S. HRG. 110–781

OVERSIGHT HEARING: UPDATE ON VA AND DOD COOPERATION AND COLLABORATION

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE

ONE HUNDRED TENTH CONGRESS

SECOND SESSION

APRIL 23, 2008

Printed for the use of the Committee on Veterans' Affairs

Available via the World Wide Web: http://www.access.gpo.gov/congress/senate

U.S. GOVERNMENT PRINTING OFFICE

42–176 PDF WASHINGTON : 2009

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2104 Mail: Stop IDCC, Washington, DC 20402–0001

COMMITTEE ON VETERANS' AFFAIRS

DANIEL K. AKAKA, Hawaii, *Chairman*

JOHN D. ROCKEFELLER IV, West Virginia
PATTY MURRAY, Washington
BARACK OBAMA, Illinois
BERNARD SANDERS, (I) Vermont
SHERROD BROWN, Ohio
JIM WEBB, Virginia
JON TESTER, Montana

RICHARD BURR, North Carolina, *Ranking Member*
ARLEN SPECTER, Pennsylvania
LARRY E. CRAIG, Idaho
KAY BAILEY HUTCHISON, Texas
LINDSEY O. GRAHAM, South Carolina
JOHNNY ISAKSON, Georgia
ROGER F. WICKER, Mississippi

WILLIAM E. BREW, *Staff Director*
LUPE WISSEL, *Republican Staff Director*

C O N T E N T S

APRIL 23, 2008

SENATORS

	Page
Akaka, Hon. Daniel K., Chairman, U.S. Senator from Hawaii	1
Burr, Hon. Richard, Ranking Member, U.S. Senator from North Carolina	2
Murray, Hon. Patty, U.S. Senator from Washington	4
Isakson, Hon. Johnny, U.S. Senator from Georgia	6
Tester, Hon. Jon, U.S. Senator from Montana	7
Brown, Hon. Sherrod, U.S. Senator from Ohio	8
Wicker, Hon. Roger F., U.S. Senator from Mississippi	10

WITNESSES

Mansfield, Gordon H., Deputy Under Secretary of Veterans Affairs, U.S. Department of Veterans Affairs; accompanied by Patrick W. Dunne, Acting Under Secretary for Benefits and Assistant Secretary for Policy and Planning	11
Prepared statement, combined with Mr. England of the U.S. Department of Defense	13
Response to written questions submitted by:	
Hon. Daniel K. Akaka	23
Hon. Jon Tester	36
England, Gordon, Deputy Secretary of Defense, U.S. Department of Defense; accompanied by David S.C. Chu, Under Secretary for Personnel and Readiness	38
Response to written questions submitted by:	
Hon. Daniel K. Akaka	40
Hon. Jon Tester	45
Atizado, Adrian M., Assistant National Legislative Director, Disabled American Veterans, on Behalf of the Authors of The Independent Budget	64
Prepared statement	66
Bowers, Todd, Director of Government Affairs, Iraq and Afghanistan Veterans of America	71
Prepared statement	73
Campos, René A., Commander, U.S. Navy (Ret.), Deputy Director, Government Relations, Military Officers Association of America	74
Prepared statement	76

OVERSIGHT HEARING: UPDATE ON VA AND DOD COOPERATION AND COLLABORATION

WEDNESDAY, APRIL 23, 2008

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

The Committee met, pursuant to notice, at 9:48 a.m., in room 418, Russell Senate Office Building, Hon. Daniel K. Akaka, Chairman of the Committee, presiding.

Present: Senators Akaka, Murray, Brown, Tester, Burr, Isakson, and Wicker.

OPENING STATEMENT OF HON. DANIEL K. AKAKA, CHAIRMAN, U.S. SENATOR FROM HAWAII

Chairman AKAKA. This hearing will come to order. Good morning and welcome to the Committee's hearing on VA and DOD and your cooperation and collaboration. More specifically, today's hearing will focus on the joint VA and DOD Senior Oversight Committee.

This is the eleventh now in a series of hearings dating back to January 2007 addressing how well VA and DOD are working together to meet the needs of returning servicemembers. This level of oversight is indicative of how important this issue is to me and the Committee. Progress has been made in this area over the last year, but much work still remains.

It is clear that the two Departments need to function as one, especially when we have veterans at risk of suicide and severe PTSD. If either DOD or VA mishandles a veteran at risk, the result can be tragic. This Committee has asked for even greater collaboration to ensure that the wounded warrior provisions of the 2008 Defense Authorization Act are carried out appropriately, namely improvements to the way in which VA and DOD care for veterans with Traumatic Brain Injuries.

VA Secretary Peake recently stated that the two Departments are currently operating under unprecedented levels of cooperation and information sharing. Secretary Gates recently declared that VA care is inconsistent. Both statements are indeed true, and both statements assure me that more can be and should be done.

This Committee will work to strengthen the relationship between the Departments. Today, we will take a closer look at the Senior Oversight Committee, the mechanism VA and DOD established last May to resolve many of the issues related to servicemembers' transition from active duty to veteran status. This special body is co-chaired by VA Deputy Secretary Gordon Mansfield and DOD Deputy Secretary Gordon England. It is vital that with the coming

change in administration there be no wavering of the energy and focus the Departments have brought to the issues of coordination and cooperation.

Given the importance of improving the care and transition of wounded servicemembers, it is critical that the Departments sustain their joint efforts for as long as there are servicemembers in combat.

I understand that the current plan is for the Senior Oversight Committee to hand over its responsibilities to the Joint Executive Council in January of next year. I am concerned that this body has neither the resources nor the leverage within the Departments to carry on this essential work. Let me be clear on that. I am committed to sustaining the energy and focus the Senior Oversight Committee has brought to bear on these issues and will take the necessary action to ensure this continues.

Without the weight of both the Department Secretaries behind solving the problems related to seamless transition and a full-time joint staff to track them, we run the risk of returning to the bureaucratic lethargy which contributed to the Walter Reed scandal. We have come too far to return to those days.

I hope that our witnesses today will provide us with a real sense of the next steps forward. As we learned last month from the families of wounded warriors, it is apparent that servicemembers, even those who are seriously wounded, are still remarkably not getting the attention and assistance they need. We owe more to those who have given so much for our country.

Thank you, and may I call on our Ranking Member for his statement.

STATEMENT OF HON. RICHARD BURR, RANKING MEMBER, U.S. SENATOR FROM NORTH CAROLINA

Senator BURR. Thank you, Mr. Chairman. Aloha. The Chairman forgot to say that this morning and I expect it every time I am here. I want to thank the Chairman.

More importantly, I want to thank our witnesses, these officials from the Department of Defense and the Department of Veterans Affairs, as I would like to refer to them from now on, the Gordon and Gordon Team. Mr. Chairman, we could not have two more capable, committed, and passionate individuals that have been tasked with the job before them that many have suggested before they would accomplish and none have. I just want to say to both of them that we are extremely fortunate to have both of you in the capacity that we do. We are fortunate that you have been tasked with what others have not been able to accomplish. And I, for one, have tremendous confidence in both of you that, at the end of this process, we will have moved forward in a very positive and understandable way.

For our wounded warriors who have sacrificed so much for our Nation, we must make sure they are provided in a quick, hassle-free, and effective way with the benefits and services they need to recover and to move on with fulfilling and productive lives. As Secretary Gates put it, "apart from the war itself, we have no higher priority [than to care for our wounded]."

But, last year, it became very clear that we have more work to do to meet the needs of these wounded warriors. I am sure we all remember the news stories about some servicemembers at Walter Reed who were dealing with lost medical records, substandard living quarters, and confusing and complex bureaucratic problems. Also, several studies and reports last year outlined system-wide problems affecting these wounded warriors. The reports stressed the need to provide better case management for injured servicemembers, to improve the flow of medical records between the Department of Defense and the VA, and to streamline the disability compensation system.

Since then, the Senior Oversight Committee has helped to bring about changes—like the new Federal Recovery Coordination Program—that I hope will improve the lives of many servicemembers and their families. Today, I look forward to hearing about the progress that has been made so far and to a candid discussion about what we still need to do to make sure that our wounded warriors are quickly provided with the support, the services, and more importantly, the benefits that they need.

But before we turn to the witnesses, Mr. Chairman, I would like to comment on one of, I think, the most important issues we will hear about today, and that is the efforts to improve the disability evaluation system. As we all know, this system often requires injured veterans to endure a lengthy, redundant, and bureaucratic process at both DOD and the VA to get their disability benefits. Before an injured servicemember can be discharged from the military, he or she may go through a lengthy, complex process with the Department of Defense to be assigned a disability rating. After going through that process, that injured servicemember may then go through a similar process at VA to get another rating that determines the monthly benefit he or she will receive from the VA. To add to the confusion, both ratings are based on the same outdated VA rating schedule. On top of that, there are complicated rules that limit how much of the benefits from the Department of Defense and the VA the veteran can get at the same time.

For more than five decades, experts have been telling us that we need to update, simplify, and modernize this system. Similar recommendations were made last year by both the Dole-Shalala Commission and the Veterans' Disability Benefits Commission. Like past reports, those distinguished commissions recommended that we get rid of the overlapping, confusing roles of two Departments in the disability rating process, completely update the VA disability rating schedule, compensate our veterans for any loss of quality-of-life, and place more emphasis on treatment and rehabilitation of our injured veterans.

As we will hear today, the Senior Oversight Committee has tried to address some of these recommendations by initiating a pilot program under which VA will assign two disability ratings, one for DOD's purposes and one for VA's purposes. But those ratings may differ and the current confusing rules banning full concurrent receipt of payments from the Department of Defense and the VA will still apply.

Mr. Chairman, this must be resolved. This Committee, along with the Department of Veterans Affairs, is charged with designing

a VA delivery system for health care that is a 21st century delivery system. I know that Gordon Mansfield is committed to do that. I know Secretary Peake is committed to do that. They cannot do it without the full cooperation of the Congress of the United States, and it is impossible for me to believe we can accomplish that if we can't reverse the difficulties that exist within the system today.

I appreciate the efforts of both Departments in trying to find ways to make the existing system work better and I hope this pilot program will improve services to injured servicemembers in the short term. But, as General Schoomaker recently said about this pilot program: "When you speed up a bad process, all you have is a fast bad process." In my view, our wounded warriors deserve better than that. I think it is time, long past time, for Congress to actually fix the system and make lasting improvements that will benefit veterans for generations to come.

Mr. Chairman, if we are willing to change this system—as recommended by commissions for over five decades—we can help ensure better benefits, and, more importantly, improved outcomes for veterans who have been injured in their service to this country. I look forward to working with you and to working with my colleagues on this Committee. Again, I welcome our witnesses and I encourage my colleagues to listen carefully to the great work of these two individuals.

I yield the floor.

Chairman AKAKA. Thank you very much, Senator Burr.

Senator Murray?

STATEMENT OF HON. PATTY MURRAY,
U.S. SENATOR FROM WASHINGTON

Senator MURRAY. Thank you very much, Chairman Akaka, Senator Burr. I appreciate your holding today's hearing as we examine the VA and the DOD's efforts to ensure our servicemembers can transition seamlessly from the military into the VA. I look forward to the progress report that you are going to present today and to hearing from our witnesses, particularly Deputy Secretary England and Deputy Secretary Mansfield. I share the Committee's thanks to both of you for the work you are doing on this important committee.

Mr. Chairman, it has been more than a year since news reports about the excessive red tape and substandard outpatient care for our wounded warriors came out, which they were facing at Walter Reed and literally across the country. Since that time, Congress, the VA, DOD, and numerous independent commissions have invested a great deal of time and work to ensure that our servicemembers don't leave the battlefield only to have to fight their own government here at home to get the benefits that they have earned.

Congress passed record levels of funding for our veterans, including $1.8 billion in veterans' funding in the supplemental appropriations bill last year. We increased veterans' spending by $3.7 billion over the President's request in the 2008 spending bill. We passed important legislation, including the Joshua Omvig Suicide Prevention Bill, which increased the VA's capacity to reduce veteran suicide, and the Wounded Warriors Act, which improves the coordination of care for servicemembers who transition from the military to

the VA. Numerous commissions, task forces, and independent review groups around the country have been studying these problems within the transition process and making hundreds of recommendations to us.

Now, a lot has been done, but we have a long way to go, I believe, to ensure that we get this process as smooth as possible. As we found out from the Walter Reed scandal, one of the biggest problems facing our wounded warriors is the difficulty working through the bureaucratic maze to get the benefits that they have earned. In order to deal with that problem, DOD and VA created Federal Recovery Care Coordinators to help our servicemembers navigate through this really difficult process. But, while DOD and VA have promised to provide a Care Coordinator to every seriously injured servicemember who wants one, so far—DOD has identified more than 4,000 servicemembers who qualify—we only have eight coordinators today. So we have a long way to go to provide the care that we promised.

We also know that a lot of work remains to be done to improve the Disability Evaluation System. It is my understanding that the pilot project that is now being run here in Washington, DC, isn't ready yet to be duplicated across the country; and this Committee must continue its work on legislation to overhaul the disability system to ensure that it is fixed.

In addition, the VA and the DOD have not satisfactorily met the requirements dealing with the creation of a Joint Electronic Health Record as required by the Wounded Warriors Act.

Mr. Chairman, the DOD and VA still have a lot of work to do to improve treatment for our troops who suffer from psychological wounds of battle. The RAND Corporation recently released a report that found that 320,000 of our troops suffer from Traumatic Brain Injury and 300,000 suffer from PTSD or major depression, yet only half of those veterans sought treatment, and of that number, only half of them received treatment that could be classified as even minimally adequate.

Now, we know that all too often the consequences of leaving PTSD and depression untreated are marital problems, drug and alcohol abuse, unemployment, and, tragically, suicide. When 300,000 troops are suffering from a serious mental health problem and only one-quarter of them are getting minimally adequate care, I think we ought to be worried. We ought to be worried that we haven't made nearly enough progress to enable us to move to the next step in the process by 2009, as the administration plans.

As the central coordinating office for all of DOD's and VA's efforts to improve this seamless transition, the Senior Oversight Committee is responsible for tracking and overseeing all the efforts to improve care for our wounded warriors. For all the reasons that I just gave, Mr. Chairman, I think it hardly seems a good time for the oversight committee to declare victory and pass its responsibilities to the Joint Executive Council. The SOC is led by senior officials. It has the influence and the staff to continue to make this important progress. And I am really concerned that if we hand those responsibilities off now, the JEC won't be able to sustain the current energy for tracking and implementing the hundreds of rec-

ommendations. I am concerned we are going to lose the little ground we have made if that occurs.

And last, Mr. Chairman, I just want to say to this Committee, I am incredibly concerned about the emails that came out from the VA yesterday downplaying the number of suicides of our veterans. This is a serious issue for our veterans, for our Americans, and particularly for us who sit on this oversight Committee. We need to have the correct information in order to have the right policies and provide the right kinds of resources, and if we can't count on the VA to tell us what they are seeing and what the facts are, we can't make the right decisions. So, I will have some more to say about that during the question and answer period, Mr. Chairman, but I think it should concern all of us as Members of this oversight Committee.

Chairman AKAKA. Thank you very much, Senator Murray.

Senator Isakson?

STATEMENT OF HON. JOHNNY ISAKSON, U.S. SENATOR FROM GEORGIA

Senator ISAKSON. Thank you very much, Mr. Chairman, and Secretary Mansfield, Secretary England, welcome. We are glad to have you today.

Every time I travel overseas, if I get anywhere near Landstuhl, I go to Landstuhl and visit our troops and the care they are getting there. I go quite frequently to Walter Reed. And when I am home in Georgia, where we have so many military installations so critically involved in the war in Iraq and the overall War on Terror, I go to Fort Benning and Fort Stewart.

During the break in March, I went to Fort Stewart and I want to report on and compliment Secretary England on what has been done at Fort Stewart in the Warrior Transition Center. Some of the concerns that Senator Murray was talking about, we have all been concerned about, but I observed a remarkable installation in response by the United States Army.

They have built a Warrior Transition Center where they are receiving—the Third ID is coming back from its third deployment in Iraq, and as they are coming back, there are a number of those soldiers who have PTSD, Traumatic Brain Injury, or the newest, which I was not aware is the most common affliction for women coming back from battle in terms of non-combat injuries, is the orthopedic problems from the amount of weight they carry, and that has become a more difficult problem particularly with 15-month deployments.

They have put a Transition Center in at Fort Stewart which is nothing short of remarkable. They did a lot of research in terms of counseling, psychotherapy, aesthetics in terms of housing, aesthetics in terms of accommodations. I sat down with 16 women who had just come back from Iraq to Fort Stewart and had been put in the Transition Center. To see the response to the relief they were getting from the treatment they were receiving by the Army and the accommodations that they were in, what the Transition Center was doing was nothing short of amazing.

Secondarily, on what we were talking about in terms of coordination with VA, they have put in a great Transition Center there, too,

so that the counseling and the assistance for those transitioning out from active duty into the VA system is the best I have seen in any facility I have visited. So, it is obvious to me, at least from the standpoint of that visit to Fort Stewart—which is a significant point of deployment for the Middle East and Iraq—that the Army has responded and that new center is something I would commend the entire Committee to go and visit, because I think it is a direct response to our attention on wounded warriors and, particularly, the attention this Committee has paid to PTSD and Traumatic Brain Injury.

To see and hear firsthand from these women in the Transition Center just back from the battlefield in Iraq about how much better they were already feeling, the response that they were getting, the environment they were in, I just want to commend Secretary England. If that is an example of what is happening around the country at facilities receiving our troops coming back from Iraq, then we are making some progress and I commend you.

Thank you, Mr. Chairman.

Chairman AKAKA. Thank you, Senator Isakson.

Senator Tester?

STATEMENT OF HON. JON TESTER,
U.S. SENATOR FROM MONTANA

Senator TESTER. Thank you, Mr. Chairman. I want to thank Ranking Member Burr, also, for holding this hearing.

Before I get into my prepared remarks, I do want to dovetail onto something that Senator Burr was talking about and that is the disability rating mechanism that is being used. I have had several hearings around the State of Montana over the last 15 months and I guess the best explanation by the veterans, they said it was nothing short of Chinese arithmetic. Now, I am not Chinese and I don't know arithmetic that well, but my guess is what they meant is that it is very complicated, very hard to understand, and doesn't necessarily work that well.

I want to step back in time a little bit. One of the most troubling moments in my first year here in the Senate was the revelation of the mistreatment of the folks, our soldiers in Walter Reed. Soldiers slipping through the cracks is something that nobody wants to see on this Committee, and I am sure it is nothing any of you folks want to see, either. But the fact is, it happened because of, I think, an overwhelming bureaucracy that we need to make more streamlined. Administrators and clerks that, quite honestly, didn't do their job.

The Walter Reed scandal was nothing less than a huge black eye for this country and, really, a betrayal of the promise that we make our young people when we send the men and women of this country into war and ask them to put their lives on the line. I think they and their families feel like when they are in service and they get out, they have some coverage, some medical care, and when it is not there, it is regretful.

We have made a lot of progress over the last year. You folks need to be commended for that. We have a long ways to go. Much of the credit not only goes to you folks, but also to the servicemen and

their families who spoke out and made us take notice of what was happening as far as conditions on the ground and in facilities.

We have worked to make the transition better for our service folks, but there is much more work to be done, particularly—particularly, but not exclusively—in the area of the National Guard and Reserves, of those folks falling through the bureaucratic cracks.

It was just last March that a young Montana National Guard soldier named Chris Dana committed suicide. It was a wake-up call for us all. He had served in Iraq in 2004 and 2005 and by all accounts had been a model soldier. In response to that suicide, the Montana National Guard, the State government, a panel of mental health care experts in the State combined to issue several recommendations designed to prevent something like happened in Chris's tragic suicide from ever happening again.

One of those recommendations was that the VA and the DOD collaborate to establish a system by which separating Guardsmen can automatically enroll in the VA health, and if eligible, into that disability compensation system. I understand that there are some potential problems with that, but I think it is something that we need to continue to work toward because I think it is the right thing to do. We have been talking about it for about 20 years and I think it is important.

The other thing is the infrastructure problem with IT between VA and DOD. It is my understanding that DOD does not transmit to the VA all of the relevant data that the VA needs to understand a veteran's eligibility for VA medical care. Maybe that has changed recently, but that is my understanding. That needs to change and it needs to change soon. Guard and Reserve soldiers' benefit claims are denied far more often than their active duty brethren. That also needs to change, and we must also look at some of the reasons why that is the case and think about how we can change that scenario.

Once again, Mr. Chairman, thanks for the hearing. I think we will have a good question and answer session after your testimony. Thank you folks for being here.

Chairman AKAKA. Thank you, Senator Tester.

Senator Brown?

STATEMENT OF HON. SHERROD BROWN,
U.S. SENATOR FROM OHIO

Senator BROWN. Thank you, Mr. Chairman. Thank you for holding this hearing. And Deputy Secretary England and Deputy Secretary Mansfield, good to see you again. Thank you for being here today.

I especially want to thank the Veterans Service Organizations that will testify later. I thank you for your service to our country and thank you for your ongoing commitment and service to veterans in our great country. Thank you for all that.

We know that much of the work this Committee has tried to do this last year has revolved around the transition from soldier to citizen, and we have made progress, but as Senator Murray and others pointed out, the progress has been uneven and slower than we would like.

In the last 15 months since Senator Tester and I came to the Senate, I have done in my State about 95 roundtables where I invite a cross-section of the community to sit down and talk about issues that concern them. There will be 20, 25 people there. Some of them have been exclusively with veterans. Others have been with veterans' service officers there and other advocates for veterans.

I hear repeated stories about continued problems in the transition from soldier to citizen, particularly at one roundtable at the Lou Stokes Medical Center in Cleveland, which I did late last year. There were probably 20 people sitting around the room, all recent returnees, all who had left the service and were returned from Iraq and Afghanistan. As they went around the table and talked about their experience, every single one of them except for one, who was an air woman from a unit in Britain, every single one of them talked about when they left the service, they were asked repeatedly to re-up, to re-up, to re-up. But when they left, their commanding officer showed little interest other than, "give us back your gear," showed little interest in their transition to civilian life, told them very little about education benefits, about health benefits, about whom they could call on when they came back to Ohio. That is why the work that you are both doing—both at the VA and the Department of Defense—is so very, very important.

I think it is a positive sign that the VA has started to implement recommendations from the Dole-Shalala Commission, but as Senator Murray pointed out, the Federal Recovery Coordinators are a good place to start, but there are only eight, and eight people to manage the care for the most severely injured veterans obviously is grossly inadequate.

One story, another specific story I would like to share for a moment, Mr. Chairman, last month, Glenn Minney, an Iraq veteran from Chillicothe, Ohio, is sitting in sort of South-Central Ohio, in Appalachia. He met with me and shared his transition experience. He had testified before the House Veterans' Committee earlier that day, I believe. He had survived an IED blast in April. He was treated for his headaches with ibuprofen and for his scratchy eyes he was given pink eye medication. It wasn't until December, nearly 8 months after he was injured, that Glenn Minney was diagnosed with severe TBI. He advocated for increased attention to eye trauma in relation to TBI to prevent other veterans from suffering the months of uncertainty that he endured as his sight continued to deteriorate.

TBI and PTSD are intimately related to vision problems, to cognitive issues, to memory lapses, to anger, to frustration, to other mental health issues, as we all have come to see. Under the National Defense Authorization for fiscal year 2008, DOD is to establish a Center of Excellence for the treatment of eye injury and a registry of these injuries. It is a level of attention needed for the constellation, if you will, of conditions that our Nation's veterans may face.

I look forward to hearing about plans for establishing this center. I look forward to working with all of you as we move forward with these necessary improvements.

Thank you, and thank you, Mr. Chairman.

Chairman AKAKA. Thank you, Senator Brown.

Senator Wicker?

STATEMENT OF HON. ROGER F. WICKER, U.S. SENATOR FROM MISSISSIPPI

Senator WICKER. Thank you, Mr. Chairman. I appreciate the fact that Senator Isakson and Senator Tester talked about the progress that is being made, and certainly when good things are happening, they ought to be mentioned and credit ought to be given where credit is due.

Having said that, I do hope we can spend some time in this hearing today talking about a real frustration of mine, and that is the slow progress being made by VA and DOD with regard to the interoperability of medical records and the seamless transition of health information technology, Electronic Medical Records, from the Department of Defense to the VA Health Care Systems.

My understanding is this has been a 10-year process. Ten years ago, the DOD and VA began pursuing ways to share data in their health information systems. But today, the information across different service branches and the VA still remain a morass of data, with pockets of progress and piles of duplicative paperwork.

GAO evaluated the progress last year and recommended that the Departments: number 1, designate one lead agency; number 2, establish a clear line of authority; number 3, develop a master plan with agreed-upon milestones.

In October of last year, I was Ranking Member of the VA-Military Construction Appropriations Subcommittee, and DOD provided me with a summary of progress on these recommendations which basically set forth that: number 1, DOD rejected the need for a lead agency that had been recommended by the GAO; number 2, said their line of authority was basically as good as it gets for bureaucracies; and number 3, said that they are developing a master plan but that timelines and priorities within it are likely to shift.

Now, this Congress responded with language in two appropriation conference reports. The language from the conference report in the fiscal year 2008 defense appropriations bill said this. "Electronic Medical Record interoperability: The conferees direct the Departments of Defense and Veterans Affairs to issue a joint report to the Congressional Defense Committees by March 3, 2008, detailing the actions being taken by each Department to achieve an interoperable Electronic Medical Record, EMR. The report should include but not be limited to a detailed spending plan for the use of funding provided in the Joint Incentive Fund, as well as identify all ongoing and planned projects and programs." A master plan, if you will.

The language from the conference report of fiscal year 2008 military construction-VA appropriations was similar. The Appropriations Committees, House and Senate, directed the Departments of Defense and Veterans Affairs to issue a joint report to the Committees on Appropriations detailing actions being taken by each Department. The request, the directive, March 3 and April 1, was explicit. Neither one of those dates have been met.

Now, 2 weeks ago, my office contacted the VA and DOD to check on the status of these directed reports. We were told, in response,

that the Departments were finishing up an interim report to explain why the progress report has not been finished. But also, we were assured that the master plan would be completed by April 30, a date which is fast approaching.

I still have not received an interim report detailing why the progress report has not been submitted, and I will say to our distinguished panelists and to my fellow Senators that I am disappointed and frustrated at the lack of attention to an explicit directive by the Congress.

So, I would hope that we will have an opportunity to discuss this and to talk about what the Departments need from this Congress to move forward on a system to develop an Electronic Medical Record that can be used by the servicemember when he or she is in the DOD, and can seamlessly transfer over to the veteran when that veteran comes under the jurisdiction of the VA.

Thank you, Mr. Chairman.

Chairman AKAKA. Thank you very much, Senator Wicker.

I now welcome our witnesses. I welcome our witnesses from the Departments of Defense and Veterans Affairs. I appreciate your all being here today and look forward to your testimony.

First, I welcome Gordon England, Deputy Secretary of Defense. He is accompanied by Dr. David Chu, Under Secretary for Personnel and Readiness. I also welcome Gordon Mansfield, Deputy Under Secretary of Veterans Affairs. Mr. Mansfield is accompanied by Patrick Dunne, Acting Under Secretary for Benefits and Assistant Secretary for Policy and Planning.

I thank all of you for joining us today and your full statements will appear in the record of the Committee.

Secretary England, we will begin with your remarks.

Mr. ENGLAND. Let me defer to Secretary Mansfield. I mean, this is his committee, Mr. Chairman, and we have a joint statement; so if you don't mind, I would like to defer to my good friend here.

Chairman AKAKA. Thank you very much.

Mr. ENGLAND. And I will just make a few comments.

Chairman AKAKA. Thank you, Secretary England. We will defer to Secretary Mansfield.

STATEMENT OF GORDON H. MANSFIELD, DEPUTY UNDER SECRETARY OF VETERANS AFFAIRS, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY PATRICK W. DUNNE, ACTING UNDER SECRETARY FOR BENEFITS AND ASSISTANT SECRETARY FOR POLICY AND PLANNING

Mr. MANSFIELD. Chairman Akaka, Senator Burr, and Members of the Committee, I appreciate this opportunity to appear before you today.

The Department of Veterans Affairs and the Department of Defense have a positive good news report to give you today on our enhanced partnership to ensure today's active duty servicemembers and veterans receive the benefits, the care, and the services a grateful nation has promised them. They have surely earned that.

I am especially pleased to have worked with Gordon England, Deputy Secretary for the Department of Defense, over the past year. Gordon and I have had a unique opportunity to focus the attention of both Departments on the needs of those we serve, our

servicemembers and veterans. We have concentrated attention on the need for a seamless transition from DOD to VA. I want to publicly thank him for his leadership, which has allowed us to accomplish so much. The ties between the two organizations have been strengthened and lines of communication are now available across the two Departments. I want to also note that the two Department Secretaries were joined by the two Deputy Secretaries last week to discuss these issues.

Allow me a moment to mention the recent departure of Admiral Dan Cooper as Under Secretary of Veterans Benefits. Admiral Cooper was an integral part of the success of the SOC and has been involved with it since its inception. His leadership and dedication will be missed, but fortunately we have an able leader stepping into his place. Pat Dunne has experience with the SOC and with these issues. Pat will do a great job in helping us move forward in all these areas.

The Senior Oversight Committee has been operational since May 2007, but it is important to note that serious high-level cooperative efforts in the areas of health care and benefits delivery predate the SOC. VA and DOD formed the Joint Executive Council in February 2002. It was later codified into statute in November 2003 by actions of this Congress.

I believe it is important to identify some of the positive efforts produced under the auspices of the JEC. Dental care, especially for Reserve and National Guardsmen, the North Chicago Joint Federal Health Care Facility, Traumatic Servicemen's Group Life Insurance, benefits delivery at discharge, VBA counselors at military treatment facilities, data sharing, the Joint Executive Fund are all examples of work that predates the SOC that the JEC has worked on and in some issues continues to work on. In short, the JEC provided a starting point for the SOC. I want to commend and thank Dr. David Chu for his past and continued cooperation as my DOD partner on the JEC.

The SOC established eight lines of action which generally define the issues needing resolution. They include Disability Evaluation System; TBI and PTSD; case management; data sharing; facilities; legislation and public affairs; personnel, pay, and financial support; and then a look at what we would do if we could start over from the start if we wanted to build a system, notwithstanding what we have today.

I want to note that our excellent joint DOD and VA staff, led by Melinda Darby and Roger Dimsdale, helped identify the lines of action from the issues presented in numerous reports, investigations, or commissions which reported last year, and those include the Dole-Shalala report, Terry Scott's commission, the Marsh-West report to the Secretary of DOD, and Secretary Nicholson's report to the President. All were reviewed completely to come up with a comprehensive plan of action.

Currently, the SOC is overseeing the efforts to apply the decisions made from those line-of-action recommendations. For example, the case manager decision, the Federal Recovery Coordinators, has resulted in the VA standing up an office, hiring the first ten individuals, placing them in military treatment facilities, and hav-

ing them start the process of fulfilling that requirement. We also are in the process of bringing HHS assistance to that main office.

In another area, we have started a pilot project to have the VA complete one single medical exam which will allow DOD to make the fit/unfit decision to serve for the individual and then VA to process the claim for disability benefits if the individual is discharged from the service. That pilot will run for 1 year, until November 2008.

We realize we have more work to do. Data sharing is an example, as mentioned here, where we move to the ability to transfer patient data between our two vast systems. We are also working together on TBI-PTSD care, research and treatment, and we see a greater emphasis on these issues at our new Center of Excellence.

The SOC is prepared to come together whenever required to make decisions required by the dedicated VA and DOD staff which oversee the efforts on each one of these lines of action. We continue to address any issues regarding cooperation between the two Departments. Gordon England and I continue to discuss issues as needed. Remaining requirements stemming from the NDAA passed last session will keep us focused intently on continuous improvement.

The issue of a new Disability Benefits System remains an open item. The VA has contracted for two studies which will allow us to move forward in this area. The studies are due for completion in approximately 4 months. They deal with transition payments, compensation and quality-of-life issues in a to-be-proposed system.

The issue of rehabilitation medicine continues to evolve as we treat and evaluate the patients returning from the battlefield, entering acute care treatment, and initial rehabilitation in military treatment facilities before they transition to VA polytrauma centers and to medical centers, or in some cases to civilian Centers of Excellence for specialty care.

And finally, we are working to ensure better involvement and care by the DOD or the VA of family members, an important issue identified in the Dole-Shalala Commission. This remains a key area of concern for both VA and DOD.

That concludes my statement and I await your questions.

[The prepared joint statement of Mr. Mansfield and Mr. England follows:]

PREPARED STATEMENT OF GORDON ENGLAND, DEPUTY SECRETARY OF DEFENSE AND GORDON MANSFIELD, DEPUTY SECRETARY OF VETERANS AFFAIRS

Chairman Akaka, Senator Burr, Members of the Senate Committee on Veterans' Affairs, we deeply appreciate your steadfast support of our military and veterans and welcome the opportunity to appear here today to discuss improvements implemented and planned for the care, management, and transition of wounded, ill, and injured servicemembers. We are pleased to report that while much work remains to be completed, meaningful progress has been made.

The Administration has worked diligently—commissioning independent review groups, task forces, and a Presidential Commission—to assess the situation and make recommendations. Central to our efforts, a close partnership between our respective Departments was established, punctuated by formation of the Senior Oversight Committee (SOC) on May 8, 2007, to identify immediate corrective actions and to review and implement recommendations of the external reviews. The SOC continues work to streamline, deconflict, and expedite the two Departments' efforts to improve support of wounded, ill, and injured servicemembers' recovery, rehabilitation, and reintegration.

Specifically, we have endeavored to improve the Disability Evaluation System, established a Center of Excellence for Psychological Health and Traumatic Brain Injury, established the Federal Recovery Coordination Program, improved data sharing between the Departments of Defense (DOD) and Veterans Affairs (VA), developed housing facility inspection standards, and improved delivery of pay and benefits.

The recommended shift in the fundamental responsibilities of the Departments of Defense and Veterans Affairs, however, remains one of the most significant recommendations from the many task forces and commissions. This shift in the fundamental responsibilities would take the Department of Defense out of the disability rating business. Creating this clear line between the responsibilities of the two Departments, as specifically recommended by the Dole-Shalala Commission, would allow DOD to focus on the fit or unfit determination and streamline the transition from servicemember to veteran.

Senior high-level cooperative efforts between DOD and VA pre-date the SOC. The Joint Executive Council (JEC), which was established by the Departments in 2002 and later codified in law, is the nexus for senior leadership management of communications, coordination, and resource sharing between VA and DOD. The JEC was the starting point for the SOC. Today, the JEC continues to direct appropriate resources and expertise to specific operational areas through its two sub-councils, the Health Executive Council and the Benefits Executive Council, as mapped out in the VA/DOD Joint Strategic Plan.

SENIOR OVERSIGHT COMMITTEE

The driving principle guiding SOC efforts is the establishment of a world-class seamless continuum that is efficient and effective in meeting the needs of our wounded, ill, and injured servicemembers, veterans, and their families. The body is composed of senior DOD and VA representatives and co-chaired by the Deputy Secretary of Defense and Deputy Secretary of Veterans Affairs. Its members include: the Service Secretaries, the Chairman or Vice Chairman of the Joint Chiefs of Staff, the Service Chiefs or Vice Chiefs, the Under Secretaries of Defense for Personnel and Readiness and Comptroller, the Under Secretaries of Veterans Affairs for Benefits and Health, the Office of the Secretary of Defense General Counsel, the Assistant Secretary of Defense for Health Affairs, the Director of Administration and Management, the Principal Deputy Under Secretary of Defense for Personnel and Readiness, the Assistant Secretary of Veterans Affairs for Policy and Planning, the Deputy Under Secretary of Defense for Plans, and the Veterans Affairs Deputy Chief Information Officer. In short, the SOC brings together on a regular basis the most senior decisionmakers to ensure wholly informed, timely action.

Supporting the SOC decisionmaking process is an Overarching Integrated Product Team (OIPT), co-chaired by the Principal Deputy Under Secretary of Defense for Personnel and Readiness and the Department of Veterans Affairs Under Secretary for Benefits and composed of senior officials from both DOD and VA. The OIPT reports to the SOC and coordinates, integrates, and synchronizes work and makes recommendations regarding resource decisions.

MAJOR INITIATIVES AND IMPROVEMENTS

The two Departments are in the process of implementing more than 400 recommendations of five major studies, as well as implementing the Wounded Warrior and Veterans titles of the recently enacted National Defense Authorization Act (NDAA) for Fiscal Year 2008, Public Law 110–181. We continue to implement recommended changes through the use of policy and existing authorities. For example, in January 2008, a joint DOD/VA Federal Recovery Coordination Program was instituted to provide the ultimate, long term case/care management oversight for our recovering severely Wounded, Ill and Injured Servicemembers, Veterans, and their families across multiple, multi-disciplinary teams, and across the continuum of care from recovery to rehabilitation to reintegration. Described below are the major SOC initiatives now underway.

DISABILITY EVALUATION SYSTEM

The fundamental goal is to improve the continuum of care from the point-of-injury to community reintegration. To that end, in November of last year, a Disability Evaluation System (DES) Pilot test was implemented for disability cases originating at the three major military treatment facilities in the National Capital Region (NCR) (Walter Reed Army Medical Center, National Naval Medical Center Bethesda, and Malcolm Grow Medical Center). The pilot is a servicemember-centric initiative designed to eliminate the often confusing elements of the two current dis-

ability processes of our Departments. Key features include both a single medical examination and single disability rating for use by both Departments. A primary goal is to reduce by half the time required to transition a member to veteran status and receipt of VA benefits and compensation.

The pilot addresses those recommendations that could be implemented without legislative change from the reports of the Task Force on Returning Global War on Terror Heroes, the Independent Review Group, the President's Commission on Care for America's Returning Wounded Warriors (Dole-Shalala Commission), the Veterans' Disability Benefits Commission (Scott Commission), and the DOD Task Force on Mental Health. Its specific objectives are to improve timeliness, effectiveness, transparency, and resource utilization by integrating DOD and VA processes, eliminating duplication, and improving case management practices. To ensure a seamless transition of our wounded, ill, or injured from the care, benefits, and services of DOD to VA's system, the pilot is testing enhanced case management methods and identifying opportunities to improve the flow of information and identification of additional resources to the servicemember and family. The VA is poised to provide benefits and compensation to the veterans participating in the pilot as soon as they transition from the military.

The pilot covers all non-clinical care and administrative activities, such as case management and counseling requirements associated with disability case processing, from the point of servicemember referral to a Military Department Medical Evaluation Board (MEB) through compensation and provision of benefits to veterans by the VA. Expansion of the pilot is being considered to address:

- Performance measures—The pilot evaluation plan includes extensive quantitative and qualitative performance measures to ensure our servicemembers obtain all benefits and entitlements due by law. Although no servicemembers have completely transitioned from the pilot to veteran status, we expect a reasonable sample population to have processed through by mid-June. We'll complete our initial analysis at that time and make a determination regarding expanding the pilot. As of April 7, 2008, over 287 servicemembers were enrolled in the pilot, and we expect the first servicemember to separate within the next 30 to 60 days.
- Site assessment—The following criteria will be thoroughly analyzed by both Departments: resources, IT architecture development and fielding, case management effectiveness, training requirements, DES workload (for DOD and VA) in expansion areas, and costs.
- Case management—Most importantly, pilot expansion to a broader population will require training and certification of DES and VA administrative and case management personnel. It is anticipated that certification of the case managers and determination of the appropriate case manager staff size will be overriding factors that limit or allow expansion of the pilot to other areas.
- Phased expansion—Unlike the pilot's Physical Evaluation Board phases, which are consolidated in the NCR, the medical assessment and MEB phases occur across the Departments at numerous Medical Treatment Facilities (MTFs) and Veterans Health Administration (VHA) sites. Phased expansion of the pilot should allow MTF site preparation and training on a manageable timeline. The first in a series of meetings involving both VA and DOD personnel to address expansion of the pilot was held on March 12 and 13, 2008. VA and DOD created specific workgroups to develop recommendations for the expansion of the pilot.

The pilot is part of a larger effort including medical research into the signature injuries of the war and updating VA's Schedule for Rating Disabilities (VASRD). Proposed regulations to update the disability schedule for Traumatic Brain Injury and burn scars were published in the Federal Register on January 3, 2008. We anticipate the final rule will be published later this summer and we appreciate the review and recommendations by this Committee in support of this change.

Beyond the Pilot, the Veterans Benefits Administration (VBA) is processing claims from Very Seriously Injured (VSI) and Seriously Injured (SI) Operations Enduring Freedom (OEF) and Iraqi Freedom (OIF) veterans on a priority basis. Claims from all returning war veterans are expedited.

PSYCHOLOGICAL HEALTH AND TBI

Improvements have been made in addressing issues concerning psychological health (PH) and Traumatic Brain Injury (TBI). The focus of these efforts has been to create and ensure a comprehensive, effective, and individually focused program dedicated to prevention, protection, identification, diagnosis, treatment, recovery, and rehabilitation for our servicemembers, veterans, and families who deal with these challenging health conditions.

The DOD has a broad range of programs designed to sustain the health and well-being of every service and family member in the total military community. Because no two individuals are exactly alike, multiple avenues of care are open to create a broad safety net that meets the preferences of the individual. This continuum of care encompasses: prevention and community support services; early intervention to protect and restore before chronicity, and before the member does something rash; service-specific deployment-related preventive and clinical care before, during, and after deployment; sustained, high-quality, readily available clinical care along with specialized rehabilitative care for severe injuries or chronic illness, and transition of care for veterans to and from the VA system of care; and a strong foundation of epidemiological, clinical, and field research.

VA's Vet Centers, operated by the Readjustment Counseling Service in the Veterans Health Administration (VHA), provide community outreach and professional readjustment counseling services for war-related psychological readjustment problems, including PTSD counseling. Vet Centers may treat PTSD, family relationship problems, lack of adequate employment, lack of educational achievement, social alienation and lack of career goals, homelessness and lack of adequate resources, and other psychological problems such as depression or substance use disorder. Vet Centers are community-based facilities located outside of the larger VA medical centers in convenient easy-to-access settings. The Vet Center service mission goes beyond medical care in providing a holistic mix of services designed to treat the veteran as a whole person in his/her community setting.

Vet Centers provide an alternative to traditional mental health care that helps many combat veterans overcome the stigma and fear related to accessing professional assistance for military-related problems. Eligibility for Vet Center services is based on military service in a combat theater and does not require the veteran to go through the enrollment process.

VA is currently expanding the number of its Vet Centers. In February 2007, VA announced plans to establish 23 new Vet Centers increasing the number nationally from 209 to 232. This expansion began in 2007 and is planned for completion in 2008. More than half of the new Vet Centers are operational based on having signed a lease, having hired staff, and providing services to veterans. The remaining Vet Centers are actively pursuing and/or completing staff recruiting and lease contracting. They will all be open by the end of the fiscal year.

Since hostilities began in Afghanistan and Iraq, the focus of the Vet Center program has been on aggressive outreach at military demobilization and at National Guard and Reserve sites, as well as at other community locations that feature high concentrations of veterans and family members. To promote early intervention, the Vet Center program hired 100 OEF and OIF veteran returnees to provide outreach services to their fellow combatants. These fellow veteran outreach specialists are effective in mitigating veterans' stigma and establishing immediate rapport. From early in FY 2003 through the end of FY 2007, Vet Centers have provided readjustment services to over 268,987 veteran returnees from OEF and OIF. Of this total, more than 205,481 veterans were provided outreach services, and 63,506 were provided substantive clinical readjustment services in Vet Centers. The Readjustment Counseling Service operated a budget of $110 million in FY 2007.

Our Departments have partnered in the development of standard clinical practice guidelines for Post Traumatic Stress Disorder (PTSD), Major Depressive Disorder, Acute Psychosis, and Substance Use Disorders. Joint Clinical Practice Guidelines for the evaluation and treatment of mild Traumatic Brain Injury (TBI) are currently under development. These guidelines help practitioners determine the best available and most appropriate care for PH conditions and TBI. In an effort to ensure that providers are trained in best practices, we are partnering in providing training in evidence-based treatment for PTSD.

TBI can result in slowed reaction time, impaired decisionmaking and judgment, and decreased mental processing. Mild TBI or concussion can reduce mission effectiveness and increase risk to the injured servicemember and others in the unit. Objective cognitive performance information can give the commander critical information for informed risk decisions in mission planning and execution while providing medical providers with an objective assessment of the extent of the injury and a method of tracking recovery. To facilitate the evaluation and management of TBI cases, DOD is about to expand a program to collect baseline neurocognitive information on all Active and Reserve personnel before their deployment to combat theaters. The Army already has incorporated neurocognitive assessments as a regular part of its Soldier Readiness Processing in select locations. Additionally, select Air Force units are assessed in Kuwait before going into Iraq.

To ensure all servicemembers are screened appropriately for TBI, questions have been added to the Post-Deployment Health Assessment and the Post-Deployment

Health Reassessment. That same information is shared with VA clinicians as part of an effort to facilitate the continuity of care for the veteran or servicemember.

Rehabilitative Services and Polytrauma System of Care. VA provides clinical rehabilitative services in several specialized areas that employ the latest technology and procedures to provide our veterans with the best available care and access to rehabilitation for polytrauma and TBI, spinal cord injury, visual impairment, and other areas. Over the past 2 years, VA has implemented an integrated system of specialized care for veterans sustaining TBI and other polytraumatic injuries.

The Polytrauma System of Care consists of four regional TBI/Polytrauma Rehabilitation Centers (PRC) located in Richmond, VA; Tampa, FL; Minneapolis, MN; and Palo Alto, CA. A fifth PRC is currently under design for construction in San Antonio, TX, and is expected to open in 2011.

The four regional PRCs provide the most intensive specialized care and comprehensive rehabilitation for combat injured patients transferred from military treatment facilities. As veterans recover and transition closer to their homes, the Polytrauma System of Care provides a continuum of integrated care through 21 Polytrauma Network Sites, 76 Polytrauma Support Clinic Teams, and 54 Polytrauma Points of Contact located at VAMCs across the country.

Throughout the Polytrauma System of Care, we have established a comprehensive process for coordinating support efforts and providing information for each patient and family member. The care coordination process between the referring DOD military treatment facility and the PRC begins weeks before the active duty servicemember is transferred to VA for health care. The PRC physician monitors the medical course of recovery and is in contact with the MTF treating physician to ensure a smooth transition of clinical care.

We have come to appreciate the importance of support to family caregivers whose severely injured loved ones transition into VA health care. To that end, we are currently evaluating caregiver needs, and options to strengthen their ability to care for their loved ones.

TBI Screening. Beginning on April 14, 2007, VA has screened all OEF/OIF veterans receiving medical care within the VA for possible TBl. VHA staff received training in administering the screening tool and follow-up evaluation, and the computerized medical record system was modified to include the TBI screening clinical reminder. The clinical reminder (1) identifies veterans who need screening, (2) presents the screening tool to the provider, and (3) enters results into progress notes and into the electronic health record. VA policy requires that veterans who screen positive on the TBI screening tool be offered a follow-up evaluation with a specialty provider who can determine whether the veteran has a TBI.

To ensure appropriate staffing levels for PH, a comprehensive staffing plan for psychological health services has been developed based on a risk-adjusted, population-based model and the Services have received resources to staff that model. In addition, DOD has partnered with the Department of Health and Human Services (HHS) to provide uniformed Public Health Service officers in Medical Treatment Facilities to increase available mental health providers for DOD. The Memorandum of Agreement between the two Departments is near completion, with startup anticipated shortly. DOD program expansions, documented in an updated report to Congress submitted in February 2007, include:

- Addition of telephone-based screening for those who do not have access to the Internet including a direct referral to Military OneSource for individuals identified at significant risk;
- Availability of locally tailored, installation-level referral sources via the online screening;
- Introduction of the evidence-based Suicide Prevention Program for Department of Defense Education Activity schools to ensure education of children and parents of children who are affected by their sponsor's deployment;
- Addition of a Spanish language version for all screening tools, expanded educational materials, and integration with the newly developed pilot program on web-based self-paced care for PTSD and depression; and
- Enhancement of the web based Mental Health Self Assessment Program.

In November 2007, the Department of Defense Center of Excellence (DCoE) for Psychological Health and Traumatic Brain Injury was established as a national Center of Excellence for PH and TBI. It includes VA and HHS liaisons, as well as an external advisory panel organized under the Defense Health Board, to provide the best advisors across the country to the military health system. The center facilitates coordination and collaboration for PH and TBI related services among the Military Services and VA, promoting and informing best practice development, research, education, and training. The DCoE is designed to lead clinical efforts toward

developing excellence in practice standards, training, outreach, and direct care for our military community with psychological health and TBI concerns. It also serves as a nexus for research planning and monitoring the research in this important area of knowledge. Functionally, the DCoE is engaged in several focus areas, including:

- Mounting an anti-stigma campaign (Army's Mental Health Advisory Team V survey shows that stigma and fears of seeking help are being reduced, but there is more to do);
- Establishing effective outreach and educational initiatives;
- Promulgating a tele-health network for clinical care, monitoring, support, and follow-up;
- Coordinating an overarching program of research including all DOD assets, academia and industry, focusing on near-term advances in protection, prevention, diagnosis, and treatment;
- Providing training programs aimed at providers, line leaders, families, and community leaders; and
- Designing and planning for the National Intrepid Center of Excellence (anticipated completion in fall 2009), a building that will be located on the Bethesda campus adjacent to the new Walter Reed National Military Medical Center.

Similarly, VA's commitment to mental health has been evidenced by rapid response and action. From the beginning of Operation Enduring Freedom in Afghanistan until the end of FY 2007, nearly 800,000 service men and women separated from the Armed Forces. Almost 300,000 of them have sought care in a VA medical center or clinic. Of these, about 120,000 received at least a preliminary mental health diagnosis, with PTSD being the most common seen diagnosis (nearly 60,000). Although PTSD is the most frequently identified of the mental health conditions that can result from deployment to OEF/OIF, it is by no means the only one. Depression, for example, is a close second.

Care for OEF/OIF veterans is among the highest priorities of VA's mental health care system. For these veterans, VA has the opportunity to apply what has been learned through research and clinical experience about the diagnosis and treatment of mental health conditions to intervene early and to work to prevent the chronic or persistent courses of illnesses, especially PTSD that have occurred in too many veterans of prior eras.

VA has increased its support of mental health funding from $2 billion in 2001 to a projected amount of over $3.5 billion this year. As a result of focused efforts to build mental health staff and programs, VA has hired over 3,800 new mental health staff in medical centers and clinics over the past two and a half years for a total mental health staff of nearly 17,000.

VA and DOD have continued to work collaboratively in the area of PTSD. VA's programs in PTSD are informed by the research supported through its Office of Research and Development, and by the research, educational programs, and clinical demonstrations of its National Center for PTSD (NCPTSD) headquartered in White River Junction, Vermont; its Mental Illness Research Education and Clinical Centers, especially those in Seattle and Portland, Palo Alto and San Francisco, and Durham, as well as the Centers of Excellence for Mental Health and PTSD in Canandaigua, New York, San Diego, and Waco.

NCPTSD has been critical in conducting research establishing the effectiveness of evidence-based psychotherapies for PTSD, and for working with the clinical services in both VA and DOD to translate research findings into large scale training programs for mental health providers. In this way, VA and DOD are conducting research to develop new knowledge on effective treatments, and then organization of the programs necessary to allow veterans and servicemembers to benefit from them.

The FY 2007 Supplemental Appropriation provided DOD $900 million in additional funds to make improvements to our PH and TBI systems of care and research. These funds are important to support, expand, improve, and transform our system and are being used to leverage change through optimal planning and execution. The funds have been allocated and distributed in three phases to the Services for execution based on an overall strategic plan created by representatives from DOD and the Services with VA input. Of the $600 million O&M Funds, $566 million (94 percent) has been distributed, including $315 million for PH and $251 million for TBI. The remaining balance is reserved for expansion of promising demonstration programs and for additional costs that emerge as the plans are executed.

CARE MANAGEMENT

To improve care management, the complexities between our two care management systems are being reduced through the Federal Recovery Coordination Program, which will identify and integrate care and services for the wounded, ill, and

injured servicemember, veteran, and their families through recovery, rehabilitation, and community reintegration.

New comprehensive practices for better care, management, and transition are being implemented. These efforts include responses to requirements of the National Defense Authorization Act 2008 regarding the improvements to care, management, and transition of recovering servicemembers. Progress is being made toward an integrated continuity of quality care and service delivery with inter-Service, interagency, intergovernmental, public, and private collaboration for care, management, and transition, and the associated training, tracking, and accountability for this care. Our efforts include important reforms such as uniform training for medical and non-medical care/case managers and recovery coordinators, and a single tracking system and a comprehensive recovery plan for the seriously injured.

The joint FRCP trains and deploys Federal Recovery Coordinators (FRCs) to support medical and non-medical care/case managers in the care, management, and transition of seriously wounded, ill, and injured servicemembers, veterans, and their families. The FRCP will develop and implement web-based tools, including a Federal Individual Recovery Plan (FIRP) and a National Resource Directory for all care providers and the general public to identify and deliver the full range of medical and non-medical services. To date, the Departments have:

• Hired, trained, and placed eight Federal Recovery Coordinators (FRCs) at three of our busiest Medical Treatment Facilities as recommended by the Dole-Shalala Commission. FRCs are located at Walter Reed Army Medical Center, National Naval Medical Center in Bethesda, Brooke Army Medical Center. Recruitment efforts are ongoing to place a FRC at Naval Medical Center Balboa.

• Developed a prototype of the Federal Individual Recovery Plan (FIRP) as recommended by the Dole-Shalala Commission; and

• Produced educational/informational materials for FRCs, Multi-Disciplinary Teams, and servicemembers, veterans, families, and caregivers.

We are also in the process of:

• Developing a prototype of the National Resource Directory in partnership with Federal, state, and local governments and the private/voluntary sector, with public launch this summer;

• Producing a Family Handbook in partnership with relevant DOD/VA offices;

• Identifying workloads and waiver procedures for Medical Case/Care Managers, Non-Medical Care Managers, and Federal Recovery Coordinators; and

• Developing demonstration projects with states such as California for the seamless reintegration of veterans into local communities.

DATA SHARING BETWEEN DEFENSE AND VETERANS AFFAIRS

Steps have been taken to improve the sharing of medical information between our Departments to develop a seamless health information system. Our long-term goal is to ensure appropriate beneficiary and medical information is visible, accessible, and understandable through secure and interoperable information technology. The SOC has approved initiatives to ensure health and administrative data are made available and are viewable by both agencies. DOD and VA are securely sharing more electronic health information than at any time in the past. In addition to the outpatient prescription data, outpatient and inpatient laboratory and radiology reports, allergy information, access to provider/clinical notes, problem lists, and theater health data have recently been added. In December 2007, DOD began making inpatient discharge summary data from Landstuhl Regional Medical Center immediately available to VA facilities. The plan for information technology support of a recovery plan for use by Federal Recovery Coordinators was approved in November 2007. A single web portal to support the needs of wounded, ill, or injured servicemembers, commonly referred to as the eBenefits Web Portal, is planned based on the VA's successful eVet Web site. The Veterans Tracking Application (VTA) is a data management tool utilized by both VBA and VHA staff to track VSI and SI veterans and assist in case management and prioritizing care for all OEF and OIF veterans.

MEDICAL FACILITIES INSPECTION STANDARDS

Progress has made to ensure our wounded warriors are properly housed in appropriate facilities. Using the comprehensive Inspection Standards, all 475 military Medical Treatment Facilities (MTFs) were inspected and found to be in compliance although deferred maintenance and upgrades were cited. The Services are continuing an aggressive inspection of MTFs on a semi-annual basis to ensure continued compliance, identify maintenance requirements, and sustain a world-class envi-

ronment for medical care. In the event a deficiency is identified, the commander of the facility will submit to the Secretary of the Military Department a detailed plan to correct the deficiency, and the commander will periodically re-inspect the facility until the deficiency is corrected. All housing units for our wounded warriors have also been inspected and determined to meet applicable quality standards. The Services recognize that existing temporary medical hold housing is an interim solution and have submitted FY 2008 military construction budgets to start building appropriate housing complexes adjacent to MTFs. They will also implement periodic and comprehensive follow-up programs using surveys, interviews, focus groups, and town-hall meetings to learn how to improve housing and related amenities and services.

In the wake of reports last year about poor physical conditions in some non-VA health care facilities that housed wounded and injured servicemembers, then Secretary Nicholson ordered a national review. The snapshot revealed that the problems identified were primarily related to normal wear and tear that are continually addressed through regular inspections and maintenance. Facility leadership conducts weekly environment of care (EOC) rounds to promptly identify and correct problems. Each Veterans Integrated Service Network (VISN) has an EOC review committee that conducts random, unannounced inspections of facilities in the Network at least once a year. In addition, there are cyclic inspections, e.g., by the Office of the Inspector General. The Joint Commission makes unannounced visits to VA health care facilities as well.

TRANSITION ISSUES/PAY AND BENEFITS

VA has significantly expanded its outreach efforts to separating servicemembers to ensure they are fully informed about their VA benefits. From FY 2003 through February FY 2008, VBA military services coordinators conducted more than 41,700 VBA benefits briefings, reaching a total of more than 1.6 million active duty servicemembers. These briefings include 8,013 pre- and post-deployment briefings attended by over 493,400 activated Reserve and National Guard servicemembers. During FY 2007 alone, VBA military services coordinators provided more than 8,150 benefits briefings to over 296,800 separating and retiring military personnel. As of February of this year, we had already provided more than 3,200 briefings to about 132,600 separating servicemembers.

Servicemembers transitioning from military to civilian life can also benefit from a collaborative effort between DOD and the Department of Labor (DOL). The DOL Pre-Separation Guide, which informs servicemembers and their families of available transition assistance services and benefits, is now available at http://www.TurboTAP.org. VA's military service coordinators encourage its use during their VA benefits briefings to separating servicemembers.

Another resource tool for transitioning servicemembers is the expanded Small Business Administration's Patriot Express Loan program. The Patriot Express Loan offers a lower interest rate and an accelerated processing time. Loans are available for up to $500,000 and can be used by wounded warriors for most business purposes. DOD has also expanded Wounded Warrior Pay Entitlement information on the Defense Finance and Accounting Service (DFAS) Web site and other organizations have linked to the Web site; in July 2007, the DFAS posted an easily understood decision matrix on eligibility for Combat-Related Injury Rehabilitation Pay (CIP) which allows wounded warriors to determine their eligibility for CIP on the Web site. Additionally, through use of streamlined debt management procedures, DFAS remitted, canceled, or waived debts for over 14,126 wounded warrior accounts totaling approximately $13.17 million as of January 29, 2008.

DOD and VA have executed a Memorandum of Understanding for sharing of information concerning active duty servicemembers receiving inpatient care at VA medical centers. This expanded data sharing assists DOD pay specialists in their efforts to ensure that servicemembers and their families are receiving appropriate pay and travel benefits.

To meet the needs of families, DFAS implemented a pilot program in October 2007 to provide family members of wounded servicemembers another option to immediate access of travel advance funds. A Family Support Debit Card with a preloaded advance from their travel entitlement is provided to the family giving them immediate access to funds. This debit card method was proposed to eliminate the delays and security issues associated with other travel advance methods—cash, check, and Electronic Funds Transfer—and is being tested in three locations.

As authorized in the NDAA, the TRICARE Management Agency will implement coverage comparable to the Extended Care Health Option (ECHO) for servicemembers who incur a serious injury or illness on active duty. The respite care ben-

efit has attracted the most interest and will provide short-term care for the servicemember in order to provide rest for those who care for the servicemember at home. To further address the needs experienced by families or the servicemember's designated caregiver, DOD has launched a study to identify the extent and amount of the costs borne by families or designated caregivers when they assume the responsibility of non-medical care to their servicemember or veteran. Initial numbers and costs from this study will be provided to DOD by July 2008 with validating surveys and interviews to follow in October 2008.

DOD and VA have shared information concerning the traumatic injury protection benefit under the Servicemembers Group Life Insurance (TSGLI) and implemented plans replicating best practices. The Army is now placing subject-matter experts at MTFs to provide direct support of the TSGLI application process and improve processing time and TSGLI payment rates. Upon receipt of a completed claim form, the claim is adjudicated by the Services and paid within 3 weeks. VA's Insurance provider's payment time, upon receipt of a certified claim from the branch of Service, averages between two and 4 days. DOD has been successful using Congressional authority from the NDAA allowing continuation of deployment related pays for those recovering in the hospital after injury or illness in the combat zone. This ensures no reduction in deployment pays while the servicemember is recovering.

We are creating a compensation/benefits Web site and handbook that will help servicemembers and veterans make informed decisions about their futures. VA has just contracted for two studies regarding the recommendations of the Dole-Shalala Commission. The first study will evaluate the levels and duration of transition benefit payments to assist veterans and their families while they are in a vocational rehabilitation program. The second study will develop recommendations for creating a schedule for rating veterans' disabilities based upon current concepts of medicine and disability, taking into account the loss of quality-of-life and loss of earnings resulting from service-connected disabilities. Results of the studies will be provided to VA by August 2008.

TRANSITION

Collaboration between VA and DOD gained substantial momentum over the past year as we partnered to establish a seamless continuum to meet the needs of our wounded, ill, and injured servicemembers and their families in transition to continued military service or veteran status. The SOC is scheduled to stand down in 2009, at which time the Joint Executive Council (JEC) will be responsible for SOC initiatives. The Departments are committed to maintaining the momentum created by the SOC through the JEC. It is the intent of the JEC to honor this commitment by ensuring that all of the initiatives that were developed and tracked by the SOC are fully and successfully implemented. The SOC will establish a clear direction for the two Departments before standing down, which will be incorporated into the next iteration of the JEC's Joint Strategic Plan. A number of the positive efforts have been produced under the auspices of the JEC: Dental care for reserve and national guard, realization of a joint Federal health care facility at North Chicago, traumatic injury protection benefit under the Servicemembers' Group Life Insurance/TSGLI, Benefits Delivery at Discharge (BDD), VBA Counselors stationed at MTFs, enhanced data sharing between VA and DOD, and more than 66 projects funded from 160 million in the Joint incentive Fund.

CONCLUSION

The Senior Oversight Committee and its Overarching Integrated Product Team continue to work diligently to resolve the many outstanding issues while aggressively implementing the recommendations of Dole-Shalala, the NDAA, and the various aforementioned task forces and commissions. These efforts will expand in the future to include the recommendations of the DOD Inspector General's report on DOD/VA Interagency Care Transition, which is due shortly.

As previously stated, one of the most significant recommendations from the task forces and commissions is the shift in the fundamental responsibilities of the Departments of Defense and Veterans Affairs. The core recommendation of the Dole-Shalala Commission centers on the concept of taking the Department of Defense out of the disability rating business so that DOD can focus on the fit or unfit determination, streamlining the transition from servicemember to veteran.

We have made four fundamental changes in our support and care for wounded warriors:

- Integrated the DOD and VA into a single team.
- Identified new approaches to support outpatients (e.g., Warrior Transition Units and American's with Disabilities Act compliant barracks).

• Developed new approaches to address psychological health and the challenges of TBI.
• Revolutionized customer care.

We envision five major changes that need to be addressed:

• Create and deploy an effective performance management structure that will be functional when handed off to the JEC. The structure will be a sensor suite to ensure the system is operating as intended.
• Rationalize DOD/VA roles and responsibilities in accordance with Dole-Shalala. x Define a solution for the Reserve Component.
• Define the path toward an interoperable information environment.
• Drive home the changed approach to psychological and customer care.

While we are pleased with the quality of effort and progress made, we fully understand that there is much more to do. We also believe that the greatest improvement to the long-term care and support of America's wounded warriors and veterans will come from enactment of the provisions recommended by Dole-Shalala. We have, thus, positioned ourselves to implement these provisions and continue our progress in providing world-class support to our warriors and veterans while allowing our two Departments to focus on our respective core missions. Our dedicated, selfless servicemembers, veterans, and their families deserve the very best, and we pledge to give our very best during their recovery, rehabilitation, and return to the society they defend.

Chairman Akaka, Senator Burr, and Members of the Committee, thank you again for your generous support of our wounded, ill, and injured servicemembers, veterans, and their families. We look forward to your questions.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. DANIEL K. AKAKA TO GORDON MANSFIELD, DEPUTY SECRETARY OF THE DEPARTMENT OF VETERANS AFFAIRS

Question 1: Deputy Secretary England and Deputy Secretary Mansfield, I understand that VA and DoD are now tracking seriously injured patients through one system that is jointly administered by both Departments. The goal is that a veteran with serious TBI, for example, will not fall through the cracks and be left to battle the bureaucracy on his own when transitioning from DoD to VA care. Please elaborate on how this system is being operated and describe its successes or shortcomings.

Response: In April 2007, the Department of Veterans Affairs (VA) integrated its Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) tracking system with the Department of Defense's (DoD) joint patient tracking application. The new application, known as veterans tracking application (VTA), combines the capability of VA's previous tracking system with DoD's system which tracks service members from the battlefield through Landstuhl, Germany, and to military treatment facilities (MTF) in the States. This information from the battlefield to VA greatly assists VA case managers in transitioning the care of these patients and assists the Veterans Benefit Administration (VBA) claims processors in assessing claims.

VA, in partnership with DoD, has implemented a number of initiatives to assist seriously injured OEF/OIF service members and their families. VA health care liaisons and VA benefits counselors are stationed at 11 MTFs to educate service members about VA services and benefits. These VA employees assist active duty service members and veterans during their transfer to VA medical facilities and ensure that OEF/OIF service members receive information about VA benefits and services.

In addition, Federal recovery coordinators (FRC) are located at Walter Reed Army Medical Center in Washington, DC; Brooke Army Medical Center in San Antonio, Texas; and National Naval Medical Center in Bethesda, Maryland; to provide severely wounded, ill and injured service members, veterans, and their families with an integrated patient-centered approach to care management. An FRC serves as the ultimate resource in the oversight, development and implementation of a Federal individualized recovery plan (FIRP), which describes the objectives and resources necessary to assist the severely wounded, ill, and injured service member, veteran, and their families in achieving their life long needs and goals through recovery, rehabilitation, and reintegration to the community.

Each VA medical center has an OEF/OIF team, which includes a nurse or social worker program manager, a nurse or social worker case manager, and a transition patient advocate. Additionally, each VA medical center has a process in place to ensure that the care of all OEF/OIF service members is well-coordinated and that those who are severely ill or injured receive case management services from a nurse or social worker case manager.

On May 1, 2008, VA implemented a major initiative to contact two distinct populations of OEF/OIF veterans by telephone to inform them about changes in VA services, and to ensure they are receiving the services they need. The care management phase, launched first, will consist of those veterans identified as potential care management candidates by nature of prior use of military or veteran health care services. VA is identifying this population using information from the VTA. The global phase, launched second, will include all OEF/OIF veterans who have been discharged from the military, but have not yet engaged the VA for services. Veterans requiring additional information or care management will be assisted by the appropriate VA medical center staff to resolve any issues identified during the calls.

Question 2: Deputy Secretary Mansfield, the Dole/Shalala Commission called for DoD to get out of the business of rating disabilities. As a result, DoD and VA launched a joint disability system pilot in the Washington, DC area last November. I understand there are concerns about expanding this program until it has been tested in other areas. What difficulties have the Departments identified through the pilot and what is the plan to overcome them before the program is expanded – especially to rural areas?

Response: The Joint DoD/VA disability evaluation system (DES) pilot began in the National Capital Region (NCR) on November 26, 2007. VA and DoD have identified a number of challenges in the course of implementing the pilot. Most have been resolved and a limited number are in the process of being resolved. Although all challenges have not been completely resolved, VA and DoD believe that the solutions are clear and that it is essential to expand the pilot to test other scenarios that present new and different challenges.

The challenges that have not been fully resolved as of this time broadly fall into four general categories. They are information technology (IT) connectivity issues, tracking and reporting issues, staffing issues, and metric adjustment. A discussion of these issues follows:

1. Connectivity issues: The IT connection used by VA personnel to access VA applications is slow and does not capitalize on inherent capabilities of VA's Veterans Health Information Systems and Technology Architecture (VistA) system. Working with DoD IT community we believe a solution has been found that we expect to implement within the next 30 days.

2. Tracking and reporting issues: The current tool used to report on and manage the pilot is, by design, limited in scope, functionality and capability. It is not adequate for a significantly expanded pilot or full implementation. VA is currently assessing the viability of adapting an existing application - VTA - a Web-based tool as a replacement.

3. Staffing in the military services coordinator (MSC) and physical evaluation board liaison officer (PEBLO) positions appears inadequate to fully implement a replacement DES system. The pilot places significant new responsibilities on both positions that were already full time positions prior to the pilot. VA has identified the staffing requirements for full implementation of a national program that includes increased staffing for additional MSCs.

4. Some initial metrics such as the "examination time" and "rating time" need to be redefined into more granular components because the existing metrics do not accurately identify areas requiring process improvement. Requests for changes to the metrics have been made.

VA believes that expansion beyond NCR is essential to test how the process will work if implemented nationwide. Several challenges of expansion are as follows:

1. Conducting the pilot in medically underserved areas where there are limited DoD medical resources and VA resources are far from the installation. Options for resolving this problem include the possibility of a national contract examination support contract and the use of TRICARE providers to conduct the examinations.

2. We need to test the circumstance where the DoD medical evaluation board (MEB) is at one location but the physical location of the service member is elsewhere. For example, the Bethesda MEB has jurisdiction over all Naval and Marine Corps personnel from Maine to Ohio.

3. We would like to test the pilot in areas where there is significant existing data sharing between DoD and the Veterans Health Administration (VHA).

Question 3: Deputy Secretary Mansfield, I am pleased that the Departments have implemented the Federal Recovery Coordinator Program. However, I am aware that only eight FRCs were originally hired and now only six remain. Recent oversight work by my staff indicates that this could create serious gaps in the current case management system. Can you provide an update on the hiring of new FRCs and share what plans exist to address the gaps in care that we continue to hear about from the families of wounded servicemembers?

Response: In December 2007, VA hired the FRC program Director and Supervisor. In January 2008, VA hired eight FRCs who were place at Walter Reed Army Medical Center, Washington, DC; National Naval Medical Center, Bethesda, MD; and Brooke

Army Medical Center, San Antonio, TX. Although there have been some personnel changes, there are currently nine FRCs in place. Vacancies have been filled at National Naval Medical Center and Brooke Army Medical Center. A new position has been hired for Balboa Medical Center, and two have been place in the field at the Providence VA Medical Center (VAMC) and the Houston VAMC.

Effective June 23, 2008, there will be a 1:9 FRC to patient ratio when the newly trained FRCs are in place and caseloads are redistributed.

The FRCs actively started working with patients January 28, 2008. The FRCs develops individual recovery plans for severely wounded, ill and injured service members or veterans who meet the FRC program criteria. Phase one of the FRC program was completed May 30, 2008. A total of 77 catastrophically wounded, ill or injured service members are currently enrolled in the FRC program.

Program Expansion: The second phase of the FRC program commenced June 1, 2008, and includes veteran referrals for those severely wounded, ill, and injured service members, veterans, and families injured prior to the start of the FRC program on January 28, 2008. Further identification of this population will be conducted through a review of VA rehabilitation programs, including spinal cord injury, blind rehabilitation, and polytrauma. DoD will work with TRICARE in an effort to identify the same population for potential inclusion into the FRC program.

In addition to the current 9 FRCs, we continue to recruit for FRCs to be located at VA facilities that will target patients who have already been through the MTF and are now in the community.

Question 4: Deputy Secretary England, at the Committee's first hearing on VA and DoD cooperation in January of last year, I raised the issue of how the seriously injured and their families are informed of their rehabilitation options and benefit eligibility. There are numerous programs on the DoD side that aim to assist servicemembers and their families, all operating independently of one another, including Marine for Life, Army Wounded Warrior, and Navy Safe Harbor. What is being done to make these programs work together and ensure their effectiveness?

Question 5. Deputy Secretary England and Deputy Secretary Mansfield, please share the plan for sustaining the focus and energy of the Senior Oversight Committee into the next Administration, so as to ensure the continuity of its mission.

Response: The VA/DoD Joint Executive Council (JEC) is acutely aware of the extraordinary health care and benefits challenges for active duty service members and veterans in the post September 11 world. The JEC began to incorporate many of the recommendations emanating from the numerous Task Force reports and Presidential Commissions that were concluded during 2007 into the VA/DoD Joint Strategic Plan (JSP) for fiscal year (FY) 2008-2010. The JEC will continue this effort as it revises the JSP for FY 2009 -2011. Many of the Task Force and Presidential

Commission recommendations from 2007 are also incorporated into the VA and DoD Proud to Achieve document. The Departments report progress made on these recommendations on a quarterly basis to the Office of Management and Budget, through the President's Management Agenda scorecard.

Question 6: Deputy Secretary England, the 2008 National Defense Authorization Act required the Departments to provide Congress with a schedule for the implementation of an interoperable electronic health records system. I am disappointed that to date the Departments have failed to comply. However, I am more disturbed to learn that at Camp Arifjan, in Kuwait, an Army clinic cannot electronically transmit a prescription to a Navy pharmacy located only 20 yards away. How can we achieve record sharing between the two Departments when we cannot seem to accomplish it between two services that are only 20 yards apart from each other?

Question 7: Deputy Secretary England, I note that in your testimony you mentioned that DoD has added TBI questions to the Post-Deployment Health Assessment. Committee staff has learned first-hand from servicemembers with mild cases of TBI that they are reticent to answer these questions truthfully because of the potential impact on their futures. What can be done to overcome the stigma attached to these wounds?

Question 8: Deputy Secretary England, the 2008 National Defense Authorization Act bars VA from deducting any severance pay from a veteran's service-connected disability compensation if the qualifying disability was incurred in the line of duty in a combat zone or during performance of duty in combat-related operations, as designated by the Secretary of Defense.

On March 13, 2008, the Department of Defense issued a Directive which limits this provision to those members whose disease or injury is the direct result of armed conflict. I am concerned that the Department is not recognizing disabilities incurred under all of the circumstances required by the statute. Please explain the reasoning for the Department's narrow interpretation of this legislation.

Question 9: Deputy Secretary Mansfield, in 2006, nearly 400,000 veterans received disability compensation for tinnitus, which is fast becoming one of the most common injuries from service in Iraq and Afghanistan, especially as a corollary of TBI. Yet the nature of tinnitus and the therapies used to treat it are poorly understood. Furthermore, scant funding has been dedicated to researching this injury. I am concerned that VA is content to merely pay out benefits without developing treatment for this debilitating condition. Please discuss what VA is doing to improve understanding of tinnitus and develop therapies to treat it.

Response: VA audiology clinics have a history of treating tinnitus dating back to the early 1980s, and provide various levels of tinnitus treatment. VA tinnitus treatment involves a progressive approach ranging from patient education and reassurance to

more comprehensive services involving amplification (hearing aids), biofeedback-relaxation techniques, cognitive-behavioral therapy, drug therapy, sound therapy (masking devices), and combined techniques. The effectiveness of different treatments varies from individual to individual, and none have been shown to be effective in all patients. Because tinnitus can be caused by many conditions, the approach to tinnitus is multi-disciplinary. There is a significant association between tinnitus and noise exposure, hearing loss, brain injury, ear disease, neck and jaw injury, heart disease, and medication use. About 25 percent of tinnitus patients report that tinnitus seriously disrupts their normal lives; e.g. persistent sleep disturbance, annoyance or irritation, inability to concentrate, frustration, or depression. Some tinnitus patients present with behaviors that indicate the need for an evaluation by a psychiatrist, psychologist, or other licensed mental health professional.

VA developed a module on *Hearing Impairment*, including tinnitus, as part of the *Veterans Health Initiative* to train VA clinical providers on the association between certain health effects and military service, and to prepare health care providers to better serve their veteran patients. The Audiology and Speech Pathology Program Office has published patient education materials to help veterans understand tinnitus and tinnitus treatment options. Program officials have also met with tinnitus treatment companies to investigate efficacy and identify new opportunities for treatment and clinical research, and VA audiology clinics are receiving training on special treatment techniques.

Tinnitus is a subjective patient report and by its very nature is difficult to research. There is no standard method for describing tinnitus or objectively measuring its effects. The Institute of Medicine (IOM) studied tinnitus in its landmark report (*Noise and Military Service – Implications for Hearing Loss and Tinnitus*) and found only a few studies on military populations, and no published studies on U.S. military personnel. DoD has begun including tinnitus in post-deployment health assessments, which has facilitated greater identification of tinnitus after deployment. A widely publicized Army study found that deployed soldiers were 25 percent more likely than non-deployed soldiers to report tinnitus, and VBA reports that tinnitus is the most common service-connected disability in OEF/OIF veterans. There have been significant recent advances in the study of animal models, and emerging research using brain imaging techniques for tinnitus.

Tinnitus is a major research focus of VA's Office of Research and is included in the latest application request for Congressionally directed medical research programs. VA researchers are investigating the effectiveness of various tinnitus treatments. The VA National Center for Rehabilitative Auditory Research currently supports several projects addressing tinnitus. VA scientists have developed the audiologic tinnitus management, a research-based model of tinnitus clinical management designed for efficient implementation in VA audiology clinics. This method was developed to incorporate evaluation and treatment strategies using a progressive approach to the management of clinically-significant tinnitus. The researchers plan to

implement this program at one VA audiology clinic and then evaluate its effectiveness and acceptability to patients and audiologists. If proven to be effective, the program could establish the standard for tinnitus management at all VA medical centers and clinics. VA researchers are also developing an automated, computer-controlled diagnostic test to identify and quantify tinnitus, which is currently done by self-report. VA researchers, in collaboration with DoD researchers, are testing the effectiveness of a commercially available tinnitus masking device, and are conducting a study on auditory processing disorders associated with traumatic brain injury (TBI) and blast-related injury.

Question 10: Deputy Secretary England, given the prevalence of TBI patients with visual complications and the fact that over 1,500 OIF/OEF veterans have suffered severe eye injuries, what is the timeline for establishing and funding the Military Eye Trauma Center of Excellence?

Question 11: Deputy Secretary Mansfield, what role will VA play in establishing this Center of Excellence?

Response: During the past 6 months, VA has collaborated with DoD on the development of the eye injury registry, and the proposed Military Eye Trauma Center of Excellence. The initial meeting with DoD and VA was in October of 2007 at the Madigan Army Medical Center. In January 2008, VA appointed a person to represent VHA on the DoD committee, chaired by the Deputy Secretary of Defense for Health Affairs' office, tasked with creation of the Military Eye Trauma Center for Excellence.

At the joint VA/DoD *Visual Consequences of TBI Conference* in December 2007, there was an important discussion by VA and DoD optometrists, ophthalmologists, blind rehabilitation specialists, polytrauma experts, and administrators, about the need to better identify and provide seamless eye care and vision rehabilitation services to those service men and women who experienced a significant eye injury and/or visual impairment from TBI.

There have been numerous VA/DoD conference calls addressing the development of both the eye injury registry and Military Eye Trauma Center of Excellence. In April 2008, a face-to-face meeting was held in American Lake, WA between VA and DoD optometry and ophthalmology representatives, IT specialists, and other consultants to determine the systems and registry element requirements for implementation of the eye injury registry and Military Eye Trauma Center of Excellence.

There has been significant VA/DoD cooperation and progress in meeting the goals of the National Defense Authorization Act requirements for development of the eye injury registry and Military Eye Trauma Center of Excellence.

Question 12: Deputy Secretary England and Deputy Secretary Mansfield, please provide the most recent data available from your respective agencies on suicide among servicemembers and veterans since October 7, 2001

Response: The information and worksheet contains data on veteran suicides from two separate projects. One is an ongoing study of mortality in OEF/OIF veterans being conducted by VA's Office of Environmental Epidemiology. Identification of veterans is based on information from DoD and includes all OEF/OIF service members who were separated from active duty including National Guard and Reserve personnel. The second project is an ongoing study of suicide in veterans who have used VHA services from 2000 onward and who were alive at the start of 2001. The study includes veterans of all eras.

For both projects, information about the time and causes of death was derived from the National Death Index. Information contained in data files on causes of death from the National Death Index is only available through the end of 2005.

Study of Operation Enduring Freedom/Operation Iraqi Freedom Veterans

Population: As part of our mortality study of veterans who served in OEF or OIF, VA obtained the identities of 490,346 OEF/OIF veterans who served as part of either OEF or OIF and were separated or deactivated from military service between October 2001 and December 2005.

Data Sources: The identities of the 490,346 OEF/OIF veterans, military service characteristics, and various demographic data were provided to VA by the DoD Manpower Data Center. Vital statistics data pertaining to OEF/OIF veterans was determined by using VA's database, beneficiary identification and records locator subsystem, and deaths reported to the Social Security Administration (SSA) death master file. The beneficiary identification and records locator subsystem file has the identities of all veterans who have applied for VA benefits (including death benefits), and the SSA death master file includes all deaths reported to that agency. All veterans were matched against the beneficiary identification and records locator subsystem and SSA files using social security numbers. Cause of death data was obtained from the National Death Index. Since 1979, the Office of Vital Statistics in each State has reported deaths, including cause of death data to the National Center for Health Statistics, where the National Death Index is compiled. Causes of death were recorded using International Classification of Diseases codes 10th Revision (ICD-10). For traumatic deaths, including suicide, part of the ICD-10 codes records the method of injury. For suicides, the ICD-10 codes report the method of suicide. At the time this study began, the National Death Index had cause of death data through December 31, 2005. Using the aforementioned databases, VA identified a total of 818 deaths to include 144 suicides.

CHARACTERISTICS OF 144 SUCIDES AMONG OEF/OIF * VETERANS THROUGH 2005

The table has demographic and military service characteristics as well as death certificate data and method of suicide for the 144 suicides identified in this study.

Characteristic	Frequency	Percentage
Age at death		
20-29	78	54.1
30-39	39	27.1
40-49	14	9.7
50-59	13	9.1
Year of death		
2002	7	4.9
2003	21	14.6
2004	48	33.3
2005	68	47.2
Method of suicide		
Poisoning	7	4.9
Hanging	30	20.8
Firearm	105	72.9
Jumping	1	.7
Sharp Object	1	.7
Sex		
Male	141	97.9
Female	3	2.1
Race		
White	118	81.9
Non-White	26	18.1
Ever seen at VAMC		
Yes	33	22.9
Branch of service		
Army	73	50.7
Marines	15	10.4
Air Force	33	22.9
Navy	23	16.0
Rank		
Officer	8	5.6
Warrant Officer	1	0.7
Enlisted	135	93.7
Unit component		
Active	68	47.2
Reserve	35	24.3
National Guard	41	28.5

* These suicides were identified among a cohort of 490,346 OEF/OIF veterans selected for mortality follow-up through 2005.

Study of Veterans Using Veterans Health Administration

Population: VHA defined the population of VA patients at risk for suicide in each fiscal year as those who were alive at the start of the year, and who had received VA services during either that year or the prior one. This approach to identifying VA's patient population was developed in consultation with VA mental health leadership and assumes that patients seen in VA settings in the prior year would still be considered to be in active VA care and part of the at-risk patient population in the following year.

Data Sources: This study used data from VA's National Patient Care database to identify all veterans who used inpatient or outpatient services at any VA facility during the relevant years. Measures of vital status and cause of death were based on information from the National Death Index. The National Death Index is considered the "gold standard" for mortality assessment information and includes national data regarding dates and causes of death for all U.S. residents. This information is derived from death certificates filed in the Office of Vital Statistics for each State. National Death Index searches were performed for cohorts of VA patients who received any VA services during the relevant years, and who had no subsequent VA services through June 2006.

Veterans' age and gender were identified from VA administrative files included in the National Patient Care database. Age at the start of FY 2001 was categorized as being either less than 30, 30 to 39, 40 to 49, 50 to 59, 60 to 69, 70 to 79, or greater than or equal to 80 years. Information regarding race and ethnicity was not consistently available in the National Patient Care database for all VA patients. VA identified dates and causes of death using National Death Index data. Suicide deaths were identified using International Classification of Diseases codes X60 through X84, and Y87.0 (World Health Organization 2004).

Number of Suicides Among VHA Veterans for FY 2001-2005

Characteristic	FY 2001		FY 2002		FY 2003		FY 2004		FY 2005	
	N	%	N	%	N	%	N	%	N	%
Total*	1403	100	1737	100.0	1600	100.0	1702	100.0	1784	100.0
Total, age 20 and over	1401	100	1734	100.0	1598	100.0	1701	100.0	1781	100.0
Sex										
Male	1360	97.1	1682	97.0	1559	97.6	1647	96.8	1720	96.6
Female	41	2.9	52	3.0	39	2.4	54	3.2	61	3.4
Age Group										
20-29 yrs	26	1.9	44	2.5	38	2.4	50	2.9	38	2.1
30-39 yrs	108	7.7	119	6.9	111	6.9	105	6.2	105	5.9
40-49 yrs	240	17.1	283	16.3	272	17.0	256	15.0	254	14.3
50-59 yrs	359	25.6	437	25.2	407	25.5	424	24.9	470	26.4
60-69 yrs	202	14.4	261	15.1	264	16.5	272	16.0	291	16.3
70-79 yrs	320	22.8	393	22.7	345	21.6	381	22.4	380	21.3
80+ yrs	146	10.4	197	11.4	161	10.1	213	12.5	243	13.6
Race										
White Hispanic	30	2.1	25	1.4	32	2.0	24	1.4	29	1.6
Black Hispanic	2	0.1	1	0.1	1	0.1	2	0.1	2	0.1
Native American	2	0.1	6	0.3	3	0.2	2	0.1	7	0.4
African American	55	3.9	80	4.6	47	2.9	62	3.6	78	4.4
Asian/Pacific Islander	0	0.0	4	0.2	2	0.1	3	0.2	16	0.9
Caucasian	895	63.9	1078	62.2	894	55.9	814	47.9	1142	64.1
Unknown	417	29.8	540	31.1	619	38.7	794	46.7	507	28.5

* Includes age < 20 years old

Number of Suicides among VHA Veterans for FY 2001-2005

Characteristic		FY 2001		FY 2002		FY 2003		FY 2004		FY 2005	
		N	%	N	%	N	%	N	%	N	%
Total*		1403	100.0	1737	100.0	1600	100.0	1702	100.0	1784	100.0
Total, age 20 and over		1401	100.0	1734	100.0	1598	100.0	1701	100.0	1781	100.0
Mechanism of Suicide											
X60	Intentional self-poisoning (suicide) by & exposure to non-opioid analgesics, antipyretics, & anti-rheumatics	5	0.4	4	0.2	8	0.5	5	0.3	12	0.7
X61	Intentional self-poisoning (suicide) by & exposure to antiepileptic, sedative-hypnotic, anti-parkinsonism, & psychotropic drugs, not elsewhere classified	39	2.8	49	2.8	38	2.4	43	2.5	53	3.0
X62	Intentional self-poisoning (suicide) by & exposure to narcotics & psychodysleptics (hallucinogens), not elsewhere classified	26	1.9	42	2.4	30	1.9	27	1.6	48	2.7
X63	Intentional self-poisoning (suicide) by & exposure to other drugs acting on autonomic nervous system	1	0.1	3	0.2	1	0.1	0	0.0	2	0.1
X64	Intentional self-poisoning (suicide) by & exposure to other & unspecified drugs, medicaments, & biological substances	100	7.1	97	5.6	103	6.4	112	6.6	102	5.7
X65	Intentional self-poisoning (suicide) by & exposure to alcohol	2	0.1	2	0.1	5	0.3	0	0.0	1	0.1
66	Intentional self-poisoning (suicide) by & exposure to organic solvents & halogenated hydrocarbons & their vapors.	2	0.1	3	0.2	1	0.1	6	0.4	3	0.2
X67	Intentional self-poisoning (suicide) by & exposure to other gases & vapors	34	2.4	62	3.6	35	2.2	59	3.5	50	2.8
X68	Intentional self-poisoning (suicide) by & exposure to pesticides	1	0.1	1	0.1	1	0.1	0	0.0	0	0.0
X69	Intentional self-poisoning (suicide) by & exposure to other & unspecified chemicals & noxious substances	3	0.2	6	0.3	4	0.3	3	0.2	4	0.2

Characteristic		FY 2001		FY 2002		FY 2003		FY 2004		FY 2005	
		N	%	N	%	N	%	N	%	N	%
X70	Intentional self harm (suicide) by hanging, strangulation, & suffocation	163	11.6	214	12.3	189	11.8	207	12.2	189	10.6
X71	Intentional self harm (suicide) by drowning & submersion	17	1.2	19	1.1	12	0.8	10	0.6	15	0.8
X72	Intentional self harm (suicide) by handgun discharge	192	13.7	248	14.3	255	16.0	227	13.3	277	15.6
X73	Intentional self harm (suicide) by rifle, shotgun, & larger firearm discharge	145	10.3	174	10.0	150	9.4	171	10.1	170	9.5
X74	Intentional self harm (suicide) by other & un-specified firearm discharge	566	40.4	726	41.9	675	42.2	728	42.8	758	42.6
X75	Intentional self harm (suicide) by explosive material	0	0.0	0	0.0	0	0.0	0	0.0	2	0.1
X76	Intentional self harm (suicide) by smoke, fire, & flames	6	0.4	4	0.2	6	0.4	14	0.8	12	0.7
X77	Intentional self harm (suicide) by steam, hot vapors, & hot objects	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
X78	Intentional self harm (suicide) by sharp object	34	2.4	33	1.9	33	2.1	35	2.1	28	1.6
X79	Intentional self harm (suicide) by blunt object	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
X80	Intentional self harm (suicide) by jumping from a high place	31	2.2	18	1.0	30	1.9	27	1.6	22	1.2
X81	Intentional self harm (suicide) by jumping or lying before moving object	14	1.0	10	0.6	7	0.4	12	0.7	8	0.4
X82	Intentional self harm (suicide) by crashing of motor vehicle	1	0.1	4	0.2	5	0.3	4	0.2	7	0.4
X83	Intentional self harm (suicide) by other specified means	7	0.5	6	0.3	3	0.2	4	0.2	2	0.1
X84	Intentional self harm (suicide) by unspecified means	5	0.4	6	0.3	4	0.3	4	0.2	11	0.6
Y87	Sequelae of intentional self harm	7	0.5	3	0.2	3	0.2	3	0.2	5	0.3

Includes age < 20 years old.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. JON TESTER TO GORDON MANSFIELD, DEPUTY SECRETARY OF THE DEPARTMENT OF VETERANS AFFAIRS

Question 1: During the testimony, Deputy Secretary Mansfield stated his opinion that he believes that a number of suicides by Reserve Component veterans may be attributable to an insufficient availability of mental health services in the public at-large. Do you concur in that observation? What actions is the Department of Defense taking to improve mental health services available to Reserve Component forces?

Question 2: During the hearing, Dr. Chu stated that all service data is transmitted from the Department of Defense to the Department of Veterans Affairs when a servicemember separates. Is there any difference between data transferred to the VA for separations of members of the Reserve Component forces and active duty separations? Does this information include information relating to the character of discharge, and all other elements required to determine eligibility for enrollment in the VA health care system?

Question 3: Are there incidences in which a reserve component servicemember is called to active duty, yet does not receive a DD-214 upon discharge? If so, please explain why such a circumstance might occur, and what measures the DOD takes to ensure that these individuals are ultimately provided a copy of their DD-214?

For Deputy Secretary Mansfield:

Question 1: What measures have been or are being taken to ensure that combat veteran members of the Reserve Component forces are aware that they are not required to provide financial information in order to be enrolled in the VA medical system?

Response: (16) In addition to information included in outreach efforts as well as targeted communication products such as the enclosed Combat Veteran Fact sheet, VA issues notification that no financial information is required through Section VI, Financial Disclosure, on VA Form 10-10EZ, "Application for Health Benefits" and Section V, Financial Disclosure, on VA Form 10-10EZR, "Health Benefits Renewal Form", notifying recent combat veterans of this **10-10EZ and 10-10EZR Financial Disclosure Statement:**

> *"The financial assessment is used to determine whether certain veterans qualify for cost-free health care services for their nonservice-connected conditions and to assign their priority enrollment. You should review the table below to see if your eligibility for health care benefits requires or may be based on a financial assessment. Veterans are not required to disclose their financial information; however, VA is not currently enrolling new applicants who decline to provide their financial information unless they have a special eligibility factor. Recently discharged combat-theater veterans (e.g. OEF/OIF) have up to 5 years of enhanced enrollment opportunity without disclosing their financial information but like other*

veterans may provide it to establish their eligibility for travel reimbursement and for cost-free (outpatient) medications as well as to determine if they are subject to copayment requirements for inpatient or outpatient medical care they receive for conditions that are unrelated to their combat-experience."

Question 2: Please also explain what technical requirements, such as additional service records, would need to be met in order to establish a system by which an eligible combat veteran is automatically enrolled in the VA medical system when the veteran's service records are received from the Department of Defense.

Response: VA has identified the following business requirements and issues to resolve in order to establish a system that may enable an eligible combat veteran auto-enrollment for VA health care benefits purposes:

- Promulgation of regulations under title 38 Code of Federal Regulations (C.F.R.) §17.36 would be required to afford "auto-enrollment" authority for combat veterans. For example, 38 C.F.R. §17.36(d) requires all veterans who desire to enroll for VA health care to submit a VA Form 10-10EZ, *Application for Health Benefits*.
- Auto-enrollment may present additional challenges to VA's requirement to manage its system of enrollment under 38 United States Code (U.S.C.) §§ 1705 and 1706. This may be due in part to unknown health care usage rates of the "automatically" enrolled veteran. Enrollment does not equate to use since there is no requirement to become an active user of VA health care services for an enrollee. This in turn may lead to challenges in making meaningful assessments in terms of VA's annual enrollment decision process.
- Current DoD data sharing fails to provide VA sufficient information for VA to make an informed enrollment decision. VHA's health benefits application process and data collection support a number of downstream VHA health benefits delivery requirements such as appointment notification, medication copay determinations, eligibility for beneficiary travel, preferred facility designation, emergency contact information, as well as other pertinent business requirements for the safe and effective delivery of health care.
- VA's Form 10-10EZ requires a veteran's signature which provides authority for VA to match certain information matching, release of information, and other VA business requirements that cannot necessarily be assumed without the veteran signing an application signifying understanding and agreement.
- Enhancements to VA IT systems would be required to support automatic enrollment business processes. Changes will need to be made to interface with DoD, VA's identity management services, and VA's health care enrollment system(s). This would require substantial IT development resources and may affect other IT priorities either already in implementation or planned.

VHA has considered an alternative to auto-enrollment that we believe can achieve the same goals. That alternative is to use an auto-registration approach. This approach effectively leverages the current VA interface efforts with DoD and its strategy to link

key information systems to its core military service information system as described below. The auto-registration system leverages the availability of newly discharged veterans' military service information to create an electronic record in VHA's enrollment information system. The core record information will remain available so that it is instantaneously available whenever a veteran applies for VA health care. This approach ensures timely access to necessary eligibility information whenever the veteran decides to apply for this benefit. Both auto-enrollment and auto-registration are dependent upon necessary DoD military service information. DoD must implement processes that:

- Reliably identify OEF/OIF service members who meet basic qualifications for VA health care, e.g. character of discharge, service dates, and location/dates of combat theater deployment.
- Electronically transmit required information to VA in a timely manner.

Additional Background: Currently, VA/DoD identity repository (VADIR) database provides *most* of the military service information needed by VHA intake staff to process a veteran's application for enrollment. VHA staff can access this information via the veteran information solution (VIS) application. VIS is currently only available through a view-only Web interface. Data challenges include:

- VADIR does not have character of discharge information for members of the Reserve Component. As a result, even though VADIR has service dates and combat pay information, it cannot be used to verify eligibility for VA benefits because this vital information is missing.
- VADIR does have all necessary information for regular active duty veterans relating to military service episodes. However, VADIR does not contain medals and awards information. Consequently, VADIR can be used to determine the veteran's eligibility for enrollment, but cannot be used to enroll a veteran in Priority Group 3 based on Purple Heart Medal receipt.

Successful implementation of either an auto-enrollment registration process hinges on DoD's commitment to providing timely and authoritative identification of the service member's combat veteran status as well as other critical information (e.g. character of discharge, discharge date, etc.).

Chairman AKAKA. Thank you very much, Secretary. Secretary England?

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

Mr. ENGLAND. Chairman Akaka, also aloha. It is always good to be with you, sir, and I thank you for the opportunity, and Senator Burr and Members of the Committee.

I do want to say I do sincerely thank you for this opportunity. I think this is hugely important to have this dialog and exchange of information. This is about, as you said, Senator Burr, Secretary Gates, when he said this is the highest priority. I mean, the highest priority of the Department of Defense along with the war is indeed our wounded, our ill, our injured, and our veterans.

I will say this. Of course, I have my good colleagues with me here today who we all work together on this, but I will tell you, throughout the government, I know in the Congress and throughout DOD and VA and all of our services and a lot of our other agencies, there are people of very good faith every day working very, very hard to deal with this subject. I will tell you this, it is very complex and

very difficult because every single case is different. I mean, every single injury is different. Every single family situation is different.

So, dealing with this is hard. It is complex. And I want to thank all the people who do this every day, because the people who go forward and do this, if they had not served our Nation, I will tell you, we would not wake up tomorrow free in this Nation. So every single day, when people wake up in a land of freedom and liberty, it is because of the people who served, and so, we do owe them everything we can.

I do believe, particularly after this deep involvement on my part in this last year, I believe there are people working very hard and we have made some progress. That said, I mean, there is no finish line. This is not going to be finished. People after me and after you all—this is going to be a continuing effort to continue to improve our processes and systems for all these great Americans.

Now, we did accomplish, I believe, in the last year we have accomplished a great deal. We have gotten on the right path in a number of these areas and we are making progress. We have dealt with well over 500 recommendations last year, so it was very difficult to go through all the 500 and understand a way forward that would indeed be beneficial across the board for all these great Americans.

What we are doing now is we are trying very hard—well, first of all, we are tracking everything. So, if you come into our system, we have schedules and metrics and milestones for everything we are doing and we are going to try to bring everything we can to as much a conclusion in each of those areas by the end of this year or have it in a position that we can readily transition. I mean, we are becoming aware that it is not long off we will be in a transition to the next administration. That is a very disruptive process, because a lot of people leave. And so, we are already working very hard for a smooth transition to make sure we don't have any significant interruptions as we move to the next administration. So, we are working very hard to do that.

A comment about the SOC, the Senior Oversight Committee. It is sort of a creation of the people who are here today. I mean, we put it together because, frankly, it fit our management styles and our approaches and there are similar-type venues that we have in the Department of Defense for other areas that have worked quite well, so we put together a similar organization dealing with these issues and problems.

To some extent, it is personality-driven. Now, the comment, it goes away next January, well, it goes away next January because, frankly, the people at this table are not here after January 20 next year, and the next team may have a different approach to manage the problems. I mean, this has worked well for this management team. Senator, I can't tell you it will work well for the next management team because to some extent it depends on the style and management of the people who will be here after us. It doesn't mean it goes away, but it certainly goes away for us. There is an underlying organization in place, the JEC, which is legislatively put in place, so there will be a process to go forward and the next management team can decide if they deem to carry on the same way that we have.

Now, regarding recommendations, I would just bring up, if I could, one recommendation. We can obviously talk about this more. The one area that is evident to me is we still do not have what I call a clear bright line between DOD and Veterans Affairs in terms of responsibility, and Dole-Shalala actually put forward a recommendation to do that. Basically, what Dole-Shalala said is for DOD to decide fitness to serve—that is, can a servicemember remain in the service or would they have to leave the service and go into the VA system—and not have us in all the other aspects, you know, rehabilitation and all the other aspects of this.

So, I think just as a step forward, I think that would be a very useful discussion this year in terms of just clarifying those lines of responsibility because that, in itself, I think, would end some of the confusion our servicemembers face today. So, we can discuss that further, and I thank you for the opportunity. It is hugely important for the people who serve that we continue to get this right, so I thank you for the opportunity. I am delighted to be here with you today.

Thank you very much, sir.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. DANIEL K. AKAKA TO GORDON ENGLAND, DEPUTY SECRETARY OF THE DEPARTMENT OF DEFENSE

DOD AND VA COMBINED TRACKING OF SERIOUSLY INJURED PATIENTS

Question 1. Deputy Secretary England and Deputy Secretary Mansfield, I understand that VA and DOD are now tracking seriously injured patients through one system that is jointly administered by both Departments. The goal is that a veteran with serious TBI, for example, will not fall through the cracks and be left to battle the bureaucracy on his own when transitioning from DOD to VA care. Please elaborate on how this system is being operated and describe its successes or shortcomings.

Response. Seamless transition is a jointly sponsored DOD and VA initiative that provides transition assistance to seriously injured Servicemembers. DOD and VA together have put into practice strategies to provide appropriate, timely, and seamless transition to the most seriously injured Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) active duty Servicemembers and veterans. The highest priority is ensuring those returning from the Global War on Terror transition seamlessly from DOD military treatment facilities (MTFs) to VA medical centers (VAMCs) and receive the best possible care wherever they are. In a timely way, we want these wounded warriors to receive all the benefits they have earned through their military service and because of their sacrifices.

In response to the President's Commission on Care for America's Returning Wounded warriors, the DOD and VA signed a joint memorandum, requiring the establishment of a Federal Recovery Coordination Program (FRCP) to serve wounded, ill, and injured Servicemembers, veterans, and their families.

Recovering Servicemembers, veterans, and their families who meet the criteria for the FRCP are assigned a Federal Recovery Coordinator (FRC). The FRC serves as the participant's ultimate resource, overseeing the development and implementation of a Federal Individual Recovery Plan throughout the continuum of care. A memorandum of understanding was signed by DOD, VA, and Health and Human Services that provides overarching guidance for the role and contribution of the Public Health Service in the FRCP effort

At end state, we will have achieved a joint DOD/VA FRCP that provides the ultimate, long-term case/care management oversight for our recovering severely wounded, ill, and injured Servicemembers, veterans, and their families across multiple, multi-disciplinary teams, and across the continuum of care from recovery to rehabilitation to reintegration. We will also accomplish a coordinated process to manage identification and delivery of comprehensive services needed to meet the personal and professional needs of our recovering Servicemembers, veterans, and their families, ensuring that the right care by the right person at the right time and place is provided.

The FRCP expansion is now in its second phase and will include "look backs" for those severely wounded, ill, and injured Servicemembers, veterans, and their fami-

lies injured prior to the start of the FRCP program. Identification of this population will be conducted through a review of VA rehabilitation, to include spinal cord injury and blind rehabilitation, along with the polytrauma patients. In tandem, the DOD will work through TRICARE in an effort to identify the same population for potential inclusion into the FRCP. Staffing support has already been initiated to support this expansion effort. An additional registered nurse is already being actively recruited to champion this effort along with additional FRCs who will be placed according to geographic location of need.

In response to the National Defense Authorization Act of Fiscal Year 2008, the Wounded, Ill, and Injured Senior Oversight Committee is now jointly developing, to the extent feasible, a comprehensive policy on improvements to care, management, and transition of recovering Servicemembers. To assist in this effort, DOD provides the VA with data identifying all OEF/OIF veterans who have been discharged from military service. This information is then sent to the appropriate VA regional office listing all pending claims of these veterans. This list is updated on a weekly basis. Each VA regional office has an OEF/OIF manager, who is responsible for overseeing the OEF/OIF workload and outreach effort.

Additionally, VA social worker liaisons and benefits counselors are located at ten MTFs that receive the most severely wounded patients, including Walter Reed Army Medical Center. These social workers and counselors are critical to the seamless transition process, assisting active duty Servicemembers in their transition to VA medical facilities and the VA benefits system. This transition process helps establish a personal and trusted connection with patients and families.

In this transition process, both DOD and VA have social workers and benefits personnel that strive to fully coordinate care and information prior to a patient's transfer from an MTF to a VAMC. The FRC, with DOD and VA care coordinators, meet with the patients and their families to advise and talk them through the transition process. In transferring patients, the DOD and VA care coordinators are vital to the wounded warriors' treatment. In fact, video conference calling between the MTF and the receiving VA polytrauma center (PRC) are routinely accomplished to ensure the best transition for the patient. When feasible, the patient and family attend these video conferences to participate in discussions and to 'meet' the VA PRC team.

In conjunction with DOD, VA's Seamless Transition Program has coordinated the transfer of over 7,200 OEF/OIF severely injured or ill active duty Servicemembers. This includes ensuring the Servicemember or recently discharged veteran are enrolled in the VA medical facility for the medical services needed.

As these patients are being transferred from a DOD medical facility to the VA facility, VA benefits counselors are notified at the appropriate VA regional office of the patients' 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 a seriously injured Servicemember. All VA regional offices have designated OEF/OIF coordinators and case managers who maintain regular contact with injured veterans to make certain their needs are met.

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

Since December 2003, to ensure our veteran population from this war is kept updated on current information that may affect their health or benefits, the VA's Environmental Agents Service publish the "Operations Enduring Freedom/Iraqi Freedom Review" newsletter. This newsletter is mailed to over 800,000 Servicemembers and veterans to provide information of combat veterans, specifically the Global War on Terror heroes, who served in OEF/OIF, their families, and others interested in possible long-term health consequences of military service in Southwest Asia. The "Review" describes actions by VA and others to respond to these concerns.

ON ACHIEVING JOINTNESS IN SERVICES' INJURED SERVICEMEMBERS PROGRAMS

Question 4. Deputy Secretary England, at the Committee's first hearing on VA and DOD cooperation in January of last year, I raised the issue of how the seriously injured and their families are informed of their rehabilitation options and benefit eligibility. There are numerous programs on the DOD side that aim to assist servicemembers and their families, all operating independently of one another, including Marine for Life, Army Wounded Warrior, and Navy Safe Harbor. What is being done to make these programs work together and ensure their effectiveness?

Response. All information and coordination on rehabilitation options and compensation and benefits will be integrated into a single Servicemember, veteran, and

family-focused life plan. This plan will be a personal, customized plan for the severely and seriously wounded, ill, and injured Servicemember or veteran. The Recovery Care Coordinator (RCC) and/or the Federal Recovery Coordinator (FRC) will provide oversight of the plan to ensure the recovering Servicemember has knowledge of rehabilitation and benefits. Additional information will be available from the Wounded Warrior Resource Center provided through Military OneSource as well as through the National Resource Directory, a single, Web-based yellow book for resources and services.

In response to the President's Commission on Care for America's Returning Wounded Warriors (PCCWW) and the National Defense Authorization Act for Fiscal Year 2008 (FY 2008 NDAA), the DOD and VA established a case management working group comprised of representatives from the Services' wounded warrior programs: the Army's Wounded Warrior Program, the Navy's Safe Harbor Program, the Marine Corps' Wounded Warrior Regiment, and the Air Force's Wounded Warrior Program. Representatives from the Services' medical, family, and chaplain programs also participate in this weekly working group. The results of the DOD/VA working group meetings include:

- Implementing recommendations from the PCCWW on case/care management reform for the wounded, ill, and injured Servicemembers, veterans, and their families. Implementation included creating the Federal Recovery Coordination Program (FRCP) for severely injured servicemembers, veterans, and families and hiring of FRCs (placed at three military treatment facilities in January 2008).
- A Federal Individual Recovery Plan (FIRP), created to assist wounded, ill, and injured Servicemembers and their families in navigating through the continuum of care, is in use by the FRCs with plans to enhance its scope and information technology capabilities by mid-summer. The Services' wounded warrior programs can refer severely wounded, ill, and injured Servicemembers and veterans to the FRCP. The FRC coordinates with the Services in creating a FIRP for the Servicemember, veterans, and their families.
- Subsequently, the FY 2008 NDAA requires DOD and VA to develop and implement comprehensive policy on improvements to care, management, and transition of recovering Servicemembers and their families. This policy will allow the Services to provide world-class quality care and service delivery to wounded, ill, and injured recovering Servicemembers, veterans, and their families throughout the continuum of care from recovery and rehabilitation to reintegration.
- DOD/VA implementation of section 1611 of the FY 2008 NDAA, "Policy on Improvements to Care, Management, and Transition of Recovering Service Members," is underway. A recovery coordination program (RCP) for recovering Servicemembers (RSMs) and their families is being created. RCCs are being established within the Services and their wounded warrior programs to oversee and assist Servicemembers through their entire spectrum of care, management, transition, and rehabilitation. A uniform program for assignment of RCCs to RSMs, and uniform standards for a comprehensive recovery plan are being developed using best practices from the Services' wounded warrior programs.
- Collaboration with the Services' wounded warrior programs in establishing uniform standards for comprehensive policy for care, management, and transition of our recovering Servicemembers ensures that DOD and VA provide the best quality care throughout the phases of recovery, rehabilitation, and reintegration.

REQUEST FOR PLAN TO SUSTAIN THE SENIOR OVERSIGHT COMMITTEE IN THE NEXT ADMINISTRATION

Question 5. Deputy Secretary England and Deputy Secretary Mansfield, please share the plan for sustaining the focus and energy of the Senior Oversight Committee into the next Administration, so as to ensure the continuity of its mission.

Response. The Departments are committed to maintaining the momentum created by the Senior Oversight Committee (SOC). The SOC reflects the partnership of the two Departments' Deputy Secretaries, one of whom co-chairs the Joint Executive Committee (JEC), a statutory body. The JEC already assists the SOC in its work. It is the intent of the JEC to ensure that all of the initiatives that were developed and tracked by the SOC are fully and successfully implemented. The SOC will establish a clear direction for the two Departments, which will be incorporated into the next iteration of the JEC's Joint Strategic Plan.

DOD AND VA ELECTRONIC MEDICAL RECORDS INTEROPERABILITY

Question 6. Deputy Secretary England, the 2008 National Defense Authorization Act required the Departments to provide Congress with a schedule for the implementation of an interoperable electronic health records system. I am disappointed

that to date the Departments have failed to comply. However, I am more disturbed to learn that at Camp Arifjan, in Kuwait, an Army clinic cannot electronically transmit a prescription to a Navy pharmacy located only 20 yards away. How can we achieve record sharing between the two Departments when we cannot seem to accomplish it between two services that are only 20 yards apart from each other?

Response. The Department of Defense (DOD) and the Department of Veterans Affairs (VA) share health information today. The Departments continue to pursue enhancements to information management and technology initiatives to significantly improve the secure sharing of appropriate health information. These initiatives enhance healthcare delivery to beneficiaries and improve the continuity of care for those who have served our country.

DOD is developing a solution that will resolve the communications problem at Camp Arifjan and anticipates delivery to the Army and Navy, in October/November 2008. Army and Navy information assurance restrictions prohibit separate networks from communicating without approved network security capabilities. DOD previously identified this problem while working with the Army and Navy on a system upgrade project and initiated efforts to fund and develop a solution.

POST-DEPLOYMENT HEALTH ASSESSMENT TBI QUESTIONS

Question 7. Deputy Secretary England, I note that in your testimony you mentioned that DOD has added TBI questions to the Post-Deployment Health Assessment. Committee staff has learned first-hand from servicemembers with mild cases of TBI that they are reticent to answer these questions truthfully because of the potential impact on their futures. What can be done to overcome the stigma attached to these wounds?

Response. To further overcome the stigma, DOD has embraced the following principles to guide our plan of action:

- Sustain visible leadership to support psychological health in Servicemembers;
- Create, disseminate, and maintain excellent standards of care across the Department;
- When best practices or evidence-based recommendations to address stigma are not available, we will conduct pilots/demonstration projects to better inform quality standards; and,
- Provide constant attention to the needs of our war fighters and their families by building a strong culture of leadership and advocacy.

Chief to our approach is changing the culture to ensure that psychological issues are seen in the same way as physical issues. This will require education of senior and unit level line leaders at all stages of career progression. In addition, there will be a focus on pro-resiliency campaigns to improve the understanding of psychological issues in Servicemembers and their families.

The DOD cares deeply about the physical health, mental health, and wellbeing of each and every military member in the total military community. Preparedness for physiological and operational challenges is one way it aims to enhance resiliency and decrease the stigma associated with the invisible wounds incurred by deployment in Operation Iraqi Freedom and Operation Enduring Freedom. To build strong minds and strong bodies, we focus on the full continuum of removing or mitigating organizational risk factors, strengthening individual and family health and wellness, and improving traditional clinical diagnosis and treatment. Screening and surveillance plays a significant role in supporting our troops. Our objectives are to overcome stigma, to ensure early identification for individual conditions and concerns to afford the earliest possible intervention; identify trends as they emerge in the community so population-based changes may be made; and provide a solid structure for information management as well as continuous education and training.

EXPLANATION OF DOD'S INTERPRETATION OF SERVICE-CONNECTED DISABILITY COMPENSATION

Question 8. Deputy Secretary England, the 2008 National Defense Authorization Act bars VA from deducting any severance pay from a veteran's service-connected disability compensation if the qualifying disability was incurred in the line of duty in a combat zone or during performance of duty in combat-related operations, as designated by the Secretary of Defense. On March 13, 2008, the Department of Defense issued a Directive which limits this provision to those members whose disease or injury is the direct result of armed conflict. I am concerned that the Department is not recognizing disabilities incurred under all of the circumstances required by the statute. Please explain the reasoning for the Department's narrow interpretation of this legislation.

Response. Section 1646 of the FY 2008 NDAA enhances disability severance pay for members of the Armed Forces who have disabilities incurred in the line of duty in a combat zone. Specifically, the statute states, " . . . for a disability incurred in the line of duty in a combat zone (as designated by the Secretary of Defense for purposes of this subsection) or incurred during the performance of duty in combat-related operations as designated by the Secretary of Defense." The statutory definition and intent focus the "enhanced disability severance" on those Servicemembers whose unfitting condition is a result of participation and performance of duty in the war effort, and provide wounded warriors with enhanced disability severance compensation. The Department's policy simply implements the statute.

The Department's policy promulgated to support the statute requires a causal relationship between the armed conflict and the resulting unfitting disability. The policy further directs the Military Departments to identify Servicemembers who have either a disease or injury incurred in the line of duty as a result of armed conflict. The definition additionally defines armed conflict and gives the Military Departments maximum flexibility to define "combat-related" operations in the context of the Global War on Terror. The definition states: "Armed conflict includes a war, expedition, occupation of an area or territory, battle, skirmish, raid, invasion, rebellion, insurrection, guerrilla action, riot, or any other action in which Servicemembers are engaged with a hostile or belligerent Nation, faction, force, or terrorists. Armed conflict may also include such situations as incidents involving a member while interned as a prisoner of war or while detained against his or her will in custody of a hostile or belligerent force or while escaping or attempting to escape from such confinement, prisoner of war, or detained status."

ESTABLISHMENT AND FUNDING OF THE MILITARY EYE TRAUMA CENTER OF EXCELLENCE

Question 10. Deputy Secretary England, given the prevalence of TBI patients with visual complications and the fact that over 1,500 OEF/OIF veterans have suffered severe eye injuries, what is the timeline for establishing and funding the Military Eye Trauma Center of Excellence?

Response. The Assistant Secretary of Defense for Health Affairs is the Department of Defense's lead for the Military Eye Trauma Center of Excellence. Health Affairs has designated the Army the lead of a Tri-Service effort to establish the Military Eye Trauma Center of Excellence. On May 7, 2008, the Army presented a pre-decisional brief to Health Affairs, which included a proposed timeline, staffing, and funding requirements. Health Affairs continues to refine the recommendations and anticipates a finalized plan by June 2008.

DATA REQUEST FOR SERVICEMEMBER SUICIDE RATES SINCE OCTOBER 7, 2001

Question 11. Deputy Secretary England and Deputy Secretary Mansfield, please provide the most recent data available from your respective agencies on suicide among servicemembers and veterans since October 7, 2001.

Response. The following table depicts active duty suicides since October 7, 2001:

Department of Defense

U.S. Active Duty Military Suicides—October 7, 2001–April 29, 2008*

Calendar Year	Army	Air Force	Marine Corps	Navy	Total
2001 (Oct. 7–Dec. 31)	13	8	6	10	37
2002	73	32	21	37	163
2003	80	39	22	46	187
2004	66	55	34	46	201
2005	84	37	25	35	181
2006	100	48	25	37	210
2007	111	36	24	35	206
2008 (Jan. 1–Apr. 29)	28	14	5	5	52
Total	555	269	162	251	1,237

* Based on confirmed suicide reports—as of April 29, 2008 (data subject to change)
Sources: Defense Casualty Information Processing System, Defense Casualty Analysis System

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. JON TESTER TO GORDON ENGLAND, DEPUTY SECRETARY OF THE DEPARTMENT OF DEFENSE

AVAILABILITY OF MENTAL HEALTH SERVICES TO RESERVE COMPONENT FORCES

Question 1. Deputy Secretary England, during the testimony, Deputy Secretary Mansfield stated his opinion that he believes that a number of suicides by Reserve Component veterans may be attributable to an insufficient availability of mental health services in the public at-large. Do you concur in that observation? What actions is the Department of Defense taking to improve mental health services available to Reserve Component forces?

Response. The DOD does not currently have the mechanisms to collect sufficient data to clearly understand the epidemiology of non-active duty Reserve component suicides. The Services collect data on Reserve component Servicemembers who are on active duty, but accessing autopsies on Reserve component members who are in a civilian status is not enforceable by DOD. Without solid epidemiological support, we cannot support an opinion on whether Reserve component suicides are attributable to insufficient availability of mental health services in the public at large nor whether they differ from the age/gender-mated civilian population rates.

While there are fiscal and legal constraints on how appropriations can be expended (specifically, Reserve component members' duty status, length of time in that duty status, and combat theater history defines their access to treatment and other Defense Health Program funded initiatives), the DOD has a robust number and range of programs accessible to all members, regardless of duty status. These programs are designed to sustain the health and wellbeing of every military and family member in the total military community. Because no two individuals are exactly alike, multiple avenues of care are open to our military community to create a broad safety net that meets the preferences of the individual. DOD does not rely on one single method or program to care for our military members and families.

All Servicemembers must meet the particular standards of their Service upon entry. Once they are in the military, and particularly before, during, and after a deployment, a wide array of programs are available to them and their families. This continuum of care encompasses:

- Prevention and community support services;
- Early intervention and prevention to reduce the incidence and chronicity of potential health concerns;
- Service-specific deployment-related preventive and clinical care before, during, and after deployment;
- Sustained, high-quality, readily available clinical care along with specialized rehabilitative care for severe injuries or chronic illness, and transition of care for veterans to and from the Department of Veterans Affairs (VA) system of care; and,
- A strong foundation of epidemiological, clinical, and field research.

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

Early intervention and prevention programs include pre-deployment education and training, suicide prevention training, Military OneSource, the Mental Health Self Assessment Program, National Depression and Alcohol Day Screening, and health fairs (kits are available at www.mentalhealthscreening.org). DOD has formed a strong partnership with the VA and other Federal agencies and professional advocacy groups to provide outreach and prevention programs available to Reserve and National Guard soldiers.

Medical conditions that may limit or disqualify deployed Servicemembers are continually assessed, while screening, assessment, and educational programs take place across the entire deployment cycle. A spectrum of prevention, stress control, and mental health care are available in theater. Expanded clarification of deployment limitations for mental health conditions and psychotropic medications were put into place in November 2006, to ensure consistent standards across all branches of Service.

A post-deployment health assessment and education process is conducted upon returning from deployment to identify health concerns that might have arisen. An additional post-deployment health reassessment with additional education takes place 90 to 180 days after deployment, to identify any issues that might arise in that timeframe. Periodic health assessments are also conducted to identify any health issues a person might have prior to entering the pre-deployment cycle. In addition,

a mental health self-assessment is available 24 hours a day, 7 days a week online or by telephone as an additional tool for family members and Servicemembers.

Each Service has specific combat stress and deployment mental health support programs available before, during, and after the deployment cycle. These provide support tailored to the Service's mission and risk factors their personnel might face. In addition, cross-functional planning teams bring together subject matter experts from across the services, the Joint Staff, and DOD.

The Military Health System delivers timely, quality mental health and behavioral healthcare, including Behavioral Health in Primary Care, Mental Health Specialty Care, Clinical Practice Guidelines, and ready access to high quality, occupationally relevant primary care, along with model and demonstration programs designed to continuously learn and improve the system of care delivery. In addition, walk-in appointments are available in virtually all military mental health clinics around the world.

Military medical treatment facilities deliver rehabilitative care and specialty care. DOD partners with VA to provide state-of-the-art polytrauma centers, Traumatic Brain Injury (TBI) research and treatment, and transition assistance programs. Reserve and National Guard soldiers can make use of range of extended TRICARE health benefits.

The quality of care is maintained through active quality assurance and national quality management programs. A deployment health program evaluation process provides further validation of effective practices and programs.

Mental health deployment-related research is performed at local, Service, and interagency collaborative levels to maintain quality care in an environment of expanding knowledge. In addition, $300 million was added to the DOD congressionally-directed medical research program specifically for psychological health and TBI research.

RESERVE COMPONENT SERVICEMEMBER DATA TRANSFER FROM DOD TO VA

Question 2. Deputy Secretary England, during the hearing, Dr. Chu stated that all service data is transmitted from the Department of Defense to the Department of Veterans Affairs when a servicemember separates. Is there any difference between data transferred to the VA for separations of members of the Reserve Component forces and active duty separations? Does this information include information relating to the character of discharge, and all other elements required to determine eligibility for enrollment in the VA health care system?

Response. Data transmitted to the VA for a separating Servicemember is the same independent of the Servicemember's component. All information relating to the discharge is contained on the DD Form 214 with data that VA needs for the VA health care system. Specifically, in accordance with DOD Instruction 1336.1, "Certificate of Release or Discharge from Active Duty (DD Form 214/5 Series)," Copy No. 3, which contains block 24, characterization of service, will be sent to the VA, in accordance with section 18(a) of Public Law 100–527, "Department of Veterans Affairs Act," dated October 25, 1988. The required entries in block 18 (Remarks) of the DD Form 214 for mobilized reservists include:

- The details of the order to active duty in support of contingency operations;
- The period of service in the country to which deployed;
- Imminent danger area (if designated); and,
- Whether the member completed the period for which ordered to active duty for the purpose of post-service benefits and entitlements.

A copy is also provided to the hospital with the medical records if the individual is transferred to a VA hospital.

RESERVE COMPONENT CALL-UP AND DISCHARGE PROCESS

Question 3. Deputy Secretary England, are there incidences in which a reserve component servicemember is called to active duty, yet does not receive a DD–214 upon discharge? If so, please explain why such a circumstance might occur, and what measures the DOD takes to ensure that these individuals are ultimately provided a copy of their DD–214?

Response. The Department's policy regarding the issuance of DD Forms 214 is that Servicemembers will generally receive the "Certificate of Release or Discharge from Active Duty" document (DD Form 214) when they have completed tours of 90 days or more (including training tours). However, exceptions to the policy are allowed that provide for issuance of the document for tours less than 90 days for medical, mobilization, or other reasons, or anytime the Secretary concerned so prescribes. For example, the Department's Mobilization/Demobilization Personnel and Pay Policy for the current contingency states:

"To ensure identification of qualification for veterans' and other benefits, members of a Reserve Component who have served on active duty in response to the World Trade Center and Pentagon Attacks on or after September 11, 2001, will be issued a Certificate of Release or Discharge from Active Duty (DD Form 214) in accordance with Department of Defense Instruction 1336.1, 'Certificate of Release or Discharge from Active Duty (DD Form 214/5 Series).' The certificate will be provided on release from active duty, regardless of the number of days actually served."

The reason for the general "90-day" rule is that, in most cases, benefits attributable to or authorized by a DD Form 214 are not provided for shorter tours. If benefits would be affected, then the Department would prescribe the issuance of the form, regardless of the tour duration.

Section 1168 of title 10, United States Code, governs discharge or release from active duty. It states that ". . . a member of the Armed Forces may not be discharged or released from active duty until his discharge certificate or certificate of release from active duty (DD Form 214), as well as his final pay or a substantial part of that pay, are ready for delivery to him or his next of kin or legal representative." This does not prevent immediate transfer of a member to a facility of the Department of Veterans Affairs for necessary hospital care.

DOD policy, as well as each Service policy, states that ". . . upon release or discharge from active service, the original of DD Form 214 will be physically delivered to the separatee prior to departure from the separation activity." This occurs on the effective date of separation, or on the date that authorized travel time commences. Copies of DD Form 214 are distributed with 24 hours of the effective date of separation. When separation is effected under emergency conditions which preclude physical delivery, or when the recipient departs in advance of normal departure time (e.g., on leave in conjunction with retirement or at home awaiting separation for disability), the original DD Form 214 is mailed to the recipient on the effective date of separation. If the separation activity is unable to complete all items on the DD Form 214, the form is prepared as completely as possible and delivered to the separatee. The separatee is advised that a DD Form 215, Correction to Certificate of Release or Discharge from Active Duty, will be issued when the missing information becomes available. The Services have oversight mechanisms during the out-processing of their members to ensure that this important document is prepared and delivered.

Chairman AKAKA. Thank you very much, Secretary England. Thank you for your remarks.

I have a fast question for you. The issues that you have on your plate—this is to our two Deputy Secretaries—the issues that you have on your plate are of enormous importance and cover a huge range, as you are pointing out, Secretary England, from TBI, PTSD, case management, disability reforms, and on and on. To take on such serious and numerous matters—and this is my question to you—how often are you now both sitting down together to work through these ongoing issues?

Mr. ENGLAND. Mr. Chairman, I would say we sit down whenever we need to do that, so whenever the topic needs to be addressed by each of us, then we call the appropriate people together to do that or else Gordon and myself just talk about it ourselves. So we do have a very close relationship. I mean, it is easy for us to call each other, to get together.

When we first set up the SOC, because we had literally all these recommendations—and I believe it was 500-and-some recommendations to deal with—we were literally getting together a couple of times a week for a couple of hours, and, of course, we had a lot of lines of action working and they would report regularly to us. As time has gone on, then we were meeting like once a week, and now we meet whenever we need to. It is either every other week or every third week, so there is really no set time now.

We still have the lines of action in place. All the underlying work is still being done, but at the senior management level we meet whenever it is appropriate to get together and deal with the issues we have to deal with. So, that is what we do today. That is our modus operandi right now for the SOC.

Chairman AKAKA. Secretary Mansfield?

Mr. MANSFIELD. I would just reaffirm what Secretary England has said and make the point that we can talk to each other whenever we need to. We have done that as needed. We met weekly in an effort to make sure that we had all these issues identified, working groups put together, and then they are moving forward to carry out the desire of the Senior Oversight Council. So right now, we don't need to meet as much because we have been through the, as mentioned, 500 issues. We have got work groups in progress, and so again, we can meet as needed or talk about these issues as needed.

Chairman AKAKA. Let me, in the interest of time, just ask one question and I will pass it on. Switching gears to a very serious issue, suicide prevention is absolutely critical. There must be a sharply-focused effort to identify those at risk and to reach out to them in an effective way. It is also vital that no effort be spared to seek to reduce the stigma of seeking care.

The DOD Task Force on Mental Health and a recent RAND study estimated huge numbers of active duty soldiers and National Guard who have served in Iraq and Afghanistan and who report mental health issues. It seems obvious at this point that neither VA nor DOD is ready to deal with the increase in mental health needs of Iraq and Afghanistan service personnel. We also have inconsistent information on the number of suicides, and in some cases we know that information on suicides is being suppressed, and this was mentioned.

First, for Deputy Secretary England, what is the rate of suicide in the military? And Deputy Secretary Mansfield, what do your numbers show? And for each of you, are we facing a suicide epidemic?

Mr. ENGLAND. I am going to have Dr. Chu answer some because he has the latest data, because what I have in front of me is only through 2006. Through that period, it was all very consistent, I can tell you, for the service. I do know, though, that the Army has gone up in terms of the suicide rate, Senator, and the rest of the services have stayed relatively constant throughout. Army has gone up here in the last year, and David, do you have the latest numbers, please?

Dr. CHU. Yes, sir, that is correct. The Department's experience has been that for the Navy, Marine Corps, Air Force, while there are variations year to year in suicide rates, they are roughly stable over the years of this first decade of the 21st century. The Army has in the last 3 years seen some gradual increase. Over the last few months, and I don't want to overdo this, the Army has seen some modest diminution.

We are very much concerned with the issues that you raise. Do we have enough people? We are adding several hundred mental health providers in all the military services, and I am delighted to

say we are being assisted by the Public Health Service, which is giving us some of its officers to assist with this process.

Each service has a vigorous program of suicide prevention. They differ slightly in their content. The Air Force has done particularly well on this front over the years and is seen by many as a model in terms of ideas and procedures that we should emulate, although it, too, has seen some variability from year to year. So there is, in our judgment, no single magic answer.

I do think a central initiative does need to be, as you and others, the Secretary of Defense, have emphasized, destigmatizing our people asking for assistance, and we are trying to do this in a variety of ways inside the Department. This includes the Army teaching program in terms of mental health issues, et cetera. But it will be a long, hard effort to get this where we want it to be.

I think the good news is that on an age-adjusted basis, the Department's suicide rates as a whole tend to be a bit below the national norm. Even the Army's recent increase only puts it at approximately the national level on an age-adjusted basis. Now, there are variations within subgroups, et cetera, that one wants to pay attention to.

We take it very seriously. We are putting more people on this issue. It is a leadership matter. We are holding you accountable. We are very pleased with this new Center for Behavioral Health and Traumatic Brain Injury because we have charged its commander, Dr. Loree Sutton, with making psychological resilience prevention, not just after-the-fact care, prevention our first priority.

Chairman AKAKA. Secretary Mansfield?

Mr. MANSFIELD. Yes, sir. I want to make the point that the VA regards this issue, mental health generally, as one of the most important that we have to deal with. In fiscal year 2008, the VA will invest approximately $3 billion in general mental health services, a continuing increase in our budget. We invested $60 million in PTSD and TBI research in 2007. We employ more than 9,000 front-line mental health workers and 17,000 mental health workers in total, 3,200 of them hired in the last two-and-one-half years.

In fact, Modern Health Care recently had an article called "Brain Drain" talking about the fact that the VA's effort to go out and hire additional front-line health care personnel has put a strain on the mental health capacity of the entire country. I think that is something that we need to look at and talk about. Again, with the VA's responsibility in education in the health care arena, we need to look at doing something more in this area.

We recently put forward the nursing initiative and the nursing academy initiative, which is going into its second year this year. I have started discussions in the Department about us attempting to do something in this mental health care arena in an effort to increase the supply of mental health practitioners in the United States, which will allow us not to have to deal with this brain drain but also get excellent people on board.

Each of VA's 153 medical centers and most of our 718 community-based outpatient clinics do have world-class mental health specialists who use state-of-the-art therapies to treat mental health disorders. I would make the point that we recognize in the VA that the numbers show there have been an increase from 2001 to 2005.

For example, the number of suicides of veterans who have sought care in the VA have increased from 1,403 to 1,784. It is an issue that we are working on and making sure that we assess veterans for suicidal tendencies, that we have prevention counselors that make sure that we get the job done at the VA medical centers. And conduct the best research possible and make this a priority.

Chairman AKAKA. Let me ask for a very brief answer. Are we facing a suicide epidemic?

Mr. MANSFIELD. Sir, again, I am not the expert on numbers or on the medical or mental health care. But, looking at the numbers that CDC reports, it is informative for me to look at the fact that suicide happens to be the second- or third-largest cause of death in the population from 15 to 24 years old, many of whom are the ones that we recruit and serve in the Armed Forces. So, there is an issue in that area.

I don't know that I would call it an epidemic given the indicators that Senator Murray brought forward—that we have a large number of people coming back from a combat zone that need mental health care—and we would expect to see some kind of an increase. But, as indicated, that means we should be prepared to deal with it, and we are attempting to ramp up and make sure that we do attempt to identify each and every one of these folks and give them the care and treatment that they need so that we can deal with these issues that drive them to this.

Chairman AKAKA. Secretary England?

Mr. ENGLAND. Senator, I would say that what we need to do is make sure we don't have an epidemic. We don't in our active force today. We do have people coming back, obviously, with mental health issues and so we do need to deal with those issues promptly, as Senator Murray said. We need to do it completely, otherwise, you could have an issue in the future. So, we do not today. As Dr. Chu said, our rates are really quite stable in all of our services. They have gone up in the Army and we addressed that and we have a lot of special programs in place now to help with that issue. But you do need to deal with the issues of people returning. Otherwise, you could have a larger problem in the future, certainly.

Chairman AKAKA. Will you both provide some hard data on suicide for me for the record?

Mr. ENGLAND. Yes, sir. That is available and we do keep that updated; so, absolutely.

Mr. MANSFIELD. We will do that, sir.

Chairman AKAKA. Senator Burr?

Senator BURR. Thank you, Mr. Chairman.

I really had one question and two observations. I think I am going to make it three observations because I think the question to Gordon Mansfield may be unfair at this point. I was going to ask for an update of this 1-year pilot program, what you have seen so far. It may be premature to make an assessment, but if you feel you have one, I will let you provide that.

But to Secretary England, I would encourage you to look at the disability bill that I have introduced, specifically Title I of that bill, and see if it meets the threshold of that bright line distinction where DOD responsibilities stop and VA's start. See if it accomplishes legislatively what the commissions have identified, and

more importantly, what you as Deputy Secretary think we need in legislation to draw that distinction.

The last observation I would like to make to both of you jointly, to DOD and to VA. I think we are at a point in time where transparency is probably the most important thing that we can display—transparency of trends. It should not be a question for you, this Committee, or this country as to whether there is a trend that we should be concerned with that we should address. I don't think that there is any attempt to intentionally not share information. I think that now is a point in time where we need to focus on more openness from the standpoint of not only what we are doing, but the challenges we are up against.

To Secretary Mansfield, he and I—and I think most Committee Members—understand the mental health challenge that we have got within the VA. I personally believe that we have to make some substantial changes to encourage our veterans to take advantage of it. I think the two doctors on both ends would agree that part of our outcome problem is we don't get them early enough. We don't get them in the intense rehabilitation that all medical data today proves: that, if we get them very early and we intensify that rehabilitation, that the outcome is significantly different.

So, it has to be a collaborative effort to make sure that the incentive is there for—whether it is our active duty or whether it is our veterans—to enter into that rehabilitation. I think, clearly, the Department of Veterans Affairs has made great strides to make sure the infrastructure is, in fact, there. I am not sure that I hold Secretary Mansfield in the greatest of confidence in rural America, but I understand that we have challenges in recruitment.

But, you raise a very important point. We are bringing on board so many mental health professionals that this potentially will cause a strain on the private sector side, because the VA has recognized the possible surge and has begun to prepare for it.

So, I encourage both the VA and the Department of Defense, the more transparent these trends can be, we should be open and share that with the American people. War has consequences and the faster we can recognize the challenges you are up against, the faster the American people understand the challenges that our servicemembers are faced with, the faster we can make the changes collectively that you might need to accomplish that mission, the faster we get the active duty or the veterans in some type of treatment process. The difference is in the outcome, and I hope you will work with us aggressively to make sure that those outcomes are as optimal as we can make them.

I thank both of you, and Secretary Mansfield, if you would like to comment on the pilot, though we are just 6 months into it, I am happy to hear it.

Mr. MANSFIELD. Yes, sir, I do have some numbers for the Disability Evaluation System pilot. The total number currently in the process are 306, 94 from the Army, 56 from the Navy, 91 from the Air Force, and 65 Marines. Twenty-one of these have been rated. In other words, they have been identified, their information has been processed, they have been brought in for the exam, and then the information has been forwarded to a rating panel. Twenty-one have been rated: 19 rated 30 percent or higher; one was rated at

10 percent; and one, interestingly enough, a disability existed prior to service is the finding. I am still asking for additional information on that one. Two are pending permanent retirement. Three of those have been found fit for duty and we continue to move forward and the numbers continue to increase as we ramp up and move forward.

Senator BURR. And Gordon, as I understand it, in the pilot program, we are rating based upon DOD's current structure and VA's current structure, correct?

Mr. MANSFIELD. Well, there is one physical exam. DOD makes the decision—fit or unfit for service—based on whatever that unfitting condition may be and only that. Then it moves to the VA, and this has been traditionally the way the system works.

Senator BURR. But in the pilot program, you are still rating two different ways?

Mr. MANSFIELD. No.

Senator BURR. No? You are just doing one?

Mr. MANSFIELD. We are rating one way. The process is such that for DOD, the number of issues are limited to what makes the person fit or not fit for active duty.

Senator BURR. So you are doing one exam——

Mr. MANSFIELD. So that is——

Senator BURR [continuing]. De facto, you are creating two separate decisions, one within a very tight box for DOD, correct?

Mr. MANSFIELD. Right. And then it moves on. In other words, DOD looks at a part of it, potentially at a part of the person, and then VA looks at the total medical——

Senator BURR. And——

Mr. MANSFIELD. That is no change from what is existing now.

Senator BURR. I understand. My time is up, but I think that the ability to sort out, after five decades, the disability malaise that we have created is absolutely essential to our country's veterans and, I think, for active duty forces, as well, and understanding.

Mr. ENGLAND. Senator, again, I will go back to Dole-Shalala. I mean, Dole-Shalala does provide some recommendations here as to how to do that in terms of how to deal with disability. No more 30 percent to deal with, basically, based on a retirement program. So I think there is still merit to look at Dole-Shalala in terms of how we may help clarify some of this. I think it would be much easier for our veterans in terms of this clarification, particularly one physical and then just that determination.

So again, I will go back to Dole-Shalala. I do believe of all the discussions last year, that was very helpful as we went through all the Dole-Shalala implications in terms of easing this for the men and women who serve; and that is really, I think, at the end of the day, the criteria—how do we simplify this system. This whole system is very complex and bureaucratic, and to the extent we can simplify it, I mean, that would be helpful for us.

Senator BURR. It is my hope that we can help you do that.

Mr. ENGLAND. OK.

Senator BURR. I thank you.

Mr. ENGLAND. Thank you.

Chairman AKAKA. Thank you, Senator Burr.

Senator Murray?

Senator MURRAY. Thank you, Mr. Chairman.

Secretary Mansfield, I have to say, I am pretty frustrated today. I mean, this Committee has had to drag the VA every single day for five-and-a-half years since the War in Iraq started to give us accurate information so that we can provide the services that our men and women who served us overseas get. You know as well as I do that this Committee—in fact, the entire Senate—was extremely frustrated when several years ago Secretary Nicholson gave us inaccurate information about how long the backlogs were and how short the VA was in funding.

As a result of that, we did come back. Because we finally got accurate information, because we yelled and screamed, and because we held you to it, we were able to provide the additional mental health money that you just referred to, in order to help our men and women, particularly with mental health. But, it would not have happened unless we had finally gotten the accurate information that the VA was denying.

It is frustrating to us when we have to drag that information out of you. The Walter Reed scandal from a year ago didn't come because any agency came before us. It came because a press account showed it to us and America, and then we had to react.

So, I have to tell you, I am very angry and upset that we find out this week that several internal VA emails that were made public—not because you wanted them to, but because of a lawsuit that was occurring—showed that the VA downplayed vastly the number of suicides and suicide attempts by veterans in the last several years. Just a few months ago, in November, the VA was confronted with an analysis that said there were 6,250 veterans who had committed suicide in 2005, an average of 17 a day. VA officials said that number was inaccurate. It was much lower.

But these emails that were uncovered this week show that Dr. Katz, who is the VA's top mental health official, not only backed up those alleged numbers, but he acknowledged that the numbers were much higher than that. So, what they were telling us in November and December was that the number was lower, but inside the VA, everyone knew it was higher, and there are emails saying that and showing that to us.

And in addition to that, not only were the numbers of actual suicides inaccurate, but the emails show that VA officials also knew and didn't tell us that there were 1,000 veterans who received care in VA medical facilities attempting suicide each month. Now, to me, that is a pretty astounding fact. It is an alarm bell that all of us need to be paying attention to.

I acknowledge that we are now trying to get more mental health officials into the field. The Army, in particular, I have talked to them, worked with them, I know they are working on it. I know the challenges of the health care professions that you talk to.

But, the fact is that how do we trust what you are saying when every time we turn around, we find that what you are saying publicly is different than what you know privately. This Committee, this Congress, all of us can only act on knowledge that is accurate. It is not about a public relations war. It is about making sure we have got the right information.

So, Secretary Mansfield, can you tell me how we can trust what you are saying to us today?

Mr. MANSFIELD. Senator Murray, I share your concerns and I apologize for the fact that I have to apologize again. The last time I was before this Committee, I think I pointed out to you that if you have any specific information about a person or persons that are providing false information or not providing information that has been requested, to please contact me and that I would do everything I can to ensure that you get the information.

Senator MURRAY. Well——

Mr. MANSFIELD. I would tell you that I agree with Senator Burr. We should have complete transparency. Other than individuals' private medical information and perhaps some other information, there isn't a lot that the VA should be keeping secret that shouldn't be presented to this Committee——

Senator MURRAY. So how do you explain this?

Mr. MANSFIELD. I am not—well, I have seen one report on one set of emails. I haven't seen the total package and I am not sure that I would characterize it as attempting to keep information away from this Congress or away from——

Senator MURRAY. Secretary Mansfield, let me quote to you an email from Dr. Katz. First line, top line, "Shh!" S-h-h-exclamation point. "Our suicide prevention coordinators are identifying about 1,000 suicide attempts per month among the veterans we see in our medical facilities. Is this something we should carefully address ourselves in some sort of release before someone stumbles on it?"

The first sentence, "Shh," how do we have accurate information if inside the VA the whole culture is, "we had better not tell anybody?"

Mr. MANSFIELD. I know Dr. Katz and I know that he is dedicated to attempting to take care of veterans and that has been his professional career. I think it is unfortunate, and I agree with you the characterization of the way that email was written does not bode well and sends the wrong message. But I think what I would read in there is how do we get this information out? What is the platform, what is the method?

I have not talked to him directly about this specific email, but I do understand, as I said, your concerns and would commit to you that I would do everything, everything that I can to make sure that you do get the information that you request, the information that you need, the information that is required for us to continue an effective partnership that has allowed us to move forward, as you indicated, with additional funds, as I indicated, with more people doing the job that needs to be done.

Senator MURRAY. Well, I have two concerns. One is that we have to know what the facts are. We have to know that the VA is sharing with us what the facts are. We have to be confident that what you are telling us allows us to do our jobs.

And second, and importantly, we need to be dealing with this issue. The RAND report that I talked about a few minutes ago said that 20 percent of our military servicemembers who have returned from Iraq and Afghanistan, more than 300,000, have reported symptoms of PTSD or major depression. Of those 300,000, only half

have sought treatment, and of the half that sought treatment, only half of those are receiving, quote, "minimally adequate care."

So, Mr. Secretary, if we don't have accurate information or we can't trust the information from you, we can't deal with this. But second, and just as critically, we are not dealing with a critically important issue and that is the mental health care, the invisible wounds of war of the men and women who are coming home. The suicide rate is a red alarm bell to all of us that there is a problem out there. If that red alarm bell is being hidden inside the VA so that we are underestimating it, so we don't know about it, we in this country can't take care of a critical problem.

Mr. Secretary, I worked on a psychiatric ward during the Vietnam War. I know what happens to our soldiers and I know that if we, as a country, deny that something is happening to them, they are walking time bombs for decades. We have a responsibility when we send our men and women to war—when they come home to make sure we treat them and we treat them well, and we give them the respect and the dignity and the help and support that they need.

If we are not getting accurate numbers from you, if those numbers are being downplayed, if the attitude inside the VA is "Shh," then we are doing a disservice to the men and women we have asked to serve us. So, I am really upset about this and I hope that every conversation inside the VA is upset about this. And I hope what Senator Burr said about us having transparency has gotten through to the VA finally. We are not your enemy. We are your support team. And unless we get the accurate information, we can't be there to do our jobs. That is why I am upset.

Mr. MANSFIELD. Senator, let me again say that I apologize for the implications here. I apologize if there has been an effort. I do not believe there has been an effort to not provide the accurate information. I know that the VA has been concerned for a number of years about this mental health problem and started ramping up on this issue——

Senator MURRAY. Then why——

Mr. MANSFIELD [continuing]. Three years ago——

Senator MURRAY. Do you disagree with the RAND report?

Mr. MANSFIELD. Again, I have to make the point that we have applied the resources that this Congress gave us to deal in this issue——

Senator MURRAY. Not——

Mr. MANSFIELD [continuing]. To the extent that——

Senator MURRAY. Not requested by the administration, because they didn't have accurate numbers. We had to dig and get our own information to do that.

Mr. MANSFIELD. I did indicate the amount of money provided by the Congress——

Senator MURRAY. Thank you.

Mr. MANSFIELD [continuing]. And again, that is a partnership and I do thank you for the efforts that you and this Committee and other folks on the Hill have put forward to ensure that we are able to get the job done. And as mentioned here, we are applying significant resources in an effort to get that done.

And as indicated here, this article, which I will share with you, talks about the fact that as the VA woos behavioral health providers, the private sector is feeling the pinch. I mean, we are out there doing what we can. We have hired 3,100 more——

Senator MURRAY. Well, I hope you take the message back to the VA that we want accurate information, but I also want——

Mr. MANSFIELD. Madam, I do know, and as I indicated in our previous discussions, unfortunately, I have to admit, that you do want information. I have made that commitment and I will continue that commitment to be sure that you can get what you want.

Senator MURRAY. OK, and let me also ask you, the RAND estimates that PTSD and depression will cost as much as $6.2 billion in the 2 years following deployment, but believe that investing in high-quality treatment could save us close to $2 billion. Mr. Secretary, either one of you, do you agree or disagree with——

Mr. MANSFIELD. There is no doubt that the sooner we identify these issues, that the sooner we get qualified practitioners dealing with them, the better off these individuals are going to be. I have to tell you that one of the things that bothers me the most is the applications we have right now. For example, for Vietnam veterans who are coming in 35 or 40 years after the war and applying for PTSD benefits because——

Senator MURRAY. That is what we don't want to see 35 years from now.

Mr. MANSFIELD. Exactly. And that is the feeling in the VA, that we need to make sure that we do it different, that we do it better, that we catch these folks early, that we get them into treatment, that we make sure we take care of them. And that, I can tell you, is the Secretary's attitude, my attitude, Dr. Kussman's attitude. The VA medical corps out there, 196,000-plus people, want to make sure we take care of these individuals. That is our job. That is our requirement. That is our commitment.

Senator MURRAY. I am out of time, Mr. Chairman. Thank you.

Chairman AKAKA. Thank you, Senator Murray.

Senator Isakson?

Senator ISAKSON. Thank you, Mr. Chairman.

Secretary Mansfield, I want to commend you on the increased employment of mental health individuals and the attention to mental health. I want to echo what Senator Murray has said. We had a problem in Georgia a couple of years ago with a wing at Robins with a spike in suicide. One of the real issues in mental health to begin with is the reticence of those who are suffering to come forward themselves. The more transparent VA is on both what is available as well as issues we may have, including suicide rate, the more openness that comes there, I think the more openness that comes from those individuals who are hurting. So, I commend the remarks of Senator Murray. I think it is something for us to pay close attention to.

And I will transition now to the Fort Stewart situation. I think in your conclusion, you referred to one of the four fundamental changes you have made as identified new approaches to support outpatients and the Warrior Transition Units as a focus. What I saw was the Warrior Transition Unit at Fort Stewart, and what I saw at that unit was something I have never seen in the military

from the standpoint of the decor of the facility in which they live, the available resources, I mean, flat-screen TVs and mood music and coordinated colors, and the openness with which these—in this case, it was all women—were coming forward, talking about their problems. Is that the new fundamental change that you have made in terms of the Warrior Transition Units?

Mr. ENGLAND. Pardon me, Senator. We have the Warrior Transition Units. We actually have, I believe the Army now has 2,400 people as its warrior transition, working in that area. And I think it is important to clarify here a little bit because of the care coordinators that we were hiring.

We have now in the military and all the services, we have basically Warrior Transition Units. We have people who take care of people, and so we have squad leaders on each of these squads of military and now they take care of people. So, we have added a lot of people. I think the Army has just done an excellent job. The Marines have done an excellent job—and you are a Marine for life—so they literally follow people into communities and care for them.

When we put the Federal Care Coordinator in place, which you are right, we only have ten of them today, but they were never intended to be the person who was actually working with every individual person. They were to make sure that we literally had all the right processes in place, the right knowledge, and they would be the last resort for people. You could always go to that person if you could not get something resolved.

We are not trying to duplicate all the processes we have in place today, but we are making sure, at a senior oversight level, that we do have people working the unit and there is always someone that they have that they can go to. Specifically, we brought in VA people to do this because we wanted to be able to bridge between DOD and VA. So, we wanted people in the VA system who would be with us at DOD, go into VA, and literally be available lifetime in terms of a person they could always go to.

Our expectation is that not everybody goes to that person because we literally now have deployed teams to help every single person, as you commented on, Senator. So we keep expanding this because we know this is important. It is important not just for physical wounds but also mentally. I mean, this is very important, so we will continue to deploy. I think the Army has come a huge way in the last year in terms of putting these systems in place.

As I said before, though, there is no finish line and we will continue to work this, but it is trying to fit together these different levels of care for our people. That is where we are today. It seems to be working at this point. Still, we will continue to work it because it is important for our people, Senator.

Senator ISAKSON. Well, the implementation at Fort Stewart is pretty remarkable and it is a dramatic improvement. I commend you on what you have done there.

Secretary Mansfield, a last question before my time runs out, or a comment, on the seamless transition vis-a-vis assessment at DOD and transitioning to out of active duty and to VA. I had a field hearing at the Uptown Augusta Medical Center last August and at Eisenhower Medical Center at Fort Gordon, also in Augusta, and just a comment. I ran into a Sergeant Harris in the hospital—the

VA hospital. She had been deployed in Iraq and on her second day there was in an IED incident and has suffered from Traumatic Brain Injury. She went to DOD for assessment, and I presume this was the fit/unfit part of the assessment, and was determined to be severed from the service and was transitioned from Fort Gordon, the hospital at Eisenhower, to the VA hospital in what was, I think, the VA's first seamless transition coordination, if I remember what they did there.

Just to comment about how good that works when you don't have a hole to fall into and that seamless transition makes a difference. Sergeant Harris went into the VA facility. In 6 months, she was corrected. Her Traumatic Brain Injury was cured and she reenlisted and went back in the military. And I think that is a testimony, first, to the identification, at least in terms of Fort Gordon when she was on active duty, of the TBI, and then the immediate transition over to the VA hospital that got her the care that allowed that injury to be corrected.

So, the more you can coordinate closely between the warrior leaving the service and going to VA, the more seamless that hand-off is and the better that diagnosis is, not only do you have less problems, but you have quicker solutions, and in many cases, corrections of some of these mental health difficulties or Traumatic Brain Injury or PTSD. So, I just wanted to make that comment. That is one place where the seamless transition was implemented and it has really made a significant difference in the lives of soldiers.

I yield back, Mr. Chairman.

Chairman AKAKA. Thank you, Senator Isakson.

Senator Tester?

Senator TESTER. Yes, thank you, Mr. Chairman. I want to thank the panel for their testimony. I also want to thank Senator Murray for bringing up something that quite honestly troubles me greatly, too. It occurred to me as Senator Murray was asking her questions, this isn't really a complex issue or a difficult issue. It is really the easiest issue that you have to fix, and that is just give us good information, truthful information. It takes far less energy.

I hope it is not systematic, but I will tell you there are other agencies within this administration where I see this occurring, where they are doing stuff and they are not telling me the whole story when I ask them. They pick parts that sound good. In the end, it bites you every time.

So, I would just concur with Senator Murray and I would concur with Ranking Member Burr's thoughts on transparency. We can talk about transparency, but the proof in the pudding is really to make it happen, and it is not that difficult.

I will start out addressing Secretary Mansfield. There have been articles written—there is a recent one in the AP—about veteran suicides among Guard and Reserves being higher than active military. Do you have any idea on why this is?

Mr. MANSFIELD. No, sir. I am sorry. Again, I am not the expert in this area. What I would commit to you again is I will go back, talk to the experts, and provide you whatever information we do have.

Senator TESTER. That would——

Mr. MANSFIELD. I would imagine—again, this is my own supposition—if you come back, if you were with an active duty unit, you come back and return from the combat zone, you remain together. You have the reinforcement of that unit that has been through similar activities, whereas if you come back with National Guard and Reserve, you come home and then you deploy and you are kind of like all alone. You don't have the support group that you essentially had.

The other point I would make is that as far as the VA outreach goes, our Vet Centers are set up to deal with individuals, and again, we have added more outreach people there to go out into the field and try and find folks. But again it is a question, if you have got an active duty unit, they are easier to approach. You know where they are. Whereas with the National Guard, the only opportunity you have is when they have their monthly drill or when you can attempt to find them otherwise.

Senator TESTER. Right.

Mr. MANSFIELD. So, that would be a supposition, but I can't tell you that there is an expert background to that.

Senator TESTER. We see that similarly. When you ask your folks why this is, also ask them what they are going to do to address it, because I think it is an issue.

I want to talk about transferring medical records just for a brief second, and I have got a few questions here, so if you can be as concise as possible, it would be great. Senator Wicker talked about it a little bit, but where are we as far as medical records from DOD getting to VA in a timely manner, containing all the information they need?

Dr. CHU. Let me address that, if I may, Senator. We are near the goal line, which is to be able to send back and forth electrically medical information from the two institutions. It is built on several years of effort, as has been noted. I would be glad to furnish you separately a diagram that shows everything that can now be transferred, but by September 30 of this year, we anticipate being able to send back and forth any electronic record that either Department possesses as far as medical data are concerned.

Senator TESTER. How about discharge information?

Dr. CHU. The discharge summaries are now viewable between the two institutions on an electronic basis.

Senator TESTER. OK. Let me back up just a little bit, just so I get it. The date that this is going to be finalized, you said was——

Dr. CHU. Thirty September this year. That is our goal. We are on track to meet that goal. We have a few areas yet to make viewable in this sense, but otherwise, most of the material is there. Some of it has been there for some years.

I should also emphasize we have transferred several million medical records electronically for those who have left service to VA.

Senator TESTER. Is the VA or the DOD or both, you guys, looking at this being a starting point for automatic enrollment? Once you can transfer medical records and people know the information, you know what the problems are, it would seem to me that automatic enrollment would be a natural next step, or is that part of the conversation?

Dr. CHU. Well, if they are—I am not quite sure what you intend by automatic enrollment. If they are on active duty, they are automatically enrolled in our medical system.

Senator TESTER. Guardsmen?

Dr. CHU. Including Guardsmen.

Senator TESTER. OK.

Dr. CHU. Part of the process of bringing active duty is to put them in the medical system.

Senator TESTER. Right. OK. All right. That is fine. Benefit claims—at this point in time, Guard and Reserve soldiers are more likely to have their benefit claims denied than, as I said in my opening statement, than the active duty folks. The question I have—and any of you can answer it—is, what is being done about this?

I can tell you that in a State like Montana, if you happen to be a Guardsman or a Reservist, you live in a place like Miles City, Montana, it is a 345-mile drive because the only comp doctors are in Helena, one way. And so that may be a part of it, but just curiously, is this an issue within your organizations, within this committee, and is it being addressed?

Mr. MANSFIELD. Senator, let me make the point that it will be addressed starting when I return back to the office. I am not aware of what the difference is or the reasons for that——

Senator TESTER. OK.

Mr. MANSFIELD [continuing]. But I would commit to you again, I will give you whatever information we have. And if there is something we need to do to fix that, then we will move forward to fix it.

Senator TESTER. That would be great.

Mr. MANSFIELD. Pat Dunne is our Acting Under Secretary for Benefits and he will be working on that from now forward.

Senator TESTER. OK. There are some opportunities, I think, and if you guys are aware of it and you are working on it, that will be good. With that——

Mr. MANSFIELD. Let me just make the point, though, sir, in that area that having traveled around the country. I visited a number of regional offices, visited a number of Vet Centers and other areas. We do have a group of folks out there in our veterans benefits arena that are working actively on outreach to go find Guard and Reserve folks. We know when the units return. We have plans and people who work evenings and weekends and attend drills in an effort to try and get these folks in and get them taken care of. Now, the question of the deniability is another area, but we are working in specific areas on the Guard and Reserve issues.

Senator TESTER. That is outstanding and I commend those efforts. I think that the September 30 date for you folks being able to talk through medical records back and forth will help you track those folks much more easily upon their discharge, or upon their return back here when they are still remaining in the Guard and Reserves.

With that, thank you very much. I do want to thank you folks for being here. I think that we still have a lot of work to do. I think we are making our efforts to move forward. But I will revert back,

and Senator Murray, I wasn't aware of the points that you brought up with the emails. It is very distressing and it needs to be fixed.

Thank you, Mr. Chairman.

Mr. ENGLAND. Senator, if I could just offer one thing, we do have detailed schedules on what is currently electronically transferrable, what will occur on September 30, all the data, and then also the plan leading to next year in terms of interoperability. So, we do have all that data available in terms of every specific kind of record that you can transfer today and what you will be able to do by September of this year, and that is all available. We are pleased, if you are interested, someone can come talk to you about that. So, to whatever extent your interest is, we can follow up with you and would be pleased to do so.

Senator TESTER. Well, I appreciate that offer and if we can get some time, we will take you up on that, and we will make the time to do that. But, I think when you talk about seamless transition, this is a foundation element that has to happen or seamless transition will never happen without this. So, I appreciate your work.

Mr. MANSFIELD. Sir, we also, I would make the point, have set up the interagency office and appointed a director and deputy director to take this whole issue under their auspices. This is required by NDAA. Jointly, we have signed a memorandum and we have got these folks working on that.

Senator TESTER. Thank you.

Chairman AKAKA. Thank you, Senator Tester.

Senator Wicker?

Senator WICKER. Thank you, Mr. Chairman.

Just to immediately follow up, Secretary Mansfield, this group that you have set up, you are speaking about a group that is going to deal with the specific issue of a seamless, common, mutually accessible medical record? And who is going to be head of that group?

Mr. MANSFIELD. Senator Wicker, the National Defense Authorization Act, Section 1635, established a DOD-Department of VA Interagency Program Office with requirements for them to move forward with timelines, et cetera. So, we have now moved to the point where we have got that office being set up and individuals dedicated—Ms. Lois Kellett as the Program Office Director and Mr. Cliff Freeman is the Acting Deputy Director. That is the person from the VA.

Senator WICKER. OK.

Mr. MANSFIELD. So, both Departments are recognized in the establishment and leadership of this office.

Senator WICKER. All right. So, Dr. Chu, when you responded to Senator Tester that we were near the goal line, that is really just an interim goal line, would that be fair to say?

Dr. CHU. No, sir. It is a goal we have had for some time, as you observe, to make it possible to exchange on an electronic basis everything each agency has electronically regarding health. We are going to get there so we can see what VA has about a patient and VA can see what we have by 30 September. Most of that is already done.

The Integrated Program Office is about, OK, what does the future look like and what investments should——

Senator WICKER. I really——

Dr. CHU [continuing]. And beyond that——

Senator WICKER. That is certainly my goal, which is a much more complicated and long-term goal than you will be able to achieve by September 30, which is sending records back and forth. I don't view that as an ultimate solution. But let me ask the Secretary——

Dr. CHU. Nor do we, sir. I don't think we have a quarrel on that.

Senator WICKER. So we are——

Dr. CHU. But it is a very important achievement and would make it possible for the clinician to look at the data. That is really where I think we need to be immediately. And Senator Tester asked about something that has been of great importance to the clinicians and that is the discharge summaries, which are now viewable electronically by clinicians on both sides of this agency scene.

Senator WICKER. OK. Well, congratulations on that. But let me ask Secretary Mansfield and Secretary England this. I went ahead and discussed my frustration at length in my opening statement. The Departments were directed by the Congress to report back with a detailed master plan on actions being taken to achieve an interoperable Electronic Medical Record by a date certain, March 3 on the part of the Defense appropriations bill, and then Mil ConVA, April 1. Either one of those dates would have been fine.

But do you view it as acceptable that we have not received such a report and that when a Senator and—I take no personal affront in this—but when a Senator and his staff contacts the Department, we are told that a temporary report should be forthcoming, explaining why the Departments are late on these two requests, and we haven't even received that. So, I will let you comment on that. I don't want to fight and fuss, but it does seem to me that the Departments should be responding to the directives of the Congress.

Dr. CHU. We agree, sir.

Senator WICKER. I actually was directing my question——

Dr. CHU. I am sorry.

Senator WICKER [continuing]. To Secretary England and Secretary Mansfield.

Mr. ENGLAND. Sir, this is the responsibility of Dr. Chu, these reports.

Senator WICKER. I understand.

Mr. ENGLAND. He has it in his responsibility. And we do take it seriously and we are working and I believe you are a day or so away from getting that report, Senator. So it is very close. David, we are very close on that report?

Dr. CHU. Let me recheck. I thought we had sent one of the transmissions that you cite, but let me recheck that point. We certainly——

Senator WICKER. You have sent nothing.

Dr. CHU. Let me check——

Senator WICKER. Well, OK, Dr. Chu. How will this detailed report be submitted to the various committees and to the Congress?

Dr. CHU. In the normal manner, sir. We transmit it over the signature of the appropriate official. That could be myself. It probably would be in this circumstance. I think, as you cited, the important date here is April 30, where you want a fuller report. But let me

check on what happened to the interim reports. My recollection is we did comply with that, but I could be wrong on that point.

Senator WICKER. Secretary Mansfield, I will let you comment on that. Do I have——

Mr. MANSFIELD. Sir, I would state——

Senator WICKER [continuing]. A right to be concerned——

Mr. MANSFIELD. Yes, sir, I think you do——

Senator WICKER [continuing]. That the date was not met——

Mr. MANSFIELD. And I would make the point that I know Secretary England and Dr. Chu feel the same way I do, that we should make every attempt to comply with the requirements put on us. I do know that part of the concern here was the passage of this bill and the time it took between the first time the dates were identified and when we actually got it.

The other part is this is a vastly complicated area with two separate systems, as you know, one in DOD and one in the VA. The effort to make them compatible and work together as an interoperable system is not a simple task and it has a lot of high-level IT people working very hard and long hours in an attempt to figure out how we can do that. As Dr. Chu indicated, we have come forward and are transmitting more and more information that will allow the clinicians to use that to do a better job at treating the patients. And that remains our goal. But we have to also deal with some of the realities involved here.

Senator WICKER. Dr. Chu, will the report include timelines and an ultimate goal of actually reaching this interoperable seamless type of electronic record that can move back and forth between the systems?

Dr. CHU. That is certainly our intent, sir.

Senator WICKER. And this report that I am going to be allowed to see within a day or two is going to have those timelines?

Dr. CHU. I believe the original statutory requirement was for that report by April 30. Let me look at what happened to the interim products. I apologize if we did not deliver them on time. It was certainly our intent to deliver these things on time. So, I will check what happened to those transmissions. But the final report, yes, sir, does need to address the various statutory directions.

Mr. ENGLAND. Senator, if I could also add, though, let me also make the offer I just made to the Senator, because I think there is maybe not a full understanding of what we are doing today and what we are doing by September 30. You know, a lot of medical data is already being exchanged. There will be a lot more come September in terms of medical records.

Then the question is, for interoperable, what is it that the doctors may need in addition to what they can act on, and so that requires literally some consultation and discussion in terms of what sort of data would be available that doctors may want in addition to what is being made; and also how are those records then modified? Who has the right to do that and what is the process to do that, because obviously doctors are on each side, so what are those kind of procedures?

But it may be useful, frankly, for us to spend some time with you and discuss this in terms of where we are and maybe perhaps what your vision is as this goes forward; because I think for us, come

September 30, we will have a lot of these processes in place, a lot of this data being exchanged, and then the question will be, beyond that, what is it that the clinical people themselves need to do in addition to just receiving data between our organizations. So, to whatever extent you can perhaps further describe that, that would be helpful to us.

Senator WICKER. I am way beyond the time. I appreciate that offer and I would simply say that staff to staff, we have been actively engaged with both of your Departments in this respect and we have been having a continuous conversation on this area, which I view as very important to the servicemembers and the veterans, since we became engaged in it last year. I appreciate your invitation and I thank the Chair for indulging me on the time.

Chairman AKAKA. Thank you very much, Senator.

I do have additional questions and I will submit those for inclusion in the record. But, I must tell you with much gratitude, thank you so much for being here today and thank you so much for your testimony and your responses. I also want to commend you for trying to bring the seamless transition about. It will take time, but you have certainly set a foundation for that and I am really proud of you and what you are doing and look forward to improving the system with time.

So, I want to thank all of you for coming this morning. Thank you.

Mr. ENGLAND. Senator, thank you, and we do look forward to working with you and we thank you for having the hearing. It is very helpful to us, also, Senator. So thank you very much, sir.

Chairman AKAKA. Thank you, Secretary England.

Mr. MANSFIELD. Thank you, Mr. Chairman.

Chairman AKAKA. Thank you, Secretary Mansfield.

I want to thank the second panel for being here and tell you that I appreciate each of you being here today.

First, I welcome Adrian Atizado, Assistant National Legislative Director for the Disabled American Veterans. He is here today as a representative of members of the Independent Budget.

Next, I welcome Todd Bowers, Director of Government Affairs for Iraq and Afghanistan Veterans of America.

And finally, I welcome Commander Rene Campos, Deputy Director of Government Relations for the Military Officers Association of America.

I thank all of you for joining us today. Your full statements will appear in the record of the Committee. Mr. Atizado, let us begin with you.

STATEMENT OF ADRIAN M. ATIZADO, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS, ON BEHALF OF THE AUTHORS OF THE INDEPENDENT BUDGET

Mr. ATIZADO. Mr. Chairman, Members of the Committee, on behalf of the Independent Budget Veterans Service Organizations, composed of AMVETS, Veterans of Foreign War, Paralyzed Veterans of America, the Disabled American Veterans is pleased to present our views relating to the work of the joint Department of Defense and Veterans Affairs Oversight Committee, or the SOC.

The SOC was established subsequent to February 2007 Washington Post articles raising concerns regarding the care of injured servicemembers at Walter Reed Army Medical Center. While considering a number of external reviews and reports as mentioned by the previous panel, as well as pertinent provisions in the National Defense Authorization Act, the SOC was to identify immediate corrective actions, implement recommendations, and track them.

As the sunset of the SOC approaches, we do note progress made by VA and DOD in four common areas of concern to the Independent Budget Veterans Service Organizations. The four areas are: the Disability Evaluation System, mental health and Traumatic Brain Injury, care management, and data sharing. And while the IBVSOs applaud the hard work and goals achieved thus far, much concern and questions remain that needs to be dealt with. Most of it is outlined in my written testimony. I will only highlight a few.

Staffing problems with the Disability Evaluation System persist, where board liaison, legal staff, and board physicians are not being filled and the quality support is not where it should be. Meeting staffing goals of the Army's Warrior Transition Unit also have not been met despite recent significant increases. In particular, staffing targets for the Triad, the nurse case manager, the squad leader, and primary care providers who are the backbone of these units, remain unfulfilled.

The IBVSOs are encouraged that the current number of six VA-employed Federal Recovery Coordinators—two, by the way, are higher positions, they are directors and a supervisor, therefore not really involved with the actual work of Federal Recovery Coordinators—will be expanded to ten this May. We are encouraged by that. However, for as much emphasis as was placed on the need for a single recovery coordinator before this Committee, we are deeply concerned that the small size of this program and the number of injured servicemembers currently being served is so—67 clearly does not reflect the need that this Committee and our organizations believe is out there.

The SOC focus on mental health and Traumatic Brain Injury has been on building capacity and improving services. The DOD Center of Excellence for Psychological Health and Traumatic Brain Injury was established to address needed research, education, and training. As this Committee is aware, there is a great concern over the evidence base of servicemembers and veterans suffering from mild to moderate forms of TBI. The IBVSOs are concerned that this Center of Excellence may be remiss in focusing more on mental health rather than the equally deserving Traumatic Brain Injury and untreated visual-related problems. Any delay of these conditions can hinder successful rehabilitation of severely injured veterans and servicemembers.

On the line of action for data sharing, the IBVSOs applaud the SOC's approval of initiatives to ensure health administrative data are made available and are viewable by both agencies, although much work remains for the two-way electronic exchange to share not just viewable, Mr. Chairman, but computable health information between both agencies. VA health care providers are not just

clinicians, they are clinician researchers and viewable information is not conducive to that.

Clearly, the accomplishments outlined in these four areas are a good first step. However, the future of the SOC's work remains uncertain and we urge this Committee to do what it can to regain the confidence of our fighting men and women and assure the citizens of this Nation that our government is indeed carrying out its moral obligation.

The IBVSOs recommend a permanent office be established and staffed with full-time employees from both agencies well before the SOC closes its doors. Furthermore, unlike the current structure of the SOC, we believe VA should take the lead for several reasons, chief of which is that injured servicemembers and their family will come to VA, many for a lifetime of care.

Again, on behalf of the IBVSOs, Mr. Chairman, we thank this Committee for its unwavering diligence in conducting oversight on this important matter and in doing so on behalf of our Nation's disabled veterans and servicemembers. I would be happy to answer any questions you may have.

[The prepared statement of Mr. Atizado follows:]

PREPARED STATEMENT OF ADRIAN M. ATIZADO, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR OF THE DISABLED AMERICAN VETERANS

Mr. Chairman and Members of the Committee: On behalf of the four co-authors of *The Independent Budget*, AMVETS, the Veterans of Foreign Wars, and the Paralyzed Veterans of American, the Disabled American Veterans (DAV) is pleased to present our views relating to the work of the joint Department of Defense (DOD) and Department of Veterans Affairs (VA) Senior Oversight Committee.

In February 2007, the Washington Post published a series of articles regarding deficiencies in the medical care services and housing at Walter Reed Army Medical Center (WRAMC), which raised concerns regarding the care of injured Operations Enduring and Iraqi Freedom (OEF/OIF) servicemembers. In March, the Army began development of the Medical Action Plan (AMAP) to address the continuum of care, the Army's disability evaluation system and coordination with the VA.

By May 2007, the DOD established the Wounded, Ill, and Injured Senior Oversight Committee (SOC). Chartered and co-chaired by the Deputy Secretaries of VA and DOD, the SOC is to identify immediate corrective actions, and to review, implement and track recommendations from a number of external reviews. Reports to be considered include the DOD Inspector General Review of DOD/VA Interagency Care Transition,[1] DOD Task Force on Mental Health,[2] the Independent Review Group,[3] the Veterans Disability Benefits Commission,[4] the President's Interagency Task Force on Returning Global War on Terror Heroes,[5] and Commission on Care for America's Returning Wounded Warriors.[6] In addition, the SOC is to implement and track the Wounded Warrior and Veterans titles of the National Defense Authorization Act, Public Law 110–181.

Supporting the SOC decisionmaking process is an Overarching Integrated Product Team (OIPT), co-chaired by the Principal Deputy Under Secretary of Defense for Personnel and Readiness and the VA Under Secretary for Benefits and composed of senior officials from both agencies. The OIPT reports to the SOC and coordinates,

---

[1] Not yet reported.

[2] *An achievable vision: Report of the Department of Defense Task Force on Mental Health.* Department of Defense Task Force on Mental Health, June 2007.

[3] *Rebuilding the Trust: Report on Rehabilitative Care and Administrative Processes at Walter Reed Army Medical Center and National Naval Medical Center,* Independent Review Group, April 2007.

[4] *Honoring the Call to Duty: Veterans' Disability Benefits in the 21st Century,* Veterans' Disability Benefits Commission, October 3, 2007.

[5] *Task Force Report to the President: Returning Global War on Terror Heroes, Interagency Task Force on Returning Global War on Terror Heroes,* April 19, 2007.

[6] *Serve, Support, Simplify: Report of the President's Commission on Care for America's Returning Wounded Warriors,* President's Commission on Care for America's Returning Wounded Warriors, July 30, 2007.

integrates, and synchronizes work and makes recommendations regarding resource decisions. Working under a very short timeline, eight discrete Lines of Action (LOAs)[7] were established. An owner[8] for each LOA was assigned and tasked to outline planning and track milestones, identify needed resources, and develop legislative language to improvement a specific element of the overall treatment of injured servicemembers. A different LOA owner briefs the OIPT and SOC at each bi-weekly meeting.

As the sunset for the SOC approaches, we note progress made by VA and DOD on the four common areas of concern for The Independent Budget veterans service organizations (IBVSOs) and identified by the aforementioned reports and studies: Disability Evaluation System,[9] Mental Health (Post Traumatic Stress Disorder) and Traumatic Brain Injury,[10] Care Management[11] and Data Sharing.[12]

DISABILITY EVALUATION SYSTEM

DOD and VA launched a disability evaluation pilot program in November 2007 at WRAMC, the National Naval Medical Center (NNMC), and Malcolm Grow Medical Center at Andrews Air Force Base, Maryland. Using performance measures, site assessment, case management and a phased expansion, the pilot project is to specifically improve timeliness, effectiveness, transparency, and resource utilization by integrating two separate disability evaluation processes, eliminating duplication, and improving case management practices.

The pilot project uses a single physical examination conducted on VA standards by a VA physician in a defense facility. VA assigns percentage ratings on all identified disabilities which DOD will accept[13] in determining disability benefits. DOD will make a decision on whether the servicemember will or will not remain on active duty. If the service component makes the decision that the servicemember cannot continue to serve, the package goes to VA, who in turn notify the service component of the rating for each condition listed.

The defense disability system handles about 20,000 cases each year of various degrees of disability, and of those found unfit nearly 90 percent leave with a severance payment. All others are judged 30 percent or more disabled and are medically retired.[14] According to the Army, the total number of servicemembers completing the medical evaluation board process increased about 19 percent from the end of 2006 to the end of 2007. With an average caseload target established by the Army of 30 servicemembers per board liaison, the IBVSOs believe this has not been met due to shortages of board liaisons. Like the board liaison staffing shortage, legal staff[15] as well as board physicians[16] assigned to help injured servicemembers navigate the disability process are not sufficiently staffed. We also remain concerned with the number of injured servicemembers served by this pilot project compared to the number of actual injured servicemembers who would otherwise quality for participation.

According to Government Accountability Office (GAO), DOD and VA have not finalized their criteria for expanding the pilot beyond the original sites. Current evaluation plans lack key elements, such as an approach for measuring the performance of the pilot—in terms of timeliness and accuracy of decisions—against the current process, which would help planners manage for a successful expansion.[17] The IBVSOs can appreciate the need for satisfaction surveys being conducted on veterans and servicemembers who have gone through the system; however, ensuring

---

[7] Disability System, TBI/PTSD, Case Management, DOD/VA Sharing, Facilities, Clean Sheet Review, Legislation and Public Affairs, Personnel Pay and Financial Support.

[8] Disability Advisory Council, TBI Working Group, Case Management Working Group, BEC/HEC Working Group, Installation Capability Committee, OIPT Co-chairs, Continuous Process Improvement Group.

[9] William Carr, Deputy Under Secretary of Defense for Military Personnel Policy; Thomas Pamperin, VA Deputy Director for Compensation and Pension; William Feeley, VA Deputy Under Secretary for Health for Operations and Management

[10] Ellen Embrey, Deputy Assistant Secretary of Defense for Force Health Protection and Readiness; Barbara Sigford, National Program Director of Physical Medicine and Rehabilitation

[11] Lynda C. Davis, Deputy Assistant Secretary of the Navy for Military Personnel Policy; Kristin Day, Chief Consultant, Care Management and Social Work Service, Office of Patient Care Services

[12] Jones, Steve, Principal Deputy Assistant Secretary of Defense for Health Affairs, Department of Defense; Paul Tibbits, VA Deputy Chief Information Officer for Enterprise Development

[13] *Defense, VA Team Proposes Disability Process Changes,* Jim Garamone, American Forces Press Service, October 23, 2007. http://www.defenselink.mil/news/newsarticle.aspx?id=47888.

[14] ib.

[15] Attorneys and paralegals assigned by the Office of the Judge Advocate to assist during the Physical Evaluation Board Process.

[16] The Army's established goal is 1 board physician per 300 injured servicemembers.

[17] GAO–07–1256T.

due process, and reducing variability and timeliness to ensure decisions are consistent will greatly lend to fairness and confidence in the process.

CASE/CARE MANAGEMENT

Warrior Transition Units: The Army's new organizational structure for providing an integrated continuum of care for its returning servicemembers is called Warrior Transition Units. These units were designed as the center piece of the Army's Medical Action Plan. The warrior-transition program assigns each injured servicemember, or "Warriors in Transition,"[18] a "Triad" which consists of a nurse case manager to coordinate needed services and appointments, a squad leader to ensure compliance to treatment plan and a primary care provider who oversees the treatment plan. A typical Warrior Transition Unit company will have a commander, executive officer, first sergeant, six platoon sergeants and 18 squad leaders. The workload for a squad leader will be 12 patients as opposed to 50 in Medical Hold companies.[19]

At the time of the announcement in June 2007, the Army Medical Command expected to staff Warrior Transition Units with 2,419 cadre by January 2008 (the target date for new units to become fully operationally). The staffing was projected to ultimately include 743 active-component soldiers, 381 National Guard soldiers, 381 Army Reserve soldiers, and 914 Army civilians, to support an estimated population of 10,000 "Warriors in Transition." As of this writing, the Army's organizational chart maps out the Warrior Transition Unit structure serving approximately 8,000 soldiers. More non-commissioned officers are still needed to staff units and mental health professionals are needed.[20]

According to GAO, as of September 2007, 17 of the 32 units had less than 50 percent of staff in place in one or more of these critical positions.[21] In a subsequent report GAO notes, "the Army has made considerable progress in staffing this structure, increasing the number of staff assigned to key positions by almost 75 percent. However, shortfalls continue to exist in some areas—11 of the 32 U.S. Warrior Transition Units had less than 90 percent of needed staff for one or more key positions."[22] Moreover, the data generated on meeting the needs of servicemembers and families remain suspect.[23] Greater oversight is needed to ensure benchmarks are clearly indentified and defined, and that progress is measured and reported.

Federal Recovery Coordination Program (FRCP): A Federal Recovery Coordinator Director, a Federal Recovery Coordinator Supervisor, and eight Federal Recovery Coordinators were hired, trained, and deployed in January 2008. Employed by VA, the Federal Recovery Coordinator (FRC) is intended to complement VA and DOD's existing case management approach. VA's care management program includes the OEF/OIF Program Manager, Transition Patient Advocates and OEF/OIF Nurse and Social Worker Case Managers, and other case and care managers (Women Veterans, Spinal Cord Injured, Visual Impairment Service Team, and Polytrauma Support Clinic Teams). DOD's military wounded warrior programs include the Wounded Warrior Transition Units of the Army Medical Action Plan, the Army Wounded Warrior (AW2) program, the Navy's Safe Harbor Program, the Marine Corps' Marine for Life Program and the Air Force Palace HART Program.

According to our most recent data, for each of the 67 injured servicemembers who are currently enrolled in the FRCP, there are 6 FRCs. The FRC is intended to be the ultimate resource to oversee the development and implementation of services. The FRC is responsible for each enrolled servicemember the Federal Individual Recovery Plan (FIRP), which provides an individualized, integrated, longitudinal, clinical/non-clinical service plan across the continuum of care for injured servicemembers, veterans and their families. Also, the FRC is to monitor and regularly modify the FIRP in conjunction with all Multi-Disciplinary Teams to meet the requirements and needed services to ensure successful transition of servicemember and family.

---

[18] A Warrior in Transition is a medical hold-over, active-duty medical extension, medical hold, and any other active-duty Soldier who requires an MEB or has complex medical needs requiring six months or more of treatment or rehabilitation.

[19] *Warrior Transition Units at Center of Army Medical Action Plan,* Gary Sheftick and Franz Holzer, Oct 08, 2007.

[20] *General: Army still facing Warrior Transition Unit challenges,* John Vandiver, Stars and Stripes European edition, Monday, February 25, 2008.

[21] GAO–07–1256T

[22] GAO–08–514T

[23] Warrior Transition Program Satisfaction Survey was not intended to be a methodologically rigorous evaluation.

In addition to the recovery plan, the FRC will have at their disposal a National Resource Directory,[24] Family Handbook, MyEBenefits, and access to Veterans Tracking Application to assist in their work to help injured servicemembers and their families. The IBVSOs are encouraged that the current number of six[25] FRCs will be expanded to 10[26] this May; however, many questions remain such as the effectiveness of this program in meeting the need of severely injured servicemembers. For as much emphasis as was placed on the need for a single recovery coordinator, we are deeply concerned with small size and the number of injured servicemembers currently being served by this program. Another cause for concern is the enrollment into the FRCP[27] and number of servicemembers who may be eligible for the program. The potential workload and expansion of this program should be accompanied by appropriate resources being allocated.

POST TRAUMATIC STRESS DISORDER AND TRAUMATIC BRAIN INJURY

In November 2007, the DOD Center of Excellence (DCoE) for Psychological Health and Traumatic Brain Injury (TBI) was established[28] to improve the care provided to servicemembers. The SOC has developed a policy for DOD and VA to establish a National Center of Excellence for Psychological Health and TBI at Bethesda that will include VA and the Department of Health and Human Services liaisons, as well as an external advisory panel organized under the Defense Health Board, to provide the best advisors across the country to the military health system. In addition, it will coordinate the efforts across agencies to facilitate coordination and collaboration for Post Traumatic Stress Disorder (PTSD) and TBI related services among the military compents and VA, promoting and informing best practice development, research, education and training.

We applaud DOD's program to collect baseline neurocognitive information before deployment to combat theaters. The Army already has incorporated neurocognitive assessments as a regular part of its Soldier Readiness Processing in select locations. Additionally, select Air Force units are assessed in Kuwait before going into Iraq. Such information could address the National Defense Authorization Act of 2008 provision regarding creation of a TBI registry. However, we are concerned about the lack of evidence base regarding servicemembers and veterans suffering from mild to moderate forms of TBI. The emerging literature strongly suggests that even mildly injured TBI patients may have long-term mental and physical health consequences. According to DOD and VA mental health experts, mild TBI can produce behavioral manifestations that mimic PTSD or other conditions.

Additionally, TBI and PTSD can be coexisting conditions in one individual. Much is still unknown about the long-term impact of these injuries and the best treatment models to address mild-to-moderate TBI. We believe more research should be conducted into the long-term consequences of brain injury and development of best practices in its treatment; however, we suggest that any studies undertaken include older veterans of past military conflicts who may have suffered similar injuries that thus far have gone undetected, undiagnosed or misdiagnosed, and untreated. Their medical and social histories could be of enormous value to VA researchers interested in the likely long-term progression of these new injuries. Likewise, such knowledge of historic experience could help both the DOD and VA better understand the policies needed to be put into place to improve screening, diagnosis, and treatment of mild TBI in combat veterans of the future.

Another issue of concern to the IBVSOs is unidentified TBI veteran patients with undiagnosed and untreated visual-related conditions. Servicemembers and veterans suffering from undiagnosed visual impairments pose a risk for incomplete rehabilitation which can significantly affect one's ability to function independently for life. It is clear the SOC is not tracking or taking action on this issue. Moreover, it is unclear whether DOD providers are assessing and treating subtle visual-related conditions or neuro-optometric dysfunctions. The IBVSOs are concerned VA and

---

[24] In partnership with VA, DOD, and Department of Labor and based on the DisabilityInfor.gov web portal, the National Resource Directory is an inter-service/agency/governmental, public/private and non-profit resource for use by the FRC, the multiple MDTs, and the severely injured servicemembers, veterans and their families. The contents are to be managed by stakeholder/partner with the prototype for FRCs available in April, for MDTs in May, and a final public rollout in August.

[25] 8 FRCs were originally hired in January 2008, 3 FRCs at Walter Reed Army Medical Center; 2 FRCs at Brooke Army Medical Center; 3 FRCs at National Naval Medical Center.

[26] + 1 FRC at Brooke Army Medical Center; 1 FRC at Naval Medical Center San Diego

[27] Servicemembers are to be reviewed by a DOD inter-disciplinary team within three working days after admission into the military treatment facility.

[28] See also Public Law 110–181, the National Defense Authorization Act for Fiscal Year 2008, Subtitle B.

WRAMC have limited knowledge and resources to meet the demand and that there are a number of untreated visual-problems that delay and hinder rehabilitation.

It is evident families provide the "front line" of the support network for returning veterans. Spouses are often the first to identify readjustment issues and facilitate veterans' evaluation and treatment when concerns are identified. The IBVSOs strongly believe that VA and the DOD must embrace new models of support for this generation of combat veterans. Family counseling support services that are needed by recently returning OEF/OIF veterans are only available on a limited basis in VA despite increasing need for such services. The Mental Health Advisory Team V report shows that while stigma among servicemembers seeking health is reduced, this problem continues to persist. Meanwhile the Mental Health Task Force highlighted the need for marital and family counseling; however, it appears the SOC has not adopted any action to enhance TRICARE benefits to include marital and family counseling. Although geographic coverage is a major limitation, we note that the Vet Center program is one of the few VA programs to address the veteran's full range of needs within family and community where family counseling is provided when needed for the readjustment of the veteran.

DATA SHARING BETWEEN DEFENSE AND VETERANS AFFAIRS

The SOC's Line of Action to expedite VA/DOD data sharing stands in the shadow of both the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans report in 2003[29] regarding the need for an interoperable electronic medical record and the two agencies working for almost 10 years to facilitate the exchange of medical information. The IBVSOs believe the need for sharing patient information is critical particularly for the FRC and local VAMC OEF/OIF Care Management Team that require timely and reliable patient information to ensure continuity of care across the many organizational seams between VA and DOD. We understand that the SOC has approved initiatives to ensure health and administrative data, such as DOD provider/clinical notes, problem lists, and theater health data (recently added), automated Federal Individual Recovery Plan, and the My eBenefits Web Portal based on the VA's My HealtheVet Web site, are made available and are viewable by both agencies.

Success in sharing outpatient data, most recently with outpatient pharmacy (government and retail) data has lead to progress in sharing inpatient data such as inpatient laboratory and radiology reports, inpatient discharge summary data from Landstuhl Regional Medical Center, consults, admission, disposition and transfer data, allergy information, and ambulatory coding data. Moreover, the one-way transfer of information has lead to the bi-directional sharing of information including outpatient pharmacy and allergy data, laboratory results and radiology reports. Progress notes, problem lists, and history data will round off the list and by June 2008, it is expected that VA will have access to data from all DOD locations.

The IBVSO's believe VA and DOD should capitalize on their ability to share computable bi-directional allergy and pharmacy information between next-generation systems and data repositories. Computable information permits the VA and DOD systems to conduct automatic drug-drug and drug-allergy interaction checking.[30] The IBVSOs believe the DOD and VA must continue to develop electronic medical records that are computable, interoperable, and bidirectional, allowing for a two-way electronic exchange of health information. Furthermore, these electronic medical records should also include an easily transferable electronic DD–214 forwarded from the DOD to VA. This would allow the VA to expedite the claims process and give the servicemember faster access to health care and benefits.

CONCLUSION

The IBVSOs applaud efforts and accomplishments made by both agencies over the past 14 months to ensure a seamless transition for injured servicemembers and veterans to receive benefits and services they need, whether provided by VA or DOD. It is clear however, that these accomplishments are a good first step and that many challenges remain as outlined above. The IBVSOs believe the momentum generated should be sustained as the SOC sunsets. Also, the transition to whichever entity will be responsible for tracking current LOAs should be handled with the same vigor and transparency as the SOC. The IBVSOs recommend a permanent office be established and staffed with full time employees from both agencies. Furthermore, unlike the current structure in the SOC we believe VA should take the lead for several

[29] Final Report 2003, Page 27, Recommendation 3.1.

[30] Capability at seven locations and Enterprise-wide implementation is currently being scheduled.

reasons, chief of which is that injured servicemembers and their families will eventually come to VA, many for a lifetime of care.

Again, we thank this Committee for its unwavering diligence in conducting oversight on this important matter on behalf of our Nation's most recent generation of disabled veterans and servicemembers.

Chairman AKAKA. Thank you very much.

Mr. Bowers?

STATEMENT OF TODD BOWERS, DIRECTOR OF GOVERNMENT AFFAIRS, IRAQ AND AFGHANISTAN VETERANS OF AMERICA

Mr. BOWERS. Mr. Chairman and Members of the Committee, on behalf of the Iraq and Afghanistan Veterans of America and our tens of thousands of members nationwide, I thank you for the opportunity to testify today regarding this important subject. I would also like to point out that my testimony today is as Director of Government Affairs for the Iraq and Afghanistan Veterans of America and does not reflect the views and opinions of the United States Marine Corps Reserves, in which I currently serve as a Sergeant.

Over the past few years, multiple commissions have made recommendations regarding the most effective way to establish coordination between the Department of Defense and VA. These recommendations provide guidance on some of the most pressing issues affecting our Nation's newest veterans. The President's Commission on Care for America's Returning Wounded Warriors and the Veterans Disability Benefits Commission have made hundreds of recommendations and these suggestions are joined by hundreds more from internal DOD and VA task forces.

As we have seen, the complexities of instituting and coordinating these recommendations can be overwhelming. IAVA is very concerned that many of these recommendations will go where so many other committee recommendations have ended up: On a shelf, merely collecting dust.

The Wounded, Ill, and Injured Senior Oversight Committee, or SOC, has the responsibility of overseeing the implementation of many of these recommendations, and while great strides have been made in this past year, there is still much to be accomplished. As the SOC prepares to disband next year, it is our goal along with our other Veterans Service Organizations to ensure that these effective measures continue to be implemented in a timely, and most importantly, an efficient manner.

To effectively implement change, oversight is paramount. Like basic military structure, a leadership entity must be present for actions to be followed and missions to be accomplished. This is why the SOC has been so successful thus far. IAVA does not believe that it is time to abandon one leadership structure for another, and joins our colleagues here today in expressing our concerns regarding the complexities of the Senior Oversight Committee (SOC) and the VA/DOD Joint Executive Council (JEC).

Because members of the JEC have other responsibilities in addition to their oversight function, we are concerned that implementation of the recommendations will be slowed. Oversight should not be a part-time job. It is our recommendation that the JEC be appropriately staffed with full-time leadership.

Moreover, we believe that the Veterans Administration should act as the lead organization for the JEC. Many veterans and their respective Veterans Service Organizations have borne witness to the difficulties of working with the Department of Defense at times. While the DOD coordinates with our organizations via press releases, we believe that the open channels of communication established by the VA has established with our institutions an effective conduit for us to communicate whether these improvements are being felt by the men and women on the receiving end.

In addition to our concerns with the current structure of the JEC, IAVA is concerned that upcoming elections and the transition of top-level staff in the new administration will result in unnecessary delays. It is vital that the work of the SOC does not get lost in the fray. An effective plan must be established to ensure that the work of the SOC is not hindered with changes in administration and leadership.

Finally, I would like to touch on what the priorities for both the SOC and JEC should be. The SOC has established eight lines of action, or LOAs, to have a tremendous impact on the ability of new veterans to navigate the often complex transition between DOD and VA. LOA2 specifically addresses the two signature wounds of the Iraq and Afghanistan conflicts, Post Traumatic Stress Disorder and Traumatic Brain Injury. These often hidden wounds of war are both extremely complex, both in recognition and treatment.

We have heard the numbers from RAND that were released last week, so I won't go over them again, but again, I would like to highlight the importance of this problem. These numbers from RAND are not new. It is a problem that we have seen is coming and they just highlight the importance.

When we saw these numbers and we were able to have it solidified, we really do see this as a national outrage, and the responsibility of addressing this national health crisis is going to fall largely on DOD and VA. This problem is not going to go away. Many of the Members of the Committee have commented on the problems with stigma and servicemembers reaching out to seek mental health treatment. This is a massive problem that we have seen both in the active component, the Reserves, National Guard, and specifically for those who have gotten out of service.

With that, I am proud to say that IAVA has partnered with the Ad Council on a 3-year campaign to reach out to the American public through every media available, whether it be radio, television, or print ad, to reduce the stigma in regards to mental health injuries. We at IAVA focus on mental health injuries as something that can be treated and that you can become an important tool in society. That is something that is going to be difficult to change, but it is something that can change.

Over time, the rate of psychological injuries will continue to be high. Mental health wounds range in severity and can take months to years to manifest. In the aftermath of the Vietnam War, the Congressionally-mandated National Vietnam Veterans Readjustment Study estimated that approximately 15 percent of servicemembers suffered PTSD during the conflict, but as many as 30 percent suffered PTSD at some point after their service. We can expect a higher lifetime rate of mental health injuries for our Iraq and Af-

ghanistan veterans, as well. Rates of mental health injuries are increasing because of the time it takes for troops' mental health wounds to manifest. Longer tours and multiple deployments are also contributing to the higher rates of mental health injuries.

In conclusion, if we are to get ahead of the veterans' mental health crisis, we need a strong, consistent, full-time oversight committee that will address the many gaps in care facing Iraq and Afghanistan veterans. We cannot allow the accomplishments made by the SOC over the past year to be overshadowed by the lack of effective planning on how their efforts will continue.

With that, I thank you for this opportunity to testify and can answer any questions.

[The prepared statement of Mr. Bowers follows:]

PREPARED STATEMENT OF TODD BOWERS, DIRECTOR OF GOVERNMENT AFFAIRS, IRAQ AND AFGHANISTAN VETERANS OF AMERICA (IAVA)

Mr. Chairman, Ranking Member and distinguished Members of the Committee, on behalf of Iraq and Afghanistan Veterans of America, and our tens of thousands of members nationwide, I thank you for the opportunity to testify today regarding this important subject. I would like to point out that my testimony today is as the Director of Government Affairs for the Iraq and Afghanistan Veterans of America and does not reflect the views and opinions of the United States Marine Corps.

Over the past few years, multiple commissions have made recommendations regarding the most effective way to establish coordination between the DOD and VA. These recommendations provide guidance on some of the most pressing issues affecting our Nation's newest veterans. The President's Commission on Care for America's Returning Wounded Warriors and the Veterans' Disability Benefits Commission have made hundreds of recommendations, and these suggestions are joined by hundreds more from internal DOD and VA task forces. As we have seen, the complexities of instituting and coordinating these recommendations can be overwhelming. IAVA is very concerned that many of these recommendations will go where so many other committee recommendations have ended up: on a shelf, collecting dust. The Wounded, Ill and Injured Senior Oversight Committee or SOC by the Department of Defense has the responsibility of overseeing the implementation of many of these recommendations, and while great strides have been made in the past year, there is still much to be accomplished. As the SOC prepares to disband next month, it is our goal, along with other Veterans Service Organizations, to ensure that these effective measures continue to be implemented in a timely and efficient manner.

To effectively implement change, oversight is paramount. Like basic military structure, a leadership entity must be present for actions to be followed and missions to be accomplished. This is why the SOC has been so effective thus far. IAVA does not believe that this is the time to abandon one leadership structure for another, and joins our colleagues here today in expressing our concern regarding the complexities of the Senior Oversight Committee (SOC) and the DOD/VA Joint Executive Council (JEC).

Because members of the JEC have other responsibilities in addition to their oversight function, we are concerned that implementation of the recommendations will be slowed. Oversight should not be a part-time job. It is our recommendation that the JEC be appropriately staffed with full-time leadership. Moreover, we believe that the Veterans Administration should act as the lead organization for the JEC.

Many veterans and their respective Veterans Service Organizations have borne witness to the difficulties of working with the Department of Defense. While the DOD coordinates with our organizations via press releases, we believe that the open channels of communication the VA has already established with our institutions will provide an effective conduit for us to communicate whether improvements are being felt by the men and women on the receiving end.

In addition to our concerns with the current structure of the JEC, IAVA is concerned that the upcoming elections and the transition of top-level staff in the new administration will result in unnecessary delays. It is vital that the work of the SOC does not get lost in the fray. An effective plan must be established to ensure that the work of the SOC is not hindered with changes in administration and leadership.

Finally, I would like to touch on what the priorities for both the SOC and JEC should be. The SOC has established eight lines of action or LOAs that will have a tremendous impact on the ability of new veterans to navigate the often complex transition between the DOD and VA. LOA 2 specifically addresses the two signature wounds of the Iraq and Afghanistan conflicts, PTSD and TBI. These often hidden wounds of war are extremely complex both in recognition and treatment. Last week, the RAND Corporation recently released a report that should serve as a wakeup call to this Nation regarding these two injuries. From this report we have learned that the problems facing servicemembers and veterans regarding PTSD and TBI have only gotten worse. One in five new veterans are suffering from PTSD or major depression. Just half of these veterans are receiving treatment, and of those, only half are receiving minimally adequate care. Let me say that again: 300,000 troops are suffering from a serious mental health problem, and barely 25 percent are getting care that can even be called "minimally adequate."

This should be a national outrage, and the responsibility of addressing this national health crisis will fall largely on the DOD and VA. And the problem isn't going away.

Over time, the rate of psychological injuries may be higher. Mental health wounds range in severity, and can take months or years to manifest. In the aftermath of the Vietnam War, the Congressionally-mandated National Vietnam Veterans Readjustment study estimated that approximately 15 percent of servicemembers suffered PTSD during the conflict, but as many as 30 percent suffered PTSD at some point after their service. We can expect a higher lifetime rate of mental health injury for Iraq and Afghanistan veterans as well. Rates of mental health injuries are increasing not only because of the time it takes for troops' mental health wounds to manifest, however. Longer tours and multiple deployments are also contributing to higher rates of mental health injuries.

If we are to get ahead of the veterans' mental health crisis, we need a strong, consistent, full-time oversight committee that will address the many gaps in care facing Iraq and Afghanistan veterans. We cannot allow the accomplishments made by the SOC over the past year to be overshadowed by a lack of effective planning on how their efforts will continue.

Chairman AKAKA. Thank you very much, Mr. Bowers.

Commander Campos?

STATEMENT OF RENÉ A. CAMPOS, COMMANDER, U.S. NAVY (RET.), DEPUTY DIRECTOR, GOVERNMENT RELATIONS, MILITARY OFFICERS ASSOCIATION OF AMERICA

Commander CAMPOS. Chairman Akaka, thank you for the opportunity to present testimony on MOAA's views of VA and DOD cooperation and collaboration efforts and the challenges that we see both short-range and down-range. The progress made to date, including the extensive measures adopted in last year's National Defense Wounded Warrior Act, are a credit to the leadership efforts not only in the VA and DOD, but in this Committee and the Armed Services Committees.

At this point, we offer three main recommendations or priorities for consideration. First is the urgent need for continued Congressional action and oversight. It is common knowledge that the significant gains in funding, health care, and benefits didn't come about solely because of VA and DOD's leadership. Rather, it took Congress's intervention to push this relationship to the next level.

MOAA is very concerned about how VA and DOD agencies will sustain continuity of effort and oversight when the leadership comes and goes, and particularly when the new administration changes. We cannot allow our servicemembers, particularly our most vulnerable population, our wounded and disabled veterans, to fall through the cracks.

In addition to bipartisan and bicameral efforts in Congress, there is a pressing need for establishing a joint seamless transition office.

That office should be a permanent office. Last year's defense bill established a foothold in this area, but only to set up a Joint Electronic Record Office. Long-term sustainment of joint effort requires a broader change in DOD and VA organizational structure.

VA and DOD officials acknowledged the need for a Joint Transition Office at a February 12 Senate Armed Services Committee hearing. Officials agreed to provide a proposal for the establishment of that office. MOAA is not aware of any language that has been provided to the committee to date. Our hope is that military and VA leaders will follow through on that promise and submit a proposal for that office. This effort is simply too important to be someone's part-time job.

I would like to add, too, that we are also very concerned and sensitive to the fact that if we can't put seamless transition here in our own backyard in the D.C. area where the policymakers are, then we are in real big trouble implementing policy across both organizations.

A second critical issue is expanding mental health and TBI services. With nearly one-third of returning veterans suffering from PTSD, TBI, depression, or some combination thereof, we simply must find ways to expand and leverage our capacity to deliver care because there just aren't enough providers in the VA and DOD systems. You heard the comments from my colleagues, and Senator Murray's concern that was mentioned in the RAND report. Researchers also stated that this is will require a major effort to expand and improve capacity to meet the needs of veterans and servicemembers. The effort must include a focus on training more providers, must have evidence-based methods of treatment, reducing stigma and encouraging servicemembers and veterans to seek care.

And finally, we must ensure full funding of VA health care and benefits and encourage innovation in the long haul. MOAA applauds the Committee's support for additional VA funding and we commend VA's efforts in improving access and quality care to veterans. But in delivering services and care, the VA must not overlook families who need care, as well.

In that regard, we strongly urge the Committee to provide some compensation for full-time family caregivers. Too often, the need doesn't stop when the servicemember leaves active duty and goes into the VA system.

VA should also consider adapting support programs, like DOD Military OneSource and Military Family Life Consultants, which provide information and referral and counseling services. This is also a very quick way to get a program up and going with DOD's help.

We are very grateful for the Committee's strong efforts and oversight of veterans' health care and benefits. We pledge to work with you, DOD, and VA to continue the progress. Thank you very much for the opportunity to present MOAA's views on these critically important topics.

[The prepared statement of Commander Campos follows:]

PREPARED STATEMENT OF COMMANDER RENÉ A. CAMPOS, USN (RET.), DEPUTY DIRECTOR, GOVERNMENT RELATIONS, MILITARY OFFICERS ASSOCIATION OF AMERICA

Chairman Akaka, Ranking Member Burr, and distinguished Members of the Committee, on behalf of the 370,000 members of the Military Officers Association of America (MOAA), I am grateful for the opportunity to present testimony on MOAA's views of the Department of Defense (DOD) and Department of Veterans Affairs (VA) cooperation and collaboration efforts and the challenges we see, both short-range and down-range.

MOAA does not receive any grants or contracts from the Federal Government.

EXECUTIVE SUMMARY

The Global War on Terror has produced a number of challenges for DOD, for the VA, for Congress, and for our country that we are not fully prepared to meet. We must muster all the necessary resources to get out in front of the issues that will impact all generations of military members, veterans, retirees, their families, and survivors now, and for decades to come. MOAA is extremely thankful for the Committee's leadership in working with the Armed Services Committee to improve health care and benefits for wounded warriors and their families.

MOAA is encouraged by DOD and VA leadership's focused efforts and collaboration on the care of wounded warriors, disabled veterans, and their families to improve delivery of health care, benefits, and support services as servicemembers transition from the DOD into the VA system and to civilian life.

Urgency of Joint Congressional Action and Oversight. Continued bipartisan and bicameral efforts between the Veterans Affairs and Armed Services Committees are absolutely crucial to continued progress. As in the executive branch, the leadership sets the tone for the staffs. We recognize that many of the jurisdictional and funding issues are not easy to resolve, but it is absolutely imperative to nourish a continuing collaborative framework to assess, oversee, prioritize, and fund cross-jurisdictional issues affecting the health, benefits, and welfare of our military and veteran beneficiaries, especially wounded warriors and their families who are so vulnerable to inefficiencies, inconsistencies, and bureaucracies of the DOD and VA systems.

Joint Transition Office. While both DOD and VA are making great efforts to cooperate, the single greatest barrier to continued progress is the lack of an institutional structure to impel and ensure joint cooperation between the two bureaucracies. Periodic leadership committee meetings, after which DOD and VA participants return to their separate offices on opposite sides of the Potomac, simply are insufficient to alter decades of historical administrative impediments. MOAA applauds the requirement for a joint office to implement the joint electronic medical record, but this is only one of many initiatives that require full-time joint collaboration if we hope to achieve substantive progress. These issues are simply too important to the Nation to allow them to remain a part-time job.

In fact, Chairman Carl Levin (D–MI) at a February 12th Senate Armed Services Committee hearing, asked senior officials in DOD and VA to provide a legislative proposal for the establishment of a joint transition office that would provide a broader and more permanent structure for caring for our Nation's wounded than the current JEC forum. Officials agreed on the need for such an office and told the committee they would provide the language. MOAA is not aware of any language that has been provided to the Committee to date.

Expanding National Mental Health Capacity. With nearly one-third of returning veterans suffering from PTSD, TBI, depression, or some combination thereof, we simply must find ways to expand and leverage our capacity to deliver care. A new RAND study concludes that investing in proper treatment would actually save $2 billion within 2 years by improving the capacity of members and families to return to productive work. The real challenge is how to develop enough providers to meet the need. RAND and MOAA believe this will take a national campaign to:

- increase DOD's and VA's in-house mental health capacity, to attract more providers to see TRICARE beneficiaries;
- increase incentive, education, and training programs to encourage more military people, veterans, and civilians to enter mental health delivery and counseling fields;

• reduce stigma associated with seeking care and instill confidence that getting needed care will enhance, rather than detract from, servicemembers' career opportunities;

• outreach to let civilian providers know who they can contact for specialized information in treating military and veteran patients and families, provide information on DOD and VA web sites that provide military/VA-unique insights and best practices; and

• provide a clearing house for veterans and families in need to find providers or programs best-suited to their needs.

Caregiver and Family Support. More must be done to strengthen support for families, including authorization of compensation for family member caregivers of severely injured who must leave their employment to care for the servicemember. DOD and VA should each provide per diem or other appropriate compensation for these caregivers, recognizing that if government service has imposed this obligation on family caregivers, the government has an obligation to provide them some level of compensation. VA should consider implementing DOD programs like Military OneSource and Military Family Life Consultants to provide outreach services for veterans and family members.

Access to Care and Case Management. MOAA shares the concern that unnecessary delays in accessing health care can result in some veterans languishing in or giving up on the system, preventing them from getting the necessary treatment they need to improve their condition down range. MOAA commends VA's willingness to look at innovative ways to improve access and quality care outside of its traditional delivery mechanisms such as Federal Recovery Coordinators (though MOAA questions VA's and DOD's ability to manage 4,000 severely injured members with only seven of the eight FRC positions identified for the program), OEF/OIF Transition Teams in VA medical facilities to assist and facilitate coordination of care and services for veterans, a Rural Health National Advisory Committee, and a Travel Nurse Corps.

Disability Evaluation System (DES) Reform. MOAA agrees strongly that VA and DOD should realign the DES so that the Services determine fitness for duty but accept disability ratings assigned by the VA. MOAA emphatically does not support the recommendation of the Dole-Shalala Commission to eliminate the military disability retired pay system, which could substantially reduce benefits for many wounded warriors and their families.

Claims Processing. MOAA believes that VA's workload estimates do not fully reflect new claims from returning OEF/OIF veterans, including more than 615,000 National Guard and Reserve activated since September 11, 2001. MOAA strongly supports additional claims-worker positions (FTE) for FY 2009 and investment in training, technology upgrades and integration in support of claims processing.

Guard-Reserve Support. MOAA urges the Committee to continue and expand its efforts to ensure Guard and Reserve soldiers and their families receive needed transition services to make a successful readjustment to civilian status.

DOD/VA Medical and Benefits Systems Funding and Innovation. MOAA applauds the Committees' opposition to any initiatives that would reduce critical funding and resources, including the imposition of usage fees and higher drug co-payment fees for VA services. Since delayed funding authority seriously hampers program execution, MOAA urges the Committees to work with Senate and House leadership to ensure that the FY 2009 VA Appropriations Bill is signed into law before October 1 of this year.

OVERVIEW

While the stories begin to fade over the cases of wounded servicemembers who became lost in the military health care and administrative systems upon being transferred to outpatient rehabilitative care, the issues of care and support continue to be major challenges for both DOD and VA systems. MOAA is particularly concerned about how the two agencies will continue moving forward on these critical issues and who will be in charge when the leadership changes in the transition to a new Administration.

Our experience with such changes in the past has us worried that top-down commitment to seamless transition could wane when current leaders depart—not for lack of interest, but simply for lack of continuity in leadership, direction, personal knowledge, and energy.

Urgency of Joint Congressional Action and Oversight

Progress to date, including the extensive measures adopted in the FY 2008 Defense Authorization Act, are a credit to the leadership efforts not only in DOD and VA, but also in this Committee and the Armed Services Committee. We are grateful for the unprecedented cooperation among all parties to address this most urgent national priority.

But the provisions enacted last year were only a first step. Many of the steps involved pilot programs and reports to help identify what actions are needed next.

You have a significant continuity advantage over the executive branch agencies. For that reason, the continued bipartisan and bicameral efforts between the Veterans Affairs and Armed Services Committees are absolutely crucial to continued progress. As in the executive branch, the leadership sets the tone for the staffs.

We recognize that many of the jurisdictional and funding issues are not easy to resolve, but we are optimistic that our common concern for the well-being of those who have borne the overwhelming share of national sacrifice will continue to overcome those barriers that have impeded progress in the past.

It is absolutely imperative to nourish a continuing collaborative framework to assess, oversee, prioritize, and fund cross-jurisdictional issues affecting the health, benefits, and well-being of our military and veteran beneficiaries, especially wounded warriors and their families who are so vulnerable to inefficiencies, inconsistencies, and bureaucracies of the DOD and VA systems.

Joint Transition Office

One critical problem is bureaucratic stove-piping in each department. While both DOD and VA are making great efforts to cooperate, the single greatest barrier to continued progress is the lack of an institutional structure to impel and ensure joint cooperation between the two bureaucracies.

There's no doubt about the good intentions of leadership, but sustaining the current effort for the long term requires a change in organizational structure. Periodic leadership committee meetings, after which DOD and VA participants return to their separate offices on opposite sides of the Potomac, simply are insufficient to alter decades of historical administrative impediments.

The FY 2008 Defense Authorization Act established DOD/VA Interagency Program Office to oversee implementation of a joint electronic medical record, which MOAA greatly applauds. Only by establishing a joint office, staffed by full-time members of both agencies working full-time together, can we hope to address the seamless transition issues that have stymied progress for decades.

But the electronic medical record is only one of many initiatives that require full-time joint collaboration if we hope to achieve substantive progress. Now that Congress has acknowledged the necessity of this structural change for this function, it is essential to acknowledge that the same necessity applies to many other joint needs.

Chairman Carl Levin (D–MI) at a February 12th Senate Armed Services Committee hearing, asked senior officials in DOD and VA to provide a legislative proposal for the establishment of a joint transition office that would provide a broader and more permanent structure for caring for our Nation's wounded than the current JEC forum. Officials agreed on the need for such an office and told the Committee they would provide the language. MOAA is not aware of any language that has been provided to the Committee to date.

We urge the military and VA leadership present at this hearing to follow-through on that promise by submitting a proposal to Senate Committees on Veterans' Affairs and Armed Services with a legislative proposal and implementation plan for a joint office.

This simply can't be someone's part-time job. It requires a full-time joint Federal transition office, staffed by full-time DOD, service and VA personnel working in the

same office with a common joint mission: developing, implementing and overseeing the DEC's strategic plan.

This office's responsibilities should include:

Joint In-Patient Electronic Health Record—We strongly support the initiative already established in law. But we believe the 2012 objective for implementing this system is too long to wait. Congress must press DOD and VA to speed delivery as soon as humanly possible, with concrete timelines and milestones for action.

Special Needs Health Care—Polytrauma Rehabilitation Centers were established to meet the specialized clinical care needs of patients with multiple trauma conditions. They provide comprehensive inpatient rehabilitation services for individuals with complex cognitive, physical and mental health sequelae of severe disabling trauma. These centers require special oversight in order to ensure the required resources are available to include specialized staff, technical equipment and adequate bed space. This oversight must be a joint effort since it provides a significant piece of the health care continuum for severely injured personnel.

Recreational/Alternative Therapy—DOD/VA also should consider collaborating and expanding policy and resources to provide for more robust recreational and alternative therapy programs as a means to improve the quality-of-life of wounded warriors and their families, particularly as they adjust and transition into various communities and phases of the life-cycle so the VA can meet the personal and work-life needs of the veteran.

Post Traumatic Stress Disorder (PTSD), Traumatic Brain Injuries (TBI), and Mental Health/Counseling—MOAA strongly supports the provisions in the FY 2008 NDAA establishing Centers of Excellence for these programs. But the fact remains that the services and VA are already conducting multiple independent pilot projects in these areas—with independent standards, measuring processes, and objectives. MOAA is doubtful whether these centers, by themselves, will be in a position to ensure coordination and implementation of best practices across all departments and services. There simply must be a single agency in charge—a joint office, a service Executive Agent, or some other oversight activity—to provide central monitoring, guidance, evaluation, and cross feed of best practices to all concerned if we are to coherently destigmatize, identify, and treat PTSD and TBI.

MOAA believes it also is important to ensure that TBI and PTSD are identified and treated as combat injuries rather than mental health problems.

Expanding National Mental Health Capacity

Like the Committee, MOAA is greatly concerned that the exponentially growing need for mental health, behavioral, and cognitive therapy generated by the current war is coming at a time when our national capacity to deliver the level and kinds of needed care is already overwhelmed.

With nearly one-third of returning veterans suffering from PTSD, TBI, depression, or some combination thereof, we simply must find ways to expand and leverage our capacity to deliver care.

A new RAND study of psychological and cognitive needs of all servicemembers deployed in the past 6 years is particularly instructive in highlighting this need. The study entailed:

- A national survey of servicemembers who have been deployed
- Economic modeling to estimate the cost of not providing appropriate treatment (including loss of productivity and suicide)
- An evaluation of treatment services available to servicemembers and barriers to that treatment.

RAND estimates that PTSD and depression among servicemembers will cost the Nation up to $6.2 billion in the two years after deployment. The study concludes that investing in proper treatment would actually save $2 billion within two years by improving the capacity of members and families to return to productive work.

Researchers stated that "a major national effort is needed to expand and improve the capacity of mental health system to provide effective care to servicemembers and veterans. The effort must include the military, veteran and civilian health care systems, and should focus on training more providers to use high-quality, evidence-

based treatment methods and encouraging servicemembers and veterans to seek care."

The report cites the psychological toll on military members and veterans is disproportionately higher than those with physical injuries.

The real challenge is how to develop enough providers to meet the need. RAND and MOAA believe this will take a national campaign to:

- increase DOD's and VA's in-house mental health capacity, to attract more providers to see TRICARE beneficiaries;
- increase incentive, education, and training programs to encourage more military people, veterans, and civilians to enter mental health delivery and counseling fields;
- reduce stigma associated with seeking care and instill confidence that getting needed care will enhance, rather than detract from, servicemembers' career opportunities.

It is clear to MOAA that DOD/VA will have to pull out all the stops to address this issue before a real crisis erupts. Military and family members need early intervention to improve outcome—so too does DOD/VA if they expect to take charge of the situation.

Since we cannot possibly increase in-house capacity to needed levels in the short-term, we must find ways to leverage in-house expertise for use by civilian providers. That means outreach programs to let civilian providers know who they can contact for specialized information in treating military and veteran patients and families, information on DOD and VA web sites that provide military/VA-unique insights and best practices, and clearing houses for veterans and families in need to find providers or programs best-suited to their needs.

Caregiver and Family Support

Lessons learned by the DOD and Military Services over the last three decades show the increasingly active role of military family members in the success of recruiting, retention and readiness. Families also expect and need to be active participants in the care and support of their veteran. VA must be able to adjust its mission and services to meet the needs of the larger veteran community—a community that includes the family—spouses, parents, siblings, and others whom the veteran considers important in his or her life.

Several wounded warrior provisions in the recently enacted NDAA provide additional support for the caregiver of the wounded warrior, typically a family member. However, we believe more needs to be done to strengthen support for families; to include the authorization of compensation for family member caregivers of severely injured who must leave their employment to care for the servicemember. Per diem is provided while the servicemember remains on active duty, but this ceases upon medical retirement or discharge—even though members may still face years of rehabilitation and require continued full-time caregiver attention. DOD and VA must address this continuing need, recognizing that if government service has imposed this obligation on family caregivers, the government has an obligation to provide some level of compensation for those caregivers.

Left with diminishing resources and unfamiliar with military benefit and disability rules, family members are severely disadvantaged in trying to represent the interests of their veteran and the family while trying navigate complex administrative systems and procedures.

VA should consider implementing DOD programs like Military OneSource and Military Family Life consultants to provide outreach services for veterans and family members. The Military OneSource initiative, a contracted information and referral service, would provide a mechanism to set-up a program quickly, and allow for augmenting and expanding current VA programs and initiatives in the works. DOD's Military OneSource provides information and referrals to military and civilian resources, to include childcare, mental health counseling, benefits assistance, financial counseling and assistance, and other high demand support services.

Access to Care and Case Management

MOAA is especially grateful to Congress for extending VA health care for OIF/OEF veterans for five years vs. the previously authorized two. While this is a step

in the right direction, we continue to hear about huge gaps in accessing health care services in some parts of the country by those already in the system. This is due in part to the growing veterans' population, but also because of VA failing to anticipate demand or lacking the agility to respond quickly to meet emergent requirements.

Senator Burr expressed concern at a February 28 hearing about the need to provide wrap-around services to veterans at the front-end of the disability process—particularly upon entering the VA system. MOAA shares the concern that unnecessary delays in accessing health care can result in some veterans languishing in or giving up on the system, preventing them from getting the necessary treatment they need to improve their condition down range.

MOAA commends VA's willingness to look at innovative ways to improve access and quality care outside of its traditional delivery mechanisms such as:

- Federal Recovery Coordinators to serve as single case manager and advocate for severely injured, wounded or ill servicemembers and their families. MOAA however, questions VA's and DOD's ability to manage the 4,000 severely injured servicemembers currently in the system with only seven of the eight FRC positions identified for the program.
- OEF/OIF Transition Teams in VA medical facilities to assist and facilitate coordination of care and services for veterans.
- Rural Health National Advisory Committee to advise senior VA officials about health care issues affecting veterans in rural areas in order to bring services closer to the veteran.
- Travel Nurse Corps to deal with a nationwide shortage of nurses and to improve the quality of care for veterans. The Corps will enable VA nurses to travel and work throughout the Department's medical system.

VA/DOD Seamless Transition, Wounded Warrior Compensation, and Benefits

Current legacy systems are stove-piped and over-burdened—they were not built for agility or surge capability. Putting "seamless" in transition will require more than DOD/VA to make the cultural changes. Congress and the Nation must continue to pressure the systems toward change so that seamless transition becomes a reality and not just an unreached vision. Active duty and Reserve components should be able to access transition services from multiple sources, when and where they need those services.

Disability Evaluation System (DES) Reform—A number of commissions and task forces have addressed major issues that arose from the Walter Reed situation, including the Dole-Shalala Commission and the Veterans Disability Benefits Commission (VDBC), among others. The VDBC issued its final Report to Congress on October 2007. MOAA is particularly pleased that the VDBC Report calls for the reform of the VA/DOD disability evaluation system.

MOAA agrees strongly that VA and DOD should realign the DES so that the Services determine fitness for duty but accept disability ratings assigned by the VA.

MOAA emphatically does not support the recommendation of the Dole-Shalala Commission to eliminate the military disability retired pay system, which could substantially reduce benefits for many wounded warriors and their families.

Claims Processing—We believe that VA's workload estimates do not fully reflect new claims from returning OEF/OIF veterans, including more than 615,000 National Guard and Reserve activated since September 11, 2001.

Claims also are increasingly complex and require more time in developing and rating them. In 2007, more than one-quarter (26%) of the compensation workload contained eight or more disability issues. This is an increase of 168 percent since 2000.

New VA claims workers need about two years to become minimally proficient in adjudicating a VA disability claim. We note that the Committees' "Views and Estimates" to the Budget Committees on the FY 2009 VA budget underscores the importance of training to improve claims processing timelines, increase accuracy and reduce appeals workload.

MOAA strongly supports additional claims-worker positions (FTE) for FY 2009 and investment in training, technology upgrades and integration in support of claims processing.

Guard-Reserve Support—For the Reserve component, finding and accessing critical support services and health care presents unique challenges because Guard and Reserve soldiers and their families are not always able to access base services like active duty personnel. Operation tempo and increase frequency and duration of deployments are extremely tough on Guard and Reserve whose support structure is usually the civilian community that often is not sensitive or understanding to military and family issues.

MOAA appreciates the work of this Committee in seeking to address some of these needs in the FY 2008 NDAA, but more remains to be done.

We strongly urge the Committee to continue and expand its efforts to ensure Guard and Reserve soldiers and their families receive needed transition services to make a successful readjustment to civilian status.

DOD/VA Medical and Benefits Systems Funding and Innovation

For a fifth year in a row the Administration has proposed annual usage fees and higher VA drug co-payments. MOAA is grateful that the both the Senate and House Committees on Veterans' Affairs opposed these fee hikes. Like the House Committee on Veterans' Affairs, we are "puzzled as to why the Administration requests these proposals in the face of consistent Congressional opposition." We, too, are concerned about the impact of these proposals on VA's ability to deliver sustained quality care and access to services.

The DOD, VA, Congress, MOAA, and our Military Coalition partners all have reason to be concerned about the rising cost of military health care. But it is important to recognize that the bulk of the problem is a national one, not a military-veteran-specific one. To a large extent, military and VA health cost growth is a direct reflection of health care trends in the private sector.

MOAA applauds the Committees' opposition to any initiatives that would reduce critical funding and resources, including the imposition of usage fees and higher drug co-payment fees for VA services. Since delayed funding authority seriously hampers program execution, MOAA urges the Committees to work with Senate and House leadership to ensure that the FY 2009 VA Appropriations is signed into law before October 1 of this year.

MOAA thanks the Committees for recommending over $2.5 billion increase to VA health funding above the Administration's request.

It is imperative that DOD and VA continue to think out-side-of-the-box in delivering quality health care and support services through innovation and cost efficient and effective ways. This doesn't mean however, that the costs of DOD's and VA's inefficiency and effectiveness should be shouldered by servicemembers, retirees, veterans, family members, and survivors.

CONCLUSION

MOAA reiterates its profound gratitude for the extraordinary progress this Committee, DOD and VA have made in advancing a wide range of seamless transition, wounded warrior, health care, and benefit initiatives for all uniformed services personnel, veterans, their families, and survivors.

We are eager to work with the Committee in pursuit of the goals outlined in our testimony. Through innovation, cooperation, and collaboration DOD/VA can be model systems for the Nation. We must all work together to change department cultures and open our system through partnerships and outreach. MOAA looks forward to working with Congress, DOD, and VA to build a joint system of care and support for our military and veteran communities.

Thank you very much for the opportunity to present MOAA's views on these critically important topics.

Chairman AKAKA. Thank you very much, Commander, for your statement.

For each of you, let me ask you a fast question. Do you have any comments on the question as to whether or not VA is facing an epidemic? Mr. Atizado?

Mr. ATIZADO. Mr. Chairman——

Chairman AKAKA. Meaning a suicide epidemic.

Mr. ATIZADO. Yes, Mr. Chairman. Thank you for that question. I cannot tell you whether or not it is an epidemic. I don't know the technical definition, especially in a health care arena, of what an epidemic is, but I can tell you it is a shame and we are deeply disturbed by these recent events and by the course of action that had to be taken to bring to light this situation. I am sure I can speak on behalf of the other organizations for the *Independent Budget* that we will work with you and VA to ensure that this issue is taken care of appropriately. We can't have it. Thank you.

Chairman AKAKA. Thank you. Mr. Bowers?

Mr. BOWERS. Again, I agree with Adrian. I am not sure if it is an epidemic, but I will say that it is a very large problem. It is something that we have seen. The numbers are increasing. I think it is a mixture of the difficulties that many Iraq and Afghanistan veterans are facing when returning home from deployments. I also think it is a mixture of the aging population of Vietnam veterans. They are coming together at an interesting time right now, these are often difficult problems that folks face—whether it be reintegration or just dealing with past demons.

I can say that we have been very excited with VA, the way they have really promoted and established their suicide prevention hotline. Yesterday, we were very pleased to be able to sit down with Secretary Peake and hear some of the other efforts that they are taking to combat suicide. It is an extreme problem and it is something that we are very focused on and looking forward to working with this Committee, the VA, and DOD to address.

Chairman AKAKA. Thank you. Commander Campos?

Commander CAMPOS. Yes, sir. I believe that MOAA recognizes that there is a lot of concern about the mental health and that is an issue that we think has to have a lot more emphasis nationally as well as within the DOD and VA. Again, like my colleagues, I am not an expert in talking in terms of this being an epidemic, but I can say that we believe that we are experiencing a crisis in mental health provider shortages and that DOD and VA has to pull out all the stops to address this. We may not be able to address it perfectly and may not have the cadre of trained people that we need, but we need to use every vehicle that we have to provide advocates for our servicemembers and their families to address these issues; and we need to be able to make sure that those resources that are given to DOD and VA are effectively used.

I think the issues that we are facing here today are really an issue of who is in charge. I don't think we can listen to the testimony earlier and really—it is sort of like a military comment I heard over my 30 years in the military, "If everybody is in charge, then nobody is in charge." And that is why we think it is critically important to have an office that can address these issues, address them head-on, and not let these issues drop every time the administration changes or there are changes in leadership, and let it be somebody else's problem.

Chairman AKAKA. Well, thank you so much for your comments. It is great to hear you, as well as those from the administration and Members of this Committee, talk about working together. That is one of the ways that we can deal with these problems and work as quickly as we can to resolve them.

This question is to all three of you. The Dole-Shalala Commission recommended the creation of recovery plans for all servicemembers who are seriously injured since the beginning of the Afghanistan and Iraq conflicts. Do you believe the Senior Oversight Committee, and I think all of you mentioned the SOC, do you believe that this committee has been effectively doing their job in overseeing and ensuring the implementation of this program? And also, if you would add to that if you have any recommendations as to what else you think they can do. Mr. Atizado?

Mr. ATIZADO. Mr. Chairman, as I had mentioned in my testimony, we in the IBVSOs are concerned with the small size. Granted, it is a rather new program and a lot is being asked of these Federal Recovery Coordinators. I should say, a lot of expectation has been placed on these coordinators despite what has been said about them being a last resort. They are not a last resort. They have been touted to be the ultimate resource for these injured servicemembers.

And having, from what I understand, 67 enrolled in this program where a veteran can self-refer, it is concerning. This Committee is aware of the need for this kind of a single point of contact that can stand above the fray and make things happen. Now there is talk about what they can or cannot do or should or should not do. I think it is incumbent upon us to take a closer look at this, considering the hearing that was before this Committee last month, I believe it was, this is extremely important. This person is responsible for taking care of not only the servicemember, but the families, and easing the transition.

I would like to see, first and foremost, from the Senior Oversight Committee what their plans are to evaluate this program, if it is, in fact, effective. I think that is my first question with regards to their ability to be effective overseers of this program. What is the evaluation of the effectiveness of this? I will leave it at that.

Chairman AKAKA. Mr. Bowers?

Mr. BOWERS. Well, I have not had any personal contact with servicemembers who have had recovery coordinators. It is my hope that having that single point of contact is going to ease the transition from DOD to the VA, and I agree with Adrian that it is paramount that they be involved with helping the families make this transition, also.

With that said, the concern lies that, again, within our membership, we have yet to meet anybody who has had a recovery coordinator. We do believe that the program needs to be expanded, that the SOC is an effective place right now, but again, the clock is ticking to be able to oversee this program more effectively, and I think measures of effectiveness will be paramount in establishing whether this is a solid program.

Chairman AKAKA. Commander Campos?

Commander CAMPOS. I agree with my colleagues and I think that the creation of recovery plans and the recovery coordinators has

been a great step in the right direction and I do applaud—we do applaud DOD and VA for moving out on that. Again, when you have a significant population of severely injured—4,000—and you only have ten identified positions, somebody is going to fall through the cracks.

We are also concerned that programs focus only on severely injured and yet there are other servicemembers that have been wounded or injured or have the invisible wounds that don't have recovery plans. What happens to them?

So we believe that there should be some—the recovery coordinator was supposed to be the advocate for the servicemember and the family, so we want to see that truly happen. And I believe the only way for that to truly happen is to expand the number of those individuals.

Chairman AKAKA. Please share your thoughts on how successful efforts have been to streamline and improve the transition and case management processes. What else needs to be done? What more can the Senior Oversight Committee be doing in this area of case management?

Commander CAMPOS. I would say, sir, that it is very hard for us to evaluate how all these moving parts are working, as we could tell from DOD and VA today, that there are so many moving pieces and we are not in a position to even understand necessarily how far and how successful some of these initiatives are.

I do go back to the fact that we are not—we still need—the SOC has been a great because it has had the senior leadership's focus—but again, if it is not somebody's full-time job and somebody is not accountable for it, then the accountability and the responsibility is spread over organizations; and in our opinion it would be business as usual.

So, we believe that there needs to be one Seamless Transition Office to make sure that all these moving pieces that are occurring don't have unintended consequences as we implement some of the many recommendations in the Wounded Warrior Act. And somebody has to be responsible for overseeing the implementation of all these initiatives that are taking place.

Chairman AKAKA. Thank you.

Mr. BOWERS. I was fortunate enough to speak with some of our members last week who have recently made the transition from the Department of Defense to the VA. There are still many complexities that remain. With that said, everybody conveyed to me, and this was three individuals that I spoke to—that they could tell changes were coming, that they knew things were being implemented and that was sort of some of the confusion as they were making this transition. So, I think that is a good sign, but I would stand by that it is almost too early to say how much the SOC has been able to streamline the transferring from DOD to VA; but there are changes being made.

Chairman AKAKA. Thank you.

Mr. ATIZADO. It seems to me, Mr. Chairman, that much of the accomplishments that have been presented to this Committee by the previous panel speak to the main problems with what is becoming the age-old problem of seamless transition—whether it is health or data information sharing or the actual hand-off from one

agency to the other and the kind of care they receive and the housing—that they have the ability to accommodate servicemembers' family or support in that work as they recover.

But, I think what I would like to impress upon this Committee is: these are just first steps. These are not the end-all and be-all. And in those first steps, as my colleague had just mentioned, there is one important component that is missing. How well is it working?

I can appreciate surveys of satisfaction. I can appreciate when a servicemember or veteran receives the benefits that they have been fighting for. But I can also appreciate when the servicemember doesn't receive benefits that they are not aware of. How well are these things working? That is my prime concern with all the accomplishments that have been made.

Chairman AKAKA. Mr. Bowers, you recently commented that health care is inconsistent at the local level. What are your thoughts on what must be done to ensure a more standard level of care that can be available?

Mr. BOWERS. Mr. Chairman, I believe that is in regards to what we discussed about urban veterans versus rural veterans and some of the difficulties that they face in seeking treatment for different types of injuries. This is a very difficult problem. I know that there has been discussion of the VA being able to provide outreach to rural veterans via Web access and things along those lines. That is something that we have a little concern with in regards to the complexities of broadband access for rural veterans. But our number 1 issue is making sure that they receive effective mental health counseling, and I know that speaking to a lot of individuals, the often very long distances they have to travel to try and receive treatment can be very difficult.

With that said, one thing we have heard consistently, I would say, with almost all of our membership, is how incredible the Vet Centers are. And while those allow a conduit for the VA for sometimes more rural areas, it is a very effective tool for individuals to go and receive help in dealing with a lot of these issues; and then finding the correct measures to receive treatment.

There is often discussion about contracting out for a lot of treatment along these lines, and while we believe that the VA needs to be the primary source, if there is no other course of action for individuals to receive treatment, then contracting out services for rural veterans we believe would be a good step, but in the most extreme cases.

Chairman AKAKA. Commander Campos, the Army Surgeon General testified before the House Armed Services Committee that the pilot project to speed the process of evaluating and rating servicemembers' disabilities will do little more than turn a bad process into, and I quote, "a fast bad process." Do you agree with this statement, and what can we do to make it a, quote, "fast good process"?

Commander CAMPOS. Well, sir, I would have to say that we are concerned about the pilot program and what realistically we can accomplish in that program. We believe that there needs to be a single physical for the servicemember when they transition out of the military; and that VA should be the organization that deter-

mines the rating, and DOD and the services determine the fitness for duty.

The process—the pilot project is concerning to us because the individuals in the area here in D.C. is all being managed very carefully and methodically; and so, I am not sure that it can be deployed to other areas around the country where VA or military medical treatment facilities may not have the same consistencies in their own processes and their own systems. So, we are concerned about how the findings out of the pilot—what the pilot recommendations will be, what the results of the pilot, but how practical and feasible will that be able to be translated throughout the services and the VA system.

Chairman AKAKA. Commander Campos, in your testimony, you suggested that VA should consider implementing DOD programs like Military OneSource and Military Family Life, consultants to provide outreach services to veterans and their families. I would ask each of you also to comment about this. Please explain what these programs would provide that is not currently available through VA.

Commander CAMPOS. Sir, these programs sprang up around the time DOD was actually considering Military OneSource as an outreach program where the family centers at each of the installations needed some services to augment their existing services. So, they developed or contracted and set up a program called Military OneSource that allows servicemembers and families to access support services anywhere from finding child care to if they need some sort of mental health counseling; if a family is in crisis, job resources, those kinds of things. It is an EAP, if you will, for the military, an Employee Assistance Program to augment the existing family programs. Out of that program, though, it has expanded and has become very popular within the services.

Currently, the VA is not by statute—other than the Vet Centers—really don't have the mandate to do the kinds of outreach that is needed in some cases to assist families. If it is part of the member's treatment as a veteran, then the VA can support the family. But the EAP is a contracted vehicle to help servicemembers and their families connect with resources in the communities that they are in. And I think this is, again, something that is already in place that is a contracted vehicle that VA could very easily apply within their own community—I mean, within their own systems and their own initiatives—and be able to provide some of that outreach that they can't do currently, or that isn't their core competency.

So, it really has a great opportunity to either allow members to access a variety of services by phone, by Web, or they can get some counseling services anonymously in the civilian community.

Chairman AKAKA. Mr. Bowers?

Mr. BOWERS. I am going to highlight again quickly the work that we are doing with the Ad Council. We were very fortunate yesterday when we spoke with the Secretary to convey to him that we are hoping that this is going to be an effective tool for the VA to do that portion of outreach that they currently cannot do.

Part of our goal is in regards to reducing stigma of mental health. It is trying to get people to make that difficult step to get

the treatment that they need. It is our goal to be able to communicate through this campaign to let people know where they need to go, whether it be a Vet Center, utilizing the 1–800 numbers that are available within the VA, and visiting the Web site and the Web resources. We are hoping that that will be an effective step.

This is sort of a trial run, if you will, to see how effective this is going to be, because Military OneSource has been incredibly effective, although there is sometimes a tad bit of confusion in regards to the National Guard and Reserves. When they are no longer actively in the military, there is often a gap in making that transition for these individuals, and while during peacetime it isn't that difficult to go from serving your 2 days a month and 2 weeks a year, many of these individuals have served multiple deployments, so they are pretty close to being active duty. But when they transition out of their Reserve status into civilian life, there often are not the steps available for these individuals to make that change, and that is something that we are hoping we will be able to address, also.

Chairman AKAKA. Would you——

Mr. ATIZADO. Mr. Chairman, thank you for that question. I believe your question actually touches upon a couple of concerns. Military OneSource and the like are quite passive tools that the military uses to provide information and outreach and education, as well as referrals to other services. VA, on the other hand, as my colleague had mentioned, is constrained somewhat in that arena.

In addition, DOD has a much more comprehensive benefit package, particularly in regards to family services and caregiver services, when compared to VA. So there is a gap, or I should say, a break in the seam, as it were, in that particular arena.

I believe, and I can't say for certain, but I do believe VA recently had a call center, but I think it dealt more with benefits issues more so than actual referral for such things as, I don't know, housing or employment and things of that nature. But it is quite fragmented at this point. I think DOL has a program that they are trying to stand up, but again, I am not too familiar with that.

Chairman AKAKA. I want to thank all of you for your responses, as well as your testimony. I want to thank Secretary Mansfield for remaining here for this panel, as well.

Again, I thank all of you, our witnesses, for appearing today. Your input on these issues is valuable to the Committee as we work to ensure that the transition from DOD to VA for injured servicemembers is as seamless as possible. I want to thank all of you again.

This hearing is adjourned.

[Whereupon, at 12:18 p.m., the Committee was adjourned.]

○