all that is possible. As you know, a Presidential Interagency Task Force and other Commissions are working to improve the services provided to our returning wounded Global War on Terror military personnel and veterans. VA is committed to assisting their work in a collaborative effort to ensure all is being done for those who so admirably serve our Nation.

Mr. Chairman, this concludes my testimony. I would be pleased to answer any questions you may have.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. DANIEL K. AKAKA TO HON. DANIEL L. COOPER, UNDER SECRETARY FOR BENEFITS, DEPARTMENT OF VETERANS AFFAIRS

Question. If VBA were to assume responsibility for making active military disability ratings, what would be the impact on VBA's other responsibilities?

Response. If the Veterans Benefits Administration (VBA) assumed responsibility for making active military disability ratings, we would factor any additional demands into our future budget requests to Congress to ensure continued improvement in timeliness of disability claims processing.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. LARRY E. CRAIG TO HON. DANIEL L. COOPER, UNDER SECRETARY FOR BENEFITS, DEPARTMENT OF VETERANS AFFAIRS

Question 1. There is a wide array of benefits and services provided by both the Department of Veterans Affairs (VA) and the Department of Defense (DOD), yet there are discrepancies between benefits available for those on active duty versus those who are medically retired and in veteran status. This discrepancy may lead to confusion among family members who do not understand why legal distinctions exist for benefits meant to help those wounded in combat, irrespective of their status. The Wounded Warrior Project has recommended legislation to authorize a blanket overlap of DOD and VA benefits for a period of 2 years following the medical retirement of an injured servicemember or for the length of time a servicemember is held on Temporary Disability Retirement List (TDRL), whichever is later. What are your views on this idea?

Response. A combat-injured veteran should have access to the best services that are available from DOD and VA. We believe that to ensure accountability and clarity, the responsibilities of each Department must be clearly defined. We do not believe there should be different eligibility periods for those placed on the permanent disability retired list versus those placed on TDRL. A member placed on TDRL may remain on the TDRL for a maximum of 5 years. The Wounded Warrior Project proposal would give servicemembers placed on TDRL, a population whose injuries the physical evaluation board (PEB) judged to have potential for improvement, greater benefits than those servicemembers with disabilities so severe as to warrant permanent retirement.

Question 2. There exists a VA Office of Seamless Transition (OST) with a mission to facilitate the transition of servicemembers from active duty to civilian lives by coordinating VA benefits and services with those provided by DOD. Yet the OST reports only to the Under Secretary of Health. Within DOD, the Military One Source Center is designed to augment and support transition services, yet problems with coordination of the support services provided by the military services persist.

Question 2(a). Is there a need for an organizational restructuring within VA so that the transition office has authority over ALL VA benefits and services and reports directly to the Deputy Secretary of VA?

Response. The Office of Seamless Transition (OST) focuses on the issues related to the transition of severely injured servicemembers. While OST is organizationally within the Veterans Health Administration (VHA), the office has critical VBA staff who work closely on all benefits-related issues. Also, OST managers work directly with and report to VBA leadership to identify and resolve issues related to transition of servicemembers with severe injuries. Transition coordination is accomplished through the efforts of many offices throughout VA and at DOD, including the Joint Executive Council, Health Executive Council, Benefits Executive Council, and various DOD/VA working groups.

For example, the Deputy Secretary of VA and the Deputy Under Secretary of Defense for Personnel and Readiness recently established a Joint Communications Work Group to improve stakeholder awareness of sharing and collaboration initiatives and to communicate and promote results and best practices throughout the two departments. The Joint Communications Work Group will improve information flow between the two departments and ensure coordinated messages and statistics are communicated.

VA has also established a VA/DOD Coordination Office, which incorporates both the Office of Seamless Transition and the DOD Liaison Sharing Office. The establishment of this office reflects VA's ongoing commitment to ease the transition process for all veterans, and to provide the additional assistance that seriously injured veterans require. The VA/DOD Coordination Office is able to provide assistance for both the health care and benefits needs of seriously injured servicemembers and veterans.

Question 2(b). To increase interagency transition coordination, should DOD establish a mirror transition office that reports directly to the Under Secretary for Personnel and Readiness?

Response. VA cannot comment on DOD's organizational structure. We defer to DOD for response.

Question 3. If we were to start from scratch and design a new system of compensation for those who are severely injured in service, what should that system look like?

Response. Redesign of the current disability compensation system is an extremely complex task that requires extensive study. The Veterans Disability Benefits Commission has been charged by the Congress to conduct such a study and recommend changes. The Commission is expected to submit its findings in October 2007. Given the extensive research the Commission has conducted, we believe the Commission's report will form a good starting point for discussion on any fundamental changes to the system of compensation for those who are disabled as a result of their military service.

Question 4. What do you think should be the purpose of a modern compensation program and how should we regularly determine whether the program, as designed, is meeting its intended purpose?

Response. The primary intent of VA's disability compensation program is to provide compensation for loss of earning capacity. This loss of earning capacity is not intended to be based on the disabled veteran's individual impaired capacity, but the average impairment resulting from such injuries. To an extent based on periodic legislative changes, VA's disability compensation program also compensates for reduction in quality of life due to service-connected disability.

To determine whether VA benefit programs meet their intended purpose, Congress requires VA to complete program outcome studies. These studies provide valuable information to VA and to Congress, including changes that need to be made to the benefit programs. A number of these studies have been completed or are currently underway, including studies of the dependency and indemnity compensation (DIC) program, Insurance, veterans and survivors pension programs, and burial benefits.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. JOHN MCCAIN TO HON. DANIEL L. COOPER, UNDER SECRETARY FOR BENEFITS, DEPARTMENT OF VETERANS AFFAIRS

CAPACITY OF THE VA HEALTH CARE SYSTEM

Question 1. Unlike DOD, which is bound by health care access standards to purchase care from the civilian sector when it cannot be provided in-house, the VA has no legal obligation to provide care within a specified time frame, nor an obligation to purchase services from the private sector. Isn't it time to change this paradigm, especially for veterans with care needs related to their military service? Otherwise, how will VA meet the demand for health services that is one of the consequences of the war, including increased demands for rehabilitative and mental health services?

Response. Although VA has no legal obligation to provide care within a specified timef rame, VA does have established access standards in place which apply to all veterans. These standards are.

- 96 percent of primary care appointments should be within 30 days of desired date or from the creation date if a new patient.

• 93 percent of specialty care appointments should be within 30 days of the patient's desired date or from the creation date if a new patient.

In the instances when the demand for service is great and these standards cannot be met, medical centers have the authority in current law to purchase that care in the community.

PROJECTION OF FUTURE HEALTH CARE NEEDS BY AMERICA'S VETERANS

Question 2. A column by Harvard researcher Linda Bilmes asserts that "the seeds of the Walter Reed Army Medical Center scandal were sown in . . . a failure to foresee the sheer number and severity of casualties." Do you agree with that statement?

Response. VA cannot comment on Ms. Bilmes' assertion. VA is committed to ensuring it meets the needs of all veterans, including those who serve in Operations Enduring Freedom and Iraqi Freedom (OEF/OIF). VA has made every effort to account for the needs of OEF/OIF veterans within the VA enrollee health care projection model. To identify OEF/OIF veterans, we started using a DOD personnel roster in Fiscal Year (FY) 2002. The model develops projections based on the actual enrollment and use patterns of OEF/OIF veterans. However, the number and type of services that VA will need to provide OEF/OIF veterans are influenced by many unknowns, including the duration of the conflict, when OEF/OIF veterans are demobilized, and the impact of our enhanced outreach efforts. Therefore, we have included additional investments for OEF/OIF in the Fiscal Year 2008 budget to ensure that VA is able to care for al[of the health care needs of our returning veterans.

Question 3. What joint planning or analytical process exists today between DOD and the VA that did not exist in the past which will ensure a more complete understanding of the near- and long-term needs of our returning servicemembers?

Response. VA and DOD are committed to increasing collaborative and sharing activities between the Departments. This commitment is embodied in the work of the three joint councils established to facilitate collaborative initiatives and the workgroups and task forces that have emerged from them. Additional efforts to enhance cooperation and collaboration between the Departments have been initiated by individual offices/interest groups. Currently, there are three primary joint councils:

(1) VA/DOD Joint Executive Council (JEC) chaired by the Deputy Secretary of VA and the Under Secretary of Defense for Personnel and Readiness;

(2) VA/DOD Health Executive Council (HEC), chaired by the VA Under Secretary for Health and the Assistant Secretary of Defense for Health Affairs; and

(3) VA/DOD Benefits Executive Council (BEC), chaired by the VA Under Secretary for Benefits and the Assistant Secretary of Defense for Force Management.

In May 2007, VA and DOD collaborated on the formation of the senior oversight committee (SOC) to focus on opportunities to directly support the seriously ill and wounded. The SOC is co-chaired by the Deputy Secretaries of each Department and is organized around business lines of action in clinical, administrative and personnel domain areas.

In partnership with DOD, VA has implemented a number of strategies to provide timely, appropriate, and seamless transition services to the most seriously injured OEF/OIF active duty servicemembers and veterans.

VA's work to create a seamless transition for men and women as they leave the service and take up the honored title of "veteran" begins early on. Our benefits delivery at discharge program enables active duty members to register for VA health care and to file for benefits prior to their separation from active service. Our outreach network ensures returning servicemembers receive full information about VA benefits and services. And each of our medical centers and benefits offices now has a nurse or social worker program manager assigned to work with veterans returning from service in OEF/OIF.

VA has coordinated the transfer of over 6,800 severely injured or ill active duty servicemembers and veterans from DOD to VA. Our highest priority is to ensure that those returning from the Global War on Terror (GWOT) transition seamlessly from DOD military treatment facilities (MTF) to VA medical centers (VAMC) and continue to receive the best possible care available anywhere.

VA nurses, social workers, benefits counselors, and outreach coordinators explain the full array of VA services and benefits. These liaisons and coordinators assist active duty servicemembers as they transfer from MTFs to VAMCs. In addition, our VHA Liaisons help newly wounded servicemembers and their families plan a future course of treatment for their injuries after they return home. Currently, VHA liaisons and benefit counselors are located at 10 MTFs, including Walter Reed Army Medical Center, the National Naval Medical Center in Bethesda, the Naval Medical

Center in San Diego, and Womack Army Medical Center at Ft. Bragg. A national memorandum of understanding (MOU) has been signed between VA and DOD as directed by the GWOT task force, with memorandums of agreement (MOA) in place at each local facility.

Since September 2006, a VA certified rehabilitation registered nurse (CRRN) has been assigned to Walter Reed to assess and provide regular updates to our polytrauma rehabilitation centers (PRC) regarding the medical condition of incoming patients. The CRRN advises and assists families and prepares active duty servicemembers for transition to VA and the rehabilitation phase of their recovery. A second nurse liaison is being hired for national Naval Medical Center, Bethesda, and should be in place by September 2007.

Another important aspect of coordination between DOD and VA prior to a patient's transfer to VA is access to clinical information. This includes a pre-transfer review of electronic medical information via remote access capabilities. VA PRCs have been granted direct access into inpatient clinical information systems from Walter Reed Army Medical Center and National Naval Medical Center. VA and DOD are currently working together to ensure that appropriate users are adequately trained and connectivity is working and exists for all four PRCs. As of July 2007, Walter Reed Army Medical Center, Bethesda National Naval Medical Center and Brooke Army Medical Center all have achieved the capability to transmit digital radiology images and scanned inpatient records to the four PRCs.

For inpatient data not available in DOD's information systems, VA social workers embedded in the MTFs routinely ensure that the paper records are manually transferred to the receiving PRC.

The bidirectional health information exchange (BHIE) is a data exchange system that allows VA and DOD facilities. As of July 2007, BHIE data, which includes laboratory results, pharmacy and allergy data and radiology reports, may be exchanged between all DOD and all VA facilities. BHIE also now supports the ability to share discharge summaries between all VA facilities and eight DOD facilities, including the military treatment facilities in the National Capitol area.

VA understands the critical importance of supporting families during the transition from DOD to VA. We established a polytrauma call center in February 2006, to assist the families of our most seriously injured combat veterans and servicemembers. The call center operates 24 hours a day, 7 days a week to answer clinical, administrative, and benefit inquiries from polytrauma patients and family members. The center's value is threefold: it furnishes patients and their families with a one-stop source of information; it enhances overall coordination of care; and it immediately elevates any system problems to VA for resolution.

VA's Office of Seamless Transition includes outreach coordinators who regularly visit seriously injured servicemembers at Walter Reed and Bethesda. Their visits enable them to establish a personal and trusted connection with patients and their families.

These outreach coordinators help identify gaps in VA services by submitting and tracking follow-up recommendations. They encourage patients to consider participating in VA's national rehabilitation special events or to attend weekly dinners held in Washington, DC, for injured OEF/OIF returnees. In short, they are key to enhancing and advancing the successful transition of our service personnel from DOD to VA, and, in turn, to their homes and communities.

In addition, VA has developed a vigorous outreach, education, and awareness program for the National Guard and Reserve. To ensure coordinated transition services and benefits, VA signed a MOA with the National Guard in 2005. Combined with VA/National Guard State coalitions in 54 States and territories, VA has significantly improved its opportunities to access returning troops and their families. We are continuing to partner with community organizations and other local resources to enhance the delivery of VA services. At the national level, MOAs are under development with both the United States Army Reserve and the United States Marine Corps. These new partnerships will increase awareness of, and access to, VA services and benefits during the demobilization process and as service personnel return to their local communities.

VA is also reaching out to returning veterans whose wounds may be less apparent. VA is a participant in the DOD's post deployment health reassessment (PDHRA) program. DOD conducts a health reassessment 90–180 days after return from deployment to identify health issues that can surface weeks or months after servicemembers return home. DOD is sending VA electronic pre- and post-deployment health assessment (PPDHA) and PDHRA information on separated Service members and National Guard and Reserve members if the servicemember is in the VA patient treatment file (PTF).

VA actively participates in the administration of PDHRA at Reserve and Guard locations in a number of ways. We provide information about VA care and benefits; enroll interested Reservists and Guardsmen in the VA health care system; and arrange appointments for referred servicemembers. As of June 30, 2007, an estimated 109,117 servicemembers were screened, resulting in over 25,055 referrals to VA medical facilities and 12,624 referrals to Vet Centers. Of those referrals, 47.9 percent were for mental health and readjustment issues; the remaining 52.1 percent were for physical health issues.

In April 2007, VA sponsored a conference to educate VA and DOD staff about services and programs for OEF/OIF veterans. Specialized educational tracts included mental health, polytrauma and Traumatic Brain Injury, diversity and women's health, pain management, seamless transition, and prosthetics and sensory aids. Each Veterans Integrated Service Network (VISN) developed an action plan for management of OEF/OIF veterans.

In May 2007 VA and DOD established a work group for seamless transition clinical case management to improve the delivery of safe, high-quality, and timely medical care to injured or ill servicemembers through the seamless provision of case-management services in both the DOD and VA systems. The work group will use a clinical case management model to address the transition issues of our servicemembers and veterans. It will identify policies, assist in the development of qualifications and functions, and help identify potential gaps in tracking of the severely wounded from agency to agency.

DOD AND VA HEALTH INFORMATION SHARING

Question 4. According to DOD, health assessment data on separating servicemembers is being provided to VA on a monthly and weekly basis. How does VA use this data to support care of veterans today?

Response. Beginning in October 2003, the DOD Defense Manpower Data Center (DMDC) sends VA's Office of Public Health and Environmental Hazards a periodically updated personnel roster of troops who participated in OEF/OIF and who separated from active duty and became eligible for VA benefits. The latest DMDC file (received in January 2007) indicates that there are a total of 686,306 OEF/OIF veterans who separated following deployment to Afghanistan and Iraqi theaters of operation up to November 2006. For each veteran, demographics (social security number, name, date of birth, gender, education, etc.) and military service specific data (branch, rank, unit component, deployment dates, etc) are included in the record received from DOD.

VA uses this roster to evaluate the use of VA healthcare and benefits by OEF/OIF veterans. This analysis is very useful to plan allocation of VHA healthcare resources. The roster is checked against VA's inpatient and outpatient electronic patient records to determine which veterans sought treatment in VA facilities as well as the International Classification of Disease (ICD–9) diagnostic codes used to describe their diagnoses. These data indicate what types of health problems OEF/OIF veterans who presented to VA developed since deployment. The most recent report of OEF/OIF healthcare use is attached.

In addition to VA healthcare utilization data, which is based on the troop roster supplied by DMDC, DOD performs health assessments of servicemembers just prior to deployments and at the time of return from deployments. The purpose of these assessments is to screen for health concerns that warrant further medical evaluation. Since September 2005, DOD sent VA their electronic pre-deployment and post-deployment health assessments (PPDHA) of servicemembers who deactivated back to the Reserve and National Guard or who separated entirely from service. This transfer takes place monthly. More recently, DOD developed the PDHRA. The purpose of the PDHRA is to screen for physical health and mental health concerns at 90 to 180 days after return from deployments. In November 2006, DOD began monthly electronic transfers of PDHRA data to VA, and as of June 2007, VA received over 1.7 million PPDHA and PDHRA assessments on more than 706,000 separated servicemembers and deactivated Reserve/National Guard members.

The DOD deployment health assessments are available to VA health care workers in the VHA electronic health record, which is accessed during each patient encounter. These health data are used by VA clinicians to aid in the diagnosis and care of OEF/OIF veterans.

Question 5. Is the data useful for projecting future care needs, for example, for TBI, Post Traumatic Stress Disorder (PTSD), and prosthetic care? If not, are there joint efforts underway by the two departments to improve the ability to project future health care needs?

Response. Data derived from DOD's PDHRA does not allow for projecting servicemembers' need for services for Traumatic Brain Injury (TBI) and prosthetics. Data are analyzed within VA for both mental health and prosthetics to project service needs based on recent workloads for mental health programs, as well as workloads for prosthetic equipment and sensory aids and devices.

As of the second quarter of Fiscal Year 2007, 35 percent (252,095) of veterans eligible for care came to VA for clinical services. Of these, 37.7 percent received provisional diagnoses of mental disorders including 45,330 with a provisional Post Traumatic Stress Disorder (PTSD) diagnosis. These are cumulative data, and not all these veterans are found to actually have a mental disorder or, if they do, the problem may be resolved with treatment.

As of July 2007, an estimated 109,117 servicemembers were screened, resulting in more than 25,055 referrals to VA for follow-up health care. In addition to mental health, 52.1 percent of the referrals were for physical health issues.

VHA prosthetics and clinical logistics provided prosthetics, medical equipment, and supplies to 22,910 OEF/OIF veterans in Fiscal Year 2006, this includes limbs for amputees, surgical implants, visual and hearing aids, wheel chairs, braces and other orthotic devices, canes and crutches. As of second quarter Fiscal Year 2007, 18,367 OEF/OIF veterans received care in prosthetics. Based on the trend this Fiscal Year, VA anticipates a significant increase in the number of OEF/OIF veterans we will care for. These data are based on matching unique NPPD (National Prosthetic Patient Data base) patient IDs to the OEF/OIF roster obtained from VHA support service center. On a monthly basis, DOD provides VA with the latest amputee statistics from DOD's amputee patient care program-clinical databasese. This allows VA to project the number of amputees that will be discharged from MTFs and transitioned into VA care. NPPD is currently being enhanced to alert staff and flag patients' records when a consult for an OEF/OIF patient is initiated for a prosthetic appliance. This allows VA's prosthetic departments to better prioritize requests for OEF/OIF veterans.

In partnership with DOD, VA implemented a number of strategies and innovative programs to provide timely, appropriate, and seamless services to the most seriously injured OEF/OIF active duty members and veterans. One such program enables active duty members to register for VA health care and initiate the process for benefits prior to separation from active service. The centerpiece program supporting the seamless transition of seriously injured servicemembers and veterans involves placement of VA social work liaisons, benefit counselors, and outreach coordinators at MTFs to educate servicemembers about VA services and benefits.

VA and DOD continue to collaborate in the screening process for TBI. A TBI screening instrument was developed based on the experience of VA, MTFs, and the Defense and Veterans Brain Injury Center. As of April 2, 2007, VA mandated administration of the TBI screening to all OEF/OIF veterans who receive medical care from VA. Every possible reply in the TBI screening reminder generates a unique "health factor" that is stored in the "health factors file" in the VA databaseses. This will further improve VA's ability to project healthcare needs of veterans with TBI.

PRIVACY RULES AND THE SHARING OF DOD AND VA MEDICAL INFORMATION

Question 6. Congress enacted the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (Public Law 104–191) to prevent the disclosure of certain personal medical information) but permits DOD and VA to share information on individuals being treated in both systems. Yet HIPAA is often cited as a baffler to easy sharing of health data between DOD and VA. In 2003 a Presidential task force recommended that the two departments be declared a single health care system for the purposes of implementing HIPAA—in order to smooth transition of servicemembers from DOD to the VA, and to accelerate the development of shared health care information technology. What did the two departments do, if anything, in response to this recommendation?

Response. As a rule, there are no HIPAA constraints on sharing electronic data between VA and DOD. In general, the HIPAA Privacy Final Rule prohibits covered entities—health care providers that conduct certain transactions electronically, health plans, and healthcare clearinghouses—from disclosing protected health information unless a specific permitted disclosure is applicable. One special exemption pertains to DOD's sharing data with VA. This permitted disclosure, 45 CFR 164.512(k)(1)(ii), allows DOD to "disclose to VA the protected health information on an individual who is a member of the Armed Forces upon separation or discharge of the individual from military service for the purpose of a determination by VA of the individual's eligibility for or entitlement to benefits under laws administered by

the Secretary of Veterans Affairs." The VA and DOD HIPAA, privacy and General Counsel staffs worked diligently to resolve any differences in interpretation of these authorities. In June 2005, DOD and VA implemented a data-sharing MOU that outlines these agreed-upon authorities.

Question 7. Why is HIPAA still cited as a barrier to information sharing?

Response. VA does not view the HIPAA Privacy Rule as a barrier to VA/DOD information sharing.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. JOHN D. ROCKEFELLER IV TO HON. DANIEL L. COOPER, UNDER SECRETARY FOR BENEFITS, DEPARTMENT OF VETERANS AFFAIRS

Question 1. At an earlier hearing this year, VA testified that disability claims for PTSD more than double since 2000, from 130,000 to nearly 270,000 VA claims. Such claims are hard to process, and even harder to ensure consistency. What efforts are underway to help Guard and Reserves get screened for PTSD, and get the care and benefits they deserve during their 2-year window of eligibility? And I believe that this should be extended to at least 5 years.

Response. There are a variety of outreach approaches to assess members of the National Guard and Reserves for their clinical needs and benefits, including the presence of PTSD or other war-related problems.

- DOD is carrying out PDHRA in the 90–180 days following return from deployment for all servicemembers including Guards and Reserves. VA staffs from Vet Centers, VAMCs, and VBA regional offices attend PDHRA screenings, as well as Guard and Reserve meetings, to ensure that servicemembers are aware of VA services.
- The Secretary sends a letter about medical care and other benefits to each servicemember who is discharged from active duty. Every time a member of the Guards or Reserves returns from a war-zone deployment, the "2-year window" for free healthcare eligibility is re-activated.
- Vet Centers have no eligibility time limitation for services to veterans of any combat era, including OEF/OIF veterans.
- Local public service announcements are also used to alert servicemembers of the availability of VA services.
- With regard to screening for PTSD within VAMCs, whenever OEF/OIF veterans initially present for clinical care, they are screened with a set of questions for PTSD, depression, alcohol abuse, and infectious diseases endemic to Southwest Asia. The PTSD questions are repeated annually for the first 5 years after first contact and every 5 years thereafter. Depression and alcohol screens are done annually for all veterans.
- In April 2007, a set of screening questions for mild TBI was added to the set of screening questions.

Question 2. Is DOD and/or VA studying how delays in care and disability benefits affects soldiers who are struggling with mental health issues, particularly PTSD? How can such stress be minimized?

Response. There is one VA study currently underway entitled "Barriers and Facilitators to Treatment-Seeking for PTSD" that may be relevant to the issue of the impact of delays in care for veterans suffering from PTSD or other mental health issues. This study is anticipated for completion in December 2007. It is believed, however, based on clinical experience, that the longer a person waits to receive help, the greater the risk of a psychosocial problem deteriorating into a true mental disorder, or a mild form of a disorder developing more severe forms of pathology or co-occurring conditions. For example, a veteran struggling with symptoms of PTSD may attempt to control symptoms with alcohol or other drugs, which only worsens the situation and makes treatment more difficult when the person does present for care.

The solution to this potential dilemma and the way to minimize the stress of prolonged struggling with emotional or behavioral problems is to bring veterans into treatment as soon as possible, and there are a variety of approaches being used to achieve this goal. The outreach approaches mentioned above provide opportunities to draw veterans into seeking health care, particularly mental health care. In addition to the hiring of 100 OEF/OIF veterans by VA's readjustment counseling service to serve as outreach workers and counselors for OEF/OIF veterans, VA's mental health service has funded special returning veterans outreach, education and care (RVOEC) teams across the country specifically tasked to rapidly assess and address psychosocial and mental health problems of veterans who come to VAMCs and clin-

ics for care. RVOEC staffs specialize in "in-reach": contacting OEF/OIF veterans in primary-care sites including community based outpatient clinics (CBOCs) so veterans do not have to risk the potential stigma of going to a site labeled as a "mental health" for care. Indeed, stigma is a major barrier to a person seeking care for emotional or behavioral problems.

Education in the form of teaching coping skills for problems and spreading the word about the efficacy of mental health care through positive media presentations are ways to combat stigma.

Question 3. How are DOD and VA treating our National Guards and Reserves and their families? What special outreach is underway? And isn't it odd that less Guards and Reservists are seeking service than active duty? One would intuitively think that active duty soldiers have more training and support. Could it be that Guard and Reservists are just unaware of the options and benefits?

Response. VA makes absolutely no distinctions in processing claims from active duty or Guard and Reserve personnel. All claims are considered using the same laws and regulations to determine entitlement to benefits and establish the appropriate disability evaluation.

While the data do reflect differences in claims activity between active duty and Reserve and National Guard personnel, we believe a significant factor may be length of service. The majority of service-related disabilities are chronic diseases or disabilities that develop over time. Generally, Reserve or National Guard service is significantly shorter than regular active duty service, resulting in a reduced likelihood that these veterans developed chronic service-related disabilities.

Additionally, our historical data indicates military retirees are four times as likely to receive disability compensation as non-retirees. A portion of the retiree population is comprised of veterans who suffered serious injuries while on active duty, were medically discharged, and are retired on disability. This group also includes National Guard and Reserve members who are seriously injured while on active duty and medically discharged by the military. These veterans are not counted as National Guard or Reserve members for purposes of evaluating VA benefits activity, but rather as part of the active duty population.

Since the initiation of OEF/OIF, we have recognized the additional challenges presented in reaching activated Reserve and Guard troops to ensure they are fully informed about VA benefits and services. We have therefore made special efforts to reach out to returning Guard and Reserve members to ensure they are aware of the VA benefits and services available to them and provided assistance in filing claims.

VA provides transitional services to returning Guard and Reserve members through the transition assistance program, a collaborative effort of VA, DOD, and the Department of Labor. Our regional offices also provide benefits briefings at large demobilization sites and, in partnership with DOD, conduct retirement briefings and healthcare services and benefits briefings at town hall meetings, family readiness groups, and during unit drills near the home of returning Guard and Reserve members. Working with DOD, we developed a special informational brochure that summarizes benefits for National Guard and Reserve personnel. This brochure is distributed both by DOD and VA at all of our benefits briefings.

We have trained 54 National Guard transition assistance advisors (TAA)—one for each of the 50 States and 4 territories. These TAAs serve as the State-wide point of contact and coordinator for Guard members and their families regarding VA benefits and services, and assist in resolving problems with VA healthcare, benefits, and TRICARE.

As the Reserve and Guard members separate, they receive a "Welcome Home Package" that includes a letter from the Secretary, a VA pamphlet summarizing all VA benefit programs, and a timetable for submitting applications. A follow-up letter with similar information is sent 6 months following separation.

VA continues to explore additional ways to meet the needs of both the active duty and Reserve and Guard members supporting OEF/OIF, including identifying additional enhancements that can be made to our outreach program for Reserve and Guard members. On May 18, 2005, VA signed a MOU with the National Guard to provide returning OEF/OIF servicemembers with information about VA benefits and services. The National Guard includes both the Army Guard and Air Guard. Both VHA and VBA signed the MOU.

VA is also working on MOUs with the other Reserve components. The MOU with the Army Reserve is expected to be signed shortly. VA has also submitted draft MOUs to the Marine Corps Reserve and Navy Reserve. Each is under review by the respective components. VA has drafted MOUs for the Air Force Reserve and the Coast Guard Reserve, and we are in the process of contacting each of those services to begin the review process. Additionally, the National Guard is in the process of electronically scanning the service medical records of it members. They expect to

complete the process in September of 2007. We are working with them to develop a means of electronically accessing the records of any National Guard member who files a claim for VA disability compensation.

Question 4. These questions pertain to the VA/DOD Joint Executive Council FY 2006 annual report published in February 2007. The JEC was established by Congress and has been meeting for 4 years. However, it has taken 4 years to produce broad recommendations and the group proposed additional working groups to examine the issues further. In July 2006, the JEC approved a proposal to establish a VA/DOD Joint Coordination Transition Working Group that will be focused on achieving an even greater integrated approach to coordinated transition for injured and ill servicemembers and their families.

Question 4(a). Why did the JEC feel a group needed to be developed in order to achieve this approach?

Response. The JEC felt that, in order to institutionalize the seamless transition process, a joint coordinated transition working group (JCTWG) needed to be established. This working group would be responsible for establishing and promulgating an agreed-upon definition of seamless transition, and for developing performance measures and tracking performance.

Question 4(b). Who has been chosen/assigned to this working group?

Response. The proposed membership of the JCTWG is:

DOD

Program manager, policy, reports and analysis, DOD/VA
Program Coordination Office
Military Services' Severely Injured Programs
Director, DOD Transition Assistance Program
Reserve Affairs
National Guard Bureau
Health Affairs Information Management Office
DUSD P&R, Program Integration (DMDC)
Military Service PEB Offices VA
Director, Office of Seamless Transition
Director, Compensation and Pension (C&P) procedures staff
VBA OEF/OIF support team representative

Question 4(c). Have they met yet? If so, what have they developed so far?

Response. The charter for JCTWG has not been signed yet. Therefore, there have been no meetings to date.

Question 4(d). Why has it taken so long to acknowledge this problem needed another group to address transition issues for injured and ill servicemembers?

Response. Since 2004, VA and DOD have launched 28 different initiatives in order to better meet the needs of veterans and servicemembers. The intent of these initiatives is to improve care for injured and ill servicemembers returning from OEF/OIF. With such a multitude of programs operating independently of each other, the Health Executive Council determined that there was a need to coordinate these programs. Since then, there has been extensive discussion about the need to involve the Benefits Executive Council because of related benefits issues. Also, the need to improve the coordination of processes for physical exams in both DOD and VA has been discussed.

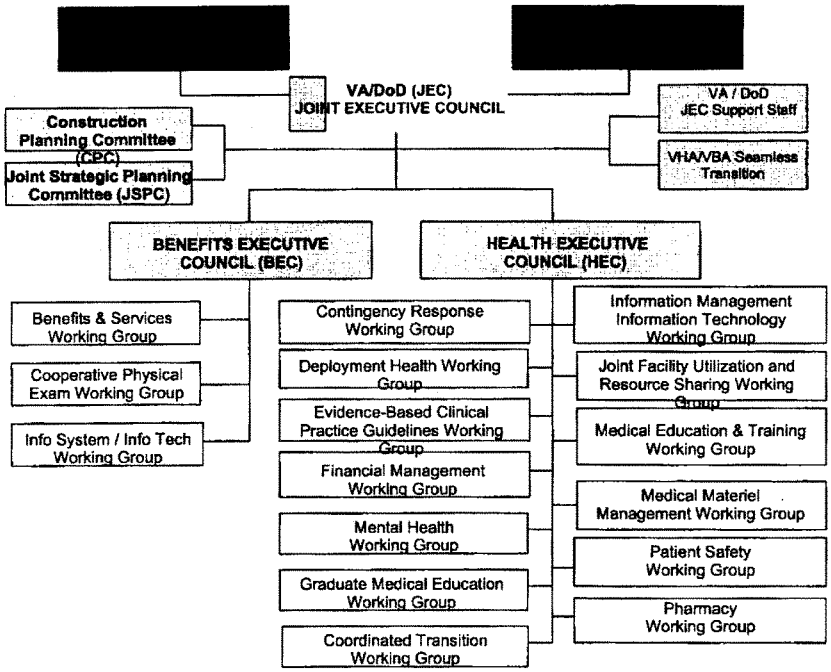
Question 4(e). The JEC has been meeting for 4 years and was established by Congress. However, it has taken 4 years to produce broad recommendations and proposed additional working groups to examine the issue further. I would request a breakdown of each council, working group, members of each, and dates of meetings. This information would be helpful in determining their level of commitment to the joint project(s).

Response. Membership to JEC, HEC and BEC and breakdown of council and working group is provided below:

VA/DoD JEC Membership List	
Department of Veterans Affairs	**Department of Defense**
Gordon Mansfield (Co-Chair), Deputy Secretary	Dr. David S.C. Chu (Co-Chair), Under Secretary of Defense, Personnel and Readiness
Michael J. Kussman, M.D; Under Secretary for Health; Veterans Health Administration	Mr. Michael L. Dominguez, Principal Deputy Under Secretary for Defense for Personnel and Readiness
Daniel L. Cooper, VADM (Ret); Under Secretary for Benefits; Veterans Benefits Administration	Dr. S. Ward Casscells, Assistant Secretary of Defense
Scott Cragg, Chief Architect, Deputy Assistant Secretary Enterprise Architecture Management	Dr. Stephen L. Jones, Principal Deputy Assistant Secretary of Defense Health Affairs
Robert J. Henke, Assistant Secretary Office of Management	Dr. Margaret Myers, Principal Deputy Director Chief Information Office
Patrick W. Dunne, Assistant Secretary for Policy and Planning	Mr. Daniel B. Denning (Acting), Assistant Secretary of the Army, Manpower & Reserves Affairs
Rita A. Reed, Principal Deputy Assistant Secretary, Office of Management	The Honorable William A. Navas, Jr., Assistant Secretary of the Navy Manpower & Reserves Affairs
	Mr. Robert Goodwin (Acting), Assistant Secretary of the Air Force Manpower & Reserves Affairs
	Mr. Thomas F. Hall, Assistant Secretary of Defense, Reserve Affairs
	Ms. Susan Hildner, Deputy Director for Program Acquisition and Internal Contracting

VA/DoD HEC Membership	
Department of Veterans Affairs	**Department of Defense**
Michael J. Kussman, M.D.; Under Secretary for Health; Veterans Health Administration	Dr. S. Ward Casscells, Assistant Secretary of Defense, Health Affairs
Gerald M. Cross, M.D., Principal Deputy Under Secretary for Health, Veterans Health Administration	Dr. Steve Jones, Principal Deputy Assistant Secretary of Defense, Health
William Feeley, Deputy Under Secretary for Health Operations and Management	Elder Granger, Brigadier General, MC, USA Deputy Director, TRICARE Management Activity
Louise Van Diepen, Chief of Staff, Under Secretary for Health	Ellen Embrey, Deputy Assistant Secretary of Defense, Force Health Protection and Readiness
Lawrence Deyton, M.D.; Chief, Public Health & Environmental Hazards Officer; Veterans Health Administration	Allen Middleton, Acting Deputy Assistant Secretary of Defense, Health Budgets and Policy
Paul Kearns, Chief Financial Officer, Veterans Health Administration	Jack Smith, M.D., Acting Deputy Assistant Secretary of Defense, Clinical and Program Policy
Craig Luigart, Chief Information Officer, Veterans Health Administration	Robert Foster, Acting Chief Information Officer, Military Health System
Chuck Campbell, Chief Health Informatics Officer, Veterans Health Administration	Lt. Gen. James Roudebush, U.S. Air Force Surgeon General, HQ USAF/SGOS
Madhulika Agarwal, M.D., M.P.H; Chief, Patient Care Services Officer; Veterans Health Administration	MG Gale S. Pollock, AN, USA; Acting Surgeon General of the Army; Office of the Surgeon General
Dr. Edward C. Huycke, Chief, DoD Coordination Office, Veterans Health Administration	VADM Donald Arthur, U.S. Navy Surgeon General, Bureau of Medicine and Surgery

VA/DoD BEC Membership	
Department of Veterans Affairs	**Department of Defense**
Daniel L. Cooper , Under Secretary for Benefits Veterans Benefits Administration	Dr. S. Ward Casscells, Assistant Secretary of Defense Health Affairs
Jack McCoy, Associate Deputy Under Secretary for Policy and Program Management , Veterans Benefits Administration	Mr. Thomas F. Hall, Assistant Secretary of Defense, Reserve Affairs
Scott Cragg, Chief Architect, Deputy Assistant Secretary Enterprise Architecture Management	Jeanne Fites, Deputy Under Secretary of Defense, Program Integration
	William Carr, Deputy Under Secretary of Defense, Military Personnel Policy
	Patricia S. Bradshaw, Deputy Under Secretary of Defense, Civilian Personnel Policy
	Leslye A. Arsht, Deputy Under Secretary of Defense, Military Community & Family Policy


VA/DoD (JEC)
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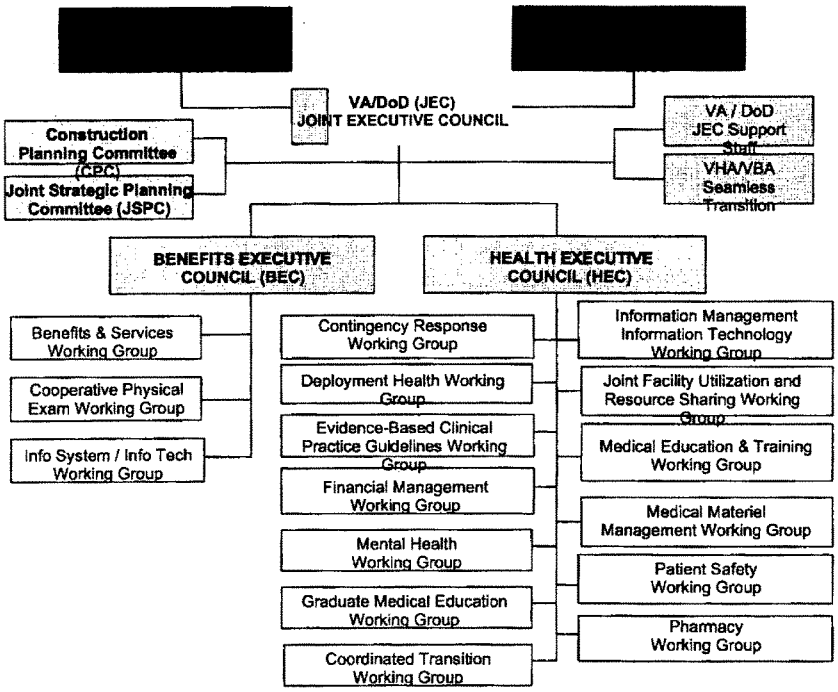
Construction Planning Committee (CPC)
Joint Strategic Planning Committee (JSPC)
VA / DoD JEC Support Staff
VHA/VBA Seamless Transition
BENEFITS EXECUTIVE COUNCIL (BEC)
HEALTH EXECUTIVE COUNCIL (HEC)
Benefits & Services Working Group
Cooperative Physical Exam Working Group
Info System / Info Tech Working Group
Contingency Response Working Group
Deployment Health Working Group
Evidence-Based Clinical Practice Guidelines Working Group
Financial Management Working Group
Mental Health Working Group
Graduate Medical Education Working Group
Coordinated Transition Working Group
Information Management Information Technology Working Group
Joint Facility Utilization and Resource Sharing Working Group
Medical Education & Training Working Group
Medical Materiel Management Working Group
Patient Safety Working Group
Pharmacy Working Group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Information Management Information Technology Working Group
Joint Facility Utilization and Resource Sharing Working Group
Medical Education & Training Working Group
Medical Materiel Management Working Group
Patient Safety Working Group
Pharmacy Working Group

The Councils have conducted the following meetings:

JEC: June 2004; November 2004; March 2005; June 2005; September 2005; January 2006; April 2006; August 2006; October 2006; January 2007; March 2007.

HEC: February 2004; September 2004; March 2005; May 2005; November 2005; March 2006; May 2006; August 2006; November 2006; February 2007

BEC: March 2005; May 2005; September 2005; December 2005; March 2006; July 2006; September 2006; December 2006; January 2007; March 2007.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. HILLARY RODHAM CLINTON TO HON. DANIEL L. COOPER, UNDER SECRETARY FOR BENEFITS, DEPARTMENT OF VETERANS AFFAIRS

TRAUMATIC BRAIN INJURIES

Question 1. Traumatic Brain Injuries have been called the "signature wound" of the Global War on Terror—TBI includes severe injuries as well as invisible wounds that result in trouble remembering appointments, holding down a job, and returning to civilian life. Additionally, the number of Post Traumatic Stress Disorder cases being diagnosed amongst returning OIF and OEF veterans is increasing with the number of repeated deployments and the stressful OPTEMPO. Distinguishing between mild TBI and Post Traumatic Stress Disorder is difficult because both conditions share common symptoms, such as irritability, anxiety and depression.

Has DOD researched and developed any computer-based tests that would assess different basic functions (or domains) of cognition—such as memory, concentration, attention, and reaction time—that could be used to detect brain injury and distinguish TB! from Post Traumatic Stress Disorder? What updated methods and tests have been incorporated in pre-deployment screening for PTSD and TBI during pre-deployment activities?

Response. VA defers to DOD as to its research and development of test to detect brain injury and distinguish TBI from PTSD.

Question 2. Servicemembers who have incurred severe TBI may never fully recover, and any chance of recovering the ability to perform daily tasks is dependent on access to intensive, specialized rehabilitation, including cognitive therapy. Active duty servicemembers can access a range of health care options including cognitive therapy—which is necessary for TBI rehabilitation—under their TRICARE plan. However, once troops are medically retired, their TRICARE coverage doesn't provide access to cognitive therapies provided at private facilities. Are you aware of the discrepancy in medical treatment options available to active duty and medically retired servicemembers who have incurred a Traumatic Brain Injury (TBI)?

Response. VA defers to DOD as to any discrepancies between medical treatment options available to active duty and medically retired servicemembers who have incurred TBI.

Question 3. Many servicemembers who have incurred serious traumatic brain injuries are fortunate to have family members or loved ones act as caregivers. However, family members of returning soldiers with TBI are often ill-equipped to handle the demands of caring for their loved one, which in some bases can become a full-time responsibility. Does the VA have any data on the number of family caregivers who have relocated or quit their job in order to provide care for a traumatic brain injured servicemember?

Response. VA does not maintain a databasese of the number of families that relocate or quit jobs in order to care for the severely wounded with TBI. However, VA facilities and programs that serve the seriously wounded throughout the polytrauma/TBI system of care provide extensive logistical, clinical, and emotional assistance to family caregivers. VA tracks family needs clinically through polytrauma/TBl case mangers that coordinate the support efforts to match the needs of each family, including those who live away from home and make changes in their employment status to be with their injured family members.

To assist family members in understanding and managing the health care demands of the veteran, every veteran admitted to one of the facilities in the polytrauma/TBI system of care is assigned a social worker case manager who is responsible for coordinating care, ensuring access to psychosocial services for patient and family, providing caregiver support within their scope of practice, and matching support services to meet family needs. polytrauma teams of specialists actively engage family members in treatment and treatment decisions. Family members are invited to join therapy sessions so that they can learn how to help the patient be as independent as possible in the home environment.

VA makes efforts to ease the financial burden of family caregivers who are away from home and work in order to support their loved ones through the rehabilitation process. Generous donations from VA voluntary services, Operation Helping Hand, Fisher House Foundation, other foundations and agencies, and local businesses frequently provide free housing, free or discounted meals, transportation, and entertainment.

VA services provided directly to families of combat veterans include: screening, assessment, education and treatment for marital and family related problems. Family members may also receive respite care, home maker home health services, education regarding care of veteran, referral to community resources, limited bereavement counseling, and support group services.

TRAUMATIC INJURY SERVICEMEMBERS' GROUP LIFE INSURANCE

Question 4. On August 25, 2006, Director Thomas M. Lastowka, Veterans Affairs Regional Office and Insurance Center, testified before the Senate Veterans' Affairs Committee on the Traumatic Injury Servicemembers' Group Life insurance program. Director Lastowka testified that the TSGLI Program has denied 1,601 retroactive claims and 248 post-December 1 claims; approximately 40 percent of all claims. What quality control procedures have been implemented to improve the dismal approval rate for submitted claims? Has VA or DOD reviewed the denied claims and determined if they warrant a retroactive TSGLI award?

Response. Traumatic Injury Protection under the Servicemembers' Group Life Insurance program (TSGLI) became effective December 1, 2005, with retroactive benefits extending back to October 7, 2001, for individuals injured in OEF/OIF. The program provides short-term financial assistance to severely injured servicemembers to help them and their families cope with expenses incurred when family members temporarily relocate to be with the member during recovery and rehabilitation. To date $203 million has been paid to nearly 3,200 individuals, with an average award of just over $64,000.

Following the practice of commercial accidental death and dismemberment policies the TSGLI legislation enumerated injuries for which payment would be made. Recognizing that there were many other traumatic injuries that members incur that would cause members to undergo the same significant recovery and rehabilitation times, VA used its authority under the legislation to extend TSGLI protection to other, non-specific, severe injuries.

Since there is a wide range of "severe injuries," VA wanted to develop a method to ensure that payments under this category were set on an equitable basis that takes into account the severity of the losses cited in the original legislation. After considering several possibilities, VA, in consultation with DOD and with the support of other stakeholders, determined that the best method would be to make payment based on how the injury impacts a member's ability to perform the activities of daily living (ADL) for an extended period of time. ADL is a standard used by the commercial insurance industry for disability and long-term-care policies.

VA published regulations stating that, if a member is unable to independently perform at least two of the six widely recognized ADL (bathing, continence, dressing, eating, toileting, or transferring), TSGLI would be payable. In addition, milestones of time were used as the determining factor. For example, $25,000 is payable on the 30th consecutive day of the inability to perform two ADL due to the injury. Another $25,000 is payable on the 60th day if the member still cannot perform at least two ADL, and so on until the 120th day when the final payment is made and the maximum benefit of $100,000 has been reached.

The nature of ADL-related conditions is subjective, compared to more readily identified losses such as amputations or loss of vision. Consequently, ADL-related claims are often filed by claimants who are uncertain whether they are eligible for TSGLI based on their conditions. VA recognizes that this degree of uncertainty results in a higher percentage of claims being disapproved. However, VA supports allowing servicemembers to submit claims and have the branches of service make the final determination of entitlement.

By law, the branches of service are charged with making TSGLI eligibility determinations, based on criteria established by VA. We believe the branches are making accurate and informed TSGLI benefit decisions based on a tiered-review approach. VA and the Office of Servicemembers' Group Life Insurance (OSGLI) jointly conducted a detailed review of approximately 230 completed claims and confirmed that the claims were adjudicated correctly under current law and regulations.

Specialized claims examiners within the TSGLI offices of each branch of service review every claim to determine whether it meets the required eligibility standards. If a claim presents complex medical issues or the claims examiner would like a sec-

ond review by a medical professional, the claim is sent to a physician who provides a final recommendation for a decision.

If a claim is disapproved, the servicemember can ask the branch of service TSGLI office to review the claim again, with or without submitting new medical evidence. If new evidence is provided, it is reviewed to see if it impacts the final decision. If the claim is disapproved after reconsideration, the claimant may file an appeal. The claim is then reviewed at a higher level of authority within each branch of service. A history of the claim and all medical documentation are provided to the officials conducting the appeal proceeding.

Now that TSGLI has been in effect for 1 year, VA, OSGLI and DOD are conducting a "Year One" review of the program, including plan design, administrative processes, and outreach. As part of the review, we are examining the need for changing the conditions covered to ensure that the intent of the program is met.

ELECTRONIC MEDICAL RECORDS

Question 5. Progress is being made by the Department of Veterans Affairs in utilizing electronic medical records. However, wounded soldiers continue to report that their paper medical records are being lost throughout the process. Why hasn't more progress been made in developing a seamless system whereby DOD and VA medical records systems would be able to integrate with one another? What is the current status of efforts to fix the medical records process in DOD so that we will not have wounded soldiers complaining of lost records?

Response. New technological and personnel initiatives are reducing the possibility that medical records will be lost. Technologically, VA recently deployed the veterans tracking application (VTA), which brings data from three sources, DOD, VHA and VBA, together for display on one platform creating the beginning of a truly veteran-centric patient tracking record. The starting point for the electronic transfer of clinical information from DOD to VA is in Afghanistan or Iraq. Information from that point on is entered in the joint patient tracking application (JPTA). When the patient is ready to be transferred to a VAMC, VA staff working at the military hospital copy the record and fax it to the VA facility, which prepares to receive the patient. VTA contains all the information in JPTA except information deemed sensitive to military activities. DOD has begun to transform key portions of these records into electronic documents accessible through VTA. This reduces the number of documents that must be copied and faxed.

The patient may ultimately be cared for at several VA and military facilities. VA is increasingly using VTA to track patients through each of these steps. VA also successfully implemented bidirectional capability at every VA medical facility, meaning that VA and DOD are able to exchange information directly from facility to facility. As of July 2007, BHIE data are now available between all DOD facilities and all VA facilities. These sites include the Walter Reed Army Medical Center and the Bethesda National Naval Medical Center, the Landstuhl Regional Medical Center in Germany and the Naval Medical Center, San Diego. VA is working closely with DOD to increase the scope of data available between DOD and VA. Throughout the remainder of the year and into 2008, the types of data shared bi-directionally will increase by adding domains such as progress notes and problem lists.

In March 2007, VA added a personal touch to seamless transition by creating 100 new transition patient advocates (TPA). TPAs are dedicated to assisting our most severely injured veterans and their families. The TPA's job is to ensure a smooth transition to VA health care facilities throughout the Nation and cut through red tape for other VA benefits. Recruitment to fill the TPA positions began in March, and to date VAMCs have hired 46 TPAs. Interviews are being conducted to fill the remaining 54 positions. Until these positions are filled, each VAMC with a vacant TPA position has detailed an employee to perform that function. We believe these new patient advocates will help VA assure that no severely injured Afghanistan or Iraq veteran falls through the cracks. VA will continue to adapt its health care system to meet the unique medical issues facing our newest generation of combat veterans while locating services closer to their homes. DOD and VA sharing electronic health records facilitate this process.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. BARACK OBAMA TO HON. DANIEL L. COOPER, UNDER SECRETARY FOR BENEFITS, DEPARTMENT OF VETERANS AFFAIRS

Question 1. I want to raise an issue with you that was reported by *Salon*, the online magazine, just yesterday. Based on documents they obtained, it appears that the VA's Seamless Transition Task Force knew in 2004 about the bureaucratic mess

at Walter Reed and within the military health care system. I am deeply concerned that one of the officials that should have known about this, Dr. Michael Kussman, has been nominated by President Bush to be Under Secretary for Health for the Veterans Health Administration. I am writing the President today to convey my concerns over this matter and obtain additional information before we confirm Dr. Kussman.

But I also want to ask you about your knowledge of this situation. Were you briefed at the time on the results of the Task Force's work? Did you report these issues to DOD? What other steps did the VA take when it knew of these issues?

Response. *Salon* magazine was incorrect in its assertion that VA knew of serious problems at Walter Reed Army Medical Center as early as 2004. *Salon* magazine cited as its source a report entitled "Walter Reed Focus Groups: OEF/OIF Service members and their Caregivers," prepared for VA's Seamless Transition Task Group. The report is a description of the results of two interview sessions conducted at Walter Reed on August 19, 2004. These interview sessions were held to elicit from seriously wounded or ill OEF/OIF servicemembers and their families their perspective on how well VA was assisting them in understanding their transition from a MTF to the VA system. The focus groups were not designed to determine conditions at Walter Reed or at any MTF. This report was used by the seamless transition task force to develop an action plan to improve the transition of the seriously wounded to VA's health care system.

Question 2. A VA focus group report obtained by *Salon* magazine noted that Walter Reed officials had assumed that a soldier chasing down benefits in a wheelchair was "ambulatory enough" to get the checklist done. In the soldier's words: "I was in a wheelchair and they expected me to push myself all the way over to Building 11 back and forth. One hand was in a bandage and one leg I couldn't use and they wanted me to push myself around the post pretty much. It just became more of a hassle and my mom did it." Did you know your Agency's report said this?

Response. The intent of the VA focus groups referenced by *Salon* magazine was not to examine the conditions of Walter Reed Army Medical Center. Rather, the purpose of the focus groups was to gather first hand information and perspectives from seriously wounded or ill OEF/OIF veterans and their families on how well VA was assisting them in understanding their transition from a military treatment facility to VA's system of health care and benefits.

The results from these focus groups were shared with DOD's members of the joint seamless transition task force and helped identify and validate the need for numerous initiatives to ease the transition of servicemembers to VA's system. Examples of these initiatives include placing full-time VA caseworkers at military treatment facilities, improving VA's ability to receive medical records from DOD, and creating regular consultations between DOD and VA physicians to improve care for individual patients.

Question 3. According to VA data obtained by Veterans for America through the FOIA process, Guard and Reservists are half as likely to file a VA claim, as compared to active-duty servicemembers. And it appears that VA claims of Guard and Reservists are twice as likely to be rejected. What is being done to address this disparity?

Response. VA makes absolutely no distinctions in processing claims from active duty or Guard and Reserve personnel. All claims are considered using the same laws and regulations to determine entitlement to benefits and establish the appropriate disability evaluation.

While the data does reflect differences in claims activity between active duty and Reserve and National Guard personnel, we believe a significant factor may be length of service. The majority of service-related disabilities are chronic diseases or disabilities that develop over time. Generally, Reserve or National Guard service is significantly shorter than regular active duty service, resulting in a reduced likelihood that these veterans developed chronic service-related disabilities.

Additionally, our historical data indicates military retirees are four times as likely to receive disability compensation as non-retirees. A portion of the retiree population is comprised of veterans who suffered serious injuries while on active duty, were medically discharged, and are retired on disability. This group also includes National Guard and Reserve members who are seriously injured while on active duty and medically discharged by the military. These veterans are not counted as National Guard or Reserve members for purposes of assessing VA benefits activity, but rather as part of the active duty population.

Since the initiation of OEF/OIF, we have recognized the additional challenges presented in reaching activated Reserve and Guard troops to ensure they are fully informed about VA benefits and services. We have therefore made special efforts to

reach out to returning Guard and Reserve members to ensure they are aware of VA benefits and services available to them and provided assistance in filing claims.

VA provides transitional services to returning Guard and Reserve members through the Transition Assistance Program, a collaborative effort of VA, DOD, and the Department of Labor. Our regional offices provide benefits briefings at large demobilization sites and, in partnership with DOD, conduct retirement briefings and healthcare services and benefits briefings at town hall meetings, family readiness groups, and during unit drills near the home of returning Guard and Reserve members. Working with DOD, we developed a special informational brochure that summarizes benefits for National Guard and Reserve personnel. This brochure is distributed both by DOD and VA at all of our benefits briefings.

We have trained 54 National Guard TAAs—one for each of the 50 States and 4 territories. These TAAs serve as the State-wide point of contact and coordinator for Guard members and their families regarding VA benefits and services, and assist in resolving problems with VA healthcare, benefits, and TRICARE.

As the Reserve and Guard members separate, they receive a "Welcome Home Package" that includes a letter from the Secretary, a VA pamphlet summarizing all VA benefit programs, and a timetable for submitting applications. A follow-up letter with similar information is sent 6 months following separation.

VA continues to explore additional ways to meet the needs of both the active duty and Reserve and Guard members supporting OEF/OIF, including identifying additional enhancements that can be made to our outreach program for Reserve and Guard members. On May 18, 2005, VA signed a MOU with the National Guard to provide returning OEF/OIF servicemembers with information about VA benefits and services. The National Guard includes both the Army Guard and Air Guard. Both VHA and VBA signed the MOU.

VA is also working on MOUs with the other reserve components. The MOU with the Army Reserve is expected to be signed by the end of May 2007. VA has also submitted draft MOUs to the Marine Corps Reserve and Navy Reserve. Each is under review by the respective components. VA has drafted MOUs for the Air Force Reserve and the Coast Guard Reserve, and we are in the process of contacting each of those services to begin the review process. Additionally, the National Guard is in the process of electronically scanning the service medical records of its members. They expect to complete the process in September of 2007. We are working with them to develop a means of electronically accessing the records of any National Guard member who files a claim for VA disability compensation.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. MARK PRYOR TO HON. DANIEL L. COOPER, UNDER SECRETARY FOR BENEFITS, DEPARTMENT OF VETERANS AFFAIRS

Question 1. TRICARE currently allows beneficiaries direct access to non-physician mental health professionals, such as clinical social workers, marriage and family therapists, and psychiatric nurses. Beneficiaries seeking treatment from licensed TRICARE mental health counselors, however, are first required to obtain a physician referral prior to seeing a counselor. What is the intent of this restriction, and with such a notably low number of available mental health professionals available to the VA, doesn't this restriction contribute to the already severe backlog in cases?

Response. VA would like to clarify that we do not have "a notably low number of available mental health professionals available to the VA." VA has a large system of mental health professionals—psychiatrists, psychologists, social workers, psychiatric nurses, and other mental health providers—and that system is expanding rapidly to meet the needs of returning veterans. Data confirm that mental health staffing has increased steadily since Fiscal Year 2005, and it is projected to continue to increase in Fiscal Year 2008.

VA defers to the Department of Defense to respond to the inquiry regarding TRICARE needs or policies.

Question 2. When a soldier is killed in the line of duty, a surviving spouse is entitled to annuities such as the Survivor Benefit Plan (SBP) and Dependency and Indemnity Compensation (DIC), among others. It is my understanding that in certain cases the SBP and DIC are offset (the DIC is subtracted from the SBP), thereby reducing the monetary compensation for 1,800 line-of-duty and 57,000 retiree surviving spouses. What circumstances warrant this offset? Could we eliminate the offset and plausibly create two independent annuities?

Response. As required by 10 U.S.C. 1450(c)(1), if an SBP beneficiary becomes eligible for DIC payments, his or her SBP payment is reduced by an amount equal the DIC benefit. If the DIC benefit exceeds the SBP payment, the beneficiary is no

longer entitled to receive SBP benefits. The current offset is consistent with benefits provided in the private sector. It avoids duplication of two complementary Federal benefits programs established for the same purpose—providing a lifetime annuity for the survivor of an active, retired, or former servicemember.

RESPONSE TO WRITTEN QUESTION SUBMITTED BY HON. JOHNNY ISAKSON TO HON. DANIEL L. COOPER, UNDER SECRETARY FOR BENEFITS, DEPARTMENT OF VETERANS AFFAIRS

Question. Should a VA representative be embedded in the Medical Evaluation Board Process from the beginning? If not, should a VA representative at least be present for the Physical Evaluation Board process?

Response. The Secretary of VA chaired the President's Interagency Task Force on Returning Global War on Terror Heroes, which reviewed VA's and DOD's disability evaluation processes. The task force report recommended development of a joint DOD/VA process for disability benefits determinations by establishing a cooperative medical and physical evaluation board process within the military service branches and the VA care system.

We do not see a role for VA in the medical evaluation board (MEB) process. The MEB process recommends a servicemember's retention, reclassification, or referral to the Service's physical evaluation board (PEB). In our view, responsibility for these decisions belongs to DOD. However, VA could play a role following the MEB's referral to the PEB.

For example, VA could conduct the examinations for the conditions that have resulted in the referral to the PEB, as well as any other conditions the servicemember believes might warrant service connection. We believe that only one evaluation should be assigned for any potentially disqualifying condition, and that VA should assign the evaluation using VA guidelines. The PEB would retain the uniquely military responsibilities of establishing fitness-for-retention standards and determining whether an individual servicemember meets those standards. VA could play a further role in reviewing new medical evidence submitted by the member if he/she appealed the initial determination. VA could then sustain or revise the previous evaluation.

RESPONSE TO WRITTEN QUESTION SUBMITTED BY HON. SAXBY CHAMBLISS TO HON. DANIEL L. COOPER, UNDER SECRETARY FOR BENEFITS, DEPARTMENT OF VETERANS AFFAIRS

Question. One suggestion I have heard regarding how to speed up the MEB/PEB process within DOD and make it more efficient and easier for our servicemembers is to embed more VA personnel within DOD to help with the transition process. Specifically, VA personnel could begin working with soldiers and possibly take charge of their paperwork and medical requirements once it is clear that a servicemember cannot be retained in the service. Please comment on how embedding VA personnel might affect the MEB/PEB process and if you think, from our servicemembers' perspective, that this would be a good idea.

Response. The Secretary of VA chaired the President's Interagency Task Force on Returning Global War on Terror Heroes, which reviewed VA's and DOD's disability evaluation processes. The Task Force Report recommended development of a joint DOD/VA process for disability benefits determinations by establishing a cooperative medical and physical evaluation board process within the military service branches and the VA care system.

We do not see a role for VA in the medical evaluation board (MEB) process. That DOD process recommends retention, reclassification, or referral to the Service's physical evaluation board (PEB). In our view, responsibility for these decisions belongs to DOD. However, VA could play a role following the MEB's referral to the PEB.

For example, VA could conduct the examinations for the conditions that have resulted in the referral to the PEB, as well as any other conditions the servicemember believes might warrant service connection. We believe that only one evaluation should be assigned for any potentially disqualifying condition and that VA should assign the evaluation using VA guidelines. The PEB would retain the uniquely military responsibilities of establishing fitness-for-retention standards and determining whether an individual servicemember meets those standards. VA could play a further role in reviewing new medical evidence submitted by the member if he/she appealed the initial determination. VA could then sustain or revise the previous evaluation.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. DANIEL K. AKAKA TO GERALD CROSS, M.D., ACTING PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS

Question 1. Can you share examples of successful efforts between DOD and VA that have helped promote a smoother transition of injured servicemembers between the health care systems of the two departments?

Response. In August 2003, the Under Secretaries for Health and Benefits established a task force to improve collaboration between Veterans Health Administration (VHA), Veterans Benefits Administration (VBA) and the Department of Defense (DOD) to ensure world class service to the men and women who served in the U.S. Armed Forces as they transition from the military to veteran status. In January 2005, the Department of Veterans Affairs (VA) established a permanent Office of Seamless Transition which reports through VA/DOD Coordination Officer to the Principal Deputy Under Secretary for Health and is composed of representatives from VHA and VBA, as well as an active duty Marine Corps officer and an Army officer. Since its inception, the seamless transition program has achieved numerous accomplishments that result in great strides toward the seamless transition of Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) servicemembers into civilian life. The ability to register for VA health care and file for benefits prior to separation from active duty is the result of the seamless transition process.

VA/DOD social work liaisons and VBA benefit counselors are now located at 10 military treatment facilities (MTFs) to assist injured and ill servicemembers in transferring their healthcare needs to VA medical facilities closest to their home or most appropriate for their medical needs and to ensure that returning servicemembers receive information and counseling about VA benefits and services. VHA staff has coordinated over 7,000 transfers of OEF/OIF servicemembers and veterans from a MTF to a VA medical facility. Active duty Army liaison officers are assigned to each of the four VA polytrauma rehabilitation centers to assist servicemembers and their families from all branches of service on issues such as pay, lodging, travel, movement of household goods, and non-medical attendant care orders. The Office of Seamless Transition established an OEF/OIF Polytrauma Call Center to assist our most seriously injured veterans and their families with clinical, administrative, and benefit inquiries. The Call Center which opened February 2006, is operational 24 hours a day, 7 days a week to answer clinical, administrative, and benefit inquiries from polytrauma patients and their families. In addition, the Call Center has contacted 870 veterans since February 2007. Through these outreach phone calls, we have been able to provide these veterans additional assistance with outstanding health or benefits concerns.

VA has implemented an automated tracking system to track servicemembers and veterans transitioning from MTFs to VA facilities. As part of this system, VHA implemented a 2007 performance measure to ensure that VHA assigns a case manager to seriously injured servicemembers being referred from a MTF to a VA treatment facility in a timely fashion. This performance measure monitors the percent of severely ill/injured servicemembers and veterans who are contacted by their assigned VA case manager within 7 days of notification of transfer to the VA system. During the period October 2006 through May 31, 2007, 169 severely ill/injured patients were transferred from MTFs to VA medical centers (VAMC). Eighty-eight percent (148) were contacted by their assigned VA case manager within 7 days of notification of transfer to VA. In April 2007, VA integrated the tracking system with DOD's joint patient tracking application (JPTA) which tracks servicemembers from the battlefield through Landstuhl, Germany, to MTFs in the states. The new application, known as the veterans tracking application (VTA), is a modified version of DOD's JPTA—a web-based patient tracking and management tool that collects, manages, and reports on patients arriving at MTFs from forward-deployed locations. VTA is completely compatible with JPTA allowing the electronic transfer of DOD tracking and medical data in JPTA on medically evacuated patients to VA on a daily basis.

VA is participating in DOD's post deployment health reassessment (PDHRA) program for returning deployed servicemembers. Since its inception, over 107,119 Reserve and Guard members have completed the PDHRA onsite screen resulting in over 25,055 referrals to VA facilities and 12,624 referrals to Vet Centers.

In order to ensure that OEF/OIF combat veterans receive high quality health care and coordinated transition services and benefits as they transition from the DOD system to the VA, VA developed a robust outreach, education and awareness program. The signing of a memorandum of agreement (MOA) between the National Guard and VA, in May 2005, and the formation of VA/National Guard State coalitions in each of the 54 States and territories now provides the opportunity for VA to gain access to returning troops and families as well as join with community re-

sources and organizations to enhance the integration of the delivery of VA services to new veterans and families. This is a major step in closer collaboration with the National Guard soldiers and airmen. A similar MOA is being developed with the U.S. Army Reserve Command and the U.S. Marine Corps at the national level. VA and the National Guard Bureau teamed up to train 54 National Guard transition assistance advisors who assist VA in advising Guard members and their families about VA benefits and services.

Question 2. Can you describe instances where there has been a significant failure of cooperation or coordination that has impeded the smooth transition of injured servicemembers?

Response. A challenge to ensuring the smooth transition of injured servicemembers between DOD and VA is coordination on the medical evaluation board/physical evaluation board (MEB/PEB) process. VA and DOD are collaborating to ensure VA is notified of severely ill or injured servicemembers transitioning to VA care and civilian life. Under this initiative, DOD began transmitting names of servicemembers entering the PEB process to VA in October 2005. When the system is fully operational, the monthly list will enable VA to contact servicemembers to inform them of potential VA benefits and to initiate transfer of healthcare services to a VAMC prior to discharge from the military.

DOD made extra efforts to make this data available to VA for outreach. However, due to a number of issues, use of the list has been limited thus far. The problems with receipt of the data include quality issues that vary widely with each file and are therefore difficult to mitigate. Further, electronic transmission of the list was interrupted from May 2006 to June 2007 due to data security issues. During this time, DOD hand-carried several lists to VA. DOD successfully transmitted lists to VA electronically in June and July 2007. VA expects that DOD will continue this electronic transmission on a monthly basis hereafter. The VA Inter-agency task force on Returning Global War on Terror Heroes closely examined issues related to better coordinating the MEB/PEB process between the VA and DOD.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. JOHN MCCAIN TO GERALD CROSS, M.D., ACTING PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS

CAPACITY OF THE VA HEALTH CARE SYSTEM

Question 1. Unlike DOD, which is bound by health care access standards to purchase care from the civilian sector when it cannot be provided in-house, the VA has no legal obligation to provide care within a specified time frame, nor an obligation to purchase services from the private sector. Isn't it time to change this paradigm, especially for veterans with care needs related to their military service? Otherwise, how will VA meet the demand for health services that is one of the consequences of the war, including increased demands for rehabilitative and mental health services?

Response. VA does have health care access standards in place which apply to all veterans. These standards are:

- 96 percent of primary care appointments should be within 30 days of the desired appointment date.
- 93 percent of specialty care appointments should be within 30 days of the desired appointment date.

When these standards cannot be met, medical centers have the option of purchasing that care in the community. Appropriate legislative authority exists for these purchases.

DOD AND VA HEALTH INFORMATION SHARING

Question 2. Shared health care information technology has been identified by Congressional and Presidential task forces for nearly a decade as a key enabler of transition for servicemembers from DOD to the VA. In spite of years of joint committees and joint programs, we continue to hear that when wounded soldiers transition from DOD to VA for their health care, they carry with them a conglomeration of health records on paper—often incomplete. Why are VA and DOD hospitals faxing important laboratory and inpatient data?

Response. VA fully supports the most seriously ill and wounded servicemembers who are being transferred to VA polytrauma centers. Currently, much of DOD inpatient data is paper-based and not electronic. Therefore, VA social workers embedded in MTFs ensure that all pertinent inpatient records are copied and transferred with

the patient. At key military treatment facilities (Walter Reed Army Medical Center, Bethesda National Naval Medical Center and Brooke Army Medical Center), DOD transmits scanned images of the paper records, along with radiology images, to VA clinicians at polytrauma centers for viewing. Images that are sent via this solution may then be made available for viewing from any VA facility where veterans' health information systems and technology architecture (VistA) Imaging is in use.

Question 3. Why are medical records still being lost?

Response. New technological and personnel initiatives are reducing the possibility that medical records will be lost. Technologically, VA recently deployed the Veterans Tracking Application (VTA), which brings data from three sources (DOD, VHA, and VBA) together for display on one platform creating the beginning of a truly veteran-centric patient tracking record. The starting point for the electronic transfer of clinical information from DOD to VA is in Afghanistan or Iraq. Information from that point on is entered in the joint patient tracking application (JPTA). When the patient is ready to be transferred to a VA medical center, VA staff working at the military hospital copy the record and fax it to the VA facility, which prepares to receive the patient. VA now has a version of JPTA called VTA. This contains all the information in JPTA except information deemed sensitive to military activities. DOD has begun to transform key portions of these records into electronic documents accessible through VTA. This reduces the number of documents that must be copied and faxed.

The patient may ultimately be cared for at several VA and military facilities. VA is increasingly using VTA to track patients through each of these steps. VA also successfully implemented bidirectional capability at every VA medical facility, meaning that VA and DOD are able to exchange information directly from facility to facility. As of July 2007, bidirectional health information exchange (BHIE) data are now available for viewing at all VA and DOD facilities. These sites include the Walter Reed Army Medical Center and the Bethesda National Naval Medical Center, the Landstuhl Regional Medical Center in Germany and the Naval Medical Center, San Diego. VA is working closely with DOD to increase the scope of data available between DOD and VA.

Throughout the remainder of the year and into 2008, the types of data shared bidirectionally will increase by adding domains such as progress notes and problem lists.

In March 2007, VA added a personal touch to seamless transition by creating 100 new transition patient advocates (TPA). They are dedicated to assisting our most severely injured veterans and their families. The TPA's job is to ensure a smooth transition to VA health care facilities throughout the Nation and cut through red tape for other VA benefits. Recruitment to fill the TPA positions began in March, and to date VAMC hired 46 TPAs. Interviews are being conducted to fill the remaining 54 positions. Until these positions are filled, each medical center with a vacant TPA position has detailed an employee to perform that function. We believe these new patient advocates will help VA assure that no severely injured Iraq or Afghanistan veteran falls through the cracks. VA will continue to adapt its health care system to meet the unique medical issues facing our newest generation of combat veterans while locating services closer to their homes. DOD and VA sharing electronic medical records facilitate this process.

Question 4. Why are these still problems for our servicemembers?

Response. Sharing electronic medical records between DOD and VA is a longstanding issue, which has been the subject of several Government Accountability Office (GAO) reviews. Developing an electronic interface to exchange computable data between disparate systems is a highly complex undertaking. VA is fully committed to ongoing collaboration with DOD and the development of interoperable electronic health records. While significant and demonstrable progress has been made in our pilots with DOD, work remains to bring this commitment to system-wide fruition. VA is always mindful of the debt our Nation owes to its veterans, and our health care system is designed to fulfill that debt. To that end VA is committed to seeing through the successful development of interoperable electronic health records. One of the biggest obstacles is identifying and agreeing upon standard data fields for these records, since VA and DOD have different needs for their respective populations.

DOD/VA Joint Executive Council (JEC), co-chaired by VA's Deputy Secretary and DOD's Under Secretary of Defense for Personnel and Readiness, continues its ongoing active executive oversight of collaborative activities, including health data sharing initiatives. VA and DOD have documented a Joint Strategic Plan (JSP) that is maintained by the JEC. The JSP contains the strategic goals, objectives and milestones for VA/DOD collaboration, including VA and DOD health data sharing activi-

ties. Under the leadership of the JEC, VA and DOD realized significant success in meeting JSP health data sharing milestones.

VA and DOD also chartered DOD/VA Health Executive Council (HEC), co-chaired by VA's Under Secretary for Health and DOD's Assistant Secretary of Defense for Health Affairs. The HEC serves to ensure full cooperation and coordination for optimal health delivery to our veterans and military beneficiaries. Through the HEC Information Management and Information Technology Work Group (co-chaired by VHA chief officer, Health Information Technology Systems and the Mental Health Services chief information officer) HEC maintains management responsibility for the implementation of electronic health data sharing activities. These data sharing activities are largely governed by DOD/VA joint electronic health records interoperability (JEHRI) plan, approved in 2002, which serves as the overarching strategy around which these data sharing activities are managed.

There are a number of ongoing pilot programs that have developed into operational capabilities to share increased amounts and types of viewable data being exchanged between VA and DOD. After a successful pilot in El Paso, Texas, VA and DOD are now sharing digital images at this location. The same is true in the Puget Sound area, Hawaii and San Antonio, Texas where VA and DOD can now share narrative text documents, such as inpatient discharge summaries.

PROJECTION OF FUTURE HEALTH CARE NEEDS
BY AMERICA'S VETERANS

Question 5. A column by Harvard researcher Linda Bilmes asserts that "the seeds of the Walter Reed Army Medical Center scandal were sown in . . . a failure to foresee the sheer number and severity of casualties." Do you agree with that statement?

Response. VA cannot comment on Ms. Bilmes' assertion. VA is committed to ensuring it meets the needs of our veterans, including those who serve in OEF/OIF. VA has made every effort to account for the needs of OEF/OIF veterans within the VA enrollee health care projection model. To identify OEF/OIF veterans, we started using a DOD personnel roster in Fiscal Year (FY) 2002 where the model develops projections based on the actual enrollment and usage patterns of OEFIOIF veterans. These projections are based on the development of separate enrollment, morbidity, and reliance assumptions for OEF/OIF veterans based on their actual enrollment and usage patterns. However, many unknowns influence the number and types of services that VA will need to provide OEF/OIF veterans, including the duration of the conflict, when OEF/OIF veterans are demobilized, and the impact of our enhanced outreach efforts. Therefore, we have included additional investments for OEF/OIF in the Fiscal Year 2008 budget to ensure that VA is able to care for all of the health care needs of our returning veterans.

Question 6. What joint planning or analytical process exists today between DOD and the VA that did not exist in the past which will ensure a more complete understanding of the near- and long-term needs of our returning servicemembers?

Response. VA and DOD are committed to increasing collaborative and sharing activities between the Departments. This commitment is embodied in the work of the three joint councils established to facilitate collaborative initiatives and the workgroups and task forces that have emerged from them. Additional efforts to enhance cooperation and collaboration between the Departments have been initiated by 6 individual offices/interest groups. At the current time there are three primary joint councils:

(1) VA/DOD JEC co-chaired by VA's Deputy Secretary and DOD's Under Secretary for Personnel and Readiness.

(2) VA/DOD HEC, co-chaired by VA's Under Secretary for Health and DOD's Assistant Secretary for Health Affairs.

(3) VA/DOD Benefits Executive Council (BEC), co-chaired by VA's Under Secretary for Benefits and DOD's Assistant Secretary for Force Management.

In May 2007, VA and DOD collaborated on the formation of the Senior Oversight Committee (SOC) to focus on opportunities to directly support the seriously ill and wounded. The SOC is co-chaired by the Deputy Secretaries of each Department and is organized around business lines of action in clinical, administrative and personnel domain areas.

In response to the Global War on Terror (GWOT) task force recommendations, DOD and VA have been actively engaged in the development of a systematic, integrated and coordinated approach to the delivery of clinical and non-clinical case management services to severely injured OEF/OIF servicemembers and veterans. This integrated approach includes the support of a single point of contact, such as a recovery coordinator, who will engage the right resources at the right time to meet

the biopsychosocial needs of the severely injured person and his or her family. In addition, the individual will benefit from a "recovery plan" based on the patient's identified needs. This plan will remain across the Departments and care settings.

In partnership with DOD, VA has implemented a number of strategies to provide timely, appropriate, and seamless transition services to the most seriously injured OEF/OIF active duty servicemembers and veterans.

VHA's work to create a seamless transition for men and women as they leave the service and take up the honored title of "veteran" begins early on. Our benefits delivery at discharge program enables active duty members to register for VA health care and to file for benefits prior to their separation from active service. Our outreach network ensures returning servicemembers receive full information about VA benefits and services. And each of our medical centers and benefits offices now has a nurse or social worker program manager assigned to work with veterans returning from OEF/OIF.

VHA has coordinated the transfer of over 7,900 severely injured or ill active duty servicemembers and veterans from DOD to VA. Our highest priority is to ensure that those returning from OEF/OIF transition seamlessly from MTFs to VAMCs and continue to receive the best possible care available anywhere.

VA social workers, benefits counselors, and outreach coordinators advise and explain the full array of VA services and benefits. These liaisons and coordinators assist active duty servicemembers as they transfer from MTFs to VA medical facilities. In addition, our social workers help newly wounded soldiers, sailors, airmen and Marines and their families plan a future course of treatment for their injuries after they return home. Currently, VA social workers and benefit liaisons are located at 10 MTFs, including Walter Reed Army Medical Center, the National Naval Medical Center Bethesda, the Naval Medical Center San Diego, and Womack Army Medical Center at Ft. Bragg. A national memorandum of understanding (MOU) has been signed between VA and DOD as directed by the GWOT task force, with memorandums of agreement (MOA) in place at each local facility.

Since September 2006, a VA certified rehabilitation registered nurse (CRRN) has been assigned to Walter Reed to assess and provide regular updates to our polytrauma rehabilitation centers (PRC) regarding the medical condition of incoming patients. The CRRN assists families and prepares active duty servicemembers for transition to VA and the rehabilitation phase of their recovery. A second nurse liaison is being hired for national Naval Medical Center, Bethesda, and should be in place by September 2007.

Another important aspect of coordination between DOD and VA prior to a patient's transfer to VA is access to clinical information. This includes a pre-transfer review of electronic medical information via remote access capabilities. The VA polytrauma centers have been granted direct access into inpatient clinical information systems from Walter Reed Army Medical Center and National Naval Medical Center. VA and DOD are currently working together to ensure that appropriate users are adequately trained and connectivity is working and exists for all four polytrauma centers. For those inpatient data that are not available in DOD's information systems, VA social workers embedded in the MTFs routinely ensure that the paper records are manually transferred to the receiving polytrauma centers.

BHIE, a data exchange system allows VA and DOD clinicians to share text-based outpatient clinical data between VA and the 10 MTFs, including Walter Reed and Bethesda.

VHA understands the critical importance of supporting families during the transition from DOD to VA. We established a Polytrauma Call Center in February 2006, to assist the families of our most seriously injured combat veterans and servicemembers. The Call Center operates 24 hours-a-day, 7 days-a-week to answer clinical, administrative, and benefit inquiries from polytrauma patients and family members. The Center's value is threefold: it furnishes patients and their families with a one-stop source of information; it enhances overall coordination of care; and, very importantly, it immediately elevates any system problems to VA for resolution.

VA's Office of Seamless Transition includes outreach coordinators who regularly visit seriously injured servicemembers at Walter Reed and Bethesda. Their visits enable them to establish a personal and trusted connection with patients and their families.

These outreach coordinators help identify gaps in VA services by submitting and tracking follow-up recommendations. They encourage patients to consider participating in VA's national rehabilitation special events or to attend weekly dinners held in Washington, DC, for injured OEF/OIF returnees. In short, they are key to enhancing and advancing the successful transition of our service personnel from DOD to VA, and, in turn, to their homes and communities.

In addition, VA has developed a vigorous outreach, education, and awareness program for the National Guard and Reserve. To ensure coordinated transition services and benefits, VA signed a MOA with the National Guard in 2005. Combined with VA/National Guard State coalitions in 54 States and territories, VA has significantly improved its opportunities to access returning troops and their families. We are continuing to partner with community organizations and other local resources to enhance the delivery of VA services.

At the national level, MOAs are under development with both the United States Army Reserve and the United States Marine Corps. These new partnerships will increase awareness of, and access to, VA services and benefits during the de-mobilization process and as service personnel return to their local communities.

VA is also reaching out to returning veterans whose wounds may be less apparent. VA is a participant in the DOD's PDHRA program. DOD conducts a health reassessment 90–180 days after return from deployment to identify health issues that can surface weeks or months after servicemembers return home.

VA actively participates in the administration of PDHRA at Reserve and Guard locations in a number of ways. We provide information about VA care and benefits; enroll interested Reservists and Guardsmen in the VA health care system; and arrange appointments for referred servicemembers. As of June 30, 2007, an estimated 109,117 servicemembers were screened, resulting in over 25,055 referrals to VA medical facilities and 12,624 referrals to Vet Centers. Of those referrals, 47.9 percent were for mental health and readjustment issues; the remaining 52.1 percent were for physical health issues.

In April 2007, VA sponsored a conference to educate VA and DOD staff about services and programs for OEF/OIF veterans. Specialized educational tracts included mental health, polytrauma and Traumatic Brain Injury, diversity and women's health, pain management, seamless transition, and prosthetics and sensory aids. Each veterans integrated service network (VISN) developed an action plan for management of OEF/OIF veterans.

In May 2007, VA and DOD established a work group for seamless transition clinical case management to improve the delivery of safe, high-quality, and timely medical care to OEF/OIF wounded warriors and other similarly injured or ill servicemembers through the seamless provision of case management services in both DOD and VA systems. The work group will use a clinical case management model to address the transition issues of our servicemembers and veterans. It will identify and define policies, assist in the development of qualifications and functions and help identify potential gaps in tracking of the severely wounded warrior from agency to agency.

DOD AND VA HEALTH INFORMATION SHARING

Question 7. According to DOD, health assessment data on separating servicemembers is being provided to the VA on a monthly and weekly basis. How does the VA use this data to support care of veterans today?

Response. Beginning in October 2003, DOD Defense Manpower Data Center (DMDC) has sent VA's Office of Public Health and Environmental Hazards a periodically updated personnel roster of troops who participated in OEF/OIF and who had separated from active duty and become eligible for VA benefits. The latest DMDC file received in January 2007 indicates that there are a total of 686,306 OEF/OIF veterans who have been separated up to November 2006 from active duty following deployment to the Afghanistan and Iraq theaters of operation. For each veteran, their demographic (social security number, name, date of birth, gender, education, etc.) and military service specific data (branch, rank, unit component, deployment dates, etc.) are included in the record received from DOD.

VA uses this roster to evaluate the VA health care use of OEF/OIF veterans. This analysis, which is based on the roster received from DOD, is very useful to plan allocation of VHA healthcare resources. The roster is checked against VA's inpatient and outpatient electronic patient records to determine which veterans have sought treatment in VA facilities as well as the International Classification of Disease (ICD–9) diagnostic codes used to describe their diagnoses. These data indicate what types of health problems OEF/OIF veterans who have presented to VA have developed since deployment. The most recent report of OEF/OIF health care utilization is attached.

In addition to VA health care utilization data, which is based on the troop roster supplied by DMDC, DOD performs health assessments of servicemembers just prior to deployments and at the time of return from deployments. The purpose of these assessments is to screen for health concerns that warrant further medical evaluation. Since September 2005, DOD has sent VA their electronic pre-deployment and

post-deployment health assessments of servicemembers who have deactivated from active-duty back to the Reserve and National Guard or who have separated entirely from service. This data transfer takes place monthly. More recently, beginning in 2005, DOD developed the PDHRA. The purpose of PDHRA is to screen for physical health and mental health concerns at 90 to 180 days after return from deployments. In November 2006, DOD began monthly electronic transfers of PDHRA data to VA, and as of June 2007, VA has received over 1.7 million PPDHA and PDHRA assessments on more than 706,000 separated servicemembers and deactivated Reserve/National Guard members.

DOD deployment health assessments are available to VA health care workers in the VHA electronic health record, which is accessed during each patient encounter. These health data are used by VA clinicians to aid in the diagnosis and care of OEF/O!F veterans.

Question 8. Is the data useful for projecting future care needs, for example, for TBI, Post Traumatic Stress Disorder (PTSD), and prosthetic care? If not, are there joint efforts underway by the two departments to improve the ability to project future health care needs?

Response. Data derived from DOD's PDHRA do not allow for projecting servicemembers' need for services for Traumatic Brain Injury (TBI) and prosthetics. Data are being analyzed within VA for both mental health and prosthetics to project mental health service needs based on recent workloads for mental health programs as well as workloads for prosthetic equipment, sensory aids and devices.

As of the second quarter of Fiscal Year 2007, 35 percent (252,095) of veterans eligible for care came to VA for clinical services. Of these, 37.7 percent received provisional diagnoses of mental disorders including 45,330 with a provisional Post Traumatic Stress Disorder (PTSD) diagnosis. These are cumulative data, and not all these veterans are found to actually have a mental disorder or, if they do, the problem may be resolved with treatment.

As of July 2007, an estimated 109,117 servicemembers were screened, resulting in more than 25,055 referrals to VA for follow-up health care. In addition to mental health, 52.1 percent of the referrals were for physical health issues.

VHA's Prosthetics and Clinical Logistics provided prosthetics and other medical equipment and supplies to 22,910 OEF/OIF veterans in Fiscal Year 2006. As of Fiscal Year 2007 second quarter, 18,367 OEF/OIF veterans have received care in prosthetics. Based on the trend thus far this FY, VA anticipates a significant increase in the number of OEF/OIF veterans we will care for in Fiscal Year 2007. This data are based on matching unique NPPD (National Prosthetic Patient Database) patient identifications to the OEF/OIF roster obtained from the VHA support service center (VSSC). On a monthly basis, DOD provides VA with the latest amputee statistics from DOD's amputee patient care program-clinical database. This allows VA to project the number of amputees that will eventually be discharged from MTFs and transitioned into VA care. Last, NPPD is currently being enhanced to alert staff and flag the patient's record when a consult for an OEF/OIF patient is initiated for a prosthetic appliance. This allows the medical facilities prosthetic departments to better prioritize requests for OEF/OIF veterans.

In partnership with DOD, VA has implemented a number of strategies and innovative programs to provide timely, appropriate, and seamless services to the most seriously injured OEF/OIF active duty members and veterans. One such program enables active duty members to register for VA health care and initiate the process for benefits prior to separation from active service. The centerpiece program supporting the seamless transition of seriously injured servicemembers and veterans involves placement of VA social work liaisons, VA benefit counselors, and outreach coordinators at MTFs to educate servicemembers about VA services and benefits.

VA and DOD continue to collaborate in the screening process for TBI. A TBI screening instrument was developed based on the experience of VA, MTFs and Defense and Veterans Brain Injury Center. As of April 2, 2007, VA mandated administration of the TBI screen to all OEF/OIF veterans who receive medical care in the VA. Every possible reply in the TBI Screening reminder generates a unique "health factor" that is stored in the "health factors file" in the VA databases. This will further improve VA's ability to project healthcare needs of veterans with TBI.

PRIVACY RULES AND THE SHARING OF DOD AND VA MEDICAL INFORMATION

Question 9. Congress enacted the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (Public Law 104–191) to prevent the disclosure of certain personal medical information, but permits DOD and VA to share information on individuals being treated in both systems. Yet HIPAA is often cited as a barrier to easy

sharing of health data between DOD and VA. In 2003, a Presidential task force recommended that the two departments be declared a single health care system for the purposes of implementing HIPAA—in order to smooth transition of servicemembers from DOD to the VA, and to accelerate the development of shared health care information technology. What did the two departments do, if anything, in response to this recommendation?

Response. As a rule, there are no HIPAA constraints on sharing electronic data between VA and DOD. In general, the HIPAA Privacy Final Rule prohibits covered entities—health care providers that conduct certain transactions electronically, health plans, and healthcare clearinghouses—from disclosing protected health information unless a specific permitted disclosure is applicable. One special exemption pertains to DOD's sharing data with VA. This permitted disclosure, 45 CFR 164.512(k)(1)(ii), allows DOD to "disclose to VA the protected health information on an individual who is a member of the Armed Forces upon separation or discharge of the individual from military service for the purpose of a determination by VA of the individual's eligibility for or entitlement to benefits under laws administered by the Secretary of Veterans Affairs." VA and DOD HIPAA, privacy and General Counsel staffs worked diligently to resolve any differences in interpretation of these authorities. In June 2005, DOD and VA implemented a data-sharing MOU that outlines these agreed-upon authorities.

Question 10. Why is HIPAA still cited as a barrier to information sharing?

Response. As a rule, there are no HIPAA constraints on sharing electronic data between VA and DOD. The HIPAA Privacy Rule has not impacted VA's health information exchange efforts as ample authority exists under this Rule for the exchange of health information both with DOD and private and public health care providers.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. SAXBY CHAMBLISS TO GERALD CROSS, M.D., ACTING PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS

Question 1. One suggestion I have heard regarding how to speed up the MEB/PEB process within DOD and make it more efficient and easier for our servicemembers is to embed more VA personnel within DOD to help with the transition process. Specifically, VA personnel could begin working with soldiers and possibly take charge of their paperwork and medical requirements once it is clear that a servicemember cannot be retained in the Service. Can you comment on how embedding VA personnel might affect the MEB/PEB process and if you think, from our servicemembers' perspective, that this would be a good idea?

Response. Expanding VA and DOD's partnership to include coordination on the MEB/PEB process is an excellent idea. It is the logical next step in ensuring that servicemembers experience a smooth transition from military to civilian life. VA staff is participating in the Army's transformation initiative for the physical disability evaluation process (PDES) by participating in five process action teams (PATs) developing transformation strategies for five key components of the PDES as well as the council of colonels which is the group overseeing the initiative.

In addition, VA staff is participating in the Army medical action plan (AMAP) and fully supports the concept of getting VA personnel involved as servicemembers enter the MEB/PEB process. As part of the VA/DOD Senior Oversight Committee (SOC), October 1, 2007, VA and DOD will initiate a pilot joint disability program at Walter Reed Army Medical Center, National Naval Medical Center, Bethesda and Malcom Grow Medical Center. The goal of the pilot program is to develop one comprehensive physical exam and a joint disability evaluation board. Most, if not all, of the initiatives can be accomplished through cooperation and partnership and do not require legislative authority.

TRICARE ACCEPTANCE

Question 2. I was surprised to learn that VA hospitals do not necessarily accept TRICARE. Would ensuring that all VA hospitals accepted TRICARE be a way to improve the seamless transition of our veterans from DOD to the VA as well as ensuring that they have easy and quick access to the best health care they are entitled to?

Response. VA and DOD signed a MOU on June 29, 1995 that allows VA health care facilities to provide care for TRICARE beneficiaries. Prior to the completion of the MOU, the Deputy Under Secretary for Health for Operations and Management directed all VA medical facilities to become TRICARE network providers in order to provide timely care to DOD beneficiaries, especially those returning from the GWOT theaters. As of May 2007, approximately 94 percent of VA medical facilities

have signed TRICARE agreements with DOD's managed care support contractors. VA's goal is to have 100 percent of the VAMCs participating in TRICARE.

BUDGETING FOR ADDITIONAL PATIENTS

Question 3. Over the past fiscal year, the Atlanta VA hospital has experienced an increase in the number of Operation Iraqi Freedom/Operation Enduring Freedom unique patients of 75 percent. My guess is that the Atlanta VA hospital is not unique in the increase of Iraq and Afghanistan veterans that they are receiving. A few years ago, Congress had to add a significant amount of money to the VA health system's budget because the VA had not adequately predicted how much money they would need to take care of the patients in the VA health care system. Can you provide your assurances that the VA and specifically the VA health care system will correctly budget for the number of patients they will be required to serve in the coming years?

Response. Yes, VA uses an enrollee health care projection model to develop budget estimates based on the actual enrollment rates, age, gender, morbidity, and reliance on VA health care services of the enrolled OEF/OIF population. OEF/OIF veterans have significantly different VA health care usage patterns than non-OEF/OIF enrollees, and this difference is reflected in the estimates from the enrollee health care projection model. For example, when modeling expected demand for PTSD residential rehab services for the OEF/OIF cohort, the model reflects the fact that they are expected to need three times the number of these services than non-OEF/OIF enrollees. The model also reflects their increased need for other health care services, including physical medicine, prosthetics, and outpatient psychiatric and substance abuse treatment. On the other hand, experience indicates that OEF/OIF enrollees seek about half as much inpatient acute medicine and surgery care from the VA as non-OEF/OIF enrollees.

Many unknowns influence the number and types of services that VA will need to provide OEF/OIF veterans, including the duration of the conflict, when OEF/OIF veterans are demobilized, and the impact of our enhanced outreach efforts. VA has made every effort to account for the needs of OEF/OIF veterans within the actuarial model. Starting with the identification of OEF/OIF veterans from a roster provided by DOD the actuarial model develops projections based on the actual enrollment and usage patterns of OEF/OIF veterans since Fiscal Year 2002. These projections are based on the development of separate enrollment, morbidity, and reliance assumptions for OEF/OIF veterans based on their actual enrollment and utilization patterns. However, unknowns, such as the length of the conflict, will impact the services that VA will need to provide. Therefore, we have included additional investments for OEF/OIF in the Fiscal Year 2008 budget to ensure that VA is able to care for all of the health care needs of our returning veterans.

Chairman LEVIN. Thank you, Secretary Cooper.

Secretary Geren?

STATEMENT OF HON. PRESTON M. "PETE" GEREN III, ACTING SECRETARY OF THE ARMY, DEPARTMENT OF DEFENSE

Mr. GEREN. Thank you, Mr. Chairman.

Chairman Levin, Chairman Akaka, Senator McCain, Senator Craig, thank you for hosting this hearing. The fact that you all are meeting together jointly demonstrates that this is a problem that is not a DOD problem, not a DOD challenge, but it is a VA challenge. I think that as we study the problem further, as Secretary England alluded to, we are going to find that in order to address this issue effectively, we are going to have to reach even broader than these two Committees and partner with the entire Congress. Our Army Wounded Warrior Program is an example of that. In our Army Wounded Warrior Program, the Department of Labor, the Department of Transportation, and the Department of Homeland Security are also partners in that. So I commend these two Committees for the leadership you have shown on this.

I would also, on a personal note, like to thank all of you. Every one of you here has met with our wounded servicemen and women.

You have been to the hospitals. You have been to the facilities. That demonstrated commitment to those soldiers means so much to them, and thank you for taking your time to do that. That is greatly appreciated and it is something that resonates among the force. We need to thank you for doing that.

I would like to offer my written statement for the record and summarize, if I could, Mr. Chairman.

Chairman LEVIN. It will be made part of the record, and I have just been notified the vote is now scheduled for 10:45. It has been pushed back 15 minutes.

Mr. GEREN. I will finish before then. We have got numerous commissions and committees looking at this issue right now. We have the Dole-Shalala. Yesterday, we got the initial reports from West-Marsh. Secretary Nicholson is doing a report. General Scott's Commission is going to report out in October. They are all going to provide us with important new road maps, I am confident. But I am also confident that Omar Bradley, 50 years ago, probably got it right and the bottom line for all of these commissions is going to be a little different from what General Bradley said 50 years ago. The system needs a radical overhaul. The system doesn't work for soldiers and their families today.

We are not, as an Army, though, stopping and waiting for these new commissions to report out before we start fixing the problem. We are working aggressively, not only at Walter Reed, but throughout the system. I would like to take a moment and just summarize some of the things that have happened to this system that not work well for our soldiers and the veterans, and try to make it work as best as it can, and we have got some extraordinary leadership doing a great job of making that happen.

Many of you all have already met with the new leadership at Walter Reed, all the way from General Schoomaker down to the NCOs that are working out there. They are doing an outstanding job. General Gale Pollock, our Acting Surgeon General, who is a nurse, also has provided great leadership in this area and is making the system work.

Our focus at Walter Reed is to make sure that the soldiers out there get the kind of individual care and attention that they have to have to make this system work for them. The acute care system works well. You have all met with wounded warriors who have come from the battlefield to Landstuhl to Walter Reed, and on the acute care side, we do an extraordinary job, first class, best in the world. Outpatient care has not been up to standard and we are working to make it so.

At Walter Reed, we have built a triad of support for each wounded soldier. It has got a primary care physician that is assigned to that soldier, a nurse case manager, a ratio of 1:17 that works with that soldier from the moment he gets to Walter Reed all the way to the transition into the VA system. And then we have got, I think most importantly, we have an NCO ratio of 1:12, a squad leader, and the job of that NCO out there as part of this Warrior Transition Brigade is to make sure that he looks after those 12 soldiers. Just like that NCO would do out in the field, we are doing that same thing now at Walter Reed and that program will be fully operational by the first of next month.

We put 130 soldiers, many of them the leaders are combat veterans, many of them also are veterans of the health care system, out there to work individually with these soldiers. We are also hiring ombudsmen. Many of these are initiatives that you all have addressed in your legislation, good ideas and we are already moving out on them.

We have launched the Wounded Warrior and Family Hotline. Every one of you has a card at your desk. We are disseminating these broadly throughout the system. You see the example of the card on the board over there. The Wounded Warrior Hotline is working very well. We have had 700, 800 calls already, and those don't go into some remote call center somewhere. They go into the Army Operations Center. So if the system doesn't work, if these new advocates that we have in place to make sure they are representing the soldiers effectively aren't getting the job done, the issue gets elevated immediately with instructions to act on it, and then there is a team in place to make sure that the liaison officers, the case managers address the problems that are raised.

We have made process improvements out there. We are also making physical infrastructure improvements. As you know, all the soldiers are out of Building 18. Building 18 is empty now. We have those soldiers in barracks on the Walter Reed campus.

We welcome the results of Secretaries Marsh's and West's report from yesterday. We have worked with them over the last couple of months. Many of their initiatives, we have already put in place. We are building the soldier-centric system with a triad of support that I mentioned earlier. We are activating the Wounded Warrior Transition Brigade on April 25. And this might seem like a small gesture, but it is very important to the families. We are meeting the families at the airport, bringing them to the facility, providing them orientation, make sure that they understand what the situation of their loved one is, and also make sure that they understand how they can work through the system.

One-stop shop, also a subject of your legislation. We have a Soldiers and Families Assistance Center, which brings together the agencies, the VA, the Army, other government agencies, as well as veterans' service organizations and the Red Cross. They work together with those soldiers and their families so they can meet their needs in one place instead of multiple places.

We have a new Deputy Commanding General at Walter Reed. His job is a bureaucracy buster, and I am pleased to tell you that we have taken the number of forms that a soldier has to fill out from more than 40 down to ten. Now, you might ask, I did, why ten, but at least we are moving in the right direction.

We are committed to providing a seamless transition of medical care. That is what the soldiers deserve. That is what they need. What they have now is confusing, it is time consuming, it is arbitrary in some cases, it is unquestionably bureaucratic, and we are going to learn more through these commissions how to make it better. But under the leadership that we have seen demonstrated over the last 6 weeks, we have tried to make the system work better and I believe we are.

We also have some models out there that we can call on that I think will help us see the way into the future. We work best with

the VA where we work closest with the VA. At Eisenhower Army Medical Center in Georgia, and at Tripler Army Medical Center in Honolulu, the Army and the VA work hand-in-hand. We have relationships at every medical facility, as does the VA at their facilities, but we do have some models that can show us the way ahead and I think those are two great examples of it.

On the issue of BRAC that has been raised by many people, it is our position that with the closure of Walter Reed and the expedited construction of the facility at Bethesda and the new facility at Fort Belvoir, we can provide better care to our wounded warriors and their families in this region. We need to move ahead with that. It is important that we do that, and we are examining ways to advance the calendar on that and we look forward to working with the Congress to accomplish that.

There is good news in our treatment of wounded warriors that also has posed extraordinary challenges for the system. In World War II, about 70 percent of the people who were wounded in battle survived. Now, over 90 percent. In some cases, it is from simple innovations like one-handed tourniquet and bandages that help the blood clot. There are all sorts of other remarkable medical miracles that our Army doctors have performed that make sure that we get the soldiers the absolute best when they need it.

But this also poses a challenge for us. People are surviving that have never survived before. They are surviving with wounds that they would never survive with in private life, frankly, because of the immediate care that they get under the military health care system. That poses challenges in the near term. It poses challenges in the long term. The partnership between the DOD and VA has to work in order for us to meet our obligation to those soldiers and their families in the long term.

We have got to do more. And as I said at the beginning, that obligation extends beyond just the Department of Defense and the Veterans' Affairs Committee. It is an obligation that we are going to have to take on as a government if we are going to make it work.

This Senate and the House both have presented important pieces of legislation. We look forward to working with you. We don't have all the answers now. I can tell you, though, the Army is committed to take care of our soldiers. We share your commitment to those who have borne the battle, their widows and their orphans, and we are doing everything we can to redress the wrongs that came to light a couple of months ago and we look forward to working with you to make sure that we continue to improve the system.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Geren follows:]

PREPARED STATEMENT OF HON. PRESTON M. "PETE" GEREN III,
ACTING SECRETARY OF THE ARMY, DEPARTMENT OF DEFENSE

Chairman Levin, Chairman Akaka, Senator McCain, Senator Craig, and distinguished Members of the Senate Armed Services Committee and the Senate Veterans' Affairs Committee, thank you for inviting me here today to speak about caring for our Soldiers and their families.

There is no greater duty we have as a Nation than to ensure that those Soldiers who volunteer to defend our freedom are treated with not only the best medical and transitional care we can provide, but with the dignity and compassion they deserve.

Whether wounded in war, injured in training, or taken ill, Soldiers deserve the very best that our Nation can offer to honor their service and their sacrifice.

In some areas, regrettably, we have not lived up to that obligation. The superhuman work done by medics, fellow Soldiers, and military nurses and doctors to ensure that our Soldiers survive combat and receive quality care has been undermined by an outdated and bureaucratic system that leaves recovering Soldiers and their families frustrated and sometimes angry.

Just this past Sunday, *The Washington Post* ran a column written by Sergeant David Yancey of the Mississippi Army National Guard, a patient at Walter Reed, detailing his struggles with a bureaucracy that simply failed him. Sergeant Yancey wrote, "This is not supposed to be an adversarial system, but that's the way it feels—like another battle to fight." That is totally unacceptable, Soldiers who have been fighting or preparing to fight a war overseas should not have to fight a bureaucracy here at home, and I am committed to doing all I can and all the Army can to make the system more responsive, more dignified, and more accountable.

To be sure, the Army cannot solve the system's many problems by itself. However, based on the progress we have made to date and the work we continue doing to identify specific remedies, I know that together, the Army, the Department of Defense (DOD), the Department of Veterans Affairs (VA), and the Congress can provide the compassionate, seamless, and robust healthcare system that our Soldiers and their families have earned and deserve.

I'd like to begin by providing an update on the Army's progress in addressing issues at Walter Reed Army Medical Center. On March 15th, I testified before the Senate Armed Services Committee and vowed that the Army would work aggressively to identify and fix the problems at Walter Reed. I told the Committee that we would not wait for reports or recommendations, but that we "would fix things as we go." Today I am pleased to report that we have made a great deal of progress in the areas of infrastructure, leadership, and process-related issues, as we work toward a Soldier-centric health care system that is supported by the triad of: a caring and energetic chain of command; a primary care physician; and a Registered Nurse case manager.

The Army is committed to continuous infrastructure maintenance and improvements at Walter Reed. As you know, we no longer house Soldiers in Building 18 and are evaluating the long-term use of that facility. There is a facility assessment team onsite, contracted by the Baltimore District, U.S. Army Corps of Engineers, conducting a thorough evaluation of the installation's infrastructure.

Meanwhile, immediate information technology upgrades to provide telephone, Internet, and cable television for Soldiers in all on-post lodging facilities have been completed.

With regard to leadership issues, we believe we have the right people and the right mechanisms in place to make sure that all Soldiers who are in a transitional status are managed with care and compassion, and that they and their families are satisfied. For example, we now greet family members at the airport and escort them to the hospital, letting them know in word and deed that they and their Soldiers have a working support system.

The Warrior Transition Brigade, to which our medical holdover Soldiers are assigned, will activate on April 25th 2007 and will be fully operational on June 7th. We are adding over 130 military positions to the leadership team that provides daily care and leadership for our medical holdover soldiers, and creating new leadership posts for company commanders, first sergeants, and squad leaders. This reduces the noncommissioned leader-to-led ratio at the platoon level from 1:55 to 1:12. Just like Soldiers in every unit in the Army, these Soldiers now have a full chain of command, starting at the squad leader level, to look after their health and welfare.

A Clothing Issue Point recently began operations to replace items such as undergarments and uniforms, as appropriate, for Soldiers evacuated from theater to Walter Reed.

We have enhanced access to the hospital dining facility and established special meal cards to prevent Soldiers from losing their basic allowance for subsistence.

As many of you know, the Mologne House on the Walter Reed campus is home to many of our medical holdovers. There is now an emergency medical technician onsite at Mologne House 24 hours a day, 7 days a week, a change that has been well received by Soldiers and family members.

We have also improved information dissemination and feedback mechanisms. A weekly Newcomer's Orientation informs Soldiers and families of all programs available to them at Walter Reed. Recently, we conducted two Town Hall meetings to make sure that we are aware of the issues most important to our Warriors and their families, and have incorporated that feedback into our plans and processes. The Town Hall meetings are a success and will continue.

Soldiers and their families were given a Family Member Hero Handbook and 1–800 Hotline cards. The Hotline allows Soldiers and their families to gather information about medical care as well as suggest ways to improve our medical support systems. These cards are being distributed throughout the force, and so far the result has been very encouraging. By April 2nd, we had received 656 calls detailing 394 distinct issues. Of these roughly 202 were medical issues and 132 were tasked to MEDCOM for research and resolution.

In an effort to provide better service, we conducted a survey at Walter Reed to determine the Soldiers' view of their outpatient care experiences and have already implemented many of their suggestions. We will also continue to conduct monthly after-action reviews to assess what is working and what still needs improvement.

On the issue of process, the Soldier and Family Assistance Center (SFAC) opened its doors on March 23rd, 2007. The SFAC brings together assistance coordinators, personnel and finance experts, and representatives from key support and advocacy groups such as the U.S. Army Wounded Warrior Program, the Red Cross, Army Community Services, Army Emergency Relief, and VA. Co-locating these organizations provides one-stop service to Soldiers.

Also, we have begun a more efficient and thorough system for transferring our warriors in transition from inpatient to outpatient status. At Walter Reed, a complete review of our discharge management process resulted in a revision of standard operating procedures. We developed a discharge escort system whereby hospital staff, including the brigade leadership, comes to the Soldier to conduct discharge business, escort the Soldier to the brigade, and assist with luggage and transition into the unit. We instituted training to re-emphasize the importance of hospitality for our Soldiers and their families.

The Physical Evaluation Board (PEB) process, which determines if a Soldier is fit to continue performing his or her duties, is one of the most daunting a Soldier can face. We have significantly increased the number of Physical Evaluation Board Liaison Officers (PEBLO) to help Soldiers navigate this process. (The ratio of PEBLO to Soldier has improved from 1:45 to 1:30.) Standardization of the case management process, coupled with increased case managers and PEBLOs, has significantly improved the level of service we provide to the Soldier. And importantly, we will soon see an improved ratio of case managers to patients, from 1:50 to 1:17, to permit better coordination of treatment and evaluation.

The rest of the Army leadership and I also vowed to address similar issues around the country and in the medical system at large. For example, we are aggressively working to make improvements to the existing Physical Disability Evaluation System (PDES) to minimize the difficulties that Soldiers are facing. This system was developed half a century ago and has become overly bureaucratic and, too often, adversarial. The Army has undertaken corrective action and we are developing initiatives to overhaul or replace the current process. Indeed, rather than settle for yet another attempt to streamline current processes, our goal is to eliminate the bureaucratic morass altogether, and develop a more streamlined process to best serve our Soldiers.

As we move forward to transform the PDES, there will be areas of policy, process, and administration requiring full collaboration and coordination involving both DOD and VA. We have worked together in the past, and it is imperative that we continue that partnership in order to identify the issues, fix the problems, and improve the process for our servicemen and women.

Specific areas for improvement include: Soldier processing within Medical Evaluation Boards (MEB) and Physical Evaluation Boards (PEB); training of physicians, adjudicators, administrators, and legal advisors; establishing standard counseling packages and procedures; and ensuring that the automation systems supporting the PDES are interconnected.

Currently, the Army is determining the manpower and funding requirements for each initiative and it is our intention to implement them within the next 60 days. For example, we are reducing the number of forms Soldiers have to complete, and transmitting documents electronically rather than through the mail.

Warriors in medical transition status have been frustrated by inconsistent processing of their orders. We have issued a military personnel message that clarifies how orders for Soldiers should be processed.

We continue to address concerns that caseworkers are ill-prepared to carry out their duties. We have conducted training for our PEBLOs via Video Teleconference and in May we will hold a PEBLO Training Conference on solving problems for Soldiers in Medical Hold and Medical Holdover status.

The transition of our Warrior medical care from DOD to VA should be seamless; right now, it is not, leaving soldiers and their families confused and frustrated.

The bottom line is that the process can't be seamless if the edges don't touch. In this case, the "edges" between DOD and VA are the administrative hand-off in medical management and the disability determination. We continue to work with VA to ensure timely access to health records for VA providers. Bidirectional health information exchange is now operational at all DVA healthcare facilities and at over 200 DOD facilities. DVA and DOD, in coordination with the American Health Information Community, are working to implement the system consistent with the President's health information technology initiative. And the VA/DOD Joint Executive Council continues to pursue a variety of other efforts to achieve seamlessness on the health information technology front. We must work together to minimize the number of physical examinations and repeat diagnostic testing that our warriors in transition must undergo, and as much as possible, collocate our facilities and share resources. Again, these long-term solutions will be the result of a collaborative effort between the services, DOD, VA, other State and Federal agencies, and the Congress.

These are just a few of the actions that we have taken to address these serious issues. We have yet to receive and/or fully digest the reports of other groups that are looking into these same problems, but we look forward to reviewing their recommendations.

On April 3rd, the Army's Tiger Team concluded an exhaustive study of the Army's 11 key Medical Treatment Facilities at Forts Bragg, Gordon, Stewart, Campbell, Knox, Sam Houston, Hood, Bliss, Lewis, and Drum, and Schofield Barracks. Throughout the month of April, the Tiger Team will present its findings and recommendations to the senior Army leadership, which we anticipate will generate healthy discussion.

This month, we will also receive the report of an independent review group, co-led by former Army Secretaries Jack Marsh and Togo West. The Army will carefully study its findings and recommendations and will keep you informed as we move through the appropriate corrective actions.

Finally, the Nicholson Task Force and the Dole-Shalala Commission findings are forthcoming and will be valuable as we work together to define further and address the challenges we face.

To lead the effort to fix what is wrong are two senior Army leaders in whom I have great confidence: Maj. Gen. Gale Pollock, our Army's acting Surgeon General, and Brig. Gen. Mike Tucker, our "bureaucracy buster" who is busy "knocking down walls," so that we can improve the Army's system of caring for our wounded, injured, or sick Soldiers and establish long-term solutions to the challenges of providing a lifetime of care to them and their families.

We are under no illusions that the work ahead will be easy or quick . . . or cheap; we have a lot to do to get this right. Mending the seams and fixing the myriad issues we have recently uncovered will take energy, patience, determination and above all, political will.

Soldiers are the centerpiece of the Army and the focus of our efforts. Soldiers should not return from the battlefield to fight an antiquated bureaucracy.

Wounded, injured, and ill servicemembers and their families expect and deserve quality treatment and support as they return to their units or their communities. I know full well that the President, Secretary Gates, the Congress and the American public are committed to this effort as the cornerstone of everything we are doing. I would simply ask for your continued support as we strive to provide the best care for those who give so much to protect us all.

With your help, and the help of all the agencies involved, I know that we can match the medical care Soldiers receive at the point of injury or illness, whether on the battlefield or during training, with simple, compassionate and expeditious service that ensures every Soldier knows the Army and the Nation are indeed grateful.

Thank you again for inviting me to testify. I look forward to your questions.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. DANIEL K. AKAKA TO HON. PRESTON M. "PETE" GEREN III, ACTING SECRETARY OF THE ARMY, DEPARTMENT OF DEFENSE

Question 1. I understand that many members of the National Guard who are seeking VA disability ratings may have to wait an additional 2 to 3 months for their claim to be processed pending authorization for their National Guard unit to release their records. What can be done to resolve this problem?

Response. Your understanding is correct. There are cases in which members of the National Guard who are seeking disability rating from the Department of Veterans Affairs have waited two months or more for their claim to be processed pending au-

thorization for the release of their military health records. There was a misunderstanding of the Health Insurance Portability and Accountability Act of 1996 by some states. Two actions are being taken to correct this situation. First, we are issuing a policy letter to all states and territories clarifying the release of health information to the Department of Veterans Affairs. Second, the National Guard Bureau has appointed a Protected Health Information (PHI) Officer who will be responsible for providing policy and compliance for the National Guard related to PHI. We are committed to supporting our Guard members and we will move quickly to rectify this situation.

Question 2. The Center for the Intrepid is, by all accounts, a truly impressive, state-of-the-art facility for the treatment of individuals with major amputations. As you know, it is now run by the Army. Do you anticipate that the Army will still be operating this facility in ten years? In twenty years?

Response. We anticipate that the Army will be operating the Center for the Intrepid in conjunction with the Department of Veterans Affairs as a VA/DOD joint venture for the foreseeable future.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. LARRY E. CRAIG TO HON. PRESTON M. "PETE" GEREN III, ACTING SECRETARY OF THE ARMY, DEPARTMENT OF DEFENSE

Question 1. It is my understanding that the Army's Physical Evaluation Boards only rate conditions that are "independently unfitting." But many severely wounded servicemembers have complex injuries involving multiple body systems that, in concert, may cause a severe disability. Can you explain the basis for this policy and how it would affect those soldiers? Does this policy contribute to the relatively low percentage of Army members who receive a 30 percent rating or more through the Physical Evaluation Board process?

Response. The basis for the Army only rating independently unfitting conditions can be found in DOD Instruction 1332.39. The PEB evaluates each condition independently, determining whether that condition prevents the Soldier from performing required duties. Many wounded Soldiers are found unfit for multiple conditions, each of which is rated, and the ratings are combined to produce an overall rating for the Soldier. Individual conditions that are not determined to be unfitting are not rated by the Army, although they may be rated by the VA. The fact that the military only rates unfitting conditions does result in lower military disability ratings than would be the case if all conditions were rated.

Question 2. According to testimony provided at the hearing, the Army assigned 0 percent ratings to 27 percent of the soldiers who were found to be unfit for duty over the past 6 years. Can you explain how a condition could be "unfitting" by the Army's standards but at the same time be rated as non-disabling under the Department of Veterans Affairs (VA) rating criteria? Do these statistics suggest that the VA rating criteria do not accurately reflect the impact of some disabilities?

Response. A Soldier is found unfit when he is unable to perform appropriate duties in his or her primary military occupational specialty. This does not necessarily mean he or she would be unable to perform gainful employment in a general civilian job market. Generalized pain in knees, back, shoulders, neck, or other regions, even without significant medical findings, may nevertheless result in a finding of unfitness for Soldiers who must be able to wear helmets, body armor, carry heavy rucksacks, walk long distances, etc. A Soldier is rated at 0 percent when his medical condition qualifies for a zero percent rating in the VA Rating Schedule or does not meet the minimum criteria for a 10 percent rating. It should be noted that a 0, 10, or 20 percent rating all result in the same compensation package for a separating Soldier.

Question 3. Army regulations require that when a patient transfers to a military treatment facility or a VA Medical Center, a copy of the Inpatient Treatment Record is to accompany the patient. Yet, the Army Inspector General recently reported that this is not happening in all cases. What steps do you plan to take to address this situation?

Response. A message has gone out to all military treatment facilities (MTFs) to emphasize compliance with the appropriate Army regulations. The MTFs will ensure that local procedures for patient transfer comply with Army regulations. The Army Surgeon General will ensure that quality control measures are established to ensure appropriate records accompany all patients being transferred from other military treatment facilities or to VA medical centers.

Question 4. It is my understanding that only outpatient records are accessible via the Armed Forces Health Longitudinal Technology Application or "AHLTA," what DOD calls its "comprehensive lifelong, computer-based patient record for every Soldier, sailor, airman, and marine." So, military treatment facilities and VA providers would not be able to gain access to a servicemember's inpatient records this way, either. What is your plan for making the inpatient treatment record a part of the Electronic Health Record?

Response. Unifying electronic inpatient treatment records within the longitudinal medical record (AHLTA) is a stepwise process. Current plans call for electronic inpatient records from theater to start flowing through the Theater Medical Data Server into AHLTA, where they will be visible to AHLTA users in July 2007. They will also be accessible to Department of Veterans Affairs (VA) and theater users via the Bidirectional Health Information Exchange (BHIE) and BHIE-Theater interfaces, with a timeline currently estimated at September 2007. For Military Health System facilities which utilize an inpatient electronic record (the Clinical Information System or CIS), efforts to transfer those records to the AHLTA Clinical Data Repository are also underway. A pilot project making some CIS records visible to VA users via BHIE was recently completed successfully. As the last and most comprehensive step, VA and DOD both seek to acquire an updated inpatient electronic record; a feasibility study for this joint acquisition is underway. This record would be fully integrated into both AHLTA and VistA, the VA's electronic medical record.

Question 5. If we were to start from scratch and design a new system of compensation for those who are severely injured in service, what should that system look like?

Response. The Army is reviewing several courses of action that would update and or revamp the current compensation program for our Wounded Warriors. However, before recommending a particular course of action, it is important for us to consider the findings and recommendations of the various healthcare-related commissions. One key tenet for our consideration is whether a redesigned compensation system should include different compensation options to afford Wounded Warriors with choices that might better fit their situation.

Question 6. What do you think should be the purpose of a modern compensation program and how would we regularly determine whether the program, as designed, is meeting its intended purpose?

Response. The Army is reviewing several courses of action that would update and or revamp the current compensation program for our Wounded Warriors. However, before recommending a particular course of action, it is important for us to consider the findings and recommendations of the various healthcare-related commissions. One key tenet for our consideration is whether a redesigned compensation system should include different compensation options to afford Wounded Warriors with choices that might better fit their situation.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. JOHN MCCAIN TO HON. PRESTON M. "PETE" GEREN III, ACTING SECRETARY OF THE ARMY, DEPARTMENT OF DEFENSE

MEDICAL HOLD AT WALTER REED ARMY MEDICAL CENTER—THEN AND NOW

Question 1. On February 16, 2007, the former Commander of Walter Reed Army Medical Center, MG Weightman, reported the medical hold census was 654—those housed in or near Walter Reed Army Medical Center awaiting medical disability determinations and outpatient care. He reported that the average length of stay in medical hold was 297 days for Active Duty and 317 days for members of the Reserve. Today, according to the Army, the total number is 644. My expectation was that the Army would be establishing new boards or augmenting existing boards in order to reduce the number of wounded who are retained at Walter Reed Army Medical Center. Am I mistaken on this?

Response. The challenge is as much one of new patients arriving as it is a matter of throughput. Each Warrior must first be afforded the maximum benefit from medical care before the Medical Evaluation Board (MEB)/Physical Evaluation Board (PEB) process can begin. This recovery and rehabilitation phase is often the longest part of the process.

We have seen decreases in the number of individuals in the MEB/PEB process. The number of individuals in the MEB/PEB phase was 55 as of April 3, 2007. This was down from 95 a month earlier. The total number of Warriors in Transition was about 640 during both periods. While the aggregate number of Warriors in Transi-

tion remained constant, the transition of patients was offset by new patients arriving.

Significant changes are occurring that will affect the aggregate number in a positive direction and attend to the needs of the Warrior in Transition and his or her Family. The Warrior Transition Brigade is operational. At end-state, the brigade will consist of four companies. The 18 squad leaders within each company will assist the Warrior in medical case review, financial issues and assistance through the treatment and medical evaluation system. We have established reception procedures for Warriors and Families as well as opening of a Soldier Family Assistance Center. We have added 40 trained, clinical case managers to achieve a 1:17 case manager to Warrior ratio at Walter Reed based on that facility's uniquely complex patient population. We are also in the process of establishing a Primary Care Physician program. Our Physical Evaluation Board Liaison Officer (PEBLO) staff has undergone change as well. We have instituted a new structure with teams and designated MEB physicians and increased physical capacity and remodeled PEBLO offices. The number of PEBLO counselors has been doubled to 20. We have also increased salary levels to attract and maintain more qualified counselors. We also sent our counselors to 2 weeks of specialized training and to the 1 week worldwide PEBLO conference.

Question 2. Have you established metrics for soldiers in medical hold status to which you will hold the new leaders accountable? If so, what are they, and do they include reducing the number of soldiers who remain in a medical hold status as well as reducing the time for completed processing?

Response. The Army has experienced significant success in tracking the status of Reserve Component Medical Holdover Soldiers utilizing a tracking module developed as part of the Medical Operational Data System (MODS). Moving forward, both Medical Holdover Soldiers and Active Component Medical Hold Soldiers (collectively referred to as Warriors in Transition) will be tracked utilizing this capability. The MODS module provides the ability to track and evaluate status and length of time as a Warrior in Transition.

The Army Medical Action Plan currently being developed for deployment on June 15, 2007, establishes Warrior Transition Units. Established as distinct units with their own command and control structure and reporting to the local MTF commander, the appropriate Regional Medical Command, and ultimately the U.S. Army Medical Command, these Warrior Transition units are organized as companies and battalions with dedicated Primary Care Manager, Nurse Case Manager, and Squad Leader cells (referred to as the care triad) to provide focused management of Warriors in Transition to optimize the provision of care, progression through the U.S. Army Physical Disability Evaluation System, and seamless transition to civilian status and Department of Veteran's Affairs care and services.

The Army Medical Action Plan establishes access to care standards for Warriors in Transition designed to ensure priority scheduling and delivery of medical care. The combined capabilities being rolled out as part of the Army Medical Action Plan provide effective monitoring of Warrior in Transition progress, focused care management, efficient medical and physical evaluation and disposition, comprehensive Family support, and efficient transition to civilian status and Department of Veteran's Affairs services.

I am confident that implementation over the next weeks and months of the numerous improvements contained in the Army Medical Action Plan will provide our brave Soldiers with an unsurpassed and effective program to efficiently move them from point of injury through recovery, return to duty, or transition to civilian life. I look forward to reporting to you in the future the many successes this thorough and insightful plan both has and will continue to accomplish.

Question 3. Has the Army convened additional medical evaluation boards (MEBs) and PEBs to assist in completing pending evaluations and appeals? If so, how many? If not, why not?

Response. The Army is making significant changes to the MEB and PEB system. We are establishing Warrior Transition Units across the Army to better care for Warriors and their families. We are creating dedicated MEB physicians whose sole job is to manage the medical evaluation boards. The Army's Physical Disability Agency has more than doubled the number of adjudicators at each of its three PEBs since October 2001 and has increased administrative support capacity a commensurate amount. We also added a mobile PEB in 2004 to augment capability to conduct formal boards at our three fixed sites. In addition, we are taking steps to further increase our PEB manning to ensure all Soldiers continue to receive prompt disability processing.

CONDITIONS EXISTING PRIOR TO ENTRY ON ACTIVE DUTY

Question 4. Under existing law, members with less than 8 years of Active Duty service get zero disability compensation if it is determined that their disabling condition "existed prior to entry." This has resulted in soldiers, marines, and others—volunteers all—who have served one, two, or maybe even three tours of duty in Iraq receiving nothing when they suddenly are unfit for continued service. Do you think this 8-year rule is fair or should it be eliminated?

Response. We think that this rule prevents us from compensating Soldiers who we believe are deserving of disability benefits and who have served the Army and their country proudly and well. The law currently provides that the disabling condition must be incurred or aggravated as a result of military service, and we think that requirement is appropriate for Soldiers on their initial term of service. However, once a Soldier has served beyond a 2-year minimum we would like to see this requirement lifted, and we are in the process of proposing legislation that would change the 8-year rule to a 2-year rule.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. BARACK OBAMA TO HON. PRESTON M. "PETE" GEREN III, ACTING SECRETARY OF THE ARMY, DEPARTMENT OF DEFENSE

Question 1. Has the Army better engaged some of our Veterans Service Organizations (VSOs) in its recent efforts to make military health facilities like Walter Reed more responsive? Are there plans to include these groups more systematically in your new outreach and support efforts for families and servicemembers?

Response. The Army has better engaged VSOs in an effort to provide outreach and support to Soldiers and their Family members. The Walter Reed Army Medical Center's (WRAMC) Soldier and Family Assistance Center (SFAC) assists Soldiers who have been evacuated from a theater of operation to WRAMC and their Family members. SFAC provides VSO points of contact and services information to Soldiers and Family members. Currently two SFACs are in operation: one at WRAMC and one at Brooke Army Medical Center, Fort Sam Houston, Texas. The standard operating procedure manual for these two SFACs and others soon to be operational will address VSOs, the importance of VSO representation within the SFACs and the importance of making VSO services available to Soldiers and their Family members.

The Disabled American Veterans (DAV) has an office and a veteran service officer located within WRAMC. DAV also has veteran service officers available for Soldier representation at the Physical Evaluation Board (PEB) sites.

VSO information is found in several different Army-related and veteran Internet sites and in written resources accessible by Soldiers and Family members. Multiple sites pop up when "Veteran Service Organizations" is typed into the Army Knowledge Online search engine. The U.S. Army War College Military Family Program has published a Directory of Veterans Services and contains a link to a Veterans Affairs web site that provides a listing of VSOs. Several different free military handbooks include VSO information (i.e., 2007 Veterans Health Care Benefits). *Our Hero Handbook, A Guide for Families of Wounded Soldiers* is a comprehensive guide to assist families in understanding and navigating the military medical system. The handbook also has a section listing VSOs with descriptions of services, telephone numbers and web site addresses.

Question 2. We've heard from you today that many problems are being fixed at Walter Reed and important new casework pilot programs are just getting off the ground: should we turn around and rush to shut this down? Do you think it's wise to waive an environmental impact study of this expansion?

Response. The Department is committed to improving how we care for our wounded warriors as outpatients. This commitment and the improvements already in place will follow as we move care to Bethesda and Fort Belvoir. The Army's Environmental Impact Statement (EIS) at Fort Belvoir is well along. There is no reason to waive this important analysis at this point. The Navy is overseeing the EIS at Bethesda. I know of no Navy effort to waive the EIS at Bethesda.

Question 3. We saw reports today of a DOD recommendation to speed the process of closing Walter Reed under BRAC, despite the fact that ground hasn't been broken to expand the Bethesda facility. What is your view on this recommendation? Do you think it sends the right signal to servicemembers and care providers at Walter Reed?

Response. The Department supports the Independent Review Group's recommendation to accelerate the construction of new facilities at Bethesda National Naval Medical Center in Maryland and at Fort Belvoir, Virginia, and relocate

healthcare from Walter Reed as soon as the new facilities are ready. We believe this sends the strongest possible message to servicemembers, Families, and care providers—that they should have first-rate facilities befitting of their service. Should Congress not provide additional funds, the Department recommends using the Medical Military Construction process to implement unfunded requirements.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. JOHNNY ISAKSON TO HON. PRESTON M. "PETE" GEREN III, ACTING SECRETARY OF THE ARMY, DEPARTMENT OF DEFENSE

Question 1. How will the Army guarantee completion of the Post-Deployment Health Reassessment by soldiers as discussed in Mr. William Thresher's memorandum of March 7, 2006 for commanders of MEDCOM Regional Medical Commands?

Response. The Army's Post-Deployment Health Reassessment (PDHRA) program was implemented as a commander's program and as such, commanders are held responsible for ensuring that the Soldiers under their command are in compliance. In order to assist commanders in identifying Soldiers that require the screening, and for reporting compliance, each Soldier's status is tracked and maintained in an electronic database. Additionally, various resources have been allocated to ensure that Soldiers are screened in accordance with the Army's PDHRA policy. For the Active Component, the Army has already implemented walk-in screening capabilities at Army Medical Treatment Facilities and also schedules Soldier Readiness Processing (SRP) screening events for returning units as part of the Deployment Cycle Support (DCS) Program. For the Reserve Component, the Army continues to utilize deployable onsite contract screening teams and a 24x7 PDHRA Call Center. The Army expects 100 percent compliance for this mandatory program. The Army tracks PDHRA program compliance down to the individual Soldier level to ensure that all Soldiers complete the screen and have access to appropriate health care resources as needed. Program compliance is reported weekly at the Department of the Army level.

Question 2. Does the Army have adequate funds for execution and enforcement of the Post-Deployment Health Reassessment?

Response. The Army has adequate funds for execution and enforcement of the PDHRA.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. SAXBY CHAMBLISS TO HON. PRESTON M. "PETE" GEREN III, ACTING SECRETARY OF THE ARMY, DEPARTMENT OF DEFENSE

MEDICAL HOLDOVER PERSONNEL

Question 1. One key to effectively handling medical holdover personnel is by having active and engaged case managers. The Army has three medical holdover units in Georgia, at Fort Gordon, Fort Benning, and Fort Stewart. The Fort Benning medical holdover unit relies in part on contract case managers. I am not fundamentally opposed to contractors performing this function, but I do think it can put the mission at risk if the contract expires and new case managers cannot be recruited and hired in time to replace the old ones. Do you think there should be a regulation requiring a certain percentage of case managers to be DOD civilians or military personnel?

Response. No. A regulation requiring a certain percentage of case managers to be DOD civilians or military personnel would be too prescriptive. Commanders should have the flexibility to use military nurse case managers, hire civil service or contract for nurse case managers based on geographic location (availability/cost) and a stable and/or fluctuating Warrior in Transition population.

Question 2. In the event that contractors are utilized, what are you doing to ensure the medical holdover mission is not compromised and that our soldiers receive the necessary advocacy when they are in a medical holdover unit?

Response. Contract nurse case managers are utilized and have been since the beginning of the medical holdover program. There are several mechanisms in place to ensure the medical holdover mission is not compromised and Soldiers receive necessary advocacy. Military installations are visited periodically by higher headquarters to review the medical holdover program. These visits include records review, sensing sessions with Soldiers, cadre and nurse case managers. The chain of command—commanders, platoon sergeants and now squad leaders, the local Inspec-

tor General's office, ombudsman, and hotlines, as well as the nurse case manager, are available to serve as advocates for Soldiers.

SHORTAGE OF MEDICAL PERSONNEL

Question 3. My staff traveled across the State of Georgia last week and visited three DOD hospitals, and one comment that surfaced at every installation related to the Army's inability to offer attractive enough incentives to hire the doctors and nurses they need to execute their mission, as well as an overly burdensome bureaucratic hiring and contracting process that prevents military bases from getting the military, civilian, and contract health care providers that they need when they need them. I think you will agree that this is a problem across DOD. In my mind, we ought to be able to do whatever we need to streamline this process and give you the authorities you need to get the personnel you need in this area because it is one of the most critical areas facing our military. What, in your opinion, needs to be done here and how can Congress help?

Response. There are a number of initiatives underway within to Army to streamline this process and make a career in military medicine, whether as a civilian or in uniform, more attractive. Congress has provided the Department with broad authority to offer financial incentives for health professionals to join the military and to remain in the military beyond their service obligation. Reducing the eight-year mandatory service obligation for health professions is needed. For several years Congress has authorized the Department to allow hospital commanders to hire health professionals directly, bypassing many of the civilian personnel requirements. Making this Direct Hire Authority permanent and expanding it from 12 to 45 healthcare occupations is also important.

The National Security Personnel System provides flexibility to increase the salaries of certain health professionals' compensation beyond what current statutory authority allows. This tool is extremely important to attracting and retaining civilian health professionals. Some remedial actions can be done without legislation. The Department should consider implementing Title 38 provisions in the Delegated Agreement with the Office of Personnel Management, which allows the use of Title 38 locality pay, qualifications and classification standards for nurses.

POST-DEPLOYMENT HEALTH ASSESSMENT

Question 4. I understand that the Army requires each soldier who redeploys from theater to undergo a post-deployment health reassessment 90 to 180 days after their return. This is obviously a good idea since many conditions may not show up until several months after a deployment. However, I understand that these health assessments are not always done in person but can be done over the phone and by contractors versus military personnel. In my mind this is not ideal and allows for many conditions to be overlooked and go unreported which might then surface months or years later. Specifically, related to some of the most common conditions such as PTSD and TBI, I believe that it would be particularly hard if not impossible to diagnose these conditions over the phone. Regarding the post-deployment health assessment process, do you believe it would be wise for DOD and the Army to require these assessments to be conducted in person by military personnel?

Response. Soldiers routinely receive health care from either a civilian or military medical provider depending upon the circumstances and the availability of providers. Many of our post-deployment health reassessment (PPDHRA) events are conducted by trained military personnel; however, because of availability, we sometimes rely on licensed health care providers that are Army civilians or trained personnel under contract for the specific purpose of conducting a PDHRA screening to DOD standard. It is mandatory that each PDHRA include an interview with a qualified health care provider. This one-on-one interview is a key component of the PDHRA screen. The provider reviews each Soldier's responses, asks additional questions, and then decides whether to make a referral for an evaluation. The PDHRA is a screening assessment only and does not provide a diagnosis. The provider, however, makes a decision in each case whether to refer a Soldier for a follow-on evaluation appointment. In the majority of cases, the provider interviews are conducted face-to-face, but there is also a Call Center option available for those Soldiers located in remote locations who would not be able to attend an onsite PDHRA event. We have dispatched face-to-face screening teams to Guam, the Virgin Islands, and other remote locations. For those Soldiers that receive a referral for a behavioral health reason, any subsequent diagnosis of PTSD, or a related condition, would be made during a medical appointment by a qualified health care provider and never during the PDHRA screen.

Question 5. How do DOD and the Army ensure that soldiers actually complete these health assessments?

Response. The post-deployment health assessment (PDHA) is conducted prior to Soldiers leaving the theater of operations and is a requirement for redeployment. For both the PDHA and the PDHRA, the Army tracks compliance through the use of an electronic database. This database keeps track of all Soldiers and identifies which Soldiers have deployed and their individual eligibility and compliance status with each program. Commanders at all levels are held accountable for the compliance of all Soldiers under their command for both programs.

Chairman LEVIN. Thank you, Secretary Geren.

Dr. Cross, we understand you do not have a statement.

Dr. Cross. No, Mr. Chairman.

Chairman LEVIN. Thank you. General Scott?

STATEMENT OF LIEUTENANT GENERAL JAMES TERRY SCOTT (RET.), CHAIRMAN, VETERANS' DISABILITY BENEFITS COMMISSION

General SCOTT. Chairman Levin, Chairman Akaka, Members of the Committees, it is my pleasure to appear before you on behalf of the Veterans' Disability Benefits Commission. Mr. Chairman, I request to submit my written statement for the record.

Chairman LEVIN. It will be made part of the record.

General SCOTT. And I also would comment that my name tag should read Lieutenant General, Retired. The military should no longer be required to bear the burden of my words and actions.

[Laughter.]

Chairman LEVIN. We will also note that for the record and we will correct that as quickly as humanly possible, which means the next hearing.

[Laughter.]

General SCOTT. Sir, the Commission was established by the National Defense Authorization Act of 2004. That law charged the Commission with studying the benefits available for disabilities and deaths related to military service, more specifically the appropriateness of the level of the benefits, and how a decision is made whether to compensate a veteran.

We are in the process of doing an in-depth study of disability benefits and my written statement contains the information on the range of issues being addressed. The Commission has not completed its work and is not scheduled to present its report until October 1, 2007. We have not reached conclusions at this time. I must emphasize that my comments today are my own and not necessarily those of the Commission. However, I believe my fellow Commissioners are in agreement that significant improvement is needed in the processes and procedures that affect the transition from military to veteran status, particularly when it involves the transition of sick and injured servicemembers.

I am aware of your interest in the comparison the Commission is conducting between disability ratings made by DOD and those made by the VA. We asked our contractor, the Center for Naval Analysis, to conduct a study to determine, based on accurate data provided by the DOD, whether there are, in fact, significant differences in the ratings assigned by DOD and VA to the same individuals.

Some 83,000 records were provided by DOD of servicemembers who were found unfit for military duty during the period 2000 through 2006. Eighty-one percent of these people were rated less than 30 percent disabled and discharged, most with only severance pay. Perhaps the greatest importance to the servicemember is that he or she is not then eligible for family health care coverage. VA will provide health care for the service-disabled veteran, but not for the family unless the veteran is rated 100 percent disabled.

Over 13,000 Army soldiers were found unfit for military duty yet rated zero percent. Navy, Marine, and Air Force assigned zero percent yet unfit ratings to about 400 individuals each. We discussed this with Army and the explanation is that these soldiers were found unfit by with symptoms whose severity did not qualify for a compensable rating of at least 10 percent. For these Army soldiers rated at zero percent by DOD, the average VA rating was 56 percent.

The DOD records were matched with VA records on 2.6 million veterans receiving disability compensation. The combined VA rating for these individuals was generally higher than the DOD rating. To cite an example, those rated 0, 10, or 20 percent by DOD were rated in the 30 to 100 percent range by VA more than half of the time.

We believe the difference in the overall combined ratings is mostly caused by DOD rating fewer disabilities. The number of conditions rated by DOD is much lower than VA. DOD rated only one condition 83 percent of the time. VA rated 2.6 to 3.3 more disabilities per person than DOD. It is our understanding that DOD policy, not statutory requirements, instructs the services to rate only the disabilities found to be unfitting.

I believe that the inconsistency between the DOD ratings and the VA ratings can be largely explained by two factors. DOD rates only the condition or conditions that DOD finds unfitting, and DOD does not use the VA's schedule for rating disabilities in the same way that VA does. Variance among the service's missions also contributes. It is also apparent that DOD has a strong incentive to rate less than 30 percent so that only severance pay is awarded.

I believe that the issue of consistency of ratings should be considered in the context of a broader goal of improving the transition from active duty military member to veteran status. The goal should be to transition the person in a way that respects his or her service to our country while providing appropriate continuity of health care, financial stability, and dependent and family care. I recommend four short-term actions and a long-term realignment of function.

First, the current DOD process should be restructured to streamline the Medical Evaluation Board and Physical Evaluation Board responsibilities and procedures.

Second, DOD should immediately begin to medically evaluate and rate all disabilities that are identified as part of a comprehensive medical examination.

Third, VA and DOD should immediately conduct a joint analysis of the DOD and service instructions on rating and compare those instructions with the VA's schedule for rating disabilities and the VA's policies. This analysis should consider the soon-to-be-released

study by the Institute of Medicine on the VA rating schedule that is being conducted for the Commission.

Fourth, remove the statutory requirement that prevents veterans from being paid any compensation for the partial month in which discharge occurs and delays the second month's payment until the first day of the following month. The current requirement results in the veteran having no source of income for up to 2 months.

Turning to the long term, I recommend a major realignment of the decisionmaking processes used to decide whether a servicemember is unfit for duty and eligible for either military disability retirement or separation with severance pay and VA disability compensation. The primary features of such a realignment should be: The service determines fitness for duty. This is the most important issue for the service and it is rightly their responsibility. If found unfit, all servicemembers should be referred to the VA for rating prior to discharge. VA would assign the rating for all service-connected disabilities that are found in a comprehensive medical examination.

I am aware, as are the Members of these Committees, of the often confusing situation and status regarding compatible VA and DOD computer systems. From information made available by the two departments, it is very difficult to understand the current level of compatibility and the direction for the future. Goals, objectives, and milestones are vague and not well defined.

The Commission has found that the two departments do not currently use compatible systems, regardless of assertions to the contrary. For example, the DOD system does not have the capability, as VA's does, to digitally store inpatient discharge summaries and images from CAT scans, MRIs, and X-rays. I believe that compatible IT systems may well be one of the most important steps that can be taken to improve transition, and parenthetically, it should also help improve the timeliness of VA claims processing.

Finally, transition must address the needs of the families of the disabled, especially the severely disabled. DOD has considerable latitude to assist with transportation expenses and lodging. VA is very limited by its statutory authority. Generally, VA can provide only milage compensation for the veteran to travel for medical treatment.

Concerning long-term assistance for the severely disabled, VA is also limited to aide and attendants and house-bound stipends that may not be adequate to maintain a level of independent living. Additional benefits should be considered to support the families who are bearing the heavy burden of caring for severely injured veterans. We cannot depend on every severely injured veteran having a stable, supportive family, particularly as parents age and pass away.

In conclusion, improving the transition of wounded servicemembers in a manner that assures continuity of health care, financial stability, and family care is of the utmost importance. I hope the data that the Commission has provided you today on the comparison of VA and DOD ratings and my suggestions for addressing the existing shortcomings in the transition of wounded and injured servicemembers are useful in your deliberations. As you know, the Commission is analyzing a wide range of issues and

we look forward to submitting our report in the fall that will provide recommendations to you and the two departments. In the meantime, the Commission is available to assist you in your deliberations.

Thank you for the opportunity to speak with you today.

[The prepared statement of General Scott follows:]

PREPARED STATEMENT OF LIEUTENANT GENERAL JAMES TERRY SCOTT (RET.), CHAIRMAN, VETERANS' DISABILITY BENEFITS COMMISSION

Chairman Levin, Chairman Akaka, Ranking Member McCain, Ranking Member Craig, and Members of the Committees:

It is my distinct pleasure to appear before you on behalf of the Veterans' Disability Benefits Commission (the Commission). As you may recall, the Commission was established by the National Defense Authorization Act of 2004. The law charged the Commission with studying benefits available for disabilities and deaths related to military service, specifically:

- The appropriateness of the benefits,
- The appropriateness of the level of benefits, and
- The appropriate standards for determining whether the disability or death of a veteran should be compensated.

We are committed to meeting that charge for the betterment of all of our Nation's veterans. Many of us, who are combat veterans ourselves, have watched a new generation return from the battlefield to face the challenges of severe wounds/illnesses, unemployment, family adjustments, and mental health issues. We are ever-mindful of these challenges as we carry out our study of the benefits under the laws of the United States that compensate and assist veterans and their survivors for disabilities and deaths attributable to military service.

We have identified thirty-one research questions for further analysis, which are enclosed for the record. Commission staff, aided by the Institute of Medicine (IOM) and the Center for Naval Analyses (CNA), is in the process of methodically addressing these questions. Additionally, we have conducted a series of eight site visits throughout the country, held monthly open public meetings, and have heard from the Department of Veterans Affairs, the Department of Defense and the Services, the Department of Labor, the Social Security Administration, Veterans Service Organizations, The Military Coalition, Professional Associations, Congressional staffers, and individual veterans and family members.

The Commission has not completed its work, is not scheduled to present its report until October 1, 2007, and has not reached conclusions at this time.

I must emphasize that my comments today are my own and do not represent the views of the other members of the Commission. However, I believe my fellow Commissioners are in agreement that a great deal of improvement is needed in the overall processes and procedures that affect the transition from military to veteran status, and most emphatically when it involves the transition of our sick and injured servicemembers.

The recent media attention on Walter Reed Army Medical Center and more generally on the treatment and disability evaluation of soldiers, sailors, marines, and airmen have led to several Congressional hearings, both in the House and Senate. I believe that this intense scrutiny is appropriate and necessary.

Your Committees are specifically interested in the comparative analysis that the Commission is undertaking to assess the level of consistency between disability ratings assigned by DOD and VA. This analysis is continuing but preliminary results are available and should contribute to the dialogue on the issue.

The Commission became concerned with the consistency of DOD and VA disability ratings because of anecdotal allegations presented by individuals to the Commission, a 2002 RAND study, and the 2006 GAO report assessing the DOD Disability Evaluation System.

You may not be aware that the 1956 Bradley Commission also analyzed this issue and interestingly found that at that time the military was more generous in its ratings than VA.

In order to assess consistency of ratings between DOD and VA, the Commission asked its contractor, the Center for Naval Analyses (CNA) to compare DOD rating decisions with VA ratings. The Commission requested data in the Fall of 2006 from the Army, Navy, and Air Force on all disability separations and disability retirements from 2000 to 2006. The Navy Physical Evaluation Board handles both Navy and Marine Corps disability decisions, but we separated the data for the two Serv-

ices. As a result, 65,087 records were provided initially. The data was compared with data from VA and preliminary results were presented by CNA to the Commission at its March 22–23, 2007, public meeting. These results were posted to the Commission's Web site and shared with Senate staff.

Subsequently, on April 2, 2007, in a meeting with DOD, Commission staff was informed that the data provided by Army and Navy was not accurate in that it omitted records for individuals initially placed on TDRL for a period of stabilization and later permanently rated. Revised data was provided by Army and Navy to CNA on April 4, 2007. The revised data included a total of 83,004 records and significantly affected the analysis. The revised data was quickly analyzed and preliminary results are provided in this statement. I emphasize that these are preliminary results with more complete analysis to follow.

The disability ratings shown in Table 1 are the combined or overall ratings assigned by DOD. Those found unfit for military duty who have less than 20 years of service and are rated less than 30 percent disabled receive a severance payment but no continuing retirement payment, are not eligible for health care coverage for themselves or their families, and no other benefits from DOD. As can be seen, overall 19 percent of those rated by DOD are in the 30–100 percent range. The percentage rated 30 percent or higher ranges from 13 percent for the Army to 36 percent for the Navy. The individuals rated 30 percent or higher will receive continuing military disability retirement, health care coverage for themselves and their families, and many other military retirement benefits.

Table 1. Veterans With DOD Disability Ratings (2000–2006)

Combined disability rating	Army	Navy	Marines	Air Force	Total
0–20%	44,307 (87%)	8,603 (64%)	7,769 (82%)	6,862 (73%)	67,541 (81%)
30–100%	6,369 (13%)	4,849 (36%)	1,748 (18%)	2,497 (27%)	15,463 (19%)
Total	50,676	13,452	9,517	9,359	83,004

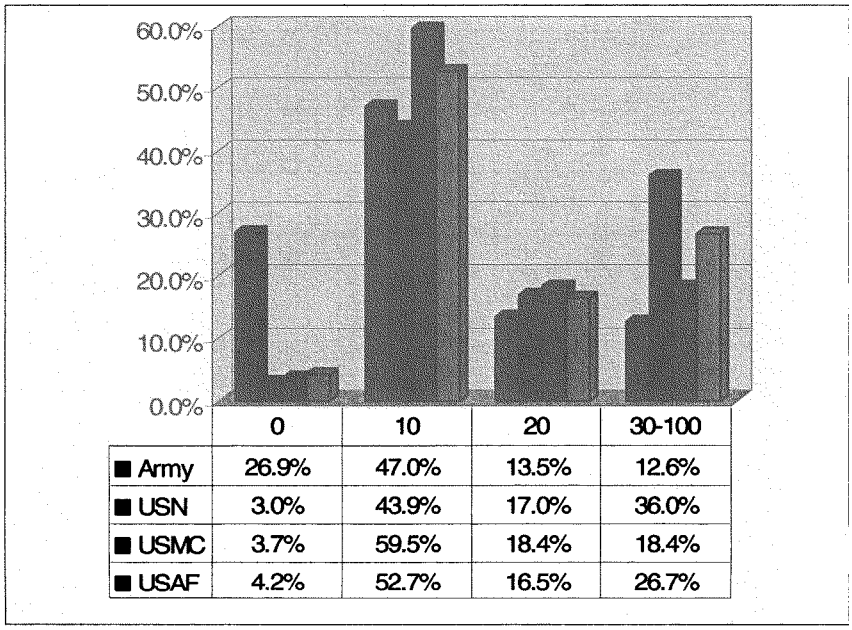
The Army data contained 13,646 records (27 percent) out of the total of 50,676 soldiers who were found unfit for duty yet assigned zero percent ratings. Navy, Marine Corps, and Air Force assigned zero percent ratings to about 400 individuals or less each. We discussed this with the Army and their explanation is that these soldiers were found unfit but with symptoms whose severity did not qualify for a compensable rating of at least 10 percent. We note, however, that whether the DOD rating is zero, ten, or twenty percent, the severance payment from DOD is the same. Of the Army zero percent ratings that matched with VA records, the average VA disability rating was 56 percent for those with 20 or more years of service and the average was 28 percent for those with less than 20 years of service and receiving severance. I suggest that an in-depth analysis of these zero percent ratings be conducted to ascertain the reasons for these ratings.

It is important to note that DOD only rates the condition or conditions that DOD finds makes the individual unfit for duty. To our knowledge, this policy is set forth in DOD directives and is not set by statute. VA rates all claimed conditions and determines whether or not each condition is service connected. For veterans rated by both agencies, DOD rated only one condition 83 percent of the time. For cases in which DOD rated one condition, VA rated an average of 3.7 conditions.

CNA compared the DOD records to data requested by the Commission from VA on all 2.6 million service-disabled veterans as of December 1, 2005. Records on service personnel separated or retired after 2004 would generally not be found in the VA data because their claims would not have been processed. Focusing on the individuals receiving DOD disability ratings from 2000 to 2004, 78 percent had also received ratings from VA by December 2005. We have requested current data from VA which will be used to update the comparison in the coming months.

Looking at the differences among the Services, Figure 1 shows that the ratings by the Navy, and to a lesser extent the Air Force are significantly different than those of the Marines and Army in the proportion of ratings in the 30–100 percent range.

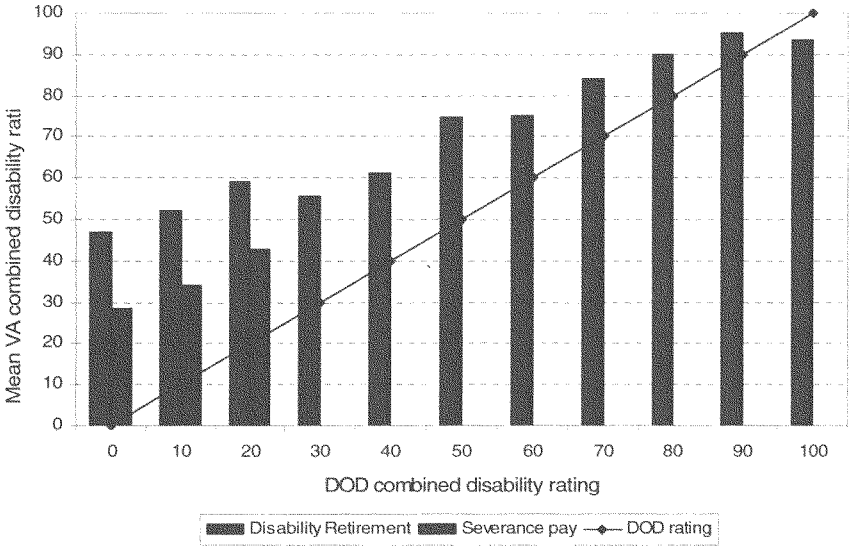
Figure 1. Distribution of Veterans by DOD disability rating



	0	10	20	30-100
Army	26.9%	47.0%	13.5%	12.6%
USN	3.0%	43.9%	17.0%	36.0%
USMC	3.7%	59.5%	18.4%	18.4%
USAF	4.2%	52.7%	16.5%	26.7%

Comparing the combined ratings by DOD to the combined ratings by VA, Figure 2 shows that VA ratings (represented by the bars) are higher on average than DOD ratings (shown on the horizontal scale and the diagonal line) at almost all levels. The green bars to the left represent those with less than 30 percent ratings and less than 20 years of service; these were provided severance pay only. For example, the green bar at the far left shows that for those assigned a zero percent rating by DOD, VA rated them an average of 29 percent. Likewise, the red bar 4th from the left shows that for those rated 30 percent by DOD, VA rated them an average of 56 percent. The difference is more pronounced for those rated less than 30 percent but eligible for retirement with 20 or more years of service as represented by the first three red bars to the left.

Figure 2. Comparison of Average VA Rating with DOD Ratings (N = 52,573)



Of all of those rated by DOD as zero, ten, or twenty percent, VA rated them at 30 percent or higher 59 percent of the time.

The number of conditions rated is very different between VA and DOD, as can be seen in Table 2, and we believe that this difference accounts for the largest portion of the difference in the overall ratings by DOD and VA. In general, VA rated 2.4 to 3.3 more disabilities than DOD.

Table 2. Average Number of VA Disabilities vs. the Number of DOD Disabilities

Service	Number of DOD Disabilities	Number of Veterans	Average Number of VA Disabilities	Difference
Total	1	42,922	3.7	2.7
	2	7,557	5.2	3.2
	3	1,660	6.1	3.1
	4+	434	6.8	2.8
Army	1	25,696	3.6	2.6
	2	4,583	5.2	3.2
	3	902	6.3	3.3
	4	239	7.0	3.0
Navy	1	8,013	3.8	2.8
	2	1,250	5.3	3.3
	3	336	6.1	3.1
	4+	139	6.4	2.4
USMC	1	5,375	3.6	2.6
	2	614	5.3	3.3
	3	124	6.0	3.0
	4+	56	6.9	2.9
USAF	1	3,840	4.2	3.2
	2	1,110	4.8	2.8
	3	298	5.7	2.7

Note: the Army data caps the number of disabilities at 4 and the Air Force cap is 3. The Air Force data only contains a single, combined percentage rating so records with more than one disability could not be considered in the analysis of individual disabilities.

Because of the difference in the number of conditions rated, it is important to analyze the ratings assigned by DOD and VA to the same diagnosis experienced by the same individual.

CNA found 26,447 matches of individual diagnoses and analyzed the seven most frequent diagnoses:

- Lumbosacral or Cervical Strain
- Arthritis
- Intervertebral Disc Syndrome
- Asthma
- Diabetes
- Knee Impairment
- PTSD

Six other diagnoses among the 20 most frequent diagnoses were also selected:

- Traumatic Brain Injury
- Migraine
- Seizure Disorder
- Bipolar
- Major Depressive Disorder
- Sleep Apnea

Together, these thirteen diagnoses comprise 16,169, or 61 percent, of the individual diagnoses matched.

CNA found that overall 73 percent of those diagnoses rated 0–20 percent by DOD were also rated 0–20 percent by VA showing general agreement between VA and DOD from the individual diagnosis perspective. In some cases the VA rating was lower, but more often VA was higher. However, for individual veterans with a combined rating of 0–20 percent from DOD, only 41percent were also rated 0–20 percent by VA. This shows the propensity for VA to give higher ratings overall due to rating more conditions.

However, for eight of the thirteen diagnoses, where DOD rated cases at 0–20 percent, VA rated cases from 30–100 percent. These include:

1. Sleep Apnea	100 percent of the time VA rated 30–100 percent
2. Seizure disorder	39 percent of the time VA rated 30–100 percent
3. PTSD	87 percent of the time VA rated 30–100 percent
	55 percent of the time VA rated 50–100 percent
4. Asthma	58 percent of the time VA rated 30–100 percent
5. Traumatic Brain Injury	40 percent of the time VA rated 30–100 percent
6. Bipolar	71 percent of the time VA rated 30–100 percent
7. Major depressive disorder	73 percent of the time VA rated 30–100 percent
8. Migraine	73 percent of the time VA rated 30–50 percent

CNA found that DOD rated 107 of 123 cases of sleep apnea as zero percent disabling, yet unfit. VA rated all 107 cases in the 30–100 percent range with 98 rated at 50 percent and one at 100 percent. 105 of the 123 cases were Army. The DOD directive provides instructions for using the VA Rating Schedule that, in effect, changes the criteria for many conditions. DOD instructions regarding sleep apnea profoundly change the criteria. For some conditions such as knee impairment, the DOD criteria is more specific and more measurable than the VA criteria, while for other conditions such as sleep apnea, the DOD criteria is less specific and less measurable.

Of the thirteen individual diagnoses analyzed, the VA ratings were statistically significantly higher than all of the Services for 8 diagnoses: lumbosacral, intervertebral disc syndrome, asthma, sleep apnea, diabetes, migraine, seizure disorder, PTSD, bipolar, and major depressive disorder. The difference was significant for 12 of 13 diagnoses for Army; the only exception being the knee. The Air Force was significantly different for 11 of the 13 diagnoses, the Navy was significant for 10 of 13 diagnoses, and Marines were significantly different for 8 of the 13 diagnoses.

Table 3. Statistical Significance of Individual Diagnoses

Diagnosis	Difference between VA and DOD is statistically significant*			
	Army	USAF	USMC	Navy
Arthritis	x			
Lumbosacral or Cervical Strain	x	x	x	x
Intervertebral Disc Syndrome	x	x	x	x
Knee Condition				
Asthma	x	x	x	x
Sleep Apnea	x	x		x
Diabetes	x	x		x
Traumatic Brain Injury (TBI)	x	x		
Migraine Headaches	x	x	x	x
Seizure Disorder	x	x	x	x
PTSD	x	x	x	x
Bipolar Disorder	x	x	x	x
Major Depressive Disorder	x	x	x	x

*''x'' marks indicate that the mean VA rating is statistically higher than DOD's rating at the 5-percent level.

Graphic presentations of these thirteen individual diagnoses are enclosed for the record.

Inconsistency in ratings between VA and DOD can largely be explained by two factors. One, DOD only rates the disability or disabilities that DOD determines makes the servicemember unfit. Second, DOD does not use the VA Rating Schedule in the same way that VA does. Variance in ratings among the Services and between VA and the Services can also be partially explained by the differences in mission between the Services and the disability determination standards they set. It is also apparent that DOD has strong incentive to assign ratings less than 30 percent so that only separation pay is required and continuing family health care is not provided.

DOD issues DODI 1332.38, which describes the Physical Disability Evaluation, and DODI 1332.39, Application of the Veterans Administration Schedule for Rating Disabilities. Army, Navy, and Air Force each provide their own directives to the field on how to implement title 10 U.S.C. and the DOD Instructions based upon the unique needs and missions of their Services. Army issues AR 600–60, Physical Performance Evaluation System and AR 635–40, Physical Evaluation for Retention, Retirement or Separation. Navy issues SECNAV 1850.4E, Department of the Navy Disability Evaluation Manual. Air Force issues the Physical Evaluation for Retention, Retirement or Separation or AFI 36–3212.

The 2006 GAO study found that DOD delegates to the Services and does not maintain accountability or monitor compliance over the Disability Evaluation System. The Services are allowed to establish different time frames for line of duty determinations, Medical Evaluation Board (MEB) referrals, MEB compositions, MEB appeals, Physical Exam Board (PEB) responsibilities and compositions, and training. RAND (2002) "identified 43 issues regarding variability in policy application across or within the military departments' . . . that affect the performance of the DES."

GAO also found that there is no common DOD database that tracks disabled servicemembers and each Service's database is different. This lack of a common database complicated the CNA comparison of DOD and VA ratings considerably. GAO also found that there is no consistency in MEB/PEB training, or in the use of counselors.

While DOD asserts that it follows the VA Schedule for Rating Disabilities, the instructions issued by DOD and the Services, in effect, change the criteria contained the Rating Schedule and how the Rating Schedule is applied.

After discharge, the former servicemember must file a claim for disability with VA. A servicemember can either go through a Benefits Delivery at Discharge (BDD) process in which they file their claims while still on active duty, or they must file a claim at one of VA's 57 regional offices after discharge. Either way, the VA process largely duplicates the process the veteran faced before discharge. As mentioned before, almost 80 percent of those discharged by DOD as unfit for duty subsequently file disability claims with VA. To the veteran, this means another round of applications, examinations, determinations, and time. Currently, the VA is experiencing a backlog of approximately 400,000 cases and takes an average of 177 days to rate a claim. When a panel of disabled servicemembers appeared before the Commission, they told us that even 1 to 2 months without financial support creates a hardship

upon them and their families. Waiting up to 6 months certainly would put these disabled servicemembers at a socio-economic disadvantage that could lead to other complications.

The Commission is also aware that there are variances in how those 57 VA regional offices rate claims. This was reported by the VA Office of the Inspector General in May 2005. VA has since contracted with the Institute for Defense Analysis to conduct an analysis of the reasons for variations in ratings among VA Regional Offices. We understand that this study will be completed shortly and the Commission has requested a briefing on the results. In addition, the Commission contracted with the Institute of Medicine (IOM) to evaluate the VA Schedule for Rating Disabilities (VASRD) and make suggestions for improvement. The IOM report should give us a better understanding of the best way to evaluate veterans' disabilities and compensate for them.

Training and certification for medical examiners and raters were also essential issues brought to the attention of the Commission. It is evident that VA is making a concerted effort to improve the examination process by improving training, developing templates for use by the examining physicians and routinely assessing the quality of exams. Yet, to date the templates are not mandatory and certification is not required.

Thus, both VA and DOD face challenges to improve rating veterans and servicemembers for disability. The CNA comparison of ratings is continuing but even at this preliminary stage, it is apparent that servicemembers are not well served by the current process to evaluate disabilities and award benefits. I believe that both short-term and long-term changes are needed to ensure equity.

For the short term, I would immediately require DOD to evaluate and rate all disabilities that are identified as part of a comprehensive medical examination. It is unfair to discharge servicemembers with ratings that reflect only one disability when often other disabilities are present and identified. This is particularly true since Army rates so many soldiers as unfit but at zero percent rating. In addition, I recommend that a thorough joint VA/DOD analysis of the DOD and Service instructions in comparison with the VA Rating Schedule be undertaken. This analysis should carefully consider the soon to be released analysis of the VA Rating Schedule by the Institute of Medicine.

Another short-term action could greatly improve a servicemember's financial stability during transition. An obstacle to an effective f, inancial transition is the current statutory requirement that disability compensation payments cannot be paid from the effective date of entitlement but are required to be delayed until the first day of the second month after they are entitled. This is true even for those filing a claim within 1 year of discharge whose entitlement date is the day after the date of discharge. This requirement was enacted as a budget saving provision in the Omnibus Budget Reconciliation Act of 1982[1]. While this restriction might seem reasonable from a cost savings standpoint, it means that servicemembers do not receive any disability benefits for up to 2 months after discharge. For example, a veteran discharged on August 2, 2006, could not be paid disability benefits for the partial month of August and could not be paid September benefits until October 1. Before this statutory change, the veteran would have received payment from the effective date which was August 3. Veterans still have to provide for themselves and their families, especially those who are unable to work. I would recommend that Congress consider changing this requirement.

For the long term, beyond disability ratings, there are other issues that should be addressed in the context of the broader goal of improving the transition from active duty military member to veteran status. In general, the goal should be to transition the person in a way that respects his or her service to our country and provides appropriate continuity of health care, financial payments, and care for dependents and family members.

I would recommend that serious consideration be given to a major realignment of the decisionmaking process used to decide if servicemembers are unfit for duty and eligible for military disability retirement or separation with severance pay and for VA disability compensation.

The major features of such a realignment should be:

1. The Services determine fitness for duty.
2. If a servicemember is found unfit, the servicemember's case should be referred to VA before discharge.
3. VA would rate and assign the percentage of disability of all service-connected disabilities found on exam.

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[1] Public Law 97–253, § 401, 96 Stat. 763, 801, now U.S.C. § 5111.

4. VA/DOD would share the cost of the exam process.

5. VA/DOD must utilize a common, electronic patient and personnel record system while maintaining quality control over existing paper records.

I believe that fitness for duty is the primary and most important issue for the Services. They each have their own unique needs for manpower to meet their missions. A servicemember's ability to perform their Military Occupational Specialty (MOS) based on their office, grade, rank or rating should be evaluated against the good of the service. That should continue. Currently, the Medical Evaluation Board (MEB) determines fitness for duty. The Services can find someone fit and return them to full duty, or issue a "profile" that limits duty. If a servicemember is found unfit under the current process, a Physical Evaluation Board (PEB) assigns a disability rating.

I suggest that the responsibility for assigning a disability rating be turned over to VA and that the DOD MEB/PEB structure be streamlined. This would provide the servicemember with a single, objective rating that would apply to both military disability retirement or severance pay and to VA disability compensation. In essence, this would expand the Benefits Delivery at Discharge process that VA has implemented and relieve DOD of the burden of making the rating decision. The disability rating should be completed prior to discharge in order to provide continuity of financial and healthcare support.

Key to this realignment would be the development and implementation of a single, comprehensive medical examination protocol that would be used by both DOD and VA. This protocol would require examining all conditions that were found on exam, and not be restricted to the "unfitting" conditions. Servicemembers would not be subjected to multiple examinations. At some locations, it may be appropriate for the examinations to be conducted by VA medical staff and at other locations DOD staff could conduct them. Training and certification of all examiners will be essential for consistent, high quality examinations.

I realize that funding of both program administration and disability benefits are of concern for both DOD and VA. Budgetary considerations are very important. But neither the taxpayer nor the servicemember being discharged for disability cares whether the costs are covered by the DOD budget or the VA budget or some combination of the two. They care that the person disabled in the service of our country is provided with prompt and appropriate compensation, health care, and other benefits.

In order for transition from military to veteran status to be seamless, effective, and efficient, VA and DOD absolutely must develop and use a common electronic system for both medical records and military personnel records. Extensive discussion of common IT systems has occurred over the years but this remains an illusive goal, not a reality. You are well aware of the problems. Our Commission has found it very difficult to fully understand the current status of compatibility between VA and DOD systems. It has also been difficult to assess the future plans of the two departments. Goals, objectives, and milestones are often vague and not well defined. I understand that the Congress has struggled with conflicting information about many of these same issues. Despite claims to the contrary, VA and DOD do not currently use compatible systems. Too much attention may be focused on developing the perfect system so that interim, short-term solutions are ignored. The DOD ALTHA system may provide a more modern platform than VA's VISTA, but in the meantime significant capability residing in the older VA system is not available to DOD users. For example, inpatient discharge summaries and digital images from CAT scans, MRIs, and X-rays have been included in VA's VISTA for many years but are not yet available in DOD's ALTHA. This means that those records and images cannot be transferred to VA upon discharge. Quick fixes are needed now to solve this problem.

If DOD and VA were required to use compatible IT systems that allowed for the immediate electronic transfer of all medical records and military personnel records, then processing new disability claims would be expedited. This may well be one of the most important steps that can be taken to speed up claims processing for those leaving the military.

An effective transition demands caring for the families of the disabled, especially in the event of severe or catastrophic disability. Currently, DOD has considerable latitude to provide the families of the severely injured with transportation, expenses, and lodging. VA is currently severely limited in what it is statutorily authorized to provide for families. This should be corrected as soon as possible. I was heartened to learn of legislation recently passed by the House of Representatives that would increase the mileage rate paid to veterans for Beneficiary Travel but this does not solve the problem for those severely wounded and disabled or their families.

DOD has an array of programs that assist with reunion and reintegration and can authorize Individual Travel Orders and per-diem to non-medical attendants. However, there is no statutory authority for VA to provide any level of support to these same families when the servicemember leaves the military and transfers to a VA Medical Center. VA is able to provide very limited long-term financial support in the form of Aid and Attendance or Housebound stipends for veterans rated 100 percent only. The amount may not be sufficient for the severely disabled to maintain independent living. And even these VA benefits are reduced during prolonged periods of hospitalization.

In conclusion, I hope that the issues and recommended solutions outlined here today will be beneficial to your Committees. The Commission is analyzing these issues and its other research questions in depth. When the analysis is completed in October we will provide you with a comprehensive report that includes recommendations that you, and the two departments can act upon. I look forward to sharing the full report with your distinguished Committees in the Fall. In the meantime, the Commission is available to assist you in any of your deliberations.

Enclosure 1

VETERANS' DISABILITY BENEFITS COMMISSION,
LIST OF RESEARCH QUESTIONS, VERSION 2 (10—4—05)

1. How well do benefits provided to disabled veterans meet Congressional intent of replacing average impairment in earnings capacity?

2. How well do benefits provided to disabled veterans meet implied Congressional intent to compensate for impairment in quality of life due to service-connected disabilities?

3. How well do benefits provided to survivors meet implied Congressional intent to compensate for the loss of the veterans/servicemembers' earning capacity and for the impairment in quality of life due to service-connected death?

4. How well do benefits provided to disabled veterans and survivors meet implied Congressional intent to provide incentive value for recruitment and retention?

5. Should the benefit package be modified?

a. Would the results be more appropriate if reduced quality of life and lost earnings were separately rated and compensated?

b. Would the results be more appropriate if the level of payment was higher before some normal "retirement age" and lower thereafter?

c. Are there negative unintended consequences resulting from the current benefit structure? Does the receipt of certain levels of compensation provide a disincentive to work or undergo therapy?

d. To what extent should VA modify its compensation policies if data from certain categories of service-connected veterans demonstrate little or no measurable loss of earning capacity and/or quality of life?

6. How well do the medical criteria in the VA Rating Schedule and VA rating regulations enable assessment and adjudication of the proper levels of disability to compensate for both the impact on quality of life and impairment in earnings capacity?

7. How does the adequacy of disability benefits provided for members of the Armed Forces compare with disability benefits provided to employees of Federal, State, and local governments, and commercial and private-sector benefit plans?

8. How do the operations of disability benefits programs compare?

a. The role of clinicians in the claims and appeals processes, and the required number of staff for this function.

b. The role of attorneys and legal staff in the claims and appeals processes, and the required number of staff for this function.

c. Compensation Claims Process

d. Appeals Process

e. Training and certification of staff and client representatives

f. Quality Assurance/Control Program

9. Pertinent law and regulations require that disability compensation be based on average impairment of earnings capacity, not on loss of individual earnings capacity.

a. Would the results be more appropriate if factors such as the individual's military rank, military specialty, pre-service occupation, education, and skill level were taken into consideration in determining benefits?

b. Would the results be more appropriate if the effect of the veteran's medical condition on his or her occupation were taken into consideration in determining benefits?

10. Should lump sum payments be made for certain disabilities or level of severity of disabilities? Should such lump sum payments be elective or mandatory? Consider the merits under different circumstances such as where the impairment is to quality of life and not to earnings capacity.

11. Should universal medical diagnostic codes be adopted by VA for disability and medical conditions rather than using a unique system? Should the VA Schedule for Rating Disabilities be replaced with the American Medical Association Guides to the Evaluation of Permanent Impairment?

12. Are benefits available to service disabled veterans at an appropriate level if not indexed to cost of living and/or locality? Should the various benefits that are presently fixed be automatically adjusted for inflation?

13. Should VA's definition for "line of duty" change? If so, how?

14. To what extent, if any, should VA policies relating to presumptive conditions be changed?

15. Should certain rating principles related to service connection be modified? (See questions below:)

a. To what extent, if any, should "age" factor into determining entitlement to service connected compensation?

b. To what extent should the benefit of the doubt rule be reconsidered or redefined?

c. To what extent should service connection on a "secondary" basis be redefined?

d. To what extent should service connection on an "aggravation" basis be redefined?

16. Do changes need to be recommended for the Individual Unemployability (IU) benefit?

17. Because Vocational Rehabilitation and Employment (VR&E) benefits are an integral part of the compensation package for many service connected veterans, what changes, if any, are needed in this program?

18. Should there be a time limit for filing an original claim for service connection? (does not include claims for service connection on a presumptive basis)

19. Currently, a pending claim terminates at the time of the veteran's death even when dependents remain. To what extent, if any, should this law be changed?

20. Certain criteria and/or levels of disability are required for entitlement to ancillary and special purpose benefits. To what extent, if any, do the required thresholds need to change?

21. What recommendations, if any, should the Commission make in regards to Concurrent Receipt policies?

22. Should the Commission explore and recommend changes to the "duty to assist" law? If so, how?

23. Should the Commission explore the Character of Discharge Standard?

24. Should compensation payments be protected from apportionments and garnishments?

25. In regards to Post Traumatic Stress Disorder (PTSD), what policy changes, if any, need to be recommended?

26. To what extent is the coordination between the Department of Veterans Affairs (VA) and the Department of Defense (DOD) adequate to meet the needs of servicemembers/veterans, particularly the needs of service-connected disabled veterans?

27. To what extent is the coordination for seriously injured and disabled servicemembers/veterans adequate within VA between the Veterans Health Administration (VHA) and the Veterans Benefits Administration (VBA) and internally within each of the Administrations? What are the internal and external impediments, challenges and gaps, and how might these barriers be overcome?

28. To what extent is the coordination adequate within DOD between the Office of the Secretary of Defense for Personnel and Readiness, Health Affairs and Force Management Policy, and the branches of Service. What are the internal and external impediments, challenges and gaps and how might these barriers be overcome?

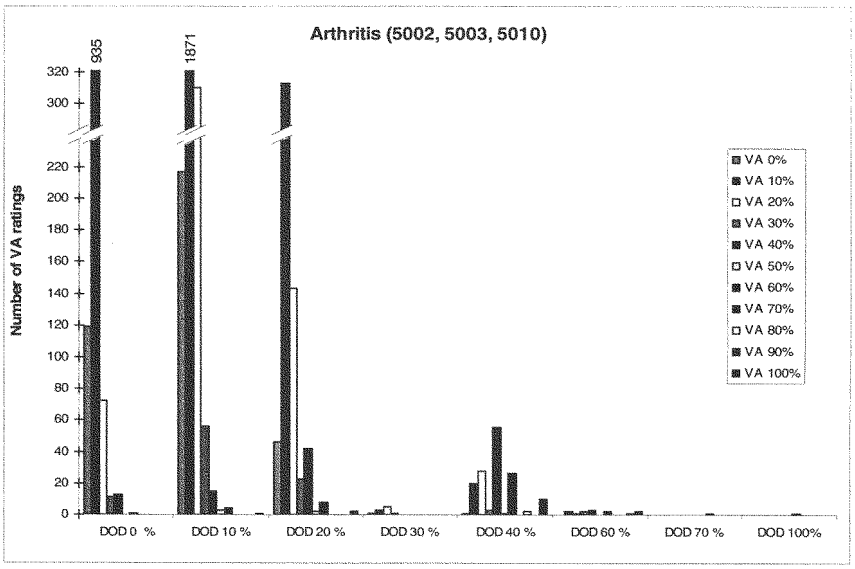
29. To what extent do DOD and VA provide disabled members/veterans the means and the opportunity to succeed in their transition to civilian life? What are the adequacy, quality, and timeliness of the benefits provided by each agency?

30. What policy and cultural shifts must be made to produce a common, shared, bidirectional data exchange of information and access to medical and personnel records between VA and DOD and within VA between VBA and VHA?

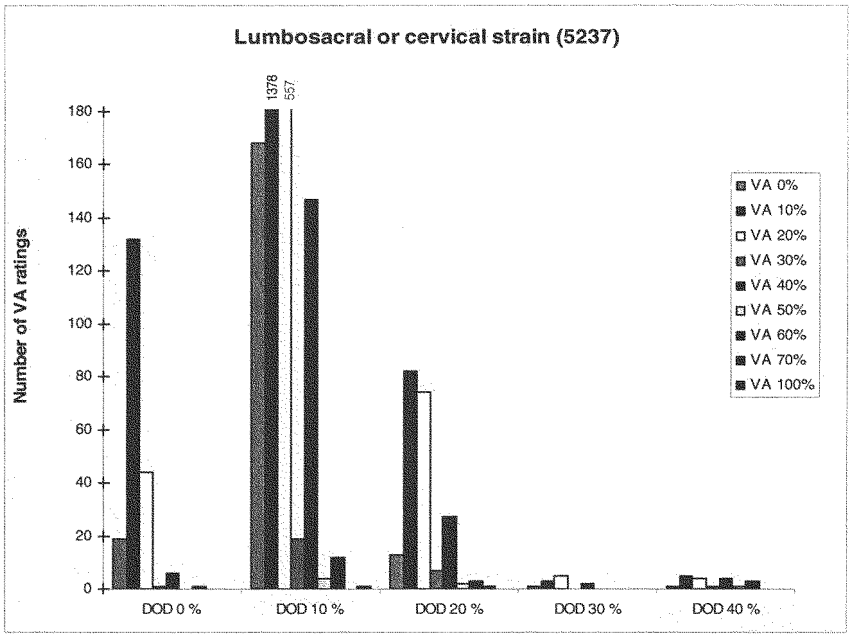
31. To what extent are the training, education and outreach programs (of DOD, VA, and DOL) adequate to ensure that the greatest number of active duty, Guard and Reserve personnel are informed of the full range of Federal Government vet-

eran benefits and services and provided tools such as a statement of education and military occupational specialties experiences adaptable to civilian job searches?

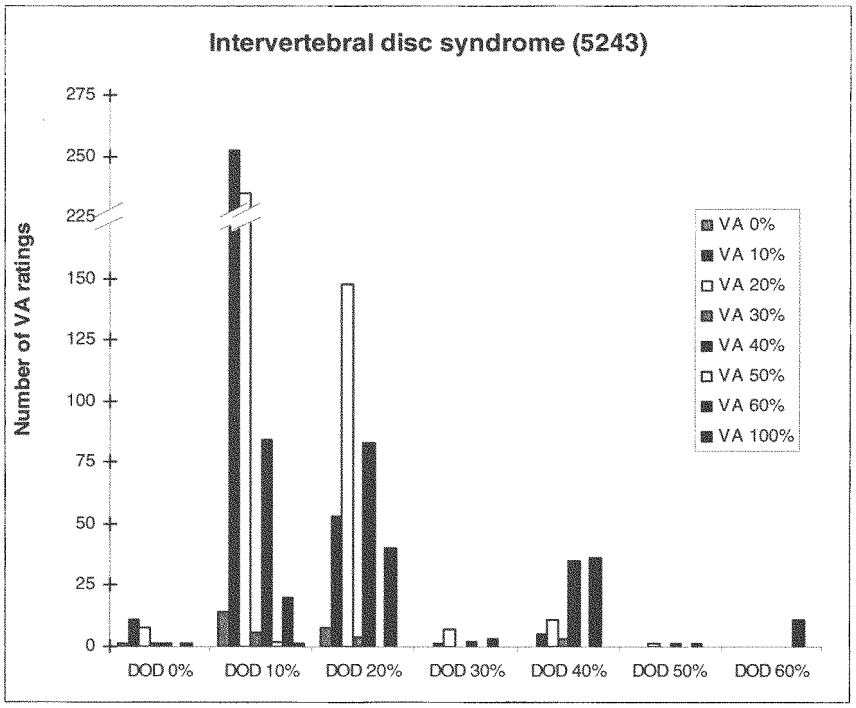
[Graphic presentations of the 13 individual diagnoses follow:]



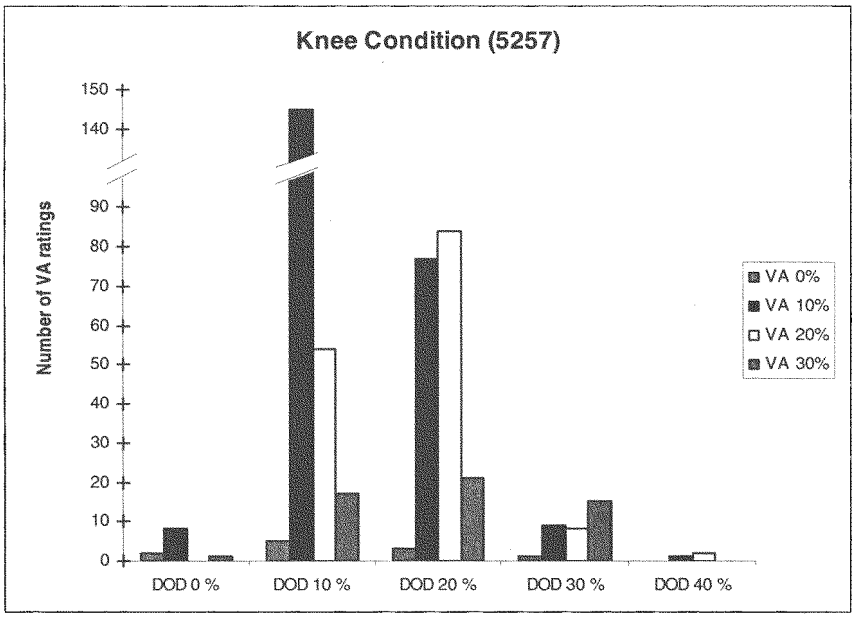
	DOD 0%	DOD 10%	DOD 20%	DOD 30%	DOD 40%	DOD 60%	DOD 70%	DOD 100%	Total
VA 0%	119	217	46	1	1	0	0	0	384
VA 10%	935	1,871	313	3	20	2	0	0	3,144
VA 20%	72	310	143	5	28	1	0	0	559
VA 30%	11	56	23	1	3	2	0	0	96
VA 40%	13	15	42	0	55	3	0	0	128
VA 50%	0	3	2	0	1	0	0	0	6
VA 60%	1	4	8	0	26	2	0	1	42
VA 70%	0	0	0	0	0	0	1	0	1
VA 80%	0	0	0	0	2	0	0	0	2
VA 90%	0	0	0	0	0	1	0	0	1
VA 100%	0	1	2	0	10	2	0	0	15
Total	1,151	2,477	579	10	146	13	1	1	4,378



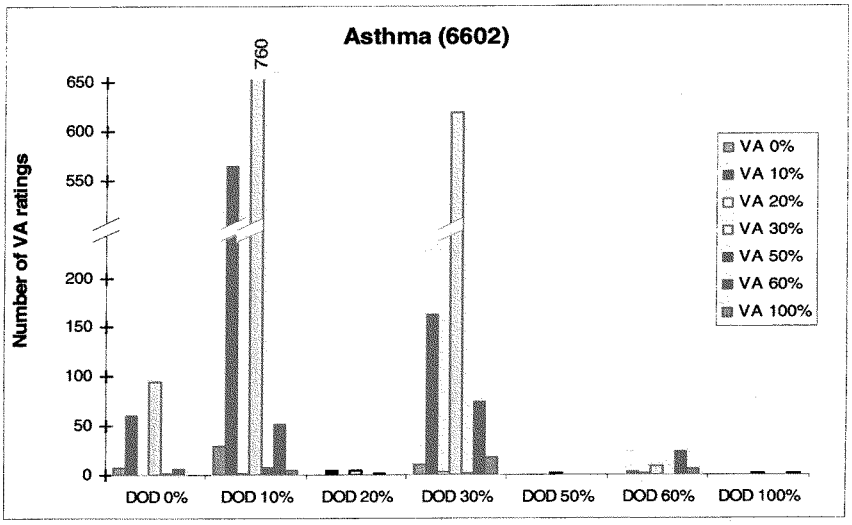
	DOD 0%	DOD 10%	DOD 20%	DOD 30%	DOD 40%	Total
VA 0%	19	168	13	1	1	202
VA 10%	132	1,378	82	3	5	1,600
VA 20%	44	577	74	5	4	704
VA 30%	1	19	7	0	1	28
VA 40%	6	147	27	2	4	186
VA 50%	0	4	2	0	1	7
VA 60%	1	12	3	0	3	19
VA 70%	0	0	1	0	0	1
VA 100%	0	1	0	0	0	1
Total	203	2,306	209	11	19	2,748



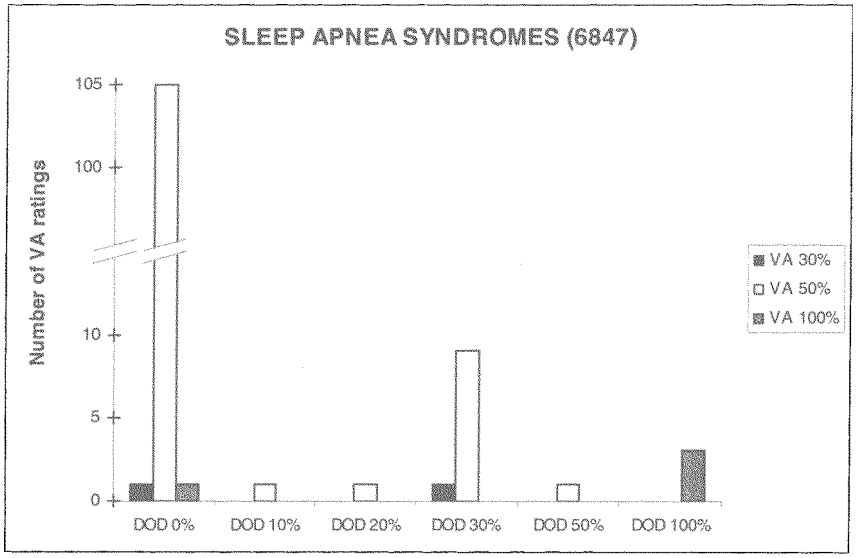
	DOD 0%	DOD 10%	DOD 20%	DOD 30%	DOD 40%	DOD 50%	DOD 60%	Total
VA 0%	1	14	8	0	0	0	0	23
VA 10%	11	252	53	1	5	0	0	322
VA 20%	8	235	148	7	11	1	0	410
VA 30%	1	6	4	0	3	0	0	14
VA 40%	1	84	83	2	35	1	0	206
VA 50%	0	2	0	0	0	0	0	2
VA 60%	1	20	40	3	36	1	11	112
VA 100%	0	1	0	0	0	0	0	1
Total	23	614	336	13	90	3	11	1,090



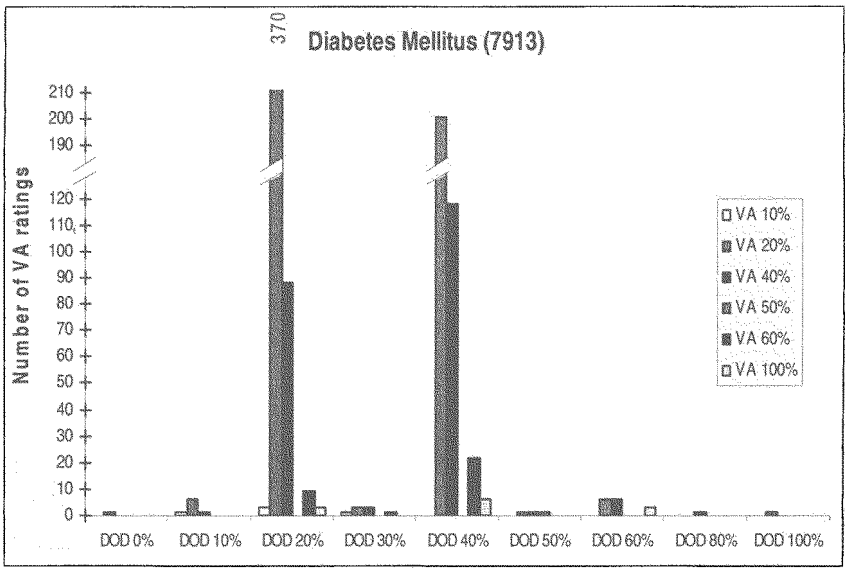
	DOD 0%	DOD 10%	DOD 20%	DOD 30%	DOD 40%	DOD 60%	Total
VA 0%	2	5	3	1	0	0	11
VA 10%	8	145	77	9	1	1	241
VA 20%	0	54	84	8	2	0	148
VA 30%	1	17	21	15	0	0	54
VA 40%	0	0	0	0	1	0	1
Total	11	221	185	33	4	1	455



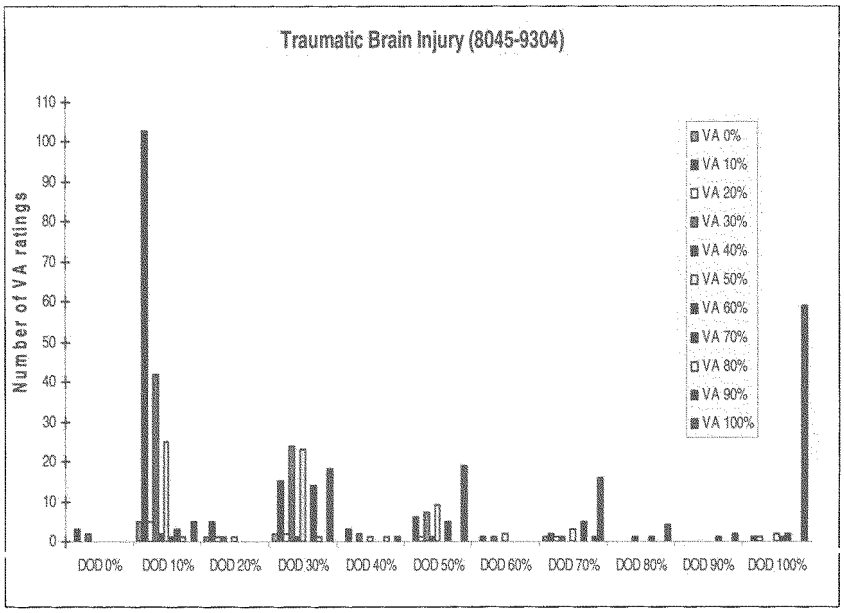
	DOD 0%	DOD 10%	DOD 20%	DOD 30%	DOD 50%	DOD 60%	DOD 100%	Total
VA 0%	7	29	0	10	0	0	0	46
VA 10%	61	565	4	162	0	3	0	795
VA 20%	0	1	0	3	0	1	0	5
VA 30%	95	760	4	619	1	9	1	1,489
VA 40%	0	0	0	0	0	0	0	0
VA 50%	1	8	0	2	0	0	0	11
VA 60%	6	51	1	74	0	23	0	155
VA 100%	0	4	0	17	0	6	2	29
Total	170	1,418	9	887	1	42	3	2,530



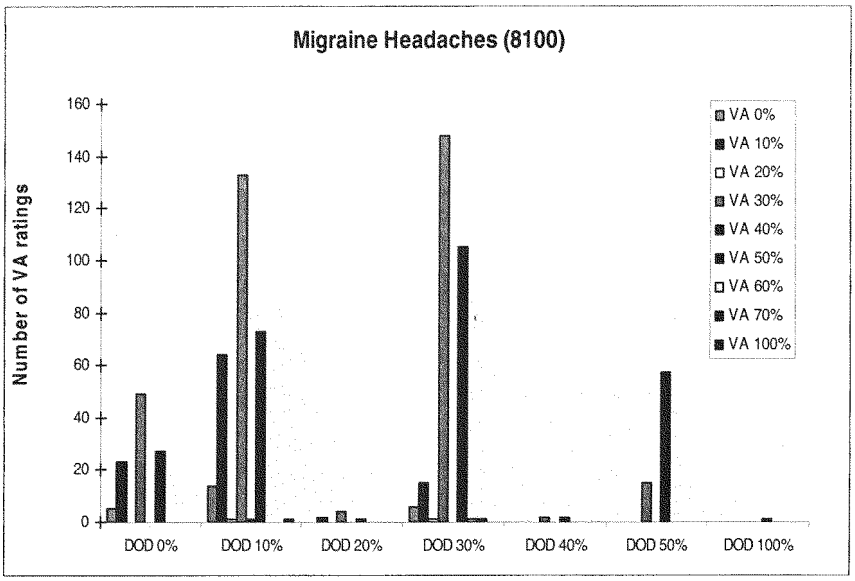
	DOD 0%	DOD 10%	DOD 20%	DOD 30%	DOD 50%	DOD 100%	Total
VA 30%	1	0	0	1	0	0	2
VA 50%	105	1	1	9	1	0	117
VA 100%	1	0	0	0	0	3	4
Total	107	1	1	10	1	3	123



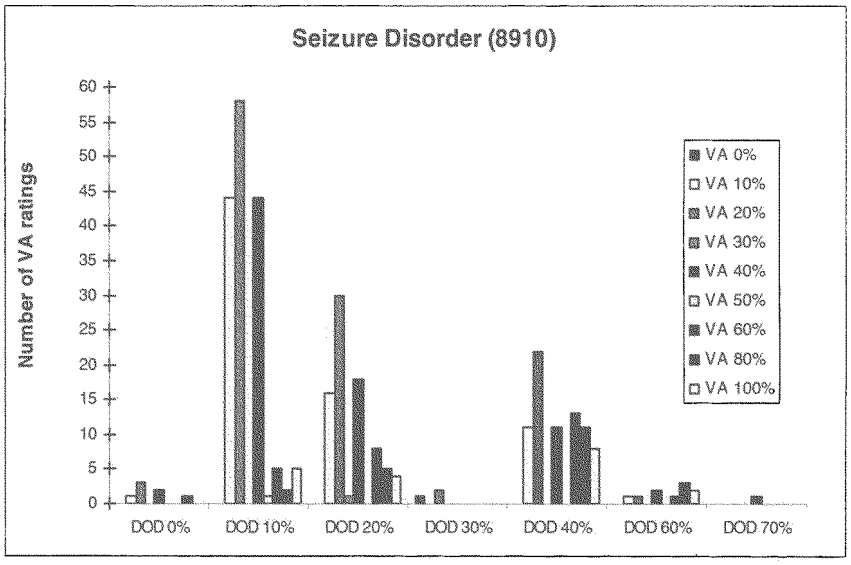
	DOD 0%	DOD 10%	DOD 20%	DOD 30%	DOD 40%	DOD 50%	DOD 60%	DOD 80%	DOD 100%	Total
VA 10%	0	1	3	1	0	0	0	0	0	5
VA 20%	1	6	370	3	201	1	6	0	1	589
VA 30%	0	0	0	0	0	0	0	0	0	0
VA 40%	0	1	88	3	118	1	6	1	0	218
VA 50%	0	0	0	0	0	1	0	0	0	1
VA 60%	0	0	9	1	22	0	0	0	0	32
VA 100%	0	0	3	0	6	0	3	0	0	12
Total	1	8	473	8	347	3	15	1	1	857



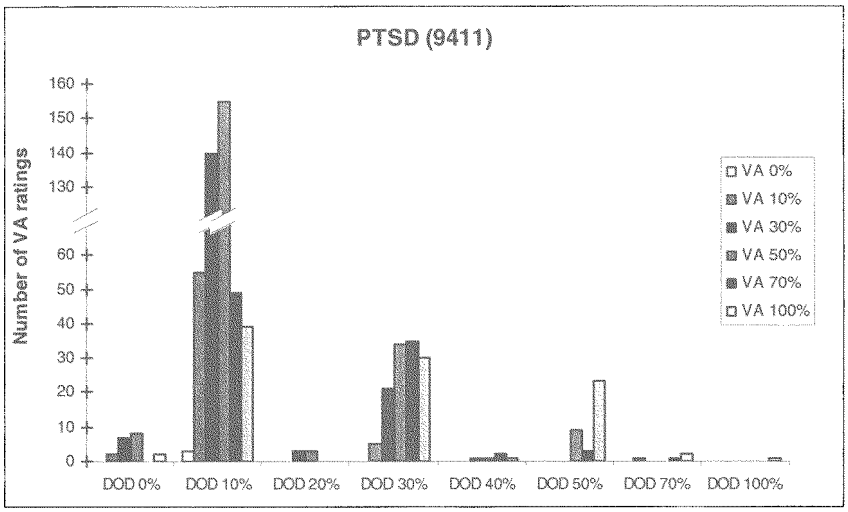
	DOD 0%	DOD 10%	DOD 20%	DOD 30%	DOD 40%	DOD 50%	DOD 60%	DOD 70%	DOD 80%	DOD 90%	DOD 100%	Total
VA 0%	0	5	1	2	0	0	0	1	0	0	0	9
VA 10%	3	103	5	15	3	6	1	2	0	0	1	139
VA 20%	0	5	1	2	0	1	0	1	0	0	1	11
VA 30%	2	42	1	24	2	7	1	1	0	0	0	80
VA 40%	0	2	0	1	0	1	0	0	1	0	0	5
VA 50%	0	25	1	23	1	9	2	3	0	0	2	66
VA 60%	0	1	0	0	0	0	0	0	0	0	1	2
VA 70%	0	3	0	14	0	5	0	5	1	1	2	31
VA 80%	0	1	0	1	1	0	0	0	0	0	0	3
VA 90%	0	0	0	0	0	0	0	1	0	0	0	1
VA 100%	0	5	0	18	1	19	0	16	4	2	59	124
Total	5	192	9	100	8	48	4	30	6	3	66	471



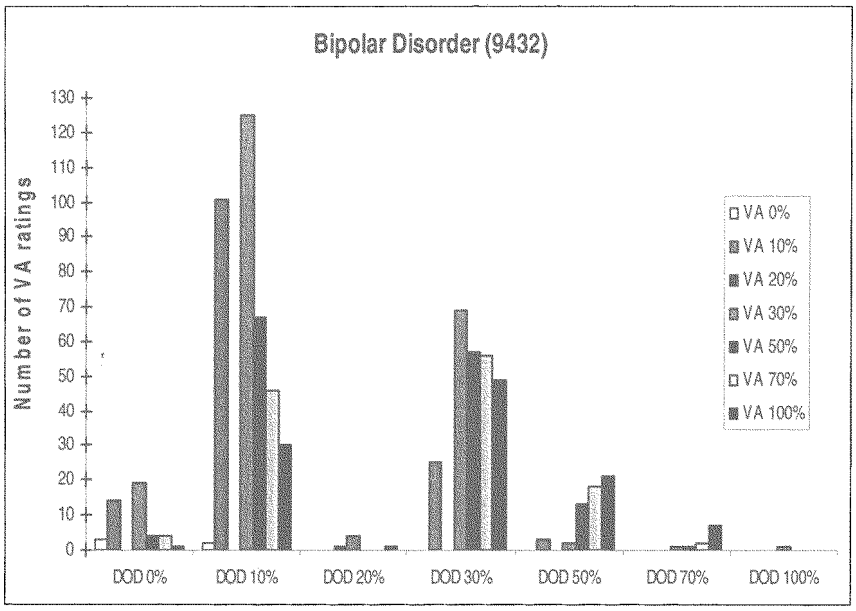
	DOD 0%	DOD 10%	DOD 20%	DOD 30%	DOD 40%	DOD 50%	DOD 100%	Total
VA 0%	5	14	0	6	0	0	0	25
VA 10%	23	64	2	15	0	0	0	104
VA 20%	0	1	0	1	0	0	0	2
VA 30%	49	133	4	148	2	15	0	351
VA 40%	0	1	0	0	0	0	0	1
VA 50%	27	73	1	105	2	57	1	266
VA 60%	0	0	0	1	0	0	0	1
VA 70%	0	0	0	1	0	0	0	1
VA 100%	0	1	0	0	0	0	0	1
Total	104	287	7	277	4	72	1	752



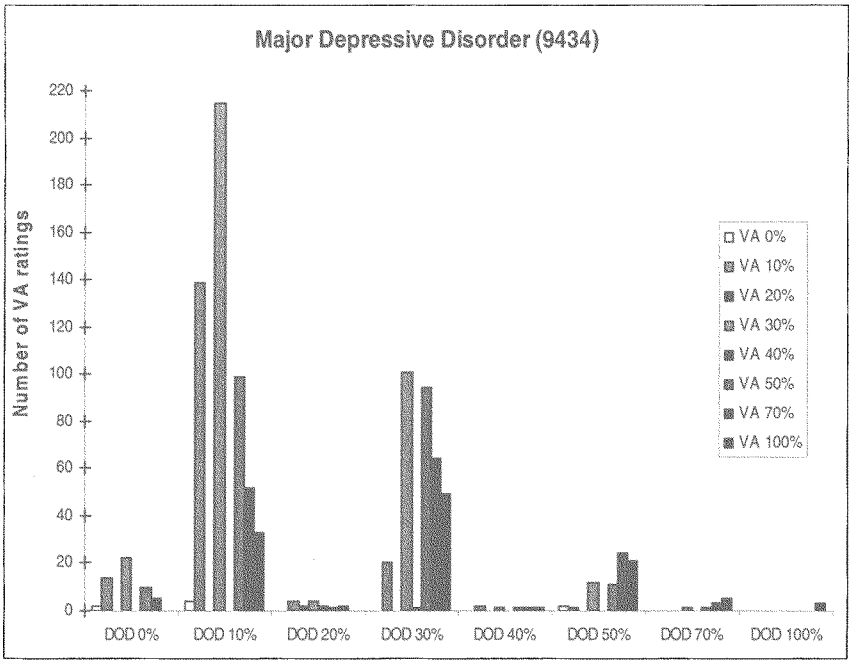
	DOD 0%	DOD 10%	DOD 20%	DOD 30%	DOD 40%	DOD 60%	DOD 70%	DOD 80%	DOD 90%	DOD 100%	Total
VA 0%	0	0	0	1	0	0	0	0	0	0	1
VA 10%	1	44	16	0	11	1	0	0	0	0	73
VA 20%	3	58	30	2	22	1	0	0	0	1	117
VA 30%	0	0	1	0	0	0	0	0	0	0	1
VA 40%	2	44	18	0	11	2	1	0	0	1	79
VA 50%	0	1	0	0	0	0	0	0	0	0	1
VA 60%	0	5	8	0	13	1	0	0	0	0	27
VA 80%	1	2	5	0	11	3	0	3	0	1	26
VA 100%	0	5	4	0	8	2	0	1	1	7	28
Total	7	159	82	3	76	10	1	4	1	10	353



	DOD 0%	DOD 10%	DOD 20%	DOD 30%	DOD 40%	DOD 50%	DOD 70%	DOD 100%	Total
VA 0%	0	3	0	0	0	0	0	0	3
VA 10%	2	55	0	5	0	0	1	0	63
VA 30%	7	140	3	21	1	0	0	0	172
VA 50%	8	155	3	34	1	9	0	0	210
VA 70%	0	49	0	35	2	3	1	0	90
VA 100%	2	39	0	30	1	23	2	1	98
Total	19	441	6	125	5	35	4	1	636



	DOD 0%	DOD 10%	DOD 20%	DOD 30%	DOD 50%	DOD 70%	DOD 100%	Total
VA 0%	3	2	0	0	0	0	0	5
VA 10%	14	101	0	25	3	0	0	143
VA 20%	0	0	1	0	0	0	0	1
VA 30%	19	125	4	69	2	1	1	221
VA 40%	0	0	0	0	0	0	0	0
VA 50%	4	67	0	57	13	1	0	142
VA 70%	4	46	0	56	18	2	0	126
VA 100%	1	30	1	49	21	7	0	109
Total	45	371	6	256	57	11	1	747



	DOD 0%	DOD 10%	DOD 20%	DOD 30%	DOD 40%	DOD 50%	DOD 70%	DOD 100%	Total
VA 0%	2	4	0	0	0	2	0	0	8
VA 10%	14	139	4	20	2	1	0	0	180
VA 20%	0	0	2	0	0	0	0	0	2
VA 30%	22	215	4	101	1	12	1	0	356
VA 40%	0	0	2	1	0	0	0	0	3
VA 50%	10	99	1	94	1	11	1	0	217
VA 70%	5	52	2	64	1	24	3	0	151
VA 100%	0	33	0	49	1	21	5	3	112
Total	53	542	15	329	6	71	10	3	1,029

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. DANIEL K. AKAKA TO LIEUTENANT GENERAL JAMES TERRY SCOTT (RET.), CHAIRMAN, VETERANS' DISABILITY BENEFITS COMMISSION

Question 1. I realize you cannot speak for the Commission, but in your personal view, based on your work as the Commission Chairman, do you have any thoughts on what is needed to improve the cooperation and coordination between DOD and VA?

Response. The Commission recognized early in its deliberations that cooperation and coordination between DOD and VA are key to the successful and "seamless" transition of servicemembers to veteran status, especially for those seriously ill or injured with service-connected disabilities. Three of the Commission's 31 approved research questions (RQs), attached for the record to my written statement, address aspects of this question [RQs 26, 29, and 30]. The Commission's final report will provide additional illumination and recommendations for areas of short-term and long-term improvement in the cooperation and coordination between the two departments.

My personal views are that VA and DOD absolutely must develop and use compatible electronic system(s) for both medical records and military personnel records. I understand that there have been extensive collaborative efforts toward compatible information technology (IT) systems between VA and DOD over the years. At a minimum, the different systems, irrespective of legacies or architecture should be able to exchange relevant data bidirectionally, in a "seamless" manner that is transparent to servicemembers/veterans. We recently learned that VA's IT budget was reduced by $400 million in Fiscal Year 2006 because of IT management concerns expressed by the House Committee on Veterans' Affairs on IT management. Such funding reductions may have unintended consequences for the very programs that need to be given priority and the service-connected disabilities.

In my personal view, VA and DOD should be required to have all medical and relevant personnel records in electronic format and allow those records to be exchanged electronically prior to a servicemember's separation from service. Further, the information should be provided to servicemembers on various Federal benefit programs from VA, Department of Labor (DOL) and Social Security Administration (SSA) early in their military service and periodically throughout their careers. All servicemembers should have a comprehensive physical examination prior to separation from the military that is suitable for VA rating purposes. A single separation examination would reduce redundancies and streamline the transition of servicemembers.

Question 2. Have you observed any best practices among the services in their disability ratings systems that should be adapted DOD-wide to reform the system?

Response. During calendar year 2006, the Commission conducted fact-finding visits to eight cities located across the country. In addition to touring VA facilities such as regional offices, medical facilities and Vet Centers, the Commission also visited DOD facilities and National Guard and Reserve units, where appropriate.

While in San Antonio, the Air Force briefed us that a Veteran Service Officer is available to assist all Air Force members going through their physical evaluation board (PEB) process. At the Brooke (Texas), Madigan (Washington) and Eisenhower (Georgia) Army hospitals, we learned that there are Army and VA counselors available to wounded soldiers to help with their military and VA disability claim processes. The Army and VA counselors worked together on records transfer and medical appointments, whether to a military or VA medical facility or regional office nearest the servicemember's duty station or home. MacDill Air Force Base medical facility (Florida) set up space for VA Compensation and Pension (C&P) contracted examinations to take place for separating servicemembers and military retirees on weekends in their facility. The Army placed a fulltime liaison at the Tampa VA Polytrauma Rehabilitation Center.

The Commission found that focused efforts to maintain ongoing communications between the local VA and DOD leadership and staff, supported by integrated services and assigned personnel working in tandem at each other's facilities produced best practices and improved disability benefits delivery to separating servicemembers.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. LARRY E. CRAIG TO LIEUTENANT GENERAL JAMES TERRY SCOTT (RET.), CHAIRMAN, VETERANS' DISABILITY BENEFITS COMMISSION

Question 1. If we were to start from scratch and design a new system of compensation for those who are severely injured in service, what should that system look like?

Response. While a great deal of improvement is needed in the overall processes and procedures that affect the transition of the severely injured into the VA disability system and the operation of the current disability system, I believe it would be impractical to design an entirely new system of compensation built from scratch. As I stated in testimony before the Committees, I believe that the military services should make the determination whether a servicemember is fit or unfit for military duty. If the Servicemember is found unfit, the overall disability rating should include all disabilities identified in a comprehensive examination and should be made by VA using the VA Schedule for Rating Disabilities (VASRD). All records, medical and personnel, should be electronic and bidirectional between VA and DOD.

Another short-term action suggested in my statement to greatly improve a servicemember's financial stability during transition would be to alter the commencement date of disability compensation payments. Current law prohibits the commencement of disability compensation payments from the effective date of entitlement. Instead, payments are required to be delayed until the first day of the second month after the disabled servicemember is first entitled to receive payments as a disabled veteran. This is true even for those filing a claim within one year of discharge whose entitlement date is the day after the date of discharge. This requirement was enacted as a budget saving provision in the Omnibus Budget Reconciliation Act of 1982.[1] While this restriction might seem reasonable from a cost savings standpoint, it means that servicemembers do not receive any disability benefits for up to 2 months after discharge. For example, a veteran discharged on August 2, 2006, could not be paid disability benefits for the partial month of August and could not be paid September benefits until October 1. Before this statutory change, the veteran would have received payment from the effective date which was August 3. Veterans still have to provide for themselves and their families, especially those who are unable to work. I would recommend that Congress consider changing this requirement.

Question 2. What do you think should be the purpose of a modern compensation program and how should we regularly determine whether the program, as designed, is meeting its intended purpose?

Response. The purpose of a modern compensation program is, and should continue to be, to compensate the injured servicemember for average loss of earning power and for loss of quality of life. In 1956, the Bradley Commission concluded that reintegration of servicemembers into civilian society was of paramount importance. I agree that reintegration through benefits such as medical care, education, vocational training and rehabilitation services are most critical.

Determining the effectiveness of the compensation programs might include recurring independent assessments on a frequent, systematic basis—certainly more frequently than every 50 years—by a group of individuals who are knowledgeable, but not employed by VA or DOD. A standing (or periodic) assessment team, board or Commission reporting directly to Congress with access to VA and DOD staff in Washington and field sites would be essential. Our report will describe in detail the methodology and recommendations aligned with answering this important question.

RESPONSE TO WRITTEN QUESTION SUBMITTED BY HON. JOHN MCCAIN TO LIEUTENANT GENERAL JAMES TERRY SCOTT (RET.), CHAIRMAN, VETERANS' DISABILITY BENEFITS COMMISSION

Question. Under existing law, members with less than 8 years of Active Duty service get zero disability compensation if it is determined that their disabling condition "existing prior to entry." This has resulted in soldiers, marines, and others—volunteers all—who have served one, two, or maybe even three tours of duty in Iraq receiving nothing when they suddenly are unfit for continued service. Do you think this 8-year rule is fair or should it be eliminated?

Response. The Commission did not request or receive data from the Services regarding pre-existing conditions. As we understand from current VA policy, VA considers aggravation of pre-existing conditions as a result of military service in its dis-

[1] Public Law 97–253, § 401, 96 Stat. 763, 801, now U.S.C. § 5111.

ability ratings, but we have not addressed the 8-year rule, as described in your question. To credibly answer your question requires further research.

In my personal view, should a disabling condition become apparent within a reasonable period of time after entry into service, separation due to failing to meet entry requirements makes sense and honors the contract between the Service and the member. Eight years after the fact, especially if those years include tour(s) in a combat zone, exceed a reasonable time period, in my opinion, and should not be used as a sole basis for declaring unfitness for continued service based on pre-existing conditions alone.

Perhaps DOD should consider the type, conditions, length and locations of service and how these and other service-connected factors may have permanently aggravated or increased the severity of a non-disabling pre-existing conditions. It is my understanding that VA does consider these factors in its disabilities ratings, if provided supporting documentation (including statements from friends and family).

RESPONSE TO WRITTEN QUESTION SUBMITTED BY HON. MARK L. PRYOR TO LIEUTENANT GENERAL JAMES TERRY SCOTT (RET.), CHAIRMAN, VETERANS' DISABILITY BENEFITS COMMISSION

Question. In your prepared statement on Department of Defense disability ratings, you point out that of approximately 50,676 records, 13,646 of them contain data showing soldiers who were found unfit for duty yet assigned a zero percent rating. What circumstances warrant this determination and what is your opinion on how the rating system can be more effective?

Response. Your question merits further investigation. As noted in my written statement, DOD only rates the condition or conditions that DOD determines to render the individual unfit for duty. By contrast, VA determines whether or not each identified condition is service-connected and rates all conditions found to be serviceconnected. For veterans rated by both agencies, DOD rated only one condition 83 percent of the time. For cases in which DOD rated one condition, VA rated an average of 3.7 conditions.

Particularly noteworthy (as your question suggests) are the number of Army soldiers rated zero percent and when matched to VA's records, are subsequently rated with substantially higher disability ratings. I suggested in my testimony and reiterate here, that an in-depth analysis of these zero percent ratings should be conducted to ascertain the reasons behind these ratings. The Commission's research produced the data, but we do not have the time to delve deeper into these anomalies.

In my opinion, the existing rating systems could be improved by requiring VA and DOD to use a single, comprehensive medical examination protocol. This would include a requirement to examine and rate all conditions that are found during the exam, and would not be restricted only to the "unfitting" condition(s). Training and certification of all examiners would also be essential for consistent, high quality examinations.

I also suggest that serious consideration be given to a major realignment of the decisionmaking process used to decide if servicemembers are unfit for duty and eligible for military disability retirement (>30 percent rating) or separation with severance pay <30 percent rating) and for VA disability compensation. Please refer to my written statement for further details on the major features of my realignment proposal.

As a separate but related issue, I offer some background perspective and the following suggestions related to S. 1252, the bill introduced by Chairman Akaka on April 30, 2007, after the joint hearing on April 12th. The stated purpose of S. 1252 is to amend title 10, United States Code, to provide for uniformity in the awarding of disability ratings for wounds or injuries incurred by members of the Armed Forces, and for other purposes.

As part of the Commission's analysis of disability ratings by VA and DOD, we found that prior to 1986, DOD instructions required that all service connected disabilities be rated regardless of whether or not the condition(s) contributed to an unfit determination, with the exception of hysterectomies. Based on a DOD General Counsel opinion, dated March 25, 1985, this policy changed. Now when determining the compensable disability rating, the Services are no longer required to consider or rate a physical condition if that condition does not render the servicemember unfit for military duty. Using this revised DOD policy, from 2000 to 2006 DOD determined that only one condition was disqualifying for 83 percent of all instances in which a servicemember was found unfit and discharged.

In order to ensure that DOD rates all disabilities identified during a comprehensive examination, the following amended wording of S. 1252 is **(highlighted)** suggested for your consideration [emphasis added]:

"(b) Consideration of **All** Applicable Medical Conditions—The Secretary of Defense shall prescribe in regulations requirements that, in making the determination of a rating of disability of a member of the armed forces for purposes of this chapter, the Secretary concerned shall **identify**, take into account, **and evaluate** all medical conditions incurred by the member while entitled to basic pay or while absent as described in section 1201(c)(3) of this title. **Each identified medical condition shall be assigned a percentage of disability utilizing the standard schedule for rating disabilities referred to in subsection (c) along with a finding of fitness** to perform the duties of the member's office, grade, rank, or rating. **If the member is found unfit by reason of any medical condition or conditions, a combined rating of disability shall be determined for the member based on all identified medical conditions utilizing the standard schedule for rating disabilities referred to in subsection (c).**"

RESPONSE TO WRITTEN QUESTION SUBMITTED BY HON. SAXBY CHAMBLISS TO LIEUTENANT GENERAL JAMES TERRY SCOTT (RET.), CHAIRMAN, VETERANS' DISABILITY BENEFITS COMMISSION

TRICARE ACCEPTANCE

Question. I was surprised to learn that VA hospitals do not necessarily accept TRICARE. Would ensuring that all VA hospitals accepted TRICARE be a way to improve the seamless transition of our veterans from DOD to the VA as well as ensuring that they have easy and quick access to the best health care they are entitled to?

Response. Under the Veterans' Disability Benefits Commission charter, health care is considered an ancillary benefit of particular importance to our service-connected disabled veterans. Timely access to quality health care for veterans with service-connected disabilities is, in my opinion, a top priority. The Commission has not addressed the issue of VA medical facilities being accepted as TRICARE providers, so I defer to VA for explanation.

Chairman LEVIN. General, thank you. That is extremely helpful data that you have presented to us.

Let me start, then, with Secretary England. We have heard now a suggestion from General Scott, speaking for himself but obviously in a very important position with the review that he is leading, that the fitness for duty determination be made by the DOD, and then there be one comprehensive physical examination by the VA and they determine the rating. That suggestion, I think, has been made previously by Secretary Chu, although I am not positive of that. Something similar to that has been recommended.

Secretary England, why not do that? Just end these really incredibly diverse, disparate treatments when you go through the DOD system, then the VA system? These numbers are pretty stunning numbers here that General Scott has given to us this morning. I don't know if you are familiar with those numbers, but it is a pretty compelling case that there is a very major gap here between the determination by the DOD as to the level of disability and that which is reached by the VA. Why not follow that recommendation? It has been made before. That specific recommendation.

Mr. ENGLAND. Mr. Chairman, I actually don't disagree. I am not sure I know enough to agree, but I was very impressed with General Scott. That is the first time I have heard at least his views of what the Commission is doing. It is in line with my thinking. I mean, there is no question. My comment was we have these two disparate systems. We actually evaluate people on the basis of fit-

ness to serve and that determines our rating. Then they go to VA and VA looks at not just that but other factors that could affect employability, and so it is two different rating systems. It certainly seems evident to me that we need to get down to some sort of a consistent process because it is confusing, and it is particularly confusing for the people who use the system, so——

Chairman LEVIN. It is not confusing, I think it is just unfair. It is unjust. The figures I heard of, 13,000 Army who got a zero disability rating, rated unfit for duty, and then when the VA gave them a rating, if I heard the numbers correctly, they were given an average rating of 56 percent. Those 13,000, as I understand it, General, is that correct?

General SCOTT. Yes, sir.

Chairman LEVIN. Those same 13,000 who were rated zero had an average VA disability of 56 percent, which means that they would have been retired medically. Their families would have been given health care and all the other benefits that go with it.

Now, we are going to need you to get us a response on this quickly because there is just a compelling argument here which needs to be addressed. I don't know what the incentive is that General Scott made reference, I think it was you, General, who made reference to a strong incentive that the DOD has to rate below 30 percent. I don't know what that incentive is other than saving money, and that is not acceptable. But the VA, if that incentive applied to the DOD, would presumably have the same unacceptable incentive about saving money.

But in any event, let me just ask Secretary England, will you get to these Committees, our two Committees, the DOD response to that specific recommendation within the next couple of weeks?

Mr. ENGLAND. Yes, we will, Senator.

Chairman LEVIN. Thank you. Again, we are on a four-minute time line here. Regarding electronic transfer of medical records, I believe in General Scott's written testimony, perhaps I missed it in his oral testimony, said that it has been difficult to understand the current status of compatibility between the two systems, the VA and the DOD, and to assess future plans of the Department. In other words, it is difficult to even grasp the plans and the current status. From everything we understand, there is a real problem here in terms of electronic transfer of medical records and that it just isn't happening in some places.

Perhaps there are some experiments going on.

But, Secretary England, this has been going on for a long time. Can you tell us what has been done to finally achieve this electronic transfer and what is the time line for doing it?

Mr. ENGLAND. Mr. Chairman, I can. I am going to turn it over to David Chu, who is more intimately familiar. I do know we are building bridge systems between while we have a more comprehensive integrated IT system, but David, if you would address in more detail.

Dr. CHU. Delighted, sir. The systems the two institutions used were, of course, designed some years ago. They are separate. Starting in 2004, we began a Bidirectional Health Information Exchange that allows the VA, using the same system it uses, to look at records from one VA hospital to another, to look at the electronic

records that DOD possesses for so-called shared patients. That is 2.2 million personnel. The major DOD installations can do the same thing currently through a Web site.

Now, General Scott is right. Not everything is currently on that system, but it has been specifically discussed and somebody mentioned that is scheduled to occur later this year. This has been a response to the task force that was appointed by the President earlier in this Administration.

For the future, I do think it is very clear, Secretary Leavitt of HHS has celebrated this plan—the two institutions have committed, subject to various technical reviews, obviously, to a common future inpatient electronic system that will ultimately make it unnecessary to have the current bridge arrangement that we have deployed. I should add, the Department does send its electronic records on all discharged personnel when they are discharged to the VA. We transferred just under four million such records. We perhaps haven't been good enough at explaining what we are doing and what we plan to do, but there is significant accomplishment already. Further accomplishment will be achieved by the end of this year.

Chairman LEVIN. Would you get us for the record your time line to achieve your future transition of these electronic records?

Dr. CHU. Delighted, sir. I will furnish a much larger diagram of the electronic information——

Just as an example, when someone enlists in the military, on a daily basis, we send a record to the VA so that they can open a file. So it begins when you start in the military.

Chairman LEVIN. If you can just get us the time line and very clearly stated what not just your plans are, but what is the time line to achieve those plans.

Senator Akaka?

Chairman AKAKA. Thank you, Mr. Chairman.

Secretary England, what is DOD doing with the services to promote consistency in their respective disability rating systems?

Mr. ENGLAND. Senator, I have had a number of discussions this week on that topic and so let me tell you what I know about it. Again, maybe somebody here can give you something a little more precise.

Each of the services evaluates fitness to serve based on their particular service. So it is perhaps not surprising that maybe Air Force is different than Marine Corps because of the nature of what military people do. So there is what appears to be, I would expect, some inconsistency just because of the fitness evaluation for the military, you know, for the job they have in their particular service, so you would expect some inconsistency in terms of just based on those facts.

On the other hand, there was a study, I understand, 2 years ago by the GAO and that conclusion was there was reasonable consistency between the services based, I guess, on all the factors that went into that.

So I will tell you, it is unclear to me, frankly, what that answer is. I mean, I can understand that they are different because of service differences. We do have the GAO Report. On the other hand, there are a lot of reports of inconsistency between the serv-

ices. So this is something I believe, frankly, for myself, needs to be looked at in more detail to really understand this. I cannot tell you today how big that problem is, what the problem is and how big it is, and that is something we are just going to have to get into. Perhaps, Dave, you know more on that subject, but that is at least where I am on this particular subject.

Dr. CHU. I might add that one source of apparent inconsistency in aggregate data is the fact that there are several major populations all being evaluated by the disability evaluation system. You have the wounded. That is, as the Secretary notes, a distinct minority of the total. You have those who are retiring at 20 or more years of service, so it is a whole different population, different set of issues involved. In fact, there is a presumption of fitness to serve because up until the day of retirement, you have been good to go in your military specialty, in general. Then you have the trainees and they present a different set of issues. That is where some of the zero percent disability ratings occur, particularly in the Army, and Mr. Geren may want to speak to that issue.

So I do think we need to disaggregate these overall data before we reach a hasty conclusion that the differences are troubling.

Chairman AKAKA. Thank you very much for that response. This is how we see it, also, that there are these inconsistencies within DOD, as you pointed out, each service has a distinct and different system within DOD.

Secretary Geren, in your efforts to reform the Army's disability rating system, what guidance are you receiving from DOD?

Mr. GEREN. I beg your pardon? What——

Chairman AKAKA. What guidance——

Mr. GEREN. Oh, what guidance——

Chairman AKAKA [continuing].—are you receiving from DOD?

Mr. GEREN. We are working directly—well, Secretary Gates is taking a very strong personal role in working this issue. From the moment he became aware of the challenges in this issue, he has been personally involved. We have had regular meetings with him as with Dr. Chu and Secretary England on this subject. Their guidance has been strong encouragement to take this problem on, to work it from our service's perspective, and he has been very supportive every step of the way. Some of these issues, as you all have noted, extend well beyond our service and we are working with the other services. The Walter Reed move to Bethesda is an example of a joint service effort.

So the OSD and the services are working hand-in-hand in this. Some of the solutions are service-centric, but the comprehensive long-term solutions are all DOD-wide, and in some cases governmentwide. But we have worked very closely with Dr. Gates and the Secretary of Defense's Office in moving ahead on this.

Chairman AKAKA. General Scott first, and then anyone else on the panel who wants to comment on this question, have you, General Scott, observed any best practices among the services and their disability rating systems that should be adapted to DOD-wide to reform the system?

General SCOTT. Not specifically in terms of best practices at this time. As I mentioned, Mr. Chairman, we are looking at a lot of data that is coming in right now, and what I presented to you

today was largely preliminary in nature, but I will take that and supply it either with our final report or if we get something useful in the interim to you. But the answer would be no at this time, sir.

Chairman AKAKA. Thank you very much. We look forward to that, Mr. Chairman. My time has expired.

Chairman LEVIN. Under the early bird rule, as our staff has explained to us, I was going to call on the two Ranking Members. They are not here, so I am going to call on two Republicans, but from that point on, we are going to go one and one on the early bird rule, which I understand for some reason that is new to me goes by seniority. So the order would then be, after McCain on the Armed Services Committee, Warner, Inhofe, Collins, Chambliss, Dole, Cornyn, Sessions, Thune, Martinez. On the Democratic side, on the Armed Services Committee would be Lieberman, Reed, Bill Nelson, Ben Nelson, Senator Clinton, Senator McCaskill, Senator Bayh. On the Veterans' Affairs Committee, it would be on the Democratic side Akaka, Murray, Sanders, Webb, Brown. For Republicans, Craig, Specter, Ensign, Burr. Don't ask me why, I am just following instructions here, but I hope it is adequate and fair.

Senator Warner?

STATEMENT OF HON. JOHN WARNER, U.S. SENATOR FROM VIRGINIA

Senator WARNER. Welcome to the Chairmanship, Mr. Levin.

[Laughter.]

Senator WARNER. Two questions for Secretary England.

Secretary England, the Base Closure and Realignment Commission concurred on closing Walter Reed. The Department envisioned transferring the important functions from that historic institution to the National Medical Center at Bethesda and a new construction facility at Fort Belvoir.

I strongly supported in the aftermath of this tragic situation at Walter Reed that we accelerate the funding profile to move forward very smoothly and quickly for a phasing out of Walter Reed and the transfer of functions to Bethesda and the new facility at Fort Belvoir. I note this morning the Acting Secretary of the Army gave a very strong endorsement to that proposal.

Added to that, we have now this morning the report from the panel that you empowered with Secretary Gates. They said as follows—that is the Jack Marsh panel—"Walter Reed Army Medical Center should be closed as soon as possible and construction of a larger Army hospital at Fort Belvoir should be expedited." As sort of the chief operating officer of the Department of Defense, do you concur in that recommendation and are you prepared to support the Secretary of the Army as he moves forward?

Mr. ENGLAND. I am prepared to support the Secretary of the Army to move forward, and Senator, I do concur it is in the best interests of our men and women to get a facility built at Bethesda, to move out of Walter Reed into Bethesda. It would then be a teaching hospital, which is very important. That is where we train all of our doctors. We also have the National Institutes of Health in that same area so that we have research in that area. Our vision is that we would have a very expert facility, a research teaching hospital which would be——

Senator WARNER. My 4 minutes are clicking on.

Mr. ENGLAND. OK.

Senator WARNER. I know exactly all of what you are saying. I just want to know if you concur in it and what steps are you now taking to accelerate the funding profile to initiate an earlier start at these two institutions.

Mr. ENGLAND. Well, we have asked to identify what specific steps we could take to accelerate and what that would cost. I do not have that on my desk yet, but we have asked that question and whatever is appropriate to do, we will do, Senator. If we don't have the funding early enough in the BRAC account, we will definitely ask for that. But it is beneficial—will be beneficial if we can accelerate whatever aspects we can at Bethesda and we will do that.

Senator WARNER. I thank you very much, and that also applies to Fort Belvoir?

Mr. ENGLAND. Yes, sir.

Senator WARNER. Fine. And I ask you to inform both Committees at your earliest convenience of your proposals and the funding profile.

Mr. ENGLAND. Senator, we will.

Senator WARNER. Thank you. My second question to you, Mr. Secretary, is as follows. With modesty, I draw on my own career in your Department, and at that time, in the middle 1970s, we envisioned going to an all-volunteer force and the concept was beginning to develop when I was Secretary of the Navy. As you know, it came into being and it was a major, major gamble by the United States military and our whole concept of defense of this Nation. It has worked beyond all expectations. It has worked magnificently, such that we have today—I think at no time in our history have we ever had a finer, more dedicated group of men and women serving in the Armed Forces of the United States.

Throughout this period of its development, some 30-plus years now, Congress at every juncture has stepped forward and responsive to successive Secretaries of Defense and Presidents to shore up the necessary infrastructure, medical care, educational care, all types of things to make that all-volunteer force work.

Yesterday, Secretary Gates addressed the Nation with regard to the new Army policy—I understand, the Marine Corps and the Guard and Reserves are separate—but the Army to go to a 15-month tour for overseas and guaranteed one year at home. What studies did you undertake as a Department to assess the impact on the viability of the all-volunteer force and its continuation?

Mr. ENGLAND. Senator, I understand that the Secretary made that decision based on the recommendation of the Acting Secretary of the Army and the Chief of Staff of the Army based on the fact that on their knowledge, at least, it would bring predictability to our men and women in uniform, which is the most important thing, I think, for all the families, is to have the predictability to know those times rather than being extended piecemeal. So this was an Army recommendation in response to prior actions, I believe, where we did just extend people and not always have the 12 months. So I think this was an understood problem and the way to address these issues.

Senator WARNER. What have you put to place—I address to you and the Acting Secretary of the Army—what benchmarks, monitoring system do you have in place, because I tell you without any reservation, this all-volunteer force is a national treasure. I do not, in any way, believe that the Congress would step forward and institute a draft, not under the present circumstances, and consequently, we have got to continue to make this all-volunteer force strong and able to serve this Nation. What benchmarks, what check points do you have in place to monitor, on a weekly basis, the viability of that force in the light of this very dramatic order that was enunciated yesterday?

Mr. ENGLAND. Well, of course, the Army monitors this regularly and we also have, of course, our retention and our recruiting numbers, which at the end of the day are very, very important, and so far, they have held very strong across the Army with our Guard and with our Reserves. So our retention number remain high and our recruiting numbers, we continue to meet even an expanded Army. So our recruiting has actually gone up during this period.

So I will tell you, my view is they are the strongest metrics in terms of the strength of our system, is how we do in terms of recruiting and retention across all the services. Senator, that is very strong.

Senator WARNER. Was this dramatic change in policy envisioned at the time the President announced on January 10 the surge operation into Baghdad which necessitated, I judge, this policy change?

Mr. ENGLAND. Senator, I guess I am not certain of that. I would have to ask Secretary Gates that. But my understanding is that this is prudent to do at this time because it does provide options for the country. So this does give us an option to extend the 20 brigade combat teams that we now have deployed in Iraq if we need to. This is a process that will allow us to do that and do it in a predictable manner.

Senator WARNER. Could Secretary Geren add any facts he wishes to this, Mr. Chairman? My time is then up.

Mr. GEREN. Sir, the recommendation from the Army that Secretary Gates acted upon is one that we have developed over the last couple of weeks. To my knowledge, it was not in the mind of the Administration at the time of the announcement of the surge. It certainly wasn't from the Army perspective. But the national treasure that is our all-volunteer force, I could not agree with you more.

Secretary England talked about the retention rates, the recruiting rates. Those certainly are indicators. But probably the most important indicator comes up through our NCOs and through our officers that work with that Army every day and it was based on their feedback, feedback that said being able to have predictable time home, being able to tell a soldier and that soldier's family that you are going to be home no less than 12 months, that was a more important factor in the family's consideration and the soldier's consideration in this policy than the impact of the additional 3 months on the tour. It is a judgment call, but it is based on the feedback and input from soldiers, from NCOs right up to the top leaders in the Army.

But we do have to watch it every single day. There are many indicators we look at. As you well know——

Senator WARNER. I thank the gentleman. That is very reassuring.

Chairman LEVIN. Thank you, Senator Warner.

Senator Inhofe?

STATEMENT OF HON. JAMES M. INHOFE, U.S. SENATOR FROM OKLAHOMA

Senator INHOFE. Thank you, Mr. Chairman. Let me just say to Senator Warner, I was a product of the draft and I was one of the last ones to believe that the all-volunteer force could be as good as it is, but I just recently made my 13th trip over to the AOR and I am just in shock. These guys are so good, and gals, and I am so proud of them.

Let me say one thing, because it hasn't been said yet, about the great job our medical practitioners are doing, the doctors and the nurses. The figure that I used in the last hearing was that 30 percent of the injured troops died in World War II, 24 percent in Vietnam, and only 9 percent now, and I think we need to talk about what a good job they are doing.

Senator Levin talked about the process and I will confine my questions to the Army, since that is what it was. We at this table deal with cases all the time. I had an Army Reservist in my State of Oklahoma that lost his leg and they diagnosed it as a fast-growing cancer and the review board granted this soldier a disability rating. Then when it arrived in Washington, they reversed this decision and said that it was not service-connected. Now, it turned out to be all right, but it does point out that, you know, this was the Army, and I am really concerned, I will say to Secretary Geren and perhaps Secretary Chu, when the Army is granting permanent disability to less than 4 percent of the cases and the Marines, 30 percent, and the Air Force, 24 percent, there has got to be something wrong.

I asked this question of General Schoomaker when he was in a couple of weeks ago and he didn't have an answer, and it would be a very difficult thing for someone to answer. What is the reason for that? Have you analyzed that and is this going to be corrected in some way? Are the Army doctors applying stricter standards than Navy or Air Force?

Mr. GEREN. The numbers that you cite, the 4 percent versus the Air Force and Navy numbers, which are in the '20s and in the '30s, that was, unfortunately, incorrectly reported and communicated to the Congress. The Army number is really right at 20 percent. The 4 percent is our permanent retirement and there is another 15 percent that falls in the temporary category. So when you look at the Navy and the Air Force numbers, those include both the temporary and the permanent. So——

Senator INHOFE. Well, I am glad for that clarification, because I hadn't heard that——

Mr. GEREN [continuing].—but we are still below the others.

Senator INHOFE. I had not heard that before.

Mr. GEREN. Yes, sir.

Senator INHOFE. In another similar question, I was kind of surprised when my staff told me, and I told them they must have misread it, about General Scott's testimony talking about the differences between the Department of Defense and the Veterans and having to do with additional severance pay and servicemembers' pay. In other words, pay is the determining factor. I didn't believe my staff until he showed me the testimony, and I will just read this sentence. "It is also apparent that DOD has strong incentive to assign ratings less than 30 percent so that only separation pay is required and continuing family health care is not provided." I have to ask Secretary England, how do you respond to his assertion that DOD reduces disability ratings as a cost-savings device?

Mr. ENGLAND. I can tell you there is no incentive to do that, Senator. I mean, maybe that is read into it, but I can tell you at least at the Secretary level, my level, senior leadership, and I think the services also, we try to treat people fairly and accurately and so there is certainly no incentive. I mean, frankly——

Senator INHOFE. General Scott, is my interpretation of your remarks accurate?

General SCOTT. The data would indicate that is one of the rationales for an assessment of less than 30 percent. Now, I can't say either from my own experience of 32 years in the military or from my experience on this Commission exactly what the motivations inside the DOD or the services might be in that regard. I do not mean to infer necessarily that that is the rationale by which these disability decisions are made. But it is a fact that they are made——

Senator INHOFE. Well, it is a factor. In fact, your statement had there, and that was the third time that you mentioned it. But the fact that it is even a factor is something that I think is disturbing. Secretary Geren, what are your thoughts on this?

Mr. GEREN. The people who are on the PD boards, that factor should not influence their decision at all. I guess I am trying to make some sense out of this finding of General Scott's Commission. When the Army or when a military department gives somebody a rating that puts them above 30 percent, there is a cost to the Army because the person is able to stay in the TRICARE health system. The same is true in the VA. Those rating boards, the higher rating they give, it is going to cost them more. So, I mean, any government program, the more people who avail themselves of the benefits of that program, it is going to cause that program to cost more, but I don't think there is any evidence to show that the people who make the decision on these evaluation boards are influenced by that at all.

Senator INHOFE. Well, you might check it out. My time is expired, but I think it is worth looking into.

Mr. GEREN. They are charged as professionals to make the best decision, but like, again, any government program that gives out benefits, you know, you could conclude that that program has an incentive not to give out that benefit. But we have found no evidence that the officers and the soldiers, and civilians who are on those boards have been influenced by that, but it is certainly something we should look into. But their job and the job of managing

the budget are very separate. We have not found evidence to that, but it is certainly worth exploring.

Chairman LEVIN. Thank you. Senator Lieberman?

STATEMENT OF HON. JOSEPH I. LIEBERMAN, U.S. SENATOR FROM CONNECTICUT

Senator LIEBERMAN. Thanks, Mr. Chairman, for an excellent hearing with some real concrete proposals and direct confrontation of the problems that we are all concerned about with the treatment of our veterans.

I do want to thank all of you who are before us for the extraordinarily high level of medical care given to our veterans on the average, and it is more than on the average, it is in most cases. We have talked about the tremendous advances in battlefield medicine and treatment of injured soldiers. I will tell you that in my opinion, in speaking to independent medical experts, the national system of Veterans' Administration hospitals is one of the best things going in our country. I can tell you that the two in Connecticut, at West Haven and Newington, have a very high level of veteran satisfaction and appreciation. So as we go into the shortcomings of the system, I do feel that we ought to thank you and feel good about the things that we are doing right to take care of our veterans.

This hearing was focused appropriately on two kinds of shortcomings, particularly the differences in disability ratings between the DOD and VA, and I think you have handled that well. We are going to monitor it, and Secretary England, I will be particularly interested in your earlier response to what General Scott has recommended today, which certainly seems to me, I am hearing, to be a very common sense and effective way to deal with the gaps in disability ratings that we are hearing about and are upset about.

Second is the large number of pending claims by veterans—this is in the VA—and I know you are taking steps to deal with that. I just really urge you, I appeal to you to be as clear with us as necessary to tell us what you need, including spending more money to hire more people or improve your systems to break this delay in dealing with claims, which can be as long as 2 years, as we have heard.

But I want to focus for a moment in my one question to go back to treatment. We are seeing a rising demand for mental health services and brain injury-related services. One study I have seen said that it predicts that one in six returning servicemembers will be diagnosed with Post Traumatic Stress Disorder and that at least one in ten will return with traumatic brain injuries. Senator Boxer and I have been working together on some of this. There is a mental health task force report due out in May. I know we have written to Secretary Gates saying we hope that General Kiley's departure will not delay that report because it is so critically important.

I want to ask both Secretary Cooper and Secretary England what both Departments are doing to deal with what seems to me and the experts to be a rising need for treating veterans who come home with PTSD and TBI.

Mr. ENGLAND. It is a rising need and it is a concern to us because, frankly, Senator, we learn more about this every day. I mean, this is something as we learn more about, literally, the brain

and how it operates and reactions, I mean, we are learning more about this. In the past, World War II, people were, "shell-shocked," right? Now, we actually understand that this is a Traumatic Brain Injury and we also understand it doesn't show up for some period of time. So we do have research into this issue to better understand it, but I agree with you here. This is an area where we need to be able to follow up with people, because otherwise we can't just let people go and then have this occur at a later date but it be too late to deal with.

I am not sure we have all those programs in place, because, frankly, we are still trying to understand and deal with this. But there is an understanding that this is a significant issue for the Department and we do have people literally studying and working this and researching to understand how we deal with this on a long-term basis. So I wish I had a definitive answer. I am just not sure we have enough knowledge to have a definitive answer, but I can tell you we will deal with it effectively and we will deal with it correctly as we gather knowledge to do so.

Senator LIEBERMAN. Secretary Cooper, how about the VA?

Mr. COOPER. Senator Lieberman, I certainly appreciate, or we appreciate your comments on the medical capability within VHA. They have done very well.

To answer your question professionally, I would like to ask Dr. Cross, who is from VHA and can handle that specifically.

Senator LIEBERMAN. Fine.

Dr. CROSS. Sir, in order to answer your question, VA has been a leader in PTSD for decades. With our National Center for PTSD, we lead the way in research and understanding how best to treat this complex condition. But we are not new to TBI, either. Fifteen years ago, we created our special centers for TBI, four of them, and now we have built them and supplemented them into a multi-disciplinary approach which we now call our Polytrauma Centers. We have promoted TBI education for our clinicians in a special course starting several years ago. As of 2 weeks ago, I checked how many we have trained in this supplemental training course. Sixty-one thousand of our clinical staff have been trained specifically, supplemental training on TBI.

But now we are doing something that I think is very creative, screening all OIF and OEF for TBI. Everyone that comes in, a new patient, we want to put them through a screen and perhaps do so periodically to assess, because we can recognize—

Senator LIEBERMAN. You mean everyone coming in claiming PTSD, or anyone coming into the system?

Dr. CROSS. We already have a screen, sir, for PTSD and we have been doing that for some time.

Senator LIEBERMAN. Right.

Dr. CROSS. We have added on the TBI, and what we are trying to do is make sure that we recognize the mild to moderate cases.

Senator LIEBERMAN. Right. Well, I appreciate that.

My time is up, but the challenge is to have the VA system be prepared to deal with this increasing number of veterans who will come back with both of these. I know you have been leaders and I do want to say that Senator Boxer and I and others are going to be introducing legislation to establish what we are calling Centers

of Excellence within the DOD, Department of Defense, to develop and support a Department-wide strategy to provide care for combat-related mental health and brain injury conditions. As soon as we get a draft of it, Secretary England and Secretary Chu, I look forward to sharing it with you and getting your response.

Mr. ENGLAND. Thank you. We do, Senator, if I can comment, I have met several times with Secretary Nicholson on this whole subject, particularly TBI, and like the Doctor said, there are four centers of excellence now in VA where our people go. I think the question, sort of the worrisome question is not how we deal with people with TBI but with people we do not know have TBI and may show up later——

Senator LIEBERMAN. Absolutely.

Mr. ENGLAND.—and so that is really sort of my focus. I believe where we know we have an issue, it is being dealt with and we have experts, but I do think, because of a lack of knowledge in this area, we need to be able to monitor this over a period of time.

Senator LIEBERMAN. Thank you. Thanks, Mr. Chairman.

Chairman LEVIN. As I said before, the best way I can figure out how to do this is to have one Democrat, then one Republican, and switch back and forth and that is what we will continue to do. However, we are going to have to, under the early bird rule, recognize Senators who were here when the gavel hit first before those who came later. It is even more complicated than that, but I have simplified this for everybody, and under that interpretation, Senator Collins would be next.

STATEMENT OF HON. SUSAN M. COLLINS, U.S. SENATOR FROM MAINE

Senator COLLINS. Thank you. I was getting worried where you were going, Mr. Chairman, with that because I was here on time.

Chairman LEVIN. Well, it showed, I am afraid.

Senator COLLINS. Secretary England, I want to echo the concerns that Senator Lieberman just enunciated about Traumatic Brain Injury. Senator Clinton and I recently introduced a bill also on this issue. My concern grew exponentially after talking to a neurologist from Maine who diagnosed a soldier who had served in Iraq with TBI and he had been misdiagnosed as having post-traumatic stress syndrome. This neurologist has attempted to teach me quite a bit about TBI. He calls it a silent killer and he believes that our Armed Forces need to do a far better job of screening our soldiers, marines, airmen, sailors, anyone who has served in Iraq or Afghanistan, when they come back State-side as part of a post-deployment medical examination. Is that being done? Is there a specific screening for Traumatic Brain Injury?

Mr. ENGLAND. David, would you address that for me?

Dr. CHU. Yes, ma'am. Here is what is being done.

First, we have promulgated and disseminated to the field and are requiring that in any incident where they believe that there has been a concussion that should be evaluated that there is a standard set of questions asked so we can record right away what we think happened and is this person someone to be flagged for this condition.

Second, we are in the process, just as you suggest, ma'am, of revising our post-deployment health assessment and the post-deployment health reassessment to deal with this issue.

And third, of course, as VA has testified, they are now evaluating every veteran who comes through, regardless of whatever the presenting condition is, for Traumatic Brain Injury.

So I think we have put in train a series of steps that are going to deal with the issue.

Senator COLLINS. Thank you. General Scott, I want to turn to your testimony and the analysis that was done by the Center for Naval Analysis for your Commission. It seems to me that you have identified some very interesting issues for this Committee to pursue. Not only is there a big difference between how the DOD rates for disability versus the Veterans Administration, but there also appears to be an extraordinary difference among the services, with the Navy and the Air Force granting disability ratings that are far higher than either the Army or the Marines.

My question to you is, based on the preliminary analysis that you have done, what do you think is the cause for the disparity within DOD among the four services? I must say that the disparity seems too pronounced to be attributable simply to the different missions of the various services. Do you have any preliminary judgments on that issue that you could share with us?

General SCOTT. Thank you for the question, Senator.

My opinion would be that there is really several things involved in it. One of them is, as you state, that there is a difference in what members of the services do. There is also probably some significant variation among how the instructions to the boards are applied. I believe I mentioned in my testimony that, to the best of our ability to determine at this point, the DOD has pretty well delegated to the services the implementation of the determination of disability. In other words, the services determine the disability based on their interpretation of the criteria, and one of the recommendations that I made was that there be a joint study actually between DOD and VA to look at the instructions that each of the services use and see if there is enough variation there to account for some of this difference, and then maybe to come out with some DOD guidance, if necessary, and then compare that with how the VA interprets and translates their disability assessments.

I would also add that one of our contractors, the Institute for Medicine, which you required us to use in the authorizing legislation, quite rightly so, they are doing a study of what the VA calls the entire rating schedule of how ratings are conducted based on body systems, and we expect to get some information out of that that VA and DOD may find useful .

Those are two of the reasons, and beyond that, ma'am, I am not sure that we have all the data in. As I mentioned early on in this, I am dealing with largely preliminary-type data, but I will be happy to furnish you an analysis of the differences as we see them as we get a little bit more data.

Senator COLLINS. Thank you.

Chairman LEVIN. Thank you, Senator Collins.

In his capacity as a Member of the Veterans' Affairs Committee, I now call on Senator Webb.

STATEMENT OF HON. JIM WEBB,
U.S. SENATOR FROM VIRGINIA

Senator WEBB. Thank you, Mr. Chairman. I might ask if you could give me 8 minutes given that I am on both Committees?

Chairman LEVIN. Nice try.

[Laughter.]

Senator WEBB. First, I would like to say, Secretary England, I would like to associate myself with the comments that the senior Senator from Virginia made with respect to this new policy that was announced yesterday and give you my utmost concern about this extension policy that has been put into place. I am stunned, quite frankly. I think it is one thing to say that we are putting predictability into the system and it is another when predictability is uniformly negative. In my view, the strategy doesn't justify this continuing abuse of people who have put their lives literally into the hands of our leadership. I think there are limits to human endurance and there are limits to what families can put up with.

You made a comment about retention numbers, and we are going to be watching those very closely. Retention numbers that I saw just 2 days ago, I don't know if you have seen them or not, with respect to West Point graduates are pretty disturbing. The West Point Class of 2000, I think, has 54 percent of that class have left the military already. The Class of 2001, I believe the number was 46 percent left pretty much as soon as their obligation was over. We have not seen that slide since the mid-1970s. I can't remember a slide like that since the Naval Academy Class of 1966, whose time expired right in the middle of Cambodia and Kent State and all of the rest of that during the Vietnam War.

So I think there is, on the one hand, serious concerns about how these policies are affecting the willingness of very fine people to stay in, and on the other, I just don't see the strategy justifying it. I think 15 months for a 12-month turnaround here is a bad trade. Senator Hagel and I put a bill in to adjust that and I hope my colleagues will look at that bill.

With respect to the issues on the table here, I have spent a good bit of my life dealing with these issues, as many people here know, having first of all grown up and served in the military, but I also spent 5 years at the Pentagon, 1 year as a Marine, and I spent 4 years of my life as a staff counsel on the Veterans' Committee dealing with these issues every day, and they are enormously complex issues. I hope my colleagues and other people will understand that.

There is almost a quadrant here when we are talking about how disability systems go into place, and what I mean by the quadrant is the military itself basically looks at who is fit for duty and who is not. The VA system is not designed simply to do that. The VA system is designed to examine people who were injured or have some level of disability on active duty and to track that disability as you go through the rest of your life. So they are not something that you can meld together. You have other systems, such as PTSD and TBI, which may not manifest themselves when you are on active duty completely, so they kind of cross the line.

But the other quadrant, and I think it was kind of interesting that in your comments, Secretary England, you mentioned that—first of all, you said you want to focus on the wounded, and I hope

you mean the wounded and the injured, because somebody who rolls over in a Jeep is not technically wounded, but they have an immediate injury that should require this sort of attention.

But the other statistics that kind of blew me away is that 89 percent of servicemembers who are being evaluated are those transitioning to retirement, according to your number, and that is, from my understanding, it wasn't the original intention of the system, that so many people who move toward retirement on longevity, as Dr. Chu mentioned, should be part of this medical disability system. The assumption is that normal wear and tear wasn't going to go into the disability system.

The one question I am going to be able to ask in this short period of time, I actually want to address it to Secretary Cooper and it follows onto the testimony that you gave in the Veterans Committee the last time that you and I were together there, and that is that when we were talking about the need for an analytical matrix to actually solve these problems. I contacted the Department of Veterans Affairs and I asked the question of how many claims adjudicators are actually on the ground, and that number came back to me is as of March 31, there were 5,409 claims adjudicators actually on the ground and that they are put on the ground on an assumption that they can turn out 109 claims a year.

Now, if we do the math on that, with a backlog that has been estimated anywhere from 400,000 to 600,000, depending on who we are listening to, they can do about 600,000 claims a year, but this isn't a static situation. As you know, we have got claims coming in all the time. So what would you need? What would you need so that we can actually get rid of this backlog?

Mr. COOPER. I think the primary thing that I need at this time is more people, as you pointed out. The budget for 2006 asked for an increase of about 450-plus individuals and the problem is, of course, that with the very complicated system that we have addressed here today, particularly the fact that we have to look at all issues on an individual veteran and we have to rate them by 10 percent increments, it takes a long time to train people. After bringing people on board, the next problem I have is training them, and we essentially figure that to get to the point of being productive, they need to have at least 1½ to 2 years of training.

We have made many changes over the last 4 or 5 years, done everything to try to make us more efficient, to consolidate where we think it is feasible, and to increase our efficiency. But I think, quite frankly, it is a very people-oriented problem and therefore it is people that I need.

Senator WEBB. Well, I would suggest, and my time has expired, that we really need to get to the number, that we can say analytically that we will fix this problem and make it one of the highest funding priorities in the Department of Veterans Affairs. We can't continue to do this not only to the Iraq and Afghanistan veterans, but to the Vietnam-era veterans who are aging out of their normal work, their career and wanting to get assistance in the system. We need to get to a number, and I want to work with you on that.

Mr. COOPER. Yes, sir.

Senator WEBB. Thank you.

Mr. COOPER. Speaking of the older veterans, by the way, you know, 54 percent of all claims we get are, in fact, second, third, and fourth claims coming back because of the aging process or deterioration in the particular condition for which they are evaluated.

Senator WEBB. I understand that. Thank you very much.

Thank you, Mr. Chairman.

Chairman LEVIN. Well, we have got a dilemma, unless Senator Specter sits down. The only early birds we have left who were here when the gavel hit are on this side. So now my question is, do I go back and forth or do I take care of the early birds according to the rule? So I am going to flip a coin and call on Senator Cornyn.

Senator CORNYN. I was just going to say, Mr. Chairman, I am sure you would do justice in your determination, and I didn't know you were going to call on me next, but thank you very much.

Chairman LEVIN. Well, that is my dilemma, folks. If you are all understanding, I will do the early birds first on this side.

Senator CORNYN. I think that is fair.

Chairman LEVIN. Thank you. I appreciate that a great deal.

STATEMENT OF HON. HILLARY RODHAM CLINTON, U.S. SENATOR FROM NEW YORK

Senator CLINTON. Thank you very much, Mr. Chairman, and thank you, gentlemen. Before I address the issues that brought us here today, I want to associate myself with the comments of both of the Senators from Virginia. Senator Warner and Senator Webb speak from a great deal of experience, and Secretary England, the announcement yesterday by Secretary Gates that deployments for active duty will be extended raises serious questions, both about the over-stretched nature of the Army, which I think is getting to a crisis point, but also about how we are going to continue to take care of those people as we put them in harm's way for longer and longer periods of time.

Our system, despite the best efforts of a lot of well-meaning people, is not working to commensurate with what we owe those who have served. I think looking at these problems that we are addressing today in the context of this longer deployment just makes the urgency even greater. I hope that the suggestions that have been talked about today from General Scott's Commission and others will be put on the fastest of tracks and work with the Congress to please get some answers to these problems.

I spent Tuesday at the VA in Syracuse, New York, and also up at Fort Drum, where I met with more than 40 returning active duty soldiers. They had been wounded and injured in both Iraq and Afghanistan, and I had a very frank discussion with them and I asked them what their situation was and here is what I heard.

Loss of their medical records was a constant refrain, something that I have heard continually. One young soldier who was wounded by an IED in Baghdad said that as he was being rolled out on his gurney to get on the plane to go back to Landstuhl, a nurse put a packet on his chest and said, "These are your medical records. Don't lose them." He said, "You know, ma'am, I didn't get to Landstuhl with my medical records." I hear that over and over again.

Physical Evaluation Board liaison officers who lack training or are just too busy, or no caseworker at all. Lack of legal assistance for the appeals process. Unfair determinations, at least in the minds of many of the soldiers and certainly on a basis of comparability due to the administrative and bureaucratic burdens placed on soldiers.

We have talked a lot today about the disability system, but I don't think it accurately reflects TBI or PTSD, amputations, hearing loss, and diseases that since the First Gulf War we have seen in some increasing numbers as military members have returned.

And then one issue which has not been mentioned and I want to put on the table is the Traumatic Servicemembers' Group Life Insurance, which has been the subject of just anguished reports to me. As you know, this is an insurance policy that many of our soldiers sign up for, and as of August 2006, over 41 percent of the claims had been denied. What I heard at Fort Drum was that it is almost a joke. They call numbers. Nobody answers. They get hung up on. They are basically told, here is the way it works. We turn you down, and if you have the energy to come back, maybe we will do something for you.

This is a disgrace and it is something that one sergeant told me just made him laugh instead of cry. His convoy had been hit by an IED. He had severe injuries. The life insurance representative told him that he would have to prove that he had been injured when he had his commanders, his doctors, and everybody else already having made that case. I think this needs to be looked at seriously and I hope, Mr. Chairman, we take a look at it, as well, because from what I am hearing, it is not performing the way it should.

I also heard there is not a single neurosurgeon deployed to Afghanistan, and one of the problems we are having with head injuries is that people are sent directly from Afghanistan to Landstuhl. That is a long trip under often stressful circumstances. At the very least, I hope, Secretary England, we can get a neurosurgical team to Bagram so that we have the facilities and the personnel there ready to take care of our young men and women.

I also was distressed to learn that Fort Drum does not have a caseworker assigned to assist wounded soldiers navigating through the disability process. A few months ago, the only caseworker assigned to the post was reassigned to an administrative position, and I heard from soldier after soldier that if it had not been for this particular caseworker, they would have really been lost.

When I asked the commanders, they told me they are not authorized to spend budget dollars from operating and maintenance accounts to hire caseworkers because they are paid from a separate medical personnel fund which is not under the control of the base commanders. Again, I think we need to look at that. One thing that these soldiers need is somebody to help them navigate through this process and for them to feel like they have someone on their side.

To follow up on Senator Webb's question, perhaps we could consider asking retired personnel to volunteer to assist us in reducing this backlog. I think we need to put as much energy and urgency into this as possible.

And finally, with respect to the electronic medical records, you know, the VA system gets very high marks, not just within the VA system itself but by external independent assessments, and yet I hear the DOD electronic medical records system is plagued by failure to comply problems. People just don't want to do it, and apparently they are not ordered to do it. Lots of slips with the information getting from the battlefield into the system.

I just think it would be a smart, efficient approach to look at taking the VistA system in VA, which is an already functioning, effective system that has a proven track record, and extending it to DOD. Instead of trying to figure out how to merge and create a new system, let us go with what works, because I think there are too many records that are being lost and people are literally falling through the cracks.

Mr. Chairman, I have a series of questions related to TBI and the legislation that I, and Senator Collins and I and Senator Bayh have introduced, and I would like to submit those for the record.

Chairman LEVIN. They will be made part of the record and we will keep the record open for the usual length of time for questions from any of the Members to be answered.

Thank you very much, Senator Clinton.

Now it will be Senator Specter.

STATEMENT OF HON. ARLEN SPECTER, U.S. SENATOR FROM PENNSYLVANIA

Senator SPECTER. Thank you, Mr. Chairman. When the recent disclosures were made about Walter Reed, I took another trip out there. I have been there on many occasions and have observed the returning troops from Iraq in the course of the past several years with the extraordinary injuries which they have. I was candidly surprised to see some with artificial limbs going back to active duty with tremendous composure and tremendous determination to continue to serve. We have had a wave of very serious brain injuries which are very debilitating. Now with the modern procedures, lives can be saved, but there is a lifetime of disability and those young men and women are returned to their families. There are real questions to the adequacy of their compensation as they are being cared for. They are in their '20s. Projecting ahead, they have 40, 50 years of disability.

One concern which I have, having been Chairman of the Veterans' Committee for some 6 years, is the adequacy of the compensation. Some of it comes from the Department of Defense, some of it comes from the Department of Veterans Affairs, but when these evaluations are made, I think inevitably, because of budget constraints, there are pressures on the evaluating personnel to hold back at least a little.

The question that I have, which could be directed at any one of the witnesses who are here today, but particularly Deputy Secretary of Defense England as the ranking DOD officer here, and at the outset thank him for his distinguished service, and to the ranking Veterans Affairs officer here, Under Secretary Cooper, has any consideration been given to a total top-to-bottom reevaluation as to the adequacy of the funds, say, in the Department of Defense—you have a big budget, you have got a lot of things you have to do with

it—to evaluate whether or not the funding available for wounded returning veterans is adequate, and the same as it applies to the Department of Veterans Affairs, whether the funds are adequate.

If there is one area of obligation which ought not to be short-changed, it is to see to it that these men and women who come back injured are properly cared for in all respects. The study should take into account the modern techniques to save lives but leaving people with terrible brain disabilities, and similarly when they come into the veterans' hospitals. We in the Congress make it a practice to visit our veterans' facilities and the efforts made there are very substantial, but there are very frequent difficulties because of inadequate funding.

Secretary England, you first. Do you think it would be a good idea to undertake such a comprehensive top-to-bottom study to see if funding is adequate for the responsibilities DOD has?

Mr. ENGLAND. Senator, I agree. I do think it is a good idea. I will tell you this. While I agree with it, I mean, my view of this, sitting where I sit, is that there is no budget constraint in this area. I mean, if people run short of money, we will reprogram money and refill those coffers. So my view where I sit is, there is no money constraint to take care of our wounded and there absolutely should not be.

That said, I will tell you I am periodically surprised with what happens in this very, very large and complex organization, so yes, it is probably appropriate to step back and make absolutely certain that that is the case, that we are not unduly constraining the system because of funding, and I would be pleased to do that. I will do it. I will direct that look just to be sure because we don't want that to happen. I mean, we do not build a limitation into this area of our enterprise. This is the most important thing we do and so we will step back and make sure we are doing it right. I appreciate the suggestion.

Senator SPECTER. Thank you, Secretary. I know my time has expired. Might we have a response, Mr. Chairman, from Secretary Cooper?

Chairman LEVIN. Yes.

Mr. COOPER. First, Senator, you discussed compensation, and in my particular part of the budget, all of the benefits that I have are mandatorily funded. There is no reason for us not to give exactly what we can, give the benefit of the doubt to the veteran, because I have two sets of money. One is the money I use to pay my people to do the work. For the money that goes to the veteran, all I have to do is say they are entitled to it and that money is available. So each year, there is mandatory money set aside for the compensation part.

For the medical side, I am of the opinion that we have sufficient money to do what is required. I would like to ask Dr. Cross to comment further on that.

Senator SPECTER. Dr. Cross?

Dr. CROSS. Yes, sir. We have the money that we need to carry out our existing mission. Our budget has increased 83 percent over this Administration. Of course, we reevaluate continually, and I want to tell you and reassure you of one particular point. OIF and OEF and the medical care that they need, the medical care that

they deserve is an absolute priority. We will find a way to make that happen no matter what.

Senator SPECTER. Thank you very much. Thank you, Mr. Chairman.

Chairman LEVIN. Thank you very much, Senator Specter.

Senator McCaskill?

STATEMENT OF HON. CLAIRE MCCASKILL, U.S. SENATOR FROM MISSOURI

Senator MCCASKILL. Thank you, Mr. Chairman.

I also would like to express similar sentiments to the two Senators from Virginia and the Senator from New York concerning the policy that was announced yesterday in terms of extending the deployment of these incredibly brave men and women who have given so much. I particularly think of their families and what kind of impact this is having on them, and I would like to particularly talk a little bit today about the Guard and Reserves. This policy affects them and their situation is slightly different than the active military in terms of what impact it has on their families. The irony, the Catch-22 of their situation is that when they come back, they have this time period during which they have got to make sure they do the right things or they lose certain benefits that they are entitled to.

You learn so much talking to the men and women who have come home. With all due respect to all of you who know so much, I have learned so much more in one-on-one conversations with men and women who have served than I have ever learned in this room because they tell me what really happens to them as they come back. And I was stunned to find out when I talked to a number of very brave men and women who served in the Missouri National Guard who have been to Iraq a number of times about this 2-year time frame they have, that they have got to do the right thing within these 2 years or they may not get everything that they are entitled to get. There is a limited amount of time that they are entitled to TRICARE when they get home, and then there is a limited amount of time that they have to access VA medical when they get home.

Has there been any consideration, since we are going to extend the amount of time they are serving over there, has anyone had a conversation as to whether or not we should extend the time during which these men and women can access benefits that I think most Americans think that they shouldn't have to dance a bureaucratic dance in order to benefit from them? Secretary England?

Mr. ENGLAND. I will let Dr. Chu talk about the specifics of time, but on the larger issue, my understanding, Senator, is it does not apply to the Guard and Reserves. The 15-and-12 is active and the Guard and Reserves will maintain the current objective, which is one-and-five. So I don't believe—there are some Guard there and they were already being extended earlier, but otherwise, I don't believe they are in this queue, but Pete, is that a——

Secretary Geren?

Mr. GEREN. That is accurate.

Senator MCCASKILL. The overall point is that when most of these men and women signed up for the Guard and Reserve, many of

them, I mean, we have traditionally had a strategic Reserve and the Guard was not seen as an operational force in our active military and it is a very important component of a voluntary military, obviously. And I look at the way—I had a young man tell me that he didn't realize until 6 months into his 2-year ticking time clock that he was even entitled to these benefits.

Now, I know what someone would tell me is, well, they are told when they are dismissed that they can get all these things, but think about what they are going through at the moment that they are dismissed. Is that the moment in time that they want another packet of paper? Is that the moment in time that they are going to be best equipped to absorb the information about what they need to do to access full benefits? I think common sense would tell us it is not the best moment in time. They don't want to hear any more about what they need to do and where they need to go. They want to get home.

Mr. ENGLAND. Can we address that, please, Dr. Chu?

Senator MCCASKILL. Sure.

Dr. CHU. We agree, ma'am. We brief before they go. That is a better time and a place. But we are also standing up what we call Turbo TAP, Transition Assistance Program, Senator, to put on the Web, put on the Internet the kind of information that you are referring to so they can do it at their leisure, and it is particularly oriented toward the Guard and Reserve for just that reason.

I will let the Veterans Affairs Department personnel comment on the 2-year window, but let me say, early during this Administration we extended TRICARE eligibility to be 90 days before mobilization, as long as you are holding orders, and 6 months thereafter at the government's expense. In addition, Congress has made TRICARE available to Reservists at very beneficial rates if they wish to continue service beyond that point in time. So people do have coverage if they wish.

The two-year window, if I recall correctly, and I defer to the VA, refers to the fact that they don't have to have a hard preexisting condition finding during that period of time to present themselves at a VA treatment facility and say, look, I think this is connected. But if it is service-connected, you have a lifetime entitlement to care from the Veterans Department, right?

Mr. COOPER. Yes, sir, that is correct. The 2-year time frame was set up, I think, by Congress to have that done, but the fact is, prior to that, to get into the VA system, a person had to have a disability. So to preclude that problem, they set up the 2 years that they could do that.

Now, a couple other things that we have done. We have had National Guard representatives come in from each State, and there is a representative that works with the Adjutant General in each State for National Guard in particular, and we have worked with them to train them to understand what they can do to help the Reserves and National Guard. Also, about 3 years ago, the Secretary set up a system whereby everybody—active duty, Reserve, National Guard—when they depart from active duty get a letter from the Secretary which delineates all of the benefits to which they are entitled. They get the same letter 6 months later because we understand there are certain veterans, like the seriously wounded, who

are not ready immediately to understand all the benefits that are available, and so we have tried to set up systems that give them continuous information.

Senator MCCASKILL. Would it be possible for somebody to call them?

Mr. COOPER. It would certainly be possible, absolutely.

Senator MCCASKILL. I just think, and Senator Clinton made the point, and what I have learned is so many of these men and women feel confused and they are almost paralyzed by the overwhelming nature of not only reintegrating with their families and their communities and finding work or returning to work, but then what they face in terms of learning how to—as one told me, you have got to learn how to game the system. You have got to learn how to use the system to your best advantage, and frankly, he said, it takes more time than I have right now. It is very clear to me that we are not getting these men and women the assistance they need in terms of navigating the system and I hope that we continue to make that a focus of our efforts.

Mr. COOPER. It is a very strong focus. We also talk to families as these men or women are deployed and talk to them during the time they are deployed. So we are reaching out in many different ways in many forms to try to help them as best we can.

Senator MCCASKILL. My time has expired, but I think we still have a lot of work to do in talking to the men and women that I have talked to that have returned home.

Mr. COOPER. Thank you.

Chairman AKAKA [presiding]. Senator Cornyn?

STATEMENT OF HON. JOHN CORNYN, U.S. SENATOR FROM TEXAS

Senator CORNYN. Thank you, Mr. Chairman, and thanks to each of our witnesses for what you do each and every day to serve our Nation and our men and women in uniform. We have a lot of work to do, I agree with Senator McCaskill.

I have just some specific questions. First, I have a question about life insurance and I have a question about how spouses of our wounded warriors are dealt with, and then one final question, Secretary Cooper, about the number of disability claims that an individual claims adjuster, or whatever the title is, handles each year.

But first of all, I, too, have been visiting with some of the families and the wounded warriors. They bring up specific concerns they have. One is a woman who is married to a soldier who was burned rather extensively and is still being evaluated. They have five children. She was essentially ordered to come to Brook Army Medical Center to attend to her husband's care, and she, of course, wanted to come anyway. She didn't need to be ordered. But the practical impact of that was that she had to quit her job. And while the wounded warrior receives their income, that may mean, and in this case for a family with five children, that the family is living on much diminished income.

I, frankly, don't know exactly what to do about that, but I wondered whether Secretary England or Secretary Chu, you might be the appropriate people to speak to that. Is there any assistance under current authorization that we could provide to the spouses

or family members who essentially give up their jobs to come care for these wounded warriors?

Dr. CHU. We do provide, under current law, assistance with travel. We pay for the travel, basically, if they wish to come, and it should be "wish." I am a little startled by the report that they were ordered to do this and that certainly bears looking into.

Senator CORNYN. I think that was one particular woman's interpretation, but the fact is, she wanted to be there——

Dr. CHU. It still bears looking into——

Senator CORNYN. She wanted to be there.

Dr. CHU. So we pay for, under the statute you have enacted, we pay for transportation for multiple trips to the bedside. We pay for per diem for a period of time to cover your expenses. But it does not go to salary replacement under the current statutes.

Mr. COOPER. May I—I don't usually like to interrupt and answer questions if I don't have to, but let me mention that a primary program that was set up 2 years ago is something called Traumatic SGLI. Traumatic SGLI was set up specifically to cover this type of problem, and it is given out predicated on what the disease or disability is, as determined by OSD.

Senator CORNYN. Is that what Senator Clinton was referring to——

Mr. COOPER. Yes, it is, and I do not know——

Senator CORNYN [continuing].—and some problems with the claims there?

Mr. COOPER. She said there was a problem, but the fact is——

Senator CORNYN. What is the purpose of that program?

Mr. COOPER [comtinuing].—that the decision is made by OSD that, yes, this person is eligible for that insurance and that then comes to us because we are the ones that take care of the insurance itself. Within 4 days, we will release a check, and it is in $25,000 increments up to a maximum $100,000, predicated upon the disability. But it was set up very specifically to help people who had to give up jobs and bring their family and live in someplace distant from their home.

Senator CORNYN. Well, thank you for that clarification. Quickly, since my time is running out, one other feature that one of these spouses of the wounded warriors mentioned to me is that some of them, of course, suffer very disabling injuries, and that is what we are talking about, how to deal with those, but she was very concerned that the life insurance which they could afford at one point, once they are separated from the service, becomes unaffordable because many of these individuals have shortened life spans and are virtually either uninsurable or insurable at only a tremendous cost which is difficult for them to afford, so they let it go and they lose that financial security that might otherwise provide them some protection.

Is there any provision under the current law made for either prepaying or providing some additional premium benefit to assist these families? I don't know who the appropriate person to ask, but Secretary Cooper?

Mr. COOPER. I think it is me again.

Senator CORNYN. Thank you.

Mr. COOPER. The SGLI does remain in effect for a brief time after the person leaves the service. However, we have other insurance policies that provide coverage for disabled veterans and the premiums are lower than what they would be commercially. So there are insurance programs and I would certainly be willing to have our people get together with your staff and talk about that very specific issue because we have a very strong insurance program within VA for this type of thing.

Senator CORNYN. I would like that. My time has expired. Let me ask just one clarification. Secretary Cooper, did you say that your claims adjustors at the VA handle 109 disability claims per year each? Did I hear that correctly?

Mr. COOPER. You heard correctly. When we take all the people in our compensation and pension program and divide them into the number of disability rating claims, it comes out to something like that. However, we have people that are doing many other types of claims, as well as public contact and outreach activities. Those people who are actually doing ratings are required to do 3.5 ratings a day. So those actually doing ratings on a day-to-day basis, of course, are doing many more. We also have others that are out at hospitals to help us ensure that we are working together with the veterans out there. So we have people placed to help us do the job better in treating the veterans.

Senator CORNYN. Thank you very much. Thank you, Mr. Chairman.

Chairman AKAKA. Thank you.

Senator Isakson?

STATEMENT OF HON. JOHNNY ISAKSON, U.S. SENATOR FROM GEORGIA

Senator ISAKSON. Thank you very much, Mr. Chairman, and I apologize to the panel and to you for being late, but this was one of those mornings. I am delighted that all of you could be here and I really have two questions and I will be brief, but I think I see General Schoomaker in the room and I want to take a moment here. I know there have been lots of questions about the Seamless Transition from DOD to VA. In our great State of Georgia, at the Eisenhower Medical Center in Augusta, Georgia, the General has single-handedly influenced a terrific transition from DOD to Veterans Health. It is a great success story. The volume of people now being processed there from Walter Reed and others has skyrocketed. I don't have my notes from a previous hearing, but it has gone up tremendously. I want to acknowledge General Schoomaker and how much I appreciate, the State of Georgia appreciates, and Augusta appreciates your demonstrating a "can-do" attitude and a "can-do" seamless system for our veterans. So that is not a question, that is just a comment that I commend to everyone.

Secondly, Secretary England—and this is a question and not a comment—this is DD Form 2900. This is the form that I understand is filled out as a serviceman is exiting the service to determine whether there is traumatic brain injury or Post Traumatic Stress Disorder. There is a nurse practitioner interview, but I am wondering if this form and what it asks, if you believe it, is ade-

quate to make that determination or if there is a different way in which we should do it or more information that we should ask for.

Mr. ENGLAND. Senator, I believe that there is a lot we still need to know about TBI and so while there are evident cases and we have facilities and all to deal with that, I mean, part of our concern is that delayed TBI, I mean, people that actually have TBI and we do not recognize that early, so we are putting in programs and VA actually evaluates people now later on to determine, you know, do they have any TBI symptoms.

So I think based on the knowledge we have today, this is an issue that we need to look at periodically. So whatever it is that we do immediately, there needs to be follow-up to that and I would say that that is the most important part of this thing, is to have a follow-up so that if we have evidence of this later on in life, that we can still help people deal with it.

Senator ISAKSON. OK, and again, I am dealing with information and things I have been told, not things I know, so I want to qualify this statement by that. But having exited the service at one time, I know how quick an exit I wanted to make and filling out forms, I could do quite quickly. There have been some conversations about maybe there is a motivation to get the forms in, to get the work done, and then later those problems come up. So it seems to me like it would be very important to ensure there were follow-up mechanisms for that evaluation to take place.

Mr. ENGLAND. Can I have Dr. Chu address this a little more in detail?

Dr. CHU. We completely agree with the issue of the serviceman eager to get home may wish to limit his or her involvement. That is the reason we have initiated a similar follow-up for everyone—active, Guard, and Reserve—3 to 6 months after they have come back, and we are revising these questions specifically to deal better with Traumatic Brain Injury symptoms.

Senator ISAKSON. My last statement is a comment that I thought I would share with all of you. We have all been working hard to see to it that the care our veterans get both while they are active DOD, under DOD, and when they leave the military is the best we can make it and VA has gotten tremendous accolades, last year in particular by being declared the gold standard, I think, in terms of an organization for health care.

I wanted to share with you that I go out to Walter Reed any time there is a Georgia soldier there that I can visit with, and I happened to be going out ahead of a scheduled appointment the Monday after the Building 18 incident hit the media, and I went on out for two reasons. One was to see the soldier that was back from Iraq, and the other was to see Building 18. And while the Building 18 situation was somewhat disappointing, the soldier that I met with had been at Walter Reed for 10 days and I did what I always do. I asked for his mother and father's name and phone number and I told him I would call them and give them my cell phone number so if there were something he needed, instead of them having to come back on the spur of the moment, maybe my office could assist him.

So I called his father and left a message and that night—my time is expired but I am going to finish this statement, if the Chairman doesn't mind——

Chairman LEVIN [presiding]. Keep going. Keep going.

Senator ISAKSON. That night, his father called me back and thanked me for it and then he said, you know, I have been reading all this stuff about the questions, he said, but I was with my son for nine of the last 10 days and I have never seen someone receive better care.

So you hear all the bad things, but that is not coming from me, that is coming from a constituent of a young man who had a very traumatic and severe arm injury. So as we work to improve the things we need to improve and make sure every case is a positive case, we can't forget the countless thousands of very positive things that are happening day in and day out in health care for our men and women in the military.

And with that said, distinguished Senator from Michigan, I was handed a note to say we ought to go in recess, but you outrank me, so I am going to yield back to you and you do whatever we need to do.

Chairman LEVIN. Fine. Thank you. We are going to go to a second round briefly and hope that some of the other Senators who were here, who didn't have a chance to ask questions and then had to go and vote, might come back in the next few minutes. We know, Secretary England, you need to leave at 12:30, we understand.

Mr. ENGLAND. I was actually hoping to leave at 12 o'clock, Senator Levin——

Chairman LEVIN. No, that is fine.

Mr. ENGLAND. Secretary Gates is——

Chairman LEVIN. We understand. We will try to accommodate you. I misspoke. They did tell me it was noon and I misspoke.

Mr. ENGLAND. Thank you.

Chairman LEVIN. Anyway, Senator Isakson, if you have additional questions, feel free to ask them. If not, I will ask questions.

Senator ISAKSON. Go right ahead, Mr. Chairman.

Chairman LEVIN. Thank you. The Army Inspector General report found that the VA schedule for rating disabilities does not accurately reflect medical conditions and ratings in today's environment. That schedule was developed when the American economy was more industrial-based. It is now more of an information age where employability does not rely as much on physical factors, although that has been changing over time, obviously.

To a greater extent in an industrial economy, losing a hand or a foot might render somebody unemployable, at least for some positions, while in the information economy—and it is not all just black and white but I think you understand what I am driving at—to a greater degree in an information economy, an amputee's professional life would not be affected by the loss of an arm or leg, for instance. On the other hand, in an information economy, PTSD or TBI might render someone more unemployable or less employable who is otherwise healthy by measures of the greater industrial economy.

I am just wondering whether or not there is any truth for that and whether or not this VA schedule for rating disabilities ade-

quately reflects any changes in medical technology as well as changing economic realities. So Secretary Cooper, let me call on you for that.

Mr. COOPER. We have attempted to look at the various ratings through the years and make some minor changes, but it is all predicated, of course, on Title 38 which was essentially put together, I think, back in 1944. This is one of the primary reasons I believe that Congress set up General Scott's Commission to look at the entire ratings schedule, as well as the application of it. So I would like to defer to General Scott.

Chairman LEVIN. All right. I know you have to leave, Secretary England, and I will call on General Scott in a moment, but since you have to leave, let me address a question to you, and I don't know if it has already been answered, just say so and I will look up your answer.

There was a GAO report in March of 2006 which criticized the Department and the services for failing to systematically determine the consistency of disability decisionmaking. The Department has issued timeliness goals for processing disability cases, but there is no collection of information to determine compliance. Finally, the consistency and the timeliness of decisions depend in part on the training that disability staff receive. However, the GAO found that the DOD is not exercising oversight over training for staff in the disability system. Are you familiar with that GAO report?

Mr. ENGLAND. No, sir, I am not. Dr. Chu, could you——

Chairman LEVIN. I will tell you what, Doctor, because I see we have got a number of Senators here and I want to call on at least a couple of them, if I could, before Secretary England leaves, and I want to yield at this point my time to, if you are ready, Senator Murray.

Mr. ENGLAND. We will get back with you on that question, Senator.

Chairman LEVIN. I am going to yield my time here. I know Senator Murray has been so deeply involved in these matters and has made such a huge commitment to reform in this area and to making changes which will help veterans that I want to yield my time now to Senator Murray so that she can ask you questions, if that is her intent, before you leave in a few minutes. Senator Murray?

STATEMENT OF HON. PATTY MURRAY,
U.S. SENATOR FROM WASHINGTON

Senator MURRAY. Mr. Chairman, thank you very much. I am delighted to be able to get back. There are a number of hearings going on, but I think this is probably one of the most important hearings that we are having in the Senate in quite some time because bringing all of you together to have a chance to see how we can solve this crisis that is facing so many of our young men and women who fought so hard for us. I was here for all of your testimony before, and General Scott, I know you are retired, you mentioned that, but I certainly was impressed with the recommendations that you brought to us and I hope, Mr. Chairman, we can incorporate some of those in whatever we need to do legislatively to help us move to a system that is seamless, that we don't lose so many of our men and women in.

I have been out talking to them, like many of us have here, and the frustration is so high among those people who just feel like the system is against them. They fought the war and now they are fighting their own system here to try and get what they have earned rightfully. So I really appreciate all of your testimony and all the Committee Members to take the time to really look at how we can get a seamless transition, and I appreciate it very much, Mr. Chairman.

I do have a couple of questions, and I am sorry I wasn't here for a number that were asked, but I am extremely concerned about the low number of permanent disability retirements. Back in 2001, we had 642 people with permanent disability. That has dropped all the way down to 209 in 2005 and it just doesn't make sense to me, looking at the statistics we have. We know that in Vietnam, the wound-to-kill ratio was 3:1. It is now 16:1, so we know we have a high number of men and women who are coming home injured.

Secretary Cooper, I wanted to ask you, there is a lot of concern out in the community that DOD is deliberately underestimating servicemen's disabilities to either lowball the cost of it or to not have it become apparent. Can you address that concern for us, perhaps tell us why there is such a low number of disability numbers and what we need to do to assure people, or what you can do to assure people, or what we are going to do in the future to make sure these people get the correct disability rating?

Mr. COOPER. Could I please divert that question to Deputy Secretary England, because it is a DOD question and I would just as soon he answer it.

Senator MURRAY. OK.

Mr. COOPER. He is here just for a few more moments.

Senator MURRAY. I will let him do that.

Mr. ENGLAND. I didn't leave in time.

[Laughter.]

Mr. ENGLAND. No, Senator, I am not familiar with the statistics. Obviously, you are right. There are more wounded now than we had before on a ratio basis. I am not sure why those numbers are lower.

I do want to comment, however. There is absolutely no incentive in this Department to save money on the backs of disabled people, people who have served our country. I mean, the people who do this are professional people. I think in aggregate, they absolutely have no idea how much money we spend, et cetera, so I think——

Senator MURRAY. Well, you should know that of those soldiers that I have talked to, many of them feel that they are being deliberately lowballed when it comes to their disability rating in order to save money.

Mr. ENGLAND. Well, let me assure you that is not the reason. I mean, I commented to Senator Specter, I would step back, because again, sometimes at my level you get inputs and it is different than what you perceive, but I can tell you, at my level, I mean, we fund what we need to fund in all of our medical and all of our disability, and if people are running short on cash we just reprogram and make that money available to them.

I believe people operate professionally within the guidelines they have in terms of making these determinations. We will step back

and make sure that is absolutely the case. But I have no evidence that that has ever occurred, but I will step back and take a look at it. I mean, if that is a concern of the people, then we will step back and look at that again.

Senator MURRAY. Well, I think all of us aggressively moving with a number of the things you have talked about to make sure that they have proper counseling, to make sure that they are supported, that their injuries are sufficiently diagnosed, will help that in the long run. But I am especially concerned about those members of the military who have been discharged, who have that unseen wound of the war, Traumatic Brain Injury or post-traumatic stress syndrome, who were rated incorrectly because, for whatever reason, lack of knowledge. How are we going to go back and capture those people and make sure that they are rated accurately?

Mr. ENGLAND. I share that concern. That is a discussion I have had, particularly TBI because it shows up later. We do have to have a way to deal with that. I know VA commented today that they actually assess people on an ongoing basis. Valid issue, valid concern. We need to make sure we address it right and we will work with VA. We are putting programs in place, but I share your concern because this is not something that shows up necessarily right away, and in fact, we are not even sure when it will show up——

Senator MURRAY. No, and there aren't ten questions you can ask because everybody is impacted differently. I was at the Polytrauma Center in Seattle last week and they said that sometimes a soldier won't even remember he was in the vicinity of an explosion as the result of that explosion. So I am hearing you all that you are moving forward to try and address those issues so we don't lose those people, but I do want to make sure that those people who have already been discharged and are now finding that they have TBI, that they aren't lost. So I would like to hear back from you as to your recommendation on that.

Mr. Chairman, I just want to point out one other quick issue and that is the whole issue of how our soldiers are rated. There was an article in the Takoma News Tribune about Fort Lewis in my home State last week that reported that allegations were being made that there was a Wal-Mart greeter test for an injured soldier. Basically, if they could respond and smile, then they were going to be OK. That was a very serious concern. I will get that article to you, but I wanted to make sure that you were investigating those allegations about what was happening there and could get a response back to us to make sure that we were not seeing that——

Mr. ENGLAND. No, I appreciate the input. We will—I appreciate knowing, hearing that, and we will get back with you, Senator. That is the first I have heard about that.

Senator MURRAY. I have had soldiers say to me, I got the Wal-Mart greeter test so I got sent back to Iraq, even though they were suffering from post-traumatic stress syndrome and TBI, which to me is a real disservice both to the men and women who are there in Iraq and need to be able to count on the soldiers in their unit, but also to that soldier himself.

Thank you, Mr. Chairman.

Chairman LEVIN. Thank you, Senator Murray, and thank you for your leadership in this area.

Senator Martinez?

STATEMENT OF HON. MEL MARTINEZ, U.S. SENATOR FROM FLORIDA

Senator MARTINEZ. Mr. Chairman, thank you very much.

I want to thank all the gentlemen here this morning for their testimony and dealing with these very, very important issues.

I thought I would also add, Secretary England, my word on the announcement yesterday, and I would say that from my perspective and the people that I have talked to, I think the predictability in their lives of knowing, for families knowing when Daddy is coming home or when Mom is going to be back or how long they are going to be home is terribly important. And understanding the stresses that the Global War on Terror is placing on our military, particularly on the Army, I think that it is a good policy. While it would be best if we had a larger Army, one that I would support and one that I think we need to address as we look to the future, I think it is important for now, as we are going through these stressful times, that we give the families the predictability that Secretary Gates gave them yesterday. So I thank him for that.

One issue that has appeared obvious to me as I have delved into this and, like others, visited with our wounded warriors is the adversarial nature of the way a disability rating and system all seems to go. I spent most of my professional life representing injured people before insurance companies and it doesn't seem to me that the attitude of an insurance adjustor ought to be the attitude with which the people that work for you, whether in the VA or in DOD, treat our wounded warriors. I think there needs to be a very different system and a much more benign system, particularly when we are dealing with combat-related injuries, not just working at a base and filling up a truck and getting a back injury. I think these are very different kinds of injuries.

One of the things that has been pointed out to me by one of our Floridians who has been injured is the issue of diagnostic codes for the Traumatic Brain Injury issue. It seems like the International Classification of Diseases does not have a specific classification or coding for DOD-wide on TBI patients and it would seem to me that that would be a good idea. Can you, Dr. Cross, or any one of you, address that specific issue?

Dr. CROSS. Senator, that is correct. When we assess the numbers of TBI, we look at a number of related ICD–9 codes. For doing statistical purposes, we look at perhaps a half-dozen of them or so that seem to be most related, for instance, post-concussive syndrome. So we think that as medical science develops in this area, this is, in fact, an unmet need that we need to look at nationwide, a better way to identify this syndrome.

Senator MARTINEZ. If we did and had a code that was specific for the syndrome, then we would also be able to track people wherever they might be in the system and at whatever point in treatment they might be, correct?

Dr. CROSS. It would assist in that.

Senator MARTINEZ. Where are we on that? Are we going to be able to——

Dr. CROSS. What we are doing right now, of course, is that we are tracking and we are case managing and screening and the screening is a really important part. The mild to moderate cases, the ones that are not so easy to recognize when they first show up, the ones that I am concerned that we may miss, we are training our folks, developed the screening test, put it in place as part of our electronic health record so that when that OIF and OEF veteran shows up, we will put him through that preliminary test, and then if that triggers any concern at all, then at least the secondary screening and further assessment and treatment.

Senator MARTINEZ. But then the coding with a certain diagnosis would also be a part of it?

Dr. CROSS. Yes, sir. Then the diagnosis goes into our electronic health record.

Mr. COOPER. Senator, may I also add——

Senator MARTINEZ. Yes, please.

Mr. COOPER [continuing].—that under the ratings system that we have in VA, we do have three separate ratings for different kinds of brain injury, TBI being one of them. So, in tracking those people and their disability ratings, we do see that.

Senator MARTINEZ. Another issue that I have also seen in visiting the Polytrauma Center in Tampa is the issue of, you know, they are getting patients, but it seems to me in talking to the patients and them that it would have been better for the patient had they been moved to a facility like this much sooner rather than been at Walter Reed, say, for months on end. It would seem to me that the care would have been more precise and their rehabilitation would have been speedier had they been at one of your very excellent veterans' Polytrauma Centers than at Walter Reed or Bethesda, perhaps. Can you comment on that, sir?

Dr. CROSS. Senator, each case is unique and I want to point out something, that we work closely with our DOD associates on a daily basis at Walter Reed, at Bethesda, Brook Army Medical Center, and other locations. Our doctors are on the phone, our doctors are on e-mail, our doctors consulting back and forth. In fact, I wanted to point out from Tampa, we have a video teleconference back to Walter Reed and Bethesda where the staff at our Polytrauma Center talk to the staff at the Walter Reed treatment facilities. This is the kind of communication that helps us assess and make a unique assessment on each individual.

Senator MARTINEZ. The issue of the life insurance, again, has been brought to my attention, and I wonder if it is true that wounded soldiers suffering from loss of cognitive function from a TBI cannot be compensated for that loss absent an inability to perform an activity of daily living. In other words, if they have no ADL dysfunction as such, that they may then not be able to qualify for what may, in fact, be a lifetime injury.

Mr. COOPER. You are correct. There are specific components in the law that are considered. An ADL is the one that covers a lot of things that are not otherwise covered specifically. So as the process works, someone helps the individual apply for TSGLI. DOD de-

cides whether that individual is eligible, and then it comes to VA to distribute the money.

Senator MARTINEZ. But it seems to me that a Traumatic Brain Injury patient who may be able to perform all the activities of daily living, it is just that his cognitive capacity is diminished, but sometimes this is fairly discrete. It is not an obvious diminution. So they are, therefore, disabled, and perhaps permanently disabled. Is it fair that they would not be able to then be compensated?

Dr. CHU. I think, Senator, you raised an excellent issue. It goes back to the statutory design of the traumatic injury insurance, which was modeled on standard commercial insurance products, and I think this issue should be looked at as part of this whole review.

Chairman LEVIN. We will, Senator, take a look at that. As a matter of fact, it is very important that you raised that issue, and if you could give us data on that, and with your leadership, Senator Martinez, on that issue, because we are going to be marking up bills and we would include that.

Senator MARTINEZ. All right. Thank you, sir.

Chairman LEVIN. Thank you so much. Senator Bayh?

Mr. ENGLAND. Mr. Chairman——

Chairman LEVIN. I know you have to leave——

Mr. ENGLAND. Does Senator Bayh have a quick question, Senator?

STATEMENT OF HON. EVAN BAYH,
U.S. SENATOR FROM INDIANA

Senator BAYH. I have just one quick question for you, Secretary, if you can hang on for 30 seconds. My understanding is that—and I hope this is in your bailiwick, if not, you can feel free to delegate it to the appropriate panelist—active duty personnel, as I understand it, who suffer from a Traumatic Brain Injury have access to private facilities, caregivers that contain some of the latest cognitive therapies. Why has the DOD decided to do that?

Mr. ENGLAND. I believe they have the right to TRICARE. I mean, that is part of what they have. They have TRICARE and they have VA, so they can select. I mean, that is just part of the package of benefits——

Senator BAYH. Well, the reason is the VA does not grant access to that kind of care. I am wondering why active duty soldiers do.

Dr. CHU. Because, sir, it is part of the TRICARE package. We don't want people to feel they are constrained in their choices and that is why we built that kind of network.

Senator BAYH. Well, implicit in that must be some sort of a determination that it is beneficial treatment.

Dr. CHU. Sir, we are not trying to——

Mr. ENGLAND. Pardon me. Sometimes, it is just closer to where they live, so it just may be physically convenient. There are four Traumatic Brain Centers, for example, VA has, but there are people who may not be close to those, but there may be a private center that is also very, very well known, so they may elect through TRICARE to go to that center.

Senator BAYH. And why is that care not available to the retirees in the VA system?

Dr. CHU. If you are retired, you also get TRICARE, so it is available to retirees.

Senator BAYH. What I have been told is that they have access to some private providers in other areas, but not for TBI services.

Dr. CHU. We will have to look at that.

Senator BAYH. Because I think the VA has considered this kind of cognitive therapy to be unproven.

Mr. ENGLAND. It has come to my attention—we have had some of these discussions, and so I can talk broadly. We have had a couple of specific cases where I know have come to my office where we worked with VA and they have gone to private TRICARE type of care, so I don't know about this broadly, Senator, but my understanding is that is available. Now, of course, there are four expert VA centers, and, of course, people tend to want to go to those centers because they are expert, but there are also very excellent private care centers and people have expressed a desire to go there. So the cases I am familiar with, they did end up at a TRICARE facility.

Senator BAYH. I am told that is a result of appealing the initial determination that they could not receive that kind of care.

Mr. ENGLAND. I don't know exactly what led to it, but my understanding is that is an option that they do have.

Senator BAYH. So what you are telling me is there's no disconnect between active and retired status, that they have access to the same kind of private care, the same kind of cognitive therapy——

Dr. CHU. Yes, Senator——

Senator BAYH [continuing].—whether they are active or retired?

Dr. CHU. The network is the same whether you are active or retired. It is the TRICARE network. If the private facility is part of the network, then, yes, sir, it is available to everybody who has TRICARE.

Senator BAYH. I don't know whether, Secretary Geren, this is appropriate for you or Secretary Cooper——

Chairman LEVIN. Senator Bayh, could we release Secretary England?

Senator BAYH. Oh, absolutely. Thank you. You have been very patient.

Mr. ENGLAND. Thank you very much. Mr. Chairman, let me just say, I sincerely appreciate it. This has been very thoughtful, it has been very helpful, and extraordinarily beneficial. So I do thank you. This has been an excellent discussion this morning. I personally have gotten a lot of input that will be very helpful as we go forward. I expect that my colleagues here have also. And we do look forward to working with you in this area. I mean, we will work collaboratively to end up with the very best process we can as we go forward and I do thank you.

Chairman LEVIN. We thank you and you are excused. We know you have got to fill the shoes of Secretary Gates today.

Senator Bayh, let me get back to you.

Senator BAYH. Thank you. I just have a couple more questions. Secretary Chu, let me get back to this. There seems to be some disconnect here. A couple of the groups that I have been in touch with, the Reserve Officers Association and the Wounded Warriors

Association, are under a different impression about whether they are granted regular access to private cognitive care when they move from active to retired status. This has been a problem, at least from their perspective, for some time now, and what I understood you to say is that it shouldn't be a problem.

Dr. CHU. It shouldn't, but if your office will forward us the specifics, we will be glad to look into these cases and understand where the confusion might arise.

Senator BAYH. OK, because there have been a number of instances and they are clearly under the impression that many of these individuals who have their status changed, not in all cases, but for TBI the kind of therapy that they have access to is not as generous. They are clearly under that impression.

Dr. CHU. If you give us the details, we will be glad to look into it.

Senator BAYH. OK. I would very much appreciate following up, because I would like to correct any deficiencies that exist and I know you feel the same way.

My final question, Mr. Chairman, would be to either Secretary Cooper, you or Secretary Geren, and I will leave it up to you gentlemen to decide who is appropriate. By the way, I appreciate all of your testimony. Secretary Geren, I was particularly impressed by your recitation of all the different things you are doing to try and get on top of some of the issues that need to be addressed. Maybe this is best left in your bailiwick, or Secretary Cooper. I will start with you.

What is the VA doing so that 2 or 3 years from now, this whole TBI situation do we have the kind of system in place that ensures that they get the state-of-the-art care that we would like to see these individuals have?

Mr. COOPER. I would like to ask Dr. Cross of VHA to please address that.

Dr. CROSS. Senator, this is an absolutely critical concern of ours, as well, so we share your concern. What we have done is this. I want to just give you a very brief answer but outline, and we can go into more detail with your staff at any time that you like. We created the TBI centers about 15 years ago and we now added to those by making them multi or Polytrauma Centers addressing a wide range of concerns, even blindness. But we have added onto that because we thought that was not enough and we want to get people closer and closer back to home and be able to follow them long-term——

Senator BAYH. Can I interrupt you for just one second, Dr. Cross? To get back to my previous questioning, is it your understanding that individuals, in addition to the VA centers that you have described, have access to private providers in addition to that, or——

Dr. CROSS. I can't answer for TRICARE directly, but my understanding is that if you are TRICARE-eligible, you would be eligible for civilian care.

Senator BAYH. Well, there is clearly a difference of opinion out there, but please continue.

Dr. CROSS. Level two, we wanted to get centers that were closer to home because we know the individual patient is not going to

stay at those four centers. We created 21 of them, and building the expertise at those sites closer to home. But then we thought, still not enough, so we created our Polytrauma Support Clinic Teams even at smaller facilities, and we have 76 of those as of this morning. And then at every facility, every medical center, a polytrauma point of contact.

So what we are doing is building for the long-term, Senator. We want to make sure that we have robust capability, geographically dispersed wherever the veteran needs it.

Senator BAYH. Good. Well, I appreciate that. This is, unfortunately, the signature injury of these conflicts and we are just beginning to understand how best to treat it, but clearly we have an obligation to these men and women for the long haul, so I am grateful for your efforts in that regard.

Secretary Chu, we will follow up with you and your office to try and——

Dr. CHU. We would be delighted, sir.

Senator BAYH [continuing].—reconcile these two different impressions that exist. Thank you very much.

Mr. GEREN. Senator, if I could say something on the blast injuries, on Traumatic Brain Injury, I would like to just add one thing that has not been discussed today. In your authorization bill last year, you all created a program for blast effect research for brain injuries, for PTSD, for loss of limb, loss of eyesight, every aspect of it, and the Army is executive agent for that program. It is up at Fort Dietrich and we are building a system that is going to—it is a joint program, looks across all the services, and try to marshal all the resources and coordinate them so we do our best research and best application of that research we possibly can.

It was an initiative that came out of the Congress a year ago and it is one where we have made great progress and I invite you and other Members of the Committee to go up to Fort Dietrich. General Schoomaker was there before he came down to Walter Reed, was in charge of that program and can speak with great detail to it. But it is a program that has made some great strides. There is much to learn, as has been reiterated today often. But the program up there is making considerable progress and it is one of the areas where the Congress and the Department have worked together to move ahead, so I want to thank you all for that.

Senator BAYH. Thank you for that information and for your efforts. Mr. Chairman, thank you.

Chairman LEVIN. Thank you, Senator Bayh.

Senator Sessions?

STATEMENT OF HON. JEFF SESSIONS,
U.S. SENATOR FROM ALABAMA

Senator SESSIONS. Thank you, Mr. Chairman.

I guess I would agree with the vast majority of our Committee that people are working very hard. We have got some great capabilities in VA and in Walter Reed. I have been out there recently, and I don't think we have a lot of criticisms of it, the actual hospital and care, although I am sure there are things that could be done to improve. But fundamentally, there is too much bureaucracy, there are too many problems with paperwork, there are too

many things not getting done on time, and I believe with some money and some determination, we can obliterate some of those walls and silos that are blocking easy communication and we can make life a lot less stressful for people who have suffered injury in the service to their country.

Secretary Geren, I am not sure I understood what you said earlier, but did you indicate that the 15-month policy would not alter the National Guard policy on deployment?

Mr. GEREN. Yes, sir, it would not. Now, there is a National Guard unit that is in theater that has already been extended to 16 months and that 16 months will stand. But the 15 month is for active duty.

Senator SESSIONS. From reading the paper, I thought different, and that is the first I have heard that. I am glad to hear that because our Guard people are under a different relationship with the military and the Department of Defense. They are part-time soldiers and it is even more difficult for them to be called up very rapidly because they have jobs, and when they come back, they have to go back to those jobs. Our contemplation for their deployment is different, although I certainly agree with the others that we have this fabulous all-volunteer active duty Army that can be overworked, also. So I am concerned about that and I am glad that you clarified this National Guard policy.

I visited Walter Reed and Bethesda a few weeks ago, 2 or 3 weeks ago, and General Schoomaker gave me a tour of the hospital and he had just—I am not sure he had even come on, maybe that day or the day before the hospital had fallen under his supervision. I noticed as he went about, he asked all the soldiers that we met with questions related to Traumatic Brain Injury. He asked them whether they were having trouble sleeping. He asked them several questions that would indicate whether or not they may have had a brain injury and he made it clear to me that he considered that a very important thing, that we were learning more about the problems of Traumatic Brain Injury, it was critical that we diagnose it early and that we help soldiers who are having difficulties, some of which are physical difficulties as a result of brain injury rather than post-traumatic stress syndrome-type situations. I did feel somewhat—I felt good about that because it is a real important part of what we are doing today.

The current backlog on VA claims has grown. We got those numbers down, I guess, Secretary Cooper, the numbers were going down several years ago. Now, they are back to about 600,000, with 800,000 applications arriving or something. What is the status now, and isn't the number of backlogged, unanswered claims higher than it was several years ago, a couple of years ago?

Mr. COOPER. The answer is, yes, they are higher. The number that we count is actually 400,000 disability claims. In 2003, we took it down to 253,000 and then a judge made a decision that made us stop dead in the water for about 4 months. His decision was that we could make no negative decisions for 1 year. That immediately shot us up to about 320,000. Since then, we have done a lot of outreach. We have done a lot of things telling people to come in and the numbers have increased.

Senator SESSIONS. How can a judge do that? The Department of Justice, somebody should be working to relieve orders that cause that much disturbance in your process, I would think.

My time has expired, so I would just point this out. If you need additional people to meet this challenge, I think you should ask for it. I also think that perhaps you could use retirees, people part-time. People who have had experience in this could help you deal with this crunch if they were paid adequately. I just would support the concept that we can't have these numbers going up. They need to be going back down, and I was hoping that we would be below 200,000 instead of being back up to 400,000.

Mr. COOPER. May I just tell you that in the last 5 months we have brought aboard 54 retired annuitants to help us do some of this work. Now, they are not direct employees, so there are certain things that they cannot do, but we bring them back——

Senator SESSIONS. Could we change the law that would help us a little bit on that?

Mr. COOPER. You might be able to. What we are using them for right now are the oldest claims because we can allow them to do that. They are also helping in training. They are helping in mentoring.

Chairman LEVIN. Thank you, Senator Sessions.

Senator Rockefeller?

STATEMENT OF HON. JOHN D. ROCKEFELLER IV, U.S. SENATOR FROM WEST VIRGINIA

Senator ROCKEFELLER. Thank you, Mr. Chairman. I apologize for being late but we are trying to make a little progress on the intelligence authorization, not much, just a little.

A couple of things. I know that Senator Warner and Senator Webb described this earlier, but I was listening to NPR this morning and they were reporting, therefore it was their report, not the actual words, the military was saying that this stretch to 15 months was to give predictability and stability to the family. I just had a very bad reaction to that simply because we all know that DOD is trying desperately to recruit and you are having a very hard time and you are offering all kinds of things. If that is the case, there is nothing wrong with saying that. The American people are prepared to hear that. But if you say, we are trying to increase the predictability for families so they can plan better for a whole year home, it struck me as difficult. I am not asking for a response.

I don't know how much mental health has been discussed here, and I am at a disadvantage that way, but you do have an executive council with VA and DOD and it is a mental health working group and it is focusing on the increasing collaboration between VA and DOD, which I am always, always for, on mental health illnesses to both VA and DOD beneficiaries.

Now, as I understand it, the assessment of opportunities for greater collaboration, which is a logical first step before you do something, on mental health issues were in education and administration and in transition of care. What I would like to get is an update, number one, what has been done with respect to these recommendations? Secondly, is there a time line as to when you wish to see them in effect?

Dr. CHU. Let me address that and invite my VA colleagues to join me. First, the intent is to pool our efforts so we can serve our populations better. We recognize some of these issues are issues that continue long after military service and that is the thrust, the theme of these initiatives.

In terms of completion——

Senator ROCKEFELLER. No, I didn't mean completion in terms of PTSD, because it can last a lifetime and usually does. I am asking when they will be in place so you can proceed—VA and DOD can proceed.

Dr. CHU. We have already put in place important elements of what we aim to achieve in this regard and that starts with, as has been discussed earlier this morning, or was discussed this morning, the ability of servicemembers who believe they have a disability that would be positive rated by DOD–VA to begin the benefits delivery process before they leave military service. So now, under the process we have put in place, you can start applying while you are on active duty to begin dealing with this rather than dealing with it after——

Senator ROCKEFELLER. I have got to understand better. What can the VA or the DOD military personnel look forward to at this point? What can they say, this is in place, this——

Dr. CHU. If they believe they have a disability that will be positively rated, they can begin applying to the VA for VA-based benefits while they are still on active duty starting 6 months before their discharge, so that the old system where you had to wait until you were discharged in order to apply, which, of course, immediately creates a gap, is——

Senator ROCKEFELLER. Understood. When you say they believe they need the help——

Dr. CHU [continuing].—we attempt to close by saying you can start——

Senator ROCKEFELLER. It is an American characteristic to deny mental illness. We are getting over it, but I would imagine that there are a lot of people denying it—you understand my question.

Dr. CHU. I understand, and on that—so in terms of availability, we are trying to move it up to start while you are active duty.

Second, in terms of trigger, in terms of clinical review, an important tool, as you know, is our assessment of your status before you depart, our reassessment when you return, and then our post-deployment reassessment 3 to 6 months after you have returned, whether you are still in the military or not. Now, those assessments are used to trigger referrals. We are in the process of sending those records also to VA so they can use the basis for their care effort. Both enterprises have sought to increase staffing levels to deal with PTSD and similar mental health problems as part of the overall demarche.

Senator ROCKEFELLER. I wish we could explore this a lot further, but my time has expired.

Chairman LEVIN. Thank you, Senator Rockefeller.

Senator Akaka?

Chairman AKAKA. Thank you very much, Mr. Chairman. I want to first ask unanimous consent, Mr. Chairman, that two items be made a part of the record of today's hearing, a statement from the

Disabled American Veterans regarding their research into the disparities of disability ratings among the military services, and the recent *U.S. News and World Report* article entitled, "Cheating Our Vets: How the Pentagon Is Shortchanging Wounded Soldiers."

Chairman LEVIN. That will be made part of the record, and any other statements of other organizations representing veterans, I know that both you and I would welcome them for our record, as well.

Chairman AKAKA. Thank you. Mr. Cooper, what prevents VA from awarding disability benefits for seriously wounded and injured servicemembers in the month following their separation from active duty?

Mr. COOPER. We attempt to decide the claim immediately. But the way the law is set up, and I think General Scott addresses it quite well in his report, is that if the judgment is made at a given point, the veteran cannot get paid during that month. If the veteran files within a year of discharge, we go back to the date of discharge. If he is discharged sometime during the month, we can't pay for that first month and he does not start accruing the pay until the beginning of the following month. So there is up to a 40- or 45-day gap—am I not right, General Scott?

General SCOTT. Yes, that is my understanding.

Mr. COOPER. So it is strictly a decision that has come about as a consequence of the omnibus bill of several years ago.

Chairman AKAKA. So what you are saying is that because of the law——

Mr. COOPER. Yes, sir.

Chairman AKAKA [continuing].—VA is not able to award disability benefits?

Mr. COOPER. Yes, and General Scott recommended that something be done about that.

Chairman AKAKA. Thank you for that.

Secretary Geren, I understand that many members of the National Guard who are seeking VA disability ratings may have to wait an additional 2 to 3 months for their claim to be processed pending authorization for their National Guard unit to release their records. I would ask you to please look into this and report back on what can be done to resolve this problem, or if you have any comments at this time on that.

Mr. GEREN. I am not familiar with that specific problem, but we certainly will look into it.

Chairman AKAKA. Thank you. General Scott, I know that you cannot speak for the Commission, but in your personal view, based on your work as the Commission Chairman, do you have any thoughts on what is needed to improve the cooperation and coordination between DOD and VA?

General SCOTT. Thank you for the question, Mr. Chairman. I would like to start out by saying that nothing I have said should be construed to imply that VA and DOD aren't doing their jobs well. What I have attempted to portray is the difficulty at the transition for a soldier, wounded or otherwise, but we are mostly focused on the wounded and injured right now, from active military service into the VA system.

I do have some specific recommendations on that. There are a number of them in my written statement and I mentioned them in the oral statement, as well. I really believe that beyond what I have already said, I don't have anything really to add to that. If you would like to follow up with a little more specific question, I will try to answer it, sir.

Chairman AKAKA. I don't at this time have any specific question except to rely on your experience and background and your knowledge of the problems we are talking about. As we work together here, we are trying to look for solutions to these problems and you have been very, very helpful today in your comments. We look forward to continuing to work with you on that.

Thank you, Mr. Chairman.

Chairman LEVIN. Thank you, Chairman Akaka.

Senator Rockefeller?

Senator ROCKEFELLER. Thank you, Mr. Chairman. I will just ask this final one.

The hearings on disability benefits vary enormously amongst the services and it sort of takes me back to Gulf War I when the services couldn't communicate with each other because they all had different—well, this is a very different kind of a difference, but it is also a very painful one and a very costly one. Each one has separate Physical Evaluation Board systems, each service. In the Air Force, 27 percent of disabled airmen receive a disabilities rating of 30 percent or higher, whereas in the Army only 4 percent of disabled soldier receive the 30 percent rating. In the Marine Corps, it is 3 percent, and that means that the ground troops who are collectively taking the brunt of all of this and getting the grievous injuries are the ones who are being rewarded with disproportionately less generous disability benefits. I am not trying to make a statement about the rules here, but I would be curious as to any comments that you had on that.

Mr. GEREN . Let me just speak to the statistics that you have cited. It was reported widely in the press, and I believe to the Congress, that the Army disability retirement number was 4 percent, and it gave the Air Force a number in the 20's and the Navy in the 30's, I believe, 34 percent. For some reason, that report failed to include temporary and permanent retirement for the Army. The Army number is actually around 20 percent, 19.5. This coming year, or the last year, it is in the low 20's. But there is a difference between the services. I am not suggesting there is not.

Our evaluation board looks at fitness for service. Every service sees its mission differently. I can't tell you today without having looked at all the different services if that explains the disparity. It is something that we have to look at. But the disability system for each service is based on fitness for service in that service, so there is some variation. But whether or not that explains that wide difference, I can't tell you today, but that is one of the issues we will certainly look at.

Senator ROCKEFELLER. What is the engine that drives the pursuit toward getting that question answered, why the differences? I mean, in other words, you are all tasked with it. Everybody has their own approach to it. But there has to be some kind of an en-

gine or an incentive or something which drives you, and I presume that is what the Board was set up for.

Mr. GEREN. I am not sure I understand which board you are referring to.

Senator ROCKEFELLER. Well, the Physical Evaluation Board systems.

Mr. GEREN. The Physical Evaluation Board system is a Title 10 product and each service uses it to determine whether or not a servicemember, in our case a soldier, is fit for duty, can remain on active duty, and we have different missions and different criteria for making that determination. So from the service perspective, that is really the reason for that board——

Senator ROCKEFELLER. So is it your point of view, in other words, the system is working exactly as it ought to be working?

Mr. GEREN. No, sir, I wouldn't draw that conclusion at this point. I am explaining the purpose behind the system. Now, as we look at this system, I believe that what we have seen and what we have learned over the last several months and what we have learned, frankly, over the last several years is this system does not work well. It is cumbersome, it is bureaucratic, in some cases it is adversarial when it should not be. I think at the end of the day, the recommendations that are going to come from the services and from these various commissions is that we come up with a new system.

What we have tried to do, working within the system, until we have that long-term fix, is make the system work better for the soldiers and we have done that by providing stronger advocacy for each of the soldiers working through the system, improving the quality of the liaison officers that work with them, improving the quality of the nurse case managers that work with them, giving them advocates to help them make the system—giving them an 800 number that they can call if the system fails.

But what I can't speak to today is a full explanation for the difference between our results, the Navy's results, the Air Force's results, but that is an area that we will look into.

Senator ROCKEFELLER. I thank you and I thank the Chairman.

Chairman LEVIN. Thank you, Senator Rockefeller.

There has been a lot of discussion today about having a single physical exam and who should do it and whether or not we ought to have a function that is given to the military as to whether you are fit for further duty, and then perhaps the VA to have the physical exam so we have one physical exam. Another approach or perhaps an interim approach to that would be for the Services to have a mandatory physical examination as a prerequisite for completing the separation process. This was a recommendation of the Presidential Task Force back in 2003.

So, Secretary Chu, what about it? What do you think about having a single mandatory physical examination before you are separated out?

Dr. CHU. I think the conclusion of the medical community is that that is probably more than you want and would threaten the excellence of the rest that you do, which ought to be focused on those who have an issue that comes forward. Now, in the military service, I think it is an issue of timing. In the military service, you are

required to have a physical examination at fixed periods, and so we do have a baseline of data as to your situation to use for the future.

Chairman LEVIN. How often is this examination given?

Dr. CHU. Our preference would be to focus on those who have a difficulty that means that there is going to be a claim. That is why we have put so much energy into the Benefits Delivery Discharge program, to address those cases with a single physical, really a single physical process would be a more accurate description, between VA and DOD at that point, make sure we do all the tests once. That means all the tests get done, but also we don't do them twice when they are overlapping, et cetera.

Chairman LEVIN. We have legislation that would accomplish that.

Dr. CHU. Sir?

Chairman LEVIN. One of the things that we are going to be asking you all for is comments on the pending legislation and the bills that have been introduced in the Senate, plus the bill that passed the House, some of which address this multiple physical examination issue. And we are going to need your comments within 14 days because we are going to have a markup.

We are going to obviously work closely with the Veterans' Affairs Committee, but the legislation has been assigned to the Armed Services Committee. I don't know if there is a sequential referral or not, but in any event, one way or another, the Veterans' Affairs Committee and any other committee that has jurisdiction over some of those issues will be not only welcome to be involved, but necessarily needs to be involved, so we will work closely with Senator Akaka and his Committee on that.

But from your perspective, we are going to need your comments on the House bill and on the Senate pending legislation, the bills that have been introduced on not just that issue, but on all the other matters which are included in those bills.

You said, Secretary Chu, that there is a routine physical examination so you have a baseline in the military. How often is that physical examination given?

Dr. CHU. It varies, but I believe it is typically several years as the minimum period of time.

Chairman LEVIN. Between exams?

Dr. CHU. Between exams, right.

Chairman LEVIN. So that is not——

Dr. CHU. For a young, healthy population, I think most people would say that is appropriate.

Chairman LEVIN. Well, it is not a great baseline, though, particularly when you are in active duty.

Dr. CHU. Well, I think this is the beauty of our electronic records system which we have moved to, as well, and that is that you can accumulate data on the patient, so the fact that you don't have a complete physical doesn't mean you don't have—let me put it positively. When you see the patient and do various tests, those are all accumulated in the record.

Chairman LEVIN. There are a number of questions which we have asked today which we will be needing replies from both of your agencies and it would be, I think, a very appropriate response to this joint hearing of two Committees if we actually could get

joint replies from our military and from the VA on issues such as the electronic records system. When is that going to be ready? What is your time line? That is a question we asked earlier, also the single physical exam and a number of other issues.

I would urge you to do that. We can't require you to do that, but we are trying to have a seamless approach here between these two Committees and that is what today's hearing really represents. It would be very, very valuable to us if your agencies would also make that same effort. I don't know if you need to print up new stationery, but somehow or other, get us letters and responses which reflect the common view.

Dr. CHU. We are committed to that, sir. In fact, perhaps if I might give you some evidence, I will send you our annual report from our joint executive council which has been in place for several years now.

Chairman LEVIN. I am not talking about a joint annual report. I am talking about specific answers to the specific questions which we have asked as to whether or not we can have a common position on a number of the key issues which have worked through this hearing. So we would just welcome that, and to the extent that you are able to do that, that would be a significant plus for us.

Chairman Akaka, I think we will leave it to you, if you would, to wind up your thoughts. Excuse me, Senator Thune, you quietly entered here. I apologize. Senator Thune?

STATEMENT OF HON. JOHN THUNE,
U.S. SENATOR FROM SOUTH DAKOTA

Senator THUNE. Thank you, Mr. Chairman, and I will be brief. I know you are interested in wrapping up and I appreciate you and Senator Akaka and your Ranking Members, Senator McCain and Senator Craig, for holding this hearing. I think this is very important that we get both the VA and the Department of Defense here together. These are issues that we all care deeply about. There is nothing more important than taking care of our military men and women.

I guess I just have a couple of quick questions maybe to wrap things up here, and I would like to direct this to General Scott. The preliminary results provided to assess the level of consistency between disability ratings assigned by the DOD and VA, in that preliminary study, the study breaks out the disability ratings by service, and I guess my question is, has any analysis been done to look at how disability ratings for members of the National Guard and Reserve compare to the VA and to the active duty services?

General SCOTT. Sir, that has not been part of the Commission's study.

Senator THUNE. Is there any thought about doing that, just to——

Dr. CHU. If I may, Senator, the GAO report from March of 2006 did actually address that question, did some fairly sophisticated statistical review of the records. It concluded, interestingly, that in terms of the percentage for rated disabilities, that if you have disability X, you did get more or less the same rating, no difference between active and Guard or Reserve. It did note there appeared to be some difference in terms of the disposition of the case in the

sense of did you get severance, did you get temporary disability, did you get a permanent disability rating, although it acknowledged it did not have enough data with which to understand why those differences might exist.

Mr. COOPER. I would say also that, in looking at some of our figures, when someone files a claim, we don't look to see if they are Reserve, National Guard, or regular. We get a claim. We then send them for a medical diagnosis and then we rate the claim with the information we have. So we attempt not to even think about that.

One of the things I have noted is that, across the board, not for individual disabilities but for Reserve versus active service, you will find the active duty has a higher percentage of compensation. However, many of the active duty members are retiring following a long military career, and so we find that their ratings are a good bit higher than those of the reservists.

The second thing is that the longer you are on active duty, the longer you are exposed to whatever problems you may have or you may get during that time. So it looks like there is a disparity if you compare the average Reserve and the average active duty servicemembers. But there are explanations for it.

The third thing, if a person is a Reservist and retired on disability, that person is identified as active duty retired. So the person that is greatly disabled who is in the Reserves and being separated is recorded in the active duty column. There is nothing I can do about that yet, but that is the way the data is now reported.

But I can guarantee you that when a person comes in, it is a person who comes in with a given disability and to the best of our ability we will do it exactly the same.

Mr. GEREN. Let me mention one thing additionally, just a safeguard in the system. If a member of the Reserve component, the Guard or Reserve appears before the Physical Evaluation Board, one of the Board members is always from the Reserve component just to make sure that that perspective is represented in the consideration. It is not saying it is fail-safe and it is something that we have looked into, but that is one of the safeguards that is built into the system.

Senator THUNE. I appreciate all of your answers to that because I think it is obviously an issue that I never heard discussed or talked about until—and getting some of that testimony to that effect is very helpful.

Mr. GEREN. Let me add something else, if I may. The Togo West-John Marsh Commission as well as many of us who have met with soldiers at Walter Reed and elsewhere, we have heard some expressions of concern. They feel that the Reserve component, the Guard and Reserve is treated differently. Those are concerns we take very seriously. It should not happen, but there are perceptions in some quarters that there are differences in treatment and we are working very hard to address those concerns. I know General Schoomaker has worked at Walter Reed to address that. I have heard him speak to his staff out there on that point.

We are one force today. As has been remarked earlier to Senator McCaskill, we are calling on the Guard and Reserve to be part of the operating force, no longer a strategic reserve. We are asking a great deal of them and their families. We are one force. We fight

as one. We train as one. And to the extent there are any vestiges in the system that cause the Reserve component to be treated less well, we are doing everything we can to wipe them out. It is not to say there aren't some vestiges of that different status, but I can assure you it is a concern of your Army leadership, DOD leadership. We are one force and we are trying to make our systems reflect that.

Senator THUNE. I appreciate it. Thank you for that expression of your commitment, and I would say that we need to—we can ill afford to have that kind of a distinction based on what we are asking the Guard and Reserve to do these days. So to the degree that there are any discrepancies that exist residual from the old days, I hope that you will continue, and if we can be helpful in that regard in any way, please let us know how we can do that, as well. Thank you. I appreciate that.

Thank you, Mr. Chairman.

Chairman LEVIN. Thank you, Senator Thune.

Senator Akaka?

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

For me, in closing, I note that I found this hearing to be quite helpful in the ongoing effort to promote greater coordination and cooperation between the Departments of Defense and Veterans Affairs.

It is apparent to me, however, that our two Committees need to continue to coordinate our efforts if there is to be lasting and long-term improvement on how the two departments work together. I want to reiterate the message that the Chairman delivered here about wanting to have joint responses also to our specific issues and questions that we may have. This is particularly true on those specific areas where there appear to be gaps in the coverage provided to servicemembers and veterans. I am not sure we need to have regular joint hearings on that, although keeping that possibility in reserve may do wonders for focusing the attention of the leadership of the two departments. But I do believe we need to seek innovative ways to meld our oversight and legislative activities.

As Chairman of the Veterans' Affairs Committee and as one of four Members who sit on both Committees, I pledge my effort to improve our joint activity, Mr. Chairman. As I said earlier, although there are two departments, both deal with the same individuals and we must ensure that servicemembers and veterans get the benefits and services they need and deserve, the benefits and services they have earned by their service.

This, I feel, has been a great hearing and I want to thank Chairman Levin for his efforts and thank all of you for your responses and your helpfulness to what we are trying to do here. Thank you very much, Mr. Chairman.

Chairman LEVIN. Thank you, Chairman Akaka. I think your statement speaks for all of us.

I thank our witnesses. We look forward to your answers. It has been a very, very helpful hearing in many ways, not just in terms of the substance, the material that we have been able to obtain and understand, but also just the fact that these two Committees have met together in this way hopefully will compel some very close

working together of the agencies that need to work together if we are going to eliminate the gaps that exist and the holes that we need to fill.

So again, with thanks to all of our witnesses, we will stand adjourned.

[Whereupon, at 12:58 p.m., the Committees were adjourned.]

A P P E N D I X

PREPARED STATEMENT OF BRIAN LAWRENCE, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Chairmen and Members of the Committees:

On behalf of the 1.3 million members of the Disabled American Veterans (DAV), thank you for the opportunity to bring greater awareness to a longstanding problem in the military disability evaluation system. In recent weeks, much attention has been drawn to substandard housing conditions found at Walter Reed Army Medical Center. While outrage over such inexcusable conditions was proper, a more serious issue than mold and mildew in dormitory rooms appears to have escaped initial public scrutiny. This problem, the serious underrating of disabilities that render servicemembers unfit for further service, adversely affects military personnel for years, perhaps the remainder of their lives.

Injured servicemembers, are routinely denied benefits to which they are entitled. This occurs for a variety of reasons. Primary among them is that some military services consistently underrate the severity of those disabling conditions found to render the servicemember unfit for further service. One veteran was recently discharged while undergoing treatment for leukemia. Although treatment for leukemia entitled the veteran to military disability retirement, a 100 percent rating, and medical care for her children, among other benefits, the Army Physical Evaluation Board (PEB) and Physical Disability Agency (PDA) awarded her a 10 percent rating and severance pay. This soldier lost lifetime commissary and exchange privileges, military health care, and all other benefits associated with military retirement. Other examples include the PDA finding that mental disorders first diagnosed in service, as determined by military doctors, pre-existed service. The PEB and PDA have found pre-existence based on such evidence as the soldier having sought guidance counseling while in high school. There are other examples of abuses in the Department of Defense (DOD) administration of its disability evaluation system.

Abuses such as these give the appearance that the DOD is seeking to avoid granting retirement benefits at the expense of war-time disabled veterans. While such an assertion may at first seem bold, one can derive few other conclusions in light of the numerous cases where nearly simultaneous disability ratings adjudicated by VA have been substantially higher than those assigned by the PEB and PDA. Over the past few months, since the DAV has once again begun efforts to urge the DOD to address this serious issue, we have collected more than fifty examples of cases where the disparity between PEB and VA ratings make it evident that a systemic problem exists. More examples arrive every week.

As a military retiree, one of the most important benefits earned is comprehensive health care coverage. TRICARE is the DOD health and dental care program for retirees and members of the uniformed services, their families, and survivors. While veterans with VA service-connected disabilities are entitled to VA health care, their family members and survivors are not. Therefore, when a servicemember with a family is denied retirement benefits, the loss of those benefits can create significant financial difficulties. Imagine how such financial burdens can add to the hardships a servicemember and his or her family must endure during an already tumultuous period. In addition to facing serious and sometimes catastrophic health concerns along with a major career change, the servicemember must incur significantly increased expenses to provide for his or her family.

There is no justification for the PEB and the PDA consistently underrating cases. PEB's do not adhere to the VA Schedule for Rating Disabilities (VASRD) as required by chapter 61 of title 10 United States Code because some in DOD assert that the law is ambiguous. The DAV asserts that this statute and the ruling by the U.S. Court of Claims in *John F. Hordechuck* vs. *The United States* (U.S. Ct. Cl. 492, 1959) make it clear that DOD must use the VASRD as its standard for rating disabilities. Our opinion conflicts with that of the DOD General Counsel, which seems

to hold that the law permits DOD to modify the VASRD for DOD purposes. While the DAV has serious reservations that such modifications are in accordance with the law, the purpose of this statement is not to debate our differences with DOD; rather, we seek legislative action to eliminate any ambiguity on this issue. Such legislation should make unmistakably clear that there is only one rating schedule, the one adopted by the Department of Veterans Affair, that the DOD does not have the authority to modify that schedule, and that decisions of the Court of Appeals for Veterans Claims interpreting the rating schedule must be followed by the DOD.

We hope that the Committees will recognize the injustices that have been imposed by the PEB and PDA on members of the Armed Forces who became ill or were injured in the line of duty. We ask that the Committees will report a bill that resolves these serious problems.

[S. 1065 introduced by Senators Clinton and Collins, and S. 1113 introduced by Senators Bayh and Clinton follow:]

II

110TH CONGRESS
1ST SESSION

S. 1065

To improve the diagnosis and treatment of traumatic brain injury in members and former members of the Armed Forces, to review and expand telehealth and telemental health programs of the Department of Defense and the Department of Veterans Affairs, and for other purposes.

IN THE SENATE OF THE UNITED STATES

MARCH 29, 2007

Mrs. CLINTON (for herself and Ms. COLLINS) introduced the following bill; which was read twice and referred to the Committee on Armed Services

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A BILL

To improve the diagnosis and treatment of traumatic brain injury in members and former members of the Armed Forces, to review and expand telehealth and telemental health programs of the Department of Defense and the Department of Veterans Affairs, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Heroes at Home Act of 2007".

1 **SEC. 2. PROTOCOL FOR ASSESSMENT AND DOCUMENTA-**
2 **TION OF COGNITIVE FUNCTIONING OF EACH**
3 **DEPLOYED MEMBERS OF THE ARMED**
4 **FORCES.**

5 (a) PROTOCOL REQUIRED.—The Secretary of De-
6 fense shall establish a protocol for the assessment and doc-
7 umentation of the cognitive (including memory) func-
8 tioning of each member of the Armed Forces before each
9 such member is deployed in Operation Enduring Freedom
10 or Operation Iraqi Freedom, to facilitate the assessment
11 of the cognitive (including memory) functioning of each
12 such member upon returning from such deployment.

13 (b) DIAGNOSIS OF TRAUMATIC BRAIN INJURY AND
14 POST TRAUMATIC STRESS DISORDER.—

15 (1) IN GENERAL.—The Secretary shall ensure
16 that the protocol required by subsection (a) provides
17 appropriate mechanisms to permit the differential
18 diagnosis of traumatic brain injury (TBI) and post
19 traumatic stress disorder (PTSD) in members of the
20 Armed Forces who return from deployment in Oper-
21 ation Enduring Freedom or Operation Iraqi Free-
22 dom.

23 (2) ADDITIONAL PURPOSES.—Except as pro-
24 vided in subsection (d), the Secretary may use the
25 protocol for such other purposes as the Secretary
26 considers appropriate.

(c) NEUROCOGNITIVE ASSESSMENTS.—

(1) IN GENERAL.—The protocol required by subsection (a) shall include the administration of computer-based neurocognitive assessments to members of the Armed Forces.

(2) FREQUENCY.—The assessments required by paragraph (1) shall be administered at least once to each member of the Armed Forces—

(A) before deploying to Operation Enduring Freedom or Operation Iraqi Freedom; and

(B) upon returning from such deployment.

(3) DEVELOPMENT OF ASSESSMENT.—In developing the computer-based assessment required by paragraph (1), the Secretary may use or adopt a current commercial product or develop a new computer-based assessment.

(4) FORMAT OF ASSESSMENT.—The format of the assessments required by paragraph (1) shall be the same for each administration described in paragraph (2).

(d) PROHIBITION ON USE OF PROTOCOL TO DETERMINE DEPLOYMENT READINESS.—The Secretary may not use the result of any assessment that is part of the protocol required by subsection (a) to determine the deployment readiness of any member of the Armed Forces.

1 (e) AVAILABILITY OF MEDICAL DATA.—The Sec-
2 retary shall make available such medical data on the cog-
3 nitive (including memory) functioning of members of the
4 Armed Forces who are deployed in Operation Enduring
5 Freedom or Operation Iraqi Freedom that is obtained
6 from the protocol required by subsection (a) as the Sec-
7 retary considers appropriate to—
8 (1) combat medics and other Department of
9 Defense personnel who provide medical services to
10 such members; and
11 (2) such entities as the Secretary considers ap-
12 propriate.
13 (f) REPORT.—Not later than one year after the date
14 of the enactment of this Act, the Secretary shall submit
15 to Congress a report on the implementation of this section.
16 (g) AUTHORIZATION OF APPROPRIATIONS.—There is
17 authorized to be appropriated to the Department of De-
18 fense to carry out this section amounts as follows:
19 (1) For fiscal year 2008, $3,750,000.
20 (2) For fiscal years 2009 through 2012, such
21 sums as may be necessary.

SEC. 3. TRAINING AND CERTIFICATION PROGRAM FOR FAMILY CAREGIVER PERSONAL CARE ATTENDANTS FOR VETERANS AND MEMBERS OF THE ARMED FORCES WITH TRAUMATIC BRAIN INJURY.

(a) PROGRAM ON TRAINING AND CERTIFICATION OF FAMILY CAREGIVER PERSONAL CARE ATTENDANTS.—The Secretary of Veterans Affairs shall establish a program on training and certification of family caregivers of veterans and members of the Armed Forces with traumatic brain injury as personal care attendants of such veterans and members.

(b) LOCATION.—The program required by subsection (a) shall be located in each of the polytrauma centers of the Department of Veterans Affairs designated as a Tier I polytrauma center.

(c) TRAINING CURRICULA.—

(1) IN GENERAL.—The Secretary of Veterans Affairs shall, in collaboration with the Secretary of Defense, develop curricula for the training of personal care attendants described in subsection (a). Such curricula shall incorporate applicable standards and protocols utilized by certification programs of national brain injury care specialist organizations.

(2) USE OF EXISTING CURRICULA.—In developing the curricula required by paragraph (1), the

1 Secretary of Veterans Affairs shall, to the extent
2 practicable, utilize and expand upon training cur-
3 ricula developed pursuant to section 744(b) of the
4 John Warner National Defense Authorization Act
5 for Fiscal Year 2007 (Public Law 109–364; 120
6 Stat. 2308).
7 (d) PROGRAM PARTICIPATION.—
8 (1) IN GENERAL.—The Secretary of Veterans
9 Affairs shall determine the eligibility of a family
10 member of a veteran or member of the Armed
11 Forces for participation in the program required by
12 subsection (a).
13 (2) BASIS FOR DETERMINATION.—A determina-
14 tion made under paragraph (1) shall be based on the
15 clinical needs of the veteran or member of the
16 Armed Forces concerned, as determined by the phy-
17 sician of such veteran or member.
18 (e) ELIGIBILITY FOR COMPENSATION.—A family
19 caregiver of a veteran or member of the Armed Forces
20 who receives certification as a personal care attendant
21 under this section shall be eligible for compensation from
22 the Department of Veterans Affairs for care provided to
23 such veteran or member.
24 (f) COSTS OF TRAINING.—

(1) TRAINING OF FAMILIES OF VETERANS.—Any costs of training provided under the program under this section for family members of veterans shall be borne by the Secretary of Veterans Affairs.

(2) TRAINING OF FAMILIES OF MEMBERS OF THE ARMED FORCES.—The Secretary of Defense shall reimburse the Secretary of Veterans Affairs for any costs of training provided under the program under this section for family members of members of the Armed Forces. Amounts for such reimbursement shall be derived from amounts available for Defense Health Program for the TRICARE program.

(g) CONSTRUCTION.—Nothing in this section shall be construed to require or permit the Secretary of Veterans Affairs to deny reimbursement for health care services provided to a veteran with a brain injury to a personal care attendant who is not a family member of such veteran.

SEC. 4. TELEHEALTH AND TELEMENTAL HEALTH SERVICES OF THE DEPARTMENT OF DEFENSE AND THE DEPARTMENT OF VETERANS AFFAIRS.

(a) TELEHEALTH AND TELEMENTAL HEALTH DEMONSTRATION PROJECT.—

(1) IN GENERAL.—The Secretary of Defense and the Secretary of Veterans Affairs shall jointly

1 establish a demonstration project to assess the feasi-
2 bility and advisability of using telehealth technology
3 to assess cognitive (including memory) functioning
4 of members and former members of the Armed
5 Forces who have sustained head trauma, in order to
6 improve the diagnosis and treatment of traumatic
7 brain injury.

8 (2) LOCATION.—

9 (A) IN GENERAL.—The Secretary of De-
10 fense and the Secretary of Veterans Affairs
11 shall carry out the demonstration project re-
12 quired by paragraph (1) at one or more loca-
13 tions selected by the Secretaries for purposes of
14 the demonstration project.

15 (B) PRIORITY FOR RURAL AREAS.—In se-
16 lecting locations to carry out the demonstration
17 project required by paragraph (1), the Sec-
18 retary of Defense and the Secretary of Veterans
19 Affairs shall give priority to locations that
20 would provide service in a rural area.

21 (3) REQUIREMENTS.—The demonstration
22 project required by paragraph (1) shall include the
23 following:

24 (A) The use of telehealth technology to as-
25 sess the cognitive (including memory) func-

1 tioning of a member or former member of the
2 Armed Forces, including the following:
3 (i) Obtaining information regarding
4 the nature of any brain injury incurred by
5 such member or former member.
6 (ii) Assessing any symptoms of trau-
7 matic brain injury in such member or
8 former member.
9 (B) The use of telehealth technology to re-
10 habilitate members or former members of the
11 Armed Forces who have traumatic brain injury,
12 and the use, to the extent practicable, of appli-
13 cable standards and protocols used by certifi-
14 cation programs of national brain injury care
15 specialist organizations in order to assess
16 progress in such rehabilitation.
17 (C) The use of telehealth technology to dis-
18 seminate education material to members and
19 former members of the Armed Forces and the
20 family members of such members on tech-
21 niques, strategies, and skills for caring for and
22 assisting such members, and to the extend prac-
23 ticable, such education materials shall incor-
24 porate training curricula developed pursuant to
25 section 744(b) of the John Warner National

1 Defense Authorization Act for Fiscal Year 2007
2 (Public Law 109–364; 120 Stat. 2308).
3 (4) USE OF PROVEN TECHNOLOGIES.—Any as-
4 sessment administered as a part of the demonstra-
5 tion project required by paragraph (1) shall incor-
6 porate telemental health technology that has proven
7 effective in the diagnosis and treatment of mental
8 health conditions associated with traumatic brain in-
9 jury.
10 (5) ADMINISTRATION.—
11 (A) IN GENERAL.—The demonstration
12 project required by paragraph (1) shall be ad-
13 ministered under the joint incentives program
14 and carried out pursuant to section 8111(d) of
15 title 38, United States Code.
16 (B) FUNDING.—Amounts to carry out the
17 demonstration project shall be derived from
18 amounts in the DOD–VA Health Care Sharing
19 Incentive Fund established under paragraph (2)
20 of such section.
21 (6) REPORT.—
22 (A) IN GENERAL.—The Secretary of De-
23 fense and the Secretary of Veterans Affairs
24 shall jointly submit to Congress a report on the

1 demonstration project required by paragraph
2 (1).
3 (B) SUBMISSION WITH ANNUAL JOINT RE-
4 PORT.—The report required by subparagraph
5 (A) shall be submitted to Congress at the same
6 time as the annual joint report required by sec-
7 tion 8111(f) of title 38, United States Code, for
8 the fiscal year following the fiscal year of the
9 date of the enactment of this Act.
10 (b) ONGOING STUDY ON TELEHEALTH AND TELE-
11 MENTAL HEALTH SERVICES.—
12 (1) IN GENERAL.—The Secretary of Defense
13 and the Secretary of Veterans Affairs shall, through
14 the Joint Executive Council (JEC) of the Depart-
15 ment of Defense and the Department of Veterans
16 Affairs, conduct an ongoing study of all matters re-
17 lating to the telehealth and telemental health serv-
18 ices of the Department of Defense and the Depart-
19 ment of Veterans Affairs.
20 (2) MATTERS STUDIED.—The matters studied
21 under paragraph (1) shall include the following:
22 (A) The number of members and former
23 members of the Armed Forces who have used
24 telehealth or telemental health services of the

1 Department of Defense or the Department of
2 Veterans Affairs.
3 (B) The extent to which members of the
4 National Guard and the Reserves are utilizing
5 telehealth or telemental health services of the
6 Department of Defense or the Department of
7 Veterans Affairs.
8 (C) The ways in which the Department of
9 Defense and the Department of Veterans Af-
10 fairs can improve the integration of telehealth
11 and telemental health services with clinical
12 medicine.
13 (D) The extent to which telehealth and
14 telemental health services of the Department of
15 Defense and the Department of Veterans Af-
16 fairs are provided in rural settings and through
17 community-based outpatient clinics (CBOCs).
18 (E) Best practices of civilian mental health
19 providers and facilities with respect to the pro-
20 vision of telehealth and telemental health serv-
21 ices, including how such practices can be adopt-
22 ed to improve telehealth and telemental health
23 services of the Department of Defense and the
24 Department of Veterans Affairs.

1 (F) The feasability and advisability of
2 partnering with civilian mental health facilities
3 to provide telehealth and telemental health serv-
4 ices to members and former members of the
5 Armed Forces.
6 (3) ANNUAL REPORTS.—Not later than one
7 year after the date of the enactment of this Act, and
8 annually thereafter, the Secretary of Defense and
9 the Secretary of Veterans Affairs shall jointly sub-
10 mit to Congress a report on the findings of the Joint
11 Executive Counsel under this subsection during the
12 preceding year.
13 **SEC. 5. DEFINITIONS.**
14 In this Act:
15 (1) The term "national brain injury care spe-
16 cialist organization" means a national organization
17 or association with demonstrated experience in pro-
18 viding training, education, and technical assistance
19 in the provision of care for individuals with brain in-
20 jury.
21 (2) The term "neurocognitive" means of, relat-
22 ing to, or involving the central nervous system and
23 cognitive or information processing abilities (think-
24 ing, memory, and reasoning), as well as sensory

1 processing (sight, hearing, touch, taste, and smell),
2 and communication (expression and understanding).
3 (3) The term "traumatic brain injury" means
4 an acquired injury to the brain, including brain inju-
5 ries caused by anoxia due to trauma and such other
6 injuries as the Secretary considers appropriate, ex-
7 cept that such term excludes brain dysfunction
8 caused by—
9 (A) congenital or degenerative disorders; or
10 (B) birth trauma.

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II

110TH CONGRESS
1ST SESSION

S. 1113

To facilitate the provision of care and services for members of the Armed Forces for traumatic brain injury, and for other purposes.

IN THE SENATE OF THE UNITED STATES

APRIL 16, 2007

Mr. BAYH (for himself and Mrs. CLINTON) introduced the following bill; which was read twice and referred to the Committee on Armed Services

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A BILL

To facilitate the provision of care and services for members of the Armed Forces for traumatic brain injury, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Traumatic Brain Injury Access to Options Act".

SEC. 2. CARE AND SERVICES FOR MEMBERS OF THE ARMED FORCES FOR TRAUMATIC BRAIN INJURY.

(a) RETENTION ON ACTIVE DUTY.—

1 (1) IN GENERAL.—Except as provided in para-
2 graph (3) and subject to paragraph (4), the Sec-
3 retary of Defense shall prescribe regulations to en-
4 sure that each member of the Armed Forces who in-
5 curs a covered traumatic brain injury while on active
6 duty in the Armed Forces shall be retained on active
7 duty in the Armed Forces for one year after the
8 medical assessment of their ability to perform their
9 activities of daily living (ADL).
10 (2) LIMITATION ON PHYSICAL EVALUATION
11 BOARD.—A member of the Armed Forces who is re-
12 tained on active duty under paragraph (1) may not
13 be evaluated by a Physical Evaluation Board for
14 purposes of determining the eligibility of the member
15 for retirement or separation for disability under law
16 during the one-year period described in that para-
17 graph.
18 (3) ELECTION OF INAPPLICABILITY.—(A) Para-
19 graph (1) shall not apply to a member of the Armed
20 Forces otherwise described by that paragraph—
21 (i) upon the election of the member; or
22 (ii) if the member is incapacitated or oth-
23 erwise incapable of making the election—
24 (I) upon the election of the family
25 member;

(II) upon the election of the legal guardian of the member under a medical power of attorney; or

(III) if the member does not have any family members or a medical power of attorney, the person appointed by the Secretary of the military department concerned to act as the medical advocate to ensure the proper receipt by the member of such care and services for the covered traumatic brain injury as are available to the member through the Department of Defense.

(B) In any case where a family member or legal guardian of a member of the Armed Forces is present, the medical advocate shall provide a written summary of benefits from the Department of Defense and the Department of Veterans Affairs that are available to the member of the Armed Forces for the injury or injuries involved.

(C) Any individual who carries out the duties of a medical advocate under this paragraph shall receive such training for the discharge of such duties, including training in applicable protocols of the Department of Defense and the Department of Vet-

erans Affairs, as the Secretary of Defense (in consultation with the Secretary of Veterans Affairs) considers appropriate.

(D) The Secretary of Defense shall prescribe regulations to carry out this paragraph.

(4) EXTENSION OF PERIOD OF RETENTION ON ACTIVE DUTY.—The period of retention of a member of the Armed Forces on active duty under paragraph (1) may be such period longer than the period otherwise provided under that paragraph as the Secretary of the military department concerned considers appropriate in light of the medical progress of the member for the covered traumatic brain injury, as determined by such Secretary in consultation with the medical personnel providing care to the member for the covered traumatic brain injury and the family member, legal guardian, or medical advocate of the member.

(5) PURPOSES OF RETENTION ON ACTIVE DUTY.—The purposes of retaining a member of the Armed Forces on active duty under paragraph (1) shall include, but not be limited to, the following:

(A) The provision of recurring medical evaluations of the member for the effects of a covered traumatic brain injury.

(B) The provision of cognitive therapy for the member for a covered traumatic brain injury, including cognitive therapy through medical facilities of the Veterans Administration and private rehabilitation hospitals or facilities with the cost of such therapy borne by the Department of Defense.

(6) SUNSET.—This subsection shall expire on the date that is five years after the date of the enactment of this Act. However, any member of the Armed Forces retained on active duty under paragraph (1) before that date may be retained on active duty in accordance with this subsection after that date.

(b) COMPTROLLER GENERAL ASSESSMENTS OF CARE AND SERVICES PROVIDED BY DEPARTMENT OF DEFENSE AND DEPARTMENT OF VETERANS AFFAIRS.—Not later than two years after the date of the enactment of this Act, and every year thereafter, the Comptroller General of the United States shall submit to Congress a report assessing the discrepancies in benefits and services available to members of the Armed Forces on active duty and medically retired members of the Armed Forces with traumatic brain injuries. Each such report shall identify and address such discrepancies.

1 (c) DEADLINE FOR REGULATIONS.—The Secretary of
2 Defense shall prescribe the regulations required by this
3 section not later than 90 days after the date of the enact-
4 ment of this Act.

5 (d) COVERED TRAUMATIC BRAIN INJURY DE-
6 FINED.—In this section, the term "covered traumatic
7 brain injury", in the case of a member of the Armed
8 Forces, means a traumatic brain injury as a result of
9 which the member is unable to perform the activities of
10 daily living (ADL) for a period of least five consecutive
11 days from the date of medical assessment.

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[From the U.S. and World News Report, posted online on April 8, 2007]

INSULT TO INJURY NEW DATA REVEAL AN ALARMING TREND: VETS' DISABILITIES ARE BEING DOWNGRADED

(By Linda Robinson)

In the middle of a battle in Fallujah in April 2004, an M80 grenade landed a foot away from Fred Ball. The blast threw the 26-year-old Marine sergeant 10 feet into the air and sent a piece of hot shrapnel into his right temple. Once his wound was patched up, Ball insisted on rejoining his men. For the next three months, he continued to go on raids, then returned to Camp Pendleton, Calif.

But Ball was not all right. Military doctors concluded that Ball was suffering from a Traumatic Brain Injury, Post Traumatic Stress Disorder (PTSD), chronic headaches, and balance problems. Ball, who had a 3.5 grade-point average in high school, was found to have a sixth-grade-level learning capability. In January of last year, the Marine Corps found him unfit for duty but not disabled enough to receive full permanent disability retirement benefits and discharged him.

Ball's situation has taken a dire turn for the worse. The tremors that he experienced after the blast are back, he can hardly walk, and he has trouble using a pencil or a fork. Ball's case is being handled by the Department of Veterans Affairs—he receives $337 a month—but while his case is under appeal, he receives no medical care. He works 16-hour shifts at a packing-crate plant near his home in East Wenatchee, Wash., but he has gone into debt to cover his $1,600 monthly mortgage and support his wife and 2-month-old son. "Life is coming down around me," Ball says. Trained to be strong and self-sufficient, Ball now speaks in tones of audible pain.

Fred Ball's story is just one of a shocking number of cases where the U.S. military appears to have dispensed low disability ratings to wounded service members with serious injuries and thus avoided paying them full military disabled retirement benefits. While most recent attention has been paid to substandard conditions and outpatient care at Walter Reed Army Medical Center, the first stop for many wounded soldiers stateside, veterans' advocates say that a more grievous problem is an arbitrary and dysfunctional disability ratings process that is short-changing the nation's newest crop of veterans. The trouble has existed for years, but now that the country is at war, tens of thousands of Americans are being caught up in it.

Now an extensive investigation by *U.S. News* and a new Army inspector general's report reveal that the system is beset by ambiguity and riddled with discrepancies. Indeed, Department of Defense data examined by *U.S. News* and military experts show that the vast majority—nearly 93 percent—of disabled troops are receiving low ratings, and more have been graded similarly in recent years. What's more, ground troops, who suffer the most combat injuries from the ubiquitous roadside bombs, have received the lowest ratings.

One counselor who has helped wounded soldiers navigate the process for over a decade believes that as many as half of them may have received ratings that are too low. Ron Smith, deputy general counsel for the Disabled American Veterans, says: "If it is even 10 percent, it is unconscionable." The DAV is chartered by Congress to represent service members as they go through the evaluation process. Its national service officers are based at each rating location, and there is a countrywide network of counselors. Smith says he recently asked the staff to cull those cases that appeared to have been incorrectly rated. Within 6 hours, he says, they had forwarded him 30 cases. "So far," Smith says, "the review supports the conclusion that a significant number of soldiers are being fairly dramatically underrated by the U.S. Army."

Magic number. In an effort to learn how extensive the problem is, *U.S. News* spent 6 weeks talking to wounded service members, their counselors, and veterans advocacy groups and reviewing Pentagon data. At first glance, the disability ratings process seems straightforward. Each branch of service has its own Physical Evaluation Boards, which can comprise military officers, medical professionals, and civilians. The PEBs determine whether the wounded or ill service members are fit for duty. If they are, it's back to work. Those found unfit are assigned a disability rating for the condition that makes them unable to do their military job. The actual rating is key, and here's why: Service members who have served less than 20 years—the great majority of wounded soldiers—who receive a rating under 30 percent are sent home with a severance check. Those who receive a rating of 30 percent or higher qualify for a host of lifelong, enviable benefits from the DOD, which include full military retirement pay (based on rank and tenure), life insurance, health insurance, and access to military commissaries.

But the system is hideously complicated in practice. The military doctors who prepare the case for the PEBs pick only one condition for the service member's rating, even though many of the current injuries are much more complex. The PEBs use the Department of Veterans Affairs ratings scale, which grades disabilities in increments of 10 a leg amputation, for example, puts a soldier at between 40 and 60 percent disabled. The PEBs claim they have the leeway to rate a soldier 20 percent disabled for pain, say, rather than 30 percent disabled for a back injury. If rated at 20 percent or below and discharged, the soldier enters the VA system as a retiree where he is evaluated again to establish his healthcare benefits. Ball, for example, was found by the VA to be 50 percent disabled for PTSD.

Since 2000, 92.7 percent of the disability ratings handed out by PEBs have been 20 percent or lower, according to Pentagon data analyzed by the Veterans' Disability Benefits Commission, which Congress formed in 2004 to look into veterans' complaints. Moreover, fewer veterans have received ratings of 30 percent or more since America went to war in Afghanistan and Iraq, according to the Pentagon's annual actuarial reports. As of 2006, for example, 87,000 disabled retirees were on the list of those exceeding the 30 percent threshold; in 2000, there were 102,000 recipients. Last year, only 1,077 of 19,902 service members made it over the 30 percent threshold.

The total amount paid out for these benefit awards has remained roughly constant in wartime and peacetime, leading disabled veterans like retired Lt. Col. Mike Parker, who has become an unofficial spokesperson on this issue, to allege that a budgetary ceiling has been imposed to contain war costs. A DOD spokesperson, Maj. Stewart Upton, said that the Pentagon "is committed to improving the Disability Evaluation System across the board and to . . . a full and fair due process with regard to disability evaluation and compensation."

Other data reveal glaring discrepancies among the military services. Even though most of those wounded in Iraq and Afghanistan have been ground troops, the Army and Marine Corps have granted far fewer members full disabled benefits than the Air Force. The Pentagon records show that 26.7 percent of disabled airmen have been rated 30 percent or more disabled, while only 4.3 percent of soldiers and 2.7 percent of marines made the grade. Services engaged in close combat, experts say, could be expected to find more members unfit for duty and meriting full retirement benefits. Instead, the Air Force decided that 2,497 airmen fall into that category while the much larger Army, with its higher tally of wounded, has accorded those benefits to only 1,763 soldiers since 2000.

How many of these veterans' cases have been decided incorrectly? Nobody knows. These statistics show trends that are clearly at odds with what logic would dictate, but there has been no effort to discover how many of those low ratings were inaccurately conferred or to ascertain why the number receiving full benefits has declined during wartime or why there is such a discrepancy between the Air Force and the other services. But there is abundant anecdotal evidence of a process cloaked in obscurity and riddled with anomalies, and of ratings that are inconsistent and often arbitrarily applied.

DAV lawyer Smith, for example, took on the case of a soldier whose radial nerve of his dominant hand had been destroyed, the same affliction former Sen. Bob Dole has. Like Dole, the soldier was unable to write with a pen or to button his shirt. "There is one and only one rating for that condition, which is 70 percent disability," says Smith. The PEB gave the soldier 30 percent, the lawyer said, "which I found to be fairly outrageous." Upon appeal to the Army Physical Disability Agency, the entity that oversees that service's disability evaluation process, the rating was raised to 60 percent. Smith recently took on another case, that of Sgt. Michael Pinero, a soldier who developed a degenerative eye condition called keratoconus that required him to wear contact lenses. Army regulations prohibit wearing contacts in combat, which should have made him ineligible for deployment and therefore unfit to perform his specific military duties. But the PEB ignored the eye condition, which Smith believes merited a 30 percent rating or more, and rated Pinero 10 percent disabled for shin splints. Smith has asked the Army to clarify whether it considers the regulation on contact lenses binding or, as one board member alleged, merely a guideline. Disputes over such distinctions are common in the Alice in Wonderland world of disability ratings.

Controversy frequently surrounds decisions on which conditions make a soldier unfit for duty. Smith took issue with a recent statement made by the Army Physical Disability Agency's legal adviser, quoted in Army Times newspaper. The official said that short-term memory loss would not necessarily render soldiers unfit for duty since they could compensate by carrying a notepad. "Memory loss is a common sign of TBI," Smith said, using the abbreviation for Traumatic Brain Injury, which has afflicted many soldiers hit by the roadside bombs commonly used in Iraq. "The rules

of engagement are a seven-step process . . . If a suicide bomber is coming at you, you cannot stop and consult your notepad," he added. "I find this demonstrative of the attitude that pervades the Physical Disability Agency," which is in charge of reviewing evaluations for accuracy and consistency.

Trying to overturn a low rating can be a full-time job and an exasperating one. Take Staff Sgt. Chris Bain, who lost the use of his arms but not his sense of humor. "They call me T-Rex because I have a big mouth and two hands and I can't do nothing with them," he jokes. He left the Army in February, but he still has plenty of fight in him. During an ambush in Taji, Iraq, in 2004, a mortar round exploded 2 feet away from him, ripping through his left arm and hand. A sniper's bullet passed through his right elbow. His buddies saved his life, throwing Bain on the hood of a humvee and rushing him to a combat hospital. Once transferred to Walter Reed, Bain refused to have his arm amputated and underwent eight surgeries to save it. That choice cost him. While an amputation would have automatically put him over the 30 percent threshold, the injury to his left arm was rated at 20 percent even though he cannot use the limb.

Bain was angry. A noncommissioned officer who had planned on 20 or 30 years in the Army, he knew his career was over, but he wasn't going to go quietly. "I wanted to be an example to all soldiers," he said. "My job was to take care of troops." He went to find Danny Soto, the DAV representative at Walter Reed he'd heard so much about. "Danny is just an awesome guy. He took great care of me, but he should not have had to," Bain says. Soto is a patron saint to many soldiers at Walter Reed. He walks the halls, finding the newly injured and urging them to collect documents for their journey through the tortuous—and, to many, capricious—system. Many soldiers are young, and after they have spent months or years recuperating, they just want to get home and are unwilling to argue for the rating they deserve. Even though he missed his wife and three children, Bain decided: "I've already been here 2 years, another one ain't going to hurt me. Too many people are getting lowballed."

With Soto's help, Bain gathered detailed medical evidence of his injuries and went to face the board. They gave him a 70 percent rating for injuries related to the blast except for his hearing loss, which was not considered unfitting since he had a hearing aid. Oddly enough, however, the board put him on the temporary disabled retirement list instead of the permanent list. "What do they think, that after 3 years, my arm is going to come back to life?"

A lifetime of adjusting lies ahead for Bain. "I can't tie my shoes, open bottles of water, or cut my own food," he says. "I have to ask for help." The 35-year-old veteran has found a new sense of purpose. He's decided to run for Congress in 2008, and fixing the veterans' system is his top priority. "I do not want this s - - - - to happen again to anyone. No one can communicate with each other. The paper trail doesn't catch up." It's a tall order, but the soldier says that he has "100,000 fights" left in him.

A systemic fix doesn't appear to be anywhere in sight. A March 2006 report by the Government Accountability Office found that Pentagon officials were not even trying to get a handle on the problem. "While DOD has issued policies and guidance to promote consistent and timely disability decisions," the report concluded, "[it] is not monitoring compliance." But the GAO report did spur Army Secretary Francis Harvey, who was forced to resign last month in the wake of the Walter Reed scandal, to order the Army's inspector general to conduct an investigation of the disability evaluation system. After almost a year of work, the inspector general's office last month issued a 311-page report that begins to pierce the confusion and opacity surrounding the process. While it does not determine how many erroneous ratings were accorded to the nearly 40,000 soldiers rated 20 percent disabled or less since 2000, it does make three critical points: (1) the ambiguity in applying the ratings schedule should end; (2) wide variance in ratings is indisputable, even among the three Army boards, and (3) the Army's oversight body is not doing its job.

Way overdue. Army officials met with *U.S. News* to discuss the inspector general's report. "This is something that has been near and dear to our hearts for a long time, and it's probably way overdue as far as having someone go and take a look at it," says a senior Army official. The inspector general's team found that Army policy was not consistent with the policies of either the Pentagon or the Department of Veterans Affairs. It recommended that the Army "align [its] adjudication of disability ratings to more closely reflect those used by the Department of Veterans Affairs." For years, the Army has asserted that it has the right to depart from VA standards on grounds that it is assessing fitness for duty and compensating for loss of military career, not decreased civilian employability.

Veterans' advocates argue that Federal law requires the military to use the Veterans Affairs Schedule for Rating Disabilities as the standard for assigning the rat-

ings. But over the years, Pentagon directives on applying the schedule have opened up a whole new gray area by saying the schedule is to be used only as a guide. And the services have interpreted them in different ways, engendering further discrepancies. Soto, the DAV national service officer at Walter Reed, says that inconsistencies are especially prevalent in complex cases of Traumatic Brain Injury and Post Traumatic Stress Disorder. "There is a saying going around the compound here," Soto says, "that if you are not an amputee, you are going to have to fight for your rating."

The inspector general's report calls for ending the ambiguities. "What we're saying is it shouldn't be left to interpretation; it should be clearly defined," says one Army official. "If there were a way to cut down on that ambiguity, I think that variance would decrease."

Finally, the report bluntly concludes that the system's internal oversight mechanism is not functioning. "The Army Physical Disability Agency's quality assurance program does not conform to DOD and Army policy," it says the same conclusion the GAO came to a year ago. The inspector general's report adds evidence of just how little the watchdog is doing to ensure that cases are correctly decided. The agency is supposed to send cases to either of two review boards when soldiers rebut their rating evaluations, but from 2002 through 2005, the agency sent only 45 out of 51,000 cases to one of the boards. The other review board has not been used at all.

The inspector general's team made 41 recommendations in all, finding among other things that the Army lacks a formal course for training the liaison officers who are supposed to guide soldiers through the PEB process, that the disposition of cases lags badly, that the computerized information systems are antiquated, and that the two key medical and personnel data bases are not integrated and cannot communicate with each other. The report has been forwarded to the action team that Army Vice Chief of Staff Richard Cody convened—one of many official groups formed since the revelations of substandard conditions and bureaucratic delays at Walter Reed.

Veterans' advocates are skeptical that the administration or the military bureaucracy will make major changes anytime soon. In testimony to Congress last month, Veterans for America director of veterans' affairs Steve Robinson recommended taking the entire ratings process away from the Pentagon and giving it to the Department of Veterans Affairs. "It's hard to ignore the fact that in time of war they are giving out less disability," he says. "Is it policy? I don't know. But it is a fact."

Congress has not responded to this problem. Says Rep. Vic Snyder, the Arkansas Democrat who chairs the House Armed Services subcommittee on military personnel: "This whole issue of disability ratings is very complex. It is not well understood by many people, including many in Congress. That is why we set up the [Veterans' Disability Benefits] Commission in 2004. We are hoping it will help us sort this out."

A lot is riding on the commission. Its chairman is Lt. Gen. Terry Scott, who retired in 1997 and ran Harvard's Kennedy School of Government's National Security Program until 2001. After the Pentagon data on the disability process were presented to the commission last week, Scott said "we still don't understand the whys and wherefores" of the skewed ratings. The core problem, he believes, is that "the military was not designed to look after severely wounded people for a long time." The commission has not yet decided what changes it will recommend, but he said there is a general sense that "one physical exam at the end of service should be enough for both agencies, DOD and VA."

Cash and staff. Any solutions that call for transferring more responsibility to the Department of Veterans Affairs will have to be matched by enormous infusions of cash and staff. Already, the VA is reeling under a backlog of over 600,000 claims from retired veterans, which the agency predicts will grow by an additional 1.6 million in the next 2 years. Harvard Prof. Linda Bilmes, an economist who has published two studies on the costs of the Iraq war and the associated veterans' costs, projects that as much as $150 billion more will be required to deal with the wounded returning from Iraq and Afghanistan.

Meanwhile, people like Danny Soto want to know who is going to stop the military boards from giving out ratings like the 10 percent given to one soldier for a skull fracture and Traumatic Brain Injury, when the VA later assigned a 100 percent rating. Soto is also frustrated by a recent case in which a soldier whose legs had been severely injured in a blast in Iraq was given only a 20 percent disability rating for pain and by the treatment of a man who has a bullet hole through his eye and suffers from seizures. As Soto sat with that soldier in front of the board, he asked why he had been placed on the temporary list. "At what point do you think he is going to fall below 30 percent?"

Soto is unsparing in his criticism of the bureaucracy. "This system," he says, "is so broke." Old soldiers say the root of the problem is an Army culture that preaches a "suck it up" attitude. "If you ask for what you are due, you are perceived to be whining or trying to pad your pocket," says a retired command sergeant major. "If you're not bleeding, you're not hurt. That's what we were taught."

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