THIRD WALTER REED OVERSIGHT HEARING: KEEPING THE NATION'S PROMISE TO OUR WOUNDED SOLDIERS

HEARING

BEFORE THE

SUBCOMMITTEE ON NATIONAL SECURITY AND FOREIGN AFFAIRS

OF THE

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

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THIRD WALTER REED OVERSIGHT HEARING: KEEPING THE NATION'S PROMISE TO OUR WOUNDED SOLDIERS

WEDNESDAY, SEPTEMBER 26, 2007

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON NATIONAL SECURITY AND FOREIGN AFFAIRS,
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM,
Washington, DC.

The subcommittee met, pursuant to notice, at 10 a.m. in room 2157, Rayburn House Office Building, Hon. John F. Tierney (chairman of the subcommittee) presiding.

Present: Representatives Tierney, Lynch, Higgins, Yarmuth, McCollum, Van Hollen, Hodes, Welch, Waxman [ex officio], Shays, Platts, Turner, Westmoreland, and Davis of Virginia [ex officio].

Also present: Representative Norton.

Staff present: Roger Sherman, deputy chief counsel; Brian Cohen, senior investigator and policy advisor; Daniel Davis, professional staff member; Teresa Coufal, deputy clerk; Caren Auchman, press assistant; Dave Turk, staff director; Andrew Su and Andy Wright, professional staff members; Davis Hake, clerk; Dan Hamilton, fellow; David Marin, minority staff director; A. Brooke Bennett, minority counsel; Grace Washbourne and Janice Spector, minority senior professional staff members; Christopher Bright, minority professional staff member; Nick Palarino, minority senior investigator and policy advisor; Brian McNicoll, minority communications director; and Benjamin Chance, minority clerk.

Mr. TIERNEY. Good morning, everybody. For some reason Mr. Shays has been unable to extricate himself from his other committee, but I expect him to be over shortly, and Mr. Davis, as well. We don't want to hold you gentlemen up. You have been kind enough to come here and give us your time, and we appreciate that.

We are going to begin our hearing entitled, "Third Walter Reed Oversight Hearing: Keeping the Nation's Promise to Our Wounded Soldiers."

I am going to ask unanimous consent that only the chairman and ranking member of the subcommittee and the chairman and ranking member of the full Oversight and Government Reform Committee be allowed to make opening statements. Without objection, that will be ordered.

I also ask unanimous consent that the written statement of former Senator Bob Dole and former Secretary Donna Shalala, Co-

Chairs of the President's Commission on Care for America's Returning Wounded Warriors, be submitted for the record. Without objection, that also is ordered.

[The prepared statement of Senator Bob Dole and Secretary Donna Shalala follows:]

TESTIMONY OF

Bob Dole

and

Donna E. Shalala

Co-Chairs

PRESIDENT'S COMMISSION ON CARE FOR AMERICA'S RETURNING WOUNDED WARRIORS

For the Record

UNITED STATES HOUSE OF REPRESENTATIVES

SUBCOMMITTEE ON NATIONAL SECURITY AND FOREIGN AFFAIRS

September 26, 2007

Mr. Chairman and members, on behalf of the President's Commission on Care for America's Returning Wounded Warriors, we respectfully submit this testimony for the record.

During the four month tenure of our Commission, we learned much during our 23 site visits, first-hand interviews with injured service members and their families, discussions with health care professionals, from military and veterans' service organizations, from the many recommendations from previous task forces and commissions, and our own survey of injured service members. From this information came the six recommendations that we presented to the President and the American people in July 2007. These recommendations fundamentally change the military and veterans' health care and services. They include:

- The first major overhaul of the disability system in more than 50 years;
- Creation of comprehensive recovery plans with recovery coordinators;
- Strengthen support for families;
- Improvement of TBI and PTSD care for service members and veterans;
- Rapid transfer of information between the DoD and VA; and
- Support for Walter Reed through 2011.

Within these 6 major recommendations are 34 actions steps, of which only 6 require Congressional action. The remaining 28 action steps can be implemented by the Departments of Defense and Veteran's Affairs; these are the focus of our testimony.

Our approach was to look at the system of care from the patient's point of view. In doing so, it became clear that our wounded warriors are not only facing difficult days of recovery and rehabilitation, but difficult to navigate and confusing bureaucratic systems. Patients need to focus on getting well not on when the paper work needs to be filed or the right form completed. We believe the solution is for every patient to have a clearly defined recovery plan initiated by those directly involved in his or her care and managed by a Recovery Coordinator. This individual, cross-trained in DoD and VA benefits and services, would work with medical personnel, existing case managers and other personnel to ensure that the service member receive all the appropriate resources in order to recover and rehabilitate. To accomplish this task, these individuals will need the appropriate authority from each Department and the independence to act for the patient's best interests. Sometimes that may mean obtaining the best care for a patient with a specific problem in the private sector. We believe it unwise to determine the "correct" case load for these Recovery Coordinators. The case load should adjust according to the patients' needs, not an arbitrary target. We also believe that placing the Recovery Coordinators in an elite unit of the Public Health Service will ensure independence.

Restructuring the disability evaluation and compensation system requires the DoD and VA to work together to develop a single physical exam to be administered by the DoD. This comprehensive physical exam, based on jointly developed standards and administered by specially trained physicians, will allow the DoD to determine if a service member is fit to serve in any military capacity and the VA to determine a disability rating based on the findings of the physical. Having the DoD administer the physical exam creates the baseline of documentation needed by every veteran applying to the VA down the road for additional rating or compensation based on events that occurred during service. This approach builds on the success of the DoD and VA's joint Benefits Delivery at Discharge (BDD) program. The BDD program allows medically separating or retiring service members to file for VA service-connected disability compensation up to 180 days before discharge. The average time to complete a claim under this program is only 68 days, a significant improvement over the average of 180 days for claims filed through the normal channels.

We have also recommended a change in the structure of VA disability compensation payments. These payments would be in addition to a DoD annuity payment for those discharged on the basis of being medically unfit for duty (based on rank and time in service). Furthermore, each disabled veteran would be able to select one of two transition payments: three months of basic pay or an enhanced stipend to obtain additional skills in an approved educational or training program. Our recommended stipend would replace the current VA provided stipend for those enrolled in vocational rehabilitation programs. The amount of our recommended stipend would be determined by a study and is likely to be higher than the currently provided VA stipend for this program. To encourage those enrolled in these programs, we recommend a bonus payment for each of the first three full years completed. We also recommend extending the time allowed for completion of these programs from the current 48 months to 72 months, with the approval of the vocational counselor and the Recovery Coordinator. This allows additional flexibility in

the time it takes to complete the programs and accommodates those who might need additional hospital care or who need or want to work part-time.

All of the returning wounded warriors we spoke with wanted to return to a productive life. We strongly believe that by investing in these men and women upfront, not only will they be better off, but we will see a surge in productivity second only to that occurring after World War II. Our Nation will be stronger and our veterans will thrive.

We also call for the VA Schedule for Rating Disabilities to be updated – and maintained – to reflect current medical diagnoses and advances. It is simply inappropriate, and a disservice, for veterans to be rated using a system with components that were last updated in 1945. The schedule must also be revised to reflect the impact of injury or illness on the quality of life of the veteran.

As part of our call for strengthening support for families, we recommend providing the necessary training to family members caring for an injured service member. Injured service members just want to go home, no matter how complex the injuries. Not only do family members need to learn how to change dressings, safely transfer an individual from a wheelchair to a bed, but they need to be taught to look for problems that might develop. When problems do develop, they need to be able to quickly reach appropriate care, and they need better information about the availability of help in their community.

We understand that the electronic transfer of medical records between the DoD and VA has been an area of specific Congressional concern. Many are calling for a single system between the two Departments. We do not believe that this is the answer. The DoD and VA can, and should, move more quickly to electronically transfer important clinical and benefit data to those who need it. We firmly believe that 80% of the needed information can be electronically transferred within the next year. It may not be truly interoperable, but it can get to users who need this information to make decisions about benefits and clinical care. Meanwhile, the current efforts to move toward fully integrated and interoperable systems should continue. Mandating a move to a single system will be costly and delay interoperability even more.

We also recommend a user-friendly, individually tailored services and benefits portal for service members, veterans, and family members. This password protected site should provide relevant information about federal, state and local benefits, programs, and services based on the user's profile. Users can view their medical appointment schedule, send and receive messages from their medical team, and view their medical history. They can plan for retirement or find out what veteran's benefits and programs exist in their state of residence. And, most importantly, they don't have to sift through a pile of brochures or read through screen after screen of online information to find what is relevant for them. It is a contemporary solution for information dissemination.

Finally, with 20% of our wounded going directly to Walter Reed, we recommend that appropriate resources be made available through 2011. The mechanisms already exist to

recruit and retain first-rate professionals at Walter Reed – the DoD simply needs to implement them.

We have been truly heartened by the response our report has received in the White House, the halls of Congress and throughout the country. The nation has rallied behind the need to help those who have put their lives on the line in service to our country – and we are optimistic that Congress and the Administration will move quickly to respond to this need by enacting our recommendations.

We thank the Subcommittee for its interest and look forward to working with you to ensure that our injured service member receive the care they deserve.

Bob Dole

Donna E. Shalala

Mr. TIERNEY. I ask unanimous consent that the gentlelady from the District of Columbia, Representative Eleanor Holmes Norton, be allowed to participate in this hearing. In accordance with our rules, she will be allowed to question the witnesses after all official members of the subcommittee have first had their turn.

I ask unanimous consent that the hearing record be kept open for 5 business days so that all members of the subcommittee will be allowed to submit a written statement for the record. Without objection, that is all ordered.

Good morning. On March 5th, we held a hearing at Walter Reed. At the medical center, we heard from Specialist Jeremy Duncan, from Annette and Dell McCloud, and from Staff Sergeant Dan Shannon about their experiences with military health care—the mold, the red tape, the frustrations; all of the situations that were reported that have frustrated all of you, as well as members of this panel.

In preparation for the hearing today, we reached back out to all of those witnesses to find out what was going on with them, to ask if there was anything else they needed for help, to get their take on how things have improved or not improved, and what our committee needed to focus on, in their opinions, with respect to our sustained and hopefully vigorous oversight.

Jeremy Duncan is at Fort Campbell fighting to rejoin his unit overseas in Iraq. Annette and Dell McCloud have noticed some improvements, but they are still navigating through the retirement compensation process. And Sergeant Shannon's most recent experiences with military health care were recounted in the Washington Post less than 2 weeks ago. He is trying to leave Walter Reed, but he has faced some additional bureaucratic roadblocks, which I think General Schoomaker can report have been overcome at this point in time.

Sergeant Shannon did tell us something that I think gets to the heart of this matter, and he said recommendations mean nothing until something is done with them. That is exactly what this oversight is all about.

At an April 17th hearing, we heard the recommendations of the Defense Secretary's Independent Review Group. Since then, the President's Commission, led by former Senator Dole and Secretary Shalala, issued their own recommendations.

The purpose of today's hearing will be to ensure that these recommendations and the human faces and stories of our Nation's wounded soldiers behind them, aren't ignored or forgotten, which unfortunately has too often happened in the past, and also to make sure that our Government is moving swiftly to address all of the problems that were identified.

This morning we will hear from top directors with the Government Accountability Office, Congress' investigatory arm, on where we are at. Instead of yet another commission or panel issuing recommendations, today we will get the first independent assessment of the progress we have made and of the challenges and obstacles that may lie ahead.

We are also going to hear directly from key officials in the Army, the Department of Defense, and the Department of Veterans Af-

fairs who have been tasked with fixing the problems and implementing all of the various recommendations.

We have been told time and time again that things are improving and that, next to the wars in Iraq and Afghanistan, taking care of our wounded soldiers is the highest priority of our military. While I believe some progress has been made, especially through some of the Army's efforts to throw significant additional resources, energy, and manpower at the problem, I would like to take a few moments to highlight some lingering concerns. I do not do this to focus on the negative. I do this because taking care of our wounded heroes is too important to not demand that we strive for the highest levels of care and respect, and that we do so with a sense of real urgency.

A number of us on the subcommittee visited Walter Reed earlier this week. We had the privilege and honor to meet with our brave men and women recovering there, and here is what we heard. First, the disability review process is broken, plain and simple. It is burdensome, archaic, and adversarial. We also heard stories of wounded soldiers so frustrated that they would tell us they were just "giving up."

Second, the challenges we face with traumatic brain injury, TBI, and post-traumatic stress disorder, PTSD, are immense. We heard stories about TBI stigma; that is, soldiers afraid to come forward for help out of fear that they would be kicked out of the military.

Third, quality control and oversight will be absolutely key going forward. While the Army has thrown significant bodies at the problem, we need systems to identify and reward great performers and to identify and deal with those treating our wounded soldiers with anything but respect.

These challenges—and countless others—won't be easy to overcome. For instance, we have known for a long time that the disability review process is broken, but we haven't had the will or the sustained focus to fix it in the past. Will the newly created Senior Oversight Committee, made up of top officials from the Department of Defense and the Veterans Administration, be up to the task of urgently and finally fixing and reinventing the disability review process? Will our military be able to hire additional top nurses and psychologists, a key challenge that the GAO has highlighted.

Finally, what are we doing now to plan for the future? In my District in Massachusetts, instead of expanding and enhancing health services and retaining specialized personnel, the Veterans Administration officials continue to push for consolidation. They are limiting options for our veterans when, unfortunately, there will clearly be a high demand for years and years to come.

As chairman of the National Security Subcommittee, I have made it a top priority to ensure that there is sustained congressional oversight and accountability so that all of those who risk their lives for the country receive the care and respect that they deserve.

And I have been routinely impressed by the seriousness and the vigor that the other members of this subcommittee have approached when they are dealing with this issue. It is vital that we continue to have open and public hearings and that we hear from rank-and-file soldiers, as well as high-ranking generals and depart-

ment heads. We have already had three hearings, and today's hearing will certainly not be the last.

We hope that in the months to come we won't have to hear about how Sergeant Shannon had yet another bureaucratic roadblock thrust in his way in his 3-year odyssey to navigate the military health care system. Rather, we hope to hear about how enormously difficult problems were finally overcome with dedication, hard work, and ingenuity.

I want to thank all of these witnesses whose hard work and ingenuity will certainly be put to the test as we meet this task.

[The prepared statement of Hon. John F. Tierney follows:]

Opening Statement of Chairman John F. Tierney at the Wednesday, September 26, 2007 hearing entitled,

"Third Walter Reed Oversight Hearing: Keeping the Nation's Promise to Our Wounded Soldiers"

Good morning. On March 5th of this year, we held a hearing at Walter Reed Army Medical Center and heard from Specialist Jeremy Duncan, Annette and Dell McLeod, and Staff Sergeant Dan Shannon about their experiences with military health care – the mold, the red tape and the frustrations.

In preparation for our hearing today, we reached back out to all of them. We wanted to see how everything was going; to ask if there was anything else we could do to help; and to get their take on how things have improved – or not improved – and what our committee needed to focus on with our sustained and vigorous oversight.

Jeremy Duncan is at Fort Campbell, fighting to rejoin his unit overseas in Iraq. Annette and Dell McLeod have noticed some improvements, but are still navigating through the retirement compensation process.

Sergeant Shannon's most recent experiences with military health care were recounted in the Washington Post less than two weeks ago. He's trying to leave Walter Reed; but he has faced some additional bureaucratic roadblocks.

Sergeant Shannon told us something that I think gets to the heart of the matter. He said: "Recommendations mean nothing until something is done with them."

At an April 17th hearing, we heard the recommendations of the Defense Secretary's Independent Review Group. Since then, the President's commission, led by former Senator Dole and Secretary Shalala, issued their own recommendations.

The purpose of today's hearing will be to ensure that these recommendations and the human faces and stories of our nation's wounded soldiers behind them aren't ignored or forgotten. Unfortunately, this has happened too often in the past and our government move swiftly to address all the problems identified.

This morning, we will hear from top directors with the Government Accountability Office (GAO) on where we currently stand. Instead of yet another commission or panel issuing recommendations, today we will get the first independent assessment of the progress we've made and the challenges and obstacles that lie ahead.

We'll also hear directly from key officials in the Army, Department of Defense and Department of Veterans Affairs, who have been tasked with fixing the problems and implementing all these recommendations.

We have been told time and time again that things are improving, and that next to the wars in Iraq and Afghanistan, taking care of our wounded soldiers is the highest priority for our military.

While I believe some progress has been made – especially through some of the Army's efforts to throw significant additional resources, energy, and manpower at the problem – I'd like to take a few minutes to highlight some concerns.
I don't do this to focus on the negative; I do this because taking care of our wounded heroes is too important not to demand that we strive for the highest levels of care and respect and that we do so with a sense of real urgency.

A number of us on the Subcommittee visited Walter Reed earlier this week. We had the privilege and honor to meet with our brave men and women recovering there. Here's what we heard:

- First, the disability review process is broken – plain and simple. It's burdensome, archaic and adversarial, and we heard stories of wounded soldiers just, and I quote, "giving up."

- Second, the challenges we face with Traumatic Brain Injury (TBI) and Post-Traumatic Stress Disorder (PTSD) are immense. We heard stories about TBI stigma; that is, of soldiers afraid to come forward for help out of fear they'd get kicked out of the military.

- Third, quality control and oversight will absolutely be key going forward. While the Army has thrown significant bodies at the problem, we need systems to identify and reward great performers – and to identify and deal with those treating our wounded soldiers with any disrespect.

These challenges – and countless others – won't be easy to overcome. For instance, we've known for a long time that the disability review process is broken, but we haven't had the will and sustained focus to fix it in the past. Will the newly-created "Senior Oversight Committee," made up of top officials from the Department of Defense and VA, be up to the task of urgently and finally fixing and reinventing the disability review process?

Will our military be able to hire additional top nurses and psychologists, a key challenge the GAO has highlighted?

Finally, what are we doing now to plan for the future? In my district in Massachusetts, instead of expanding and enhancing health services and retaining specialized personnel, VA officials continue to push for consolidation. They are limiting options for our veterans when, unfortunately, there will clearly be a high demand for years and years to come.

As Chairman of the National Security Subcommittee, I have made it a top priority to ensure there is sustained Congressional oversight and accountability so that all those who risk their lives for our country receive the care and respect they deserve. And I have been routinely impressed by the seriousness and vigor with which the other Members of this Subcommittee have approached this issue.

It is vital we continue to have open and public hearings; that we hear from rank-and-file soldiers as well as high-ranking generals and department heads. We've already had three hearings; and today's hearing will certainly not be the last.

We hope that in the months to come we won't have to hear that Sergeant Shannon had yet another bureaucratic roadblock thrust in his way in his three-year odyssey to navigate the military health care system. Rather, we hope to hear about how enormously difficult problems were finally overcome with dedication, hard work and ingenuity.

Thank you to all of our witnesses for being here today, and I now yield to the Ranking Member of the Subcommittee, Congressman Shays, for his opening remarks.

Mr. TIERNEY. I now yield to the ranking member of the committee, Mr. Davis, for his opening remarks.

Mr. DAVIS OF VIRGINIA. Thank you very much, Chairman Tierney. And I want to thank the chairman of the full committee, Mr. Waxman, for his leadership, and our ranking member, Chris Shays.

At the subcommittee's hearings in March and April, we heard about ambitious plans for improvements in the medical processing of wounded soldiers, and we heard promises to pursue these reforms with urgency. Prior to that, the Government Reform Committee heard many similar plans and promises, starting as far back as 2004, when we first tried to help soldiers caught between systems and policies not designed to handle the types and the numbers of wounds inflicted by this new global war.

After so many promises but so little progress, we need to start seeing concrete results. I applaud your persistence, Mr. Chairman, in pursuing these issues.

The report of the President's Commission on Care for America's Returning Wounded Warriors released in July sets forth another list of findings and recommendations for executive and congressional action. The Commission also urges those reforms to be pursued with a sense of urgency and strong leadership. We agree.

One of the most important of the Commission's recommendations restates the longstanding call to overhaul and standardize the disability rating systems used by the Department of Defense and the Department of Veterans Affairs. Every week my staff still hears appalling stories from wounded soldiers caught in DOD medical evaluation and physical evaluation board processes. They are trapped in a system they don't understand and that doesn't understand them. The process is seldom the same twice in a row, and often yields two different ratings, one from DOD and the other from VA. Having to run that double gauntlet causes additional pain and confusion, literally adding insult to injury. This has to stop.

The Commission is recommending a single comprehensive standardized medical examination that DOD administrators use to determine medical fitness and that VA uses to establish an initial disability level. VA would assume all responsibility for establishing permanent disability ratings and for the administration of all disability compensation and benefits programs.

I look forward to hearing from our DOD and VA witnesses today about a firm implementation deadline, details on how the integration of these evaluations will occur, and what performance standards will be put in place to make sure the consolidation serves the near and long-term needs of veterans.

We will also need to hear more about the Army's medical action plan, a road map the Army has created to address patient administrative care at Walter Reed and at all Army medical treatment facilities. The plan is comprehensive in scope and includes stabilized command and control structures, prioritizing patient support with a focus on family needs, developing training and doctrine, facilitating a continuum of care, and improving transfers to the Department of Veterans Affairs. These are worthy and long-overdue goals, but at this point they seem frustratingly incremental and risk

drawing energy and resources from the broader systematic changes that I think are clearly needed. And even those goals have to be viewed with skepticism looking back on more than 3 years of quarterly reports, missing deadlines, and glacial progress that changed the process but didn't always improve the product for the Army's wounded warriors.

Clearly, the Army has dedicated considerable manpower and resources to the new Warrior Transition Units and patient services, but better training and clean lines of responsibility and accountability are still needed. Diagnosis and treatment for this war's signature wounds—traumatic brain injuries and post-traumatic stress disorder—are still far from adequate. And those looking to find their way home from war are still hitting dead ends and a looping, baffling maze of medical and physical disability assessment procedures.

When a truck or plane gets damaged in battle, we fix it. Honor demands we do everything possible to fix the most precious assets we send into harm's way, the men and the women who volunteer to fight for us.

I look forward to the testimony of all of our witnesses today and a very frank discussion on how we can accomplish recommended reforms quickly and make sure all of our wounded warriors receive the care they deserve.

Thank you.

[The prepared statement of Hon. Tom Davis follows:]

HENRY A. WAXMAN, CALIFORNIA
CHAIRMAN

TOM DAVIS, VIRGINIA
RANKING MINORITY MEMBER

ONE HUNDRED TENTH CONGRESS
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Statement of Rep. Tom Davis
Ranking Member
Committee on Oversight and Government Reform

"Third Walter Reed Oversight Hearing: Keeping the Nation's Promise to Our Wounded Soldiers"

September 26, 2007

Thank you Chairman Tierney and Ranking Member Shays. At this Subcommittee's hearings in March and April, we heard about ambitious plans for improvements in the medical processing of wounded soldiers, and we heard promises to pursue those reforms with urgency. Before that, the Government Reform Committee heard many similar plans and promises, starting as far back as 2004 when we first tried to help soldiers caught between systems and policies not designed to handle the types and numbers of wounds inflicted by this new global war. After so many promises, but so little progress, we need to start seeing concrete results, and I applaud your persistence in pursuing these issues.

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The Commission is recommending a single, comprehensive, standardized medical examination that DOD administers and uses to determine medical fitness, and that VA uses to establish an initial disability level. VA would assume all responsibility for establishing permanent disability ratings and for administration of all disability compensation and benefits programs. I look forward to hearing from our DOD and VA witnesses today about a firm implementation deadline, details on how the integration of these evaluations will occur, and what performance standards will be put in place to make sure the consolidation serves the near and long term needs of veterans.

We also need to hear more about the Army's Medical Action Plan, a roadmap the Army has created to address patient administrative care at Walter Reed and at all Army medical treatment facilities. The plan is comprehensive in scope and includes stabilizing command and control structures, prioritizing patient support with a focus on family needs, developing training and doctrine, facilitating a continuum of care, and improving transfers to the Department of Veterans Affairs. These are worthy, and long overdue, goals. But at this point they seem frustratingly

incremental and risk drawing energy and resources from the broader, systemic changes clearly needed. And even those goals have to be viewed with skepticism, looking back on more than three years of Quarterly Reports documenting missed deadlines and glacial progress that changed the process but didn't always improve the product for the Army's wounded warriors.

Clearly, the Army has dedicated considerable manpower and resources to the new Warrior Transition Units and patient services. But better training and clear lines of responsibility and accountability are still needed. Diagnosis and treatment for this war's signature wounds - traumatic brain injuries and post-traumatic stress disorder - are still far from adequate. And those looking to find their way home from war are still hitting dead ends in a looping, baffling maze of medical and physical disability assessment procedures.

When a truck or plane gets damaged in battle, we fix it. Honor demands we do everything possible to fix the most precious assets we send into harm's way – the men and women who volunteer to fight for us. I look forward to the testimony of all our

witnesses today and to a frank discussion of how we can accomplish recommended reforms quickly and make sure all our wounded warriors receive the care they deserve.

Mr. TIERNEY. Thank you, Mr. Davis.

Mr. Waxman.

Mr. WAXMAN. Thank you very much, Mr. Chairman.

This hearing today is in the tradition of our committee's oversight with regard to military health care problems. Long before the public ever heard about the problems at Walter Reed, under the leadership of Congressman Tom Davis we held hearings on the important problems that Guard and Reserve troops were having with health care and military benefits.

Chairman Tierney, your subcommittee held the first hearing of the problems at Walter Reed, and you have continued to be a leader on this issue. I want to commend you for that.

In May the full committee had a hearing on the hundreds and thousands of soldiers who may be returning from Iraq and Afghanistan suffering from PTSD and other mental health problems.

This committee's efforts have helped uncover both new and longstanding problems with the military health care system. This oversight is some of the most important work that this committee does. Few causes are more noble than giving our injured soldiers the care they deserve.

Despite the increased attention, the pace of change at DOD and VA is intolerably slow. Again and again we see the same thing—blue ribbon task forces like the West/Marsh Commission on Walter Reed or the Dole/Shalala Commission on Military Health care provide detailed road maps to better care. DOD and VA representatives come before Congress and insist that things are getting better. Still, the horror stories about problems with the military's health care system continue.

Here is just some of the new and disturbing information we have received over the last several months: We learned from the Washington Post that Staff Sergeant John Daniel Shannon, who testified about his problems at Walter Reed before our committee in March, remained stuck in bureaucratic limbo at Walter Reed, unable to obtain his discharge, obtain VA benefits, or return to his family and pick up his life.

We received deeply troubling reports from Fort Carson, CO, indicating that the leadership there seems to utterly lack understanding, basic understanding, of the problems faced by ill and injured soldiers. Whistleblowers and investigators and struggling families have told the committee that soldiers with PTSD and PTI are being dishonorably discharged under the pretense of having pre-existing personality disorders. We have heard of one soldier who was ordered back to Iraq, despite a diagnosis of PTSD and TBI. And we have heard press reports indicating that one commander at the base recommended discharging mentally ill soldiers simply as a way to get rid of "deadwood."

We have heard from VA that they have over 1,200 unfilled psychologist, social worker, and psychiatrist positions within their ranks, and that the VA is unable to provide even the most rudimentary estimates of the number of soldiers who will need mental health care or the cost for such treatment.

And we have heard reports from the Army that suicide rates among soldiers are at their highest levels in 26 years, while 20 per-

cent of Army psychologist positions are unfilled and morale among Army mental health care providers continues to sink.

We will hear testimony from GAO and others today pointing to other persistent or emerging problems at VA and DOD. While I am looking forward to hearing testimony from all of our witnesses today—and I am happy that we will have at least some good news—I continue to be frustrated with the pace of improvement, and I worry that after 5 years of war our military health care system is over-stretched, with bigger problems coming down the line as soldiers are forced to serve more and longer deployments in Iraq and Afghanistan.

In the coming years, hundreds of thousands of soldiers will return home and will need DOD and VA care for injuries or mental illness. We can't let these soldiers and their families down.

I want to thank you for holding this hearing today. I am looking forward to see how we can make things better.

[The prepared statement of Hon. Henry A. Waxman follows:]

Statement of Rep. Henry A. Waxman
Before the Subcommittee on National Security and Foreign Affairs
September 26, 2007

Mr. Chairman, today's hearing continues a tradition of this Committee's oversight of military health care problems.

Long before the American public became aware of the troubles at Walter Reed, Tom Davis held important hearings into problems that guard and reserve troops were having with health care and military benefits. Chairman Tierney, your subcommittee held the first hearing on the problems at Walter Reed, and you've continued to lead on these issues. And in May, the full Committee had a hearing hon the hundreds of thousands of soldiers who may be returning from Iraq and Afghanistan suffering from PTSD and other mental health problems.

This Committee's efforts have helped uncover both new and long-standing problems with the military health care system. This oversight is some of the most important work that this Committee does — few causes are more noble than giving our injured soldiers the care that they deserve. despite the increased attention, athe pace of change at DOD and VA is intolerably slow..

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- We've received deeply troubling reports from Fort Carson, Colorado, indicating that the leadership there seems to utterly lack a basic understanding of the problems faced by ill and injured soldiers. Whistleblowers, investigators, and struggling families have told the Committee that soldiers with PTSD and PTI are being dishonorably discharged under the pretense of having preexisting personality disorders. We've heard of one soldier who was ordered back to Iraq despite a diagnosis of PTSD and TBI. And we've heard press reports indicating that one commander at the base recommended discharging mentally ill soldiers simply as way to get rid of — and I quote — "dead wood."

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In the coming years, hundreds of thousands of soldiers will return home and will need DOD and VA care for injuries or mental illnesses. We can't let these soldiers and their families down.

I thank you for holding this hearing today, and I'm looking forward to seeing how we can make things better.

Mr. TIERNEY. Thank you, Mr. Waxman.

Mr. Shays joined us earlier in the week out at Walter Reed and has been consistently involved with this oversight process, as well. Do you have an opening statement, Mr. Shays?

Mr. SHAYS. Thank you, Mr. Tierney, for your commitment to our subcommittee's ongoing inquiry into the medical care for the men and women of our armed forces. Previous hearings taught us well about the challenges facing our wounded warriors under current Army, Department of Defense, and Department of Veterans Affairs processes. We heard from many who were failed by the system and challenged those responsible to address these failings.

We will do that again today when we question the current commander of Walter Reed Army Medical Center about the new Army medical action plan aimed at addressing shortcomings at Walter Reed and other Army medical facilities.

In our congressional oversight responsibilities, it is important we focus on the Department of Defense's Wounded, Ill, and Injured Senior Oversight Committee's efforts to carry out the recommendations contained in the President's Commission on Care for America's Returning Wounded Warriors, commonly known as the Dole/Shalala Consumer.

In July this Commission released findings that are similar to what we found during our committee's initial investigations begun in the spring of 2004, and are comparable to those we heard from the independent review group this past spring. But the Dole/Shalala Commission's recommendations for executive and congressional action are more aggressive than those in the independent review group. Their implementation will require a collaborative commitment from the Department of Defense, the Department of Veterans Affairs, and especially from congressional committees.

Most of the real work still lies before us. As recommended in the Dole/Shalala report, we must ask some tough questions. Can we completely restructure the disability and compensation system of the Army, Air Force, Navy, Marine Corps, the Department of Defense, and the Department of Veterans Affairs in time to help the number of wounded currently in and entering the systems? Can we create comprehensive recovery plans for every serious injured service member and create a cadre of well-trained recovery coordinators for all stages in a wounded serviceman's life? Who will be responsible for seeing that these plans are carried out between departments? Where will this cadre of coordinators come from? How will they be trained?

We have learned the wounds of war extend far beyond the physical, with many patients struggling to cope with the devastating emotional impacts of war. One of the most chronic outpatient issues for our recovering soldiers has been the diagnosis and treatment of traumatic brain injury [TBI], and the post-traumatic stress disorder [PTSD]. Central to the military creed is the promise to live no soldier or Marine on the battlefield, but if we do not appropriately recognize and treat all wounds, including the issues associated with post-traumatic stress disorder and traumatic brain injury, we do precisely that—we leave them behind.

So we ask the question: how will DOD and the VA now aggressively prevent and treat post-traumatic stress disorder and trau-

matic brain injury? What standards of diagnosis and treatment will be created? Who will pay for this treatment? How will DOD and the VA move quickly to integrate medical information and data between their organizations in order to get clinical data to all essential health, administrative, and benefits professionals that need it?

I look forward to hearing our Government Accountability Office witness recommendations about what the Federal Government can do to address the needs of our wounded warriors. We owe the wounded warrior men and women of our armed services and their families, as has been pointed out already, more than we have given them to date.

I am told the President is committed to implementation of the Dole/Shalala recommendations, and I know this subcommittee is also committed to ensuring we provide the best possible care to our brave men and women.

I look forward to hearing the testimony from our distinguished panel.

I would just close, Mr. Chairman, and again thank you for your work on this and the work of your staff and our staff. One of my staff received an e-mail from a soldier in Iraq who, upon hearing of this hearing this morning, said, "You, the American people, gave us a mission to fix Iraq. We are accomplishing that mission. What we expect from you, the American people, is to help fix us when we come home broken."

Thank you, Mr. Chairman.

[The prepared statement of Hon. Christopher Shays follows:]

STATEMENT OF CONGRESSMAN CHRIS SHAYS, RANKING MEMBER

SUBCOMMITTEE ON NATIONAL SECURITY AND FOREIGN AFFAIRS

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

HEARING

"Third Walter Reed Oversight Hearing: Keeping the Nation's Promise to Our Wounded Soldiers"

September 26, 2007

Thank you, Mr. Tierney, for your commitment to our Subcommittee's ongoing inquiry into the medical care for the men and women of our armed forces.

Previous hearings taught us well the many challenges facing our wounded warriors under current Army, Department of Defense and Department of Veterans Affairs processes.

We heard from many who were failed by the system, and challenged those responsible to address their shortcomings. We will do that again today when we question the current Commander of the Walter Reed Army Medical Center about the new Army Medical Action Plan aimed at addressing shortcomings at Walter Reed.

We also fulfill the role of Congressional oversight when we question two members of the Department of Defense's Wounded, Ill and Injured Senior Oversight Committee, which will carry out the recommendations contained in the President's Commission on Care for America's Returning Wounded Warriors, commonly known as the Dole/Shalala Commission.

In July, this Commission released findings that are similar to what we found during our Committee's long-term investigation and comparable to those we heard from the Independent Review Group during our April hearing.

But the Dole/Shalala Commission's recommendations for executive and congressional action are more aggressive. Their implementation will require a collaborative commitment from the Department of Defense, the Department of Veterans Affairs and especially from Congressional Committees.

Most of the real work still lies before us. As recommended in the Dole/Shalala report we must ask some tough questions:

Can we completely restructure the disability and compensation systems of the Army, Air Force, Navy, Marine Corps, the Department of Defense and the Department of Veterans Affairs in time to help the number of wounded currently in and entering the systems?

Can we create comprehensive recovery plans for every seriously injured service member and create a cadre of well-trained recovery coordinators for all stages in a wounded service member's life?

Who will be responsible for seeing that these plans are carried out between departments?

Where will this cadre of coordinators come from? How will they be trained?

We have learned the wounds of war extend far beyond the physical, with many patients struggling to cope, in the aftermath, with the devastating emotional impacts of war. One of the most chronic outpatient issues for our recovering soldiers has been the diagnosis and treatment of traumatic brain injury and post traumatic stress disorder.

Central to the military creed is the promise to leave no soldier or Marine on the battlefield. But, if we do not appropriately recognize and treat all wounds, including the issues associated with post traumatic stress trauma and brain trauma injury, we do precisely that—we leave them behind.

And so we ask the question, how will DOD and the VA now aggressively prevent and treat post-traumatic stress disorder and traumatic brain injury?

What standards of diagnosis and treatment will be created?

Who will pay for this treatment?

How will DOD and the VA "move quickly" to integrate medical information and data between their organizations in order to get clinical data to all essential health, administrative and benefits professional that need it?

I look forward to hearing from our Government Accountability Office witness concerning their recommendations about what the federal governmental can do to address the needs of our wounded warriors.

We surely owe the wounded men and women of our armed services and their families more than we have given them to date. I am told the President is committed to implementing the Dole/Shalala recommendations.

And I know this Subcommittee is also committed to ensuring we provide the best possible care to our brave men and women.

I look forward to hearing your testimony.

Thank you Mr. Chairman.

Mr. TIERNEY. Thank you, Mr. Shays.

Now the subcommittee will, in fact, receive testimony from the witnesses before us today. I would like to begin by introducing the witnesses on our panel. We have John Pendleton, Acting Director of the Health Care Department at the U.S. Government Accountability Office. With him is Daniel Bertoni, Director of the Education, Workforce, and Income Security Department at the U.S. Government Accountability Office; Major General Eric Schoomaker, M.D., Commanding General of the North Atlantic Regional Medical Command and Walter Reed Army Medical Center; the Honorable Michael S. Dominguez, Principal Deputy Under Secretary of Defense for Personnel and Readiness, U.S. Department of Defense; and Rear Admiral Patrick Dunne, retired, Assistant Secretary for Policy and Planning at the U.S. Department of Veterans Affairs.

Welcome to all of you and thank you for joining us.

It is the policy of the subcommittee to swear you in before you testify, so I ask you to stand and raise your right hands. If there are any other persons who might be assisting you in responding to questions, would they also please rise and raise their right hands.

[Witnesses sworn.]

Mr. TIERNEY. The record will reflect that all witnesses answered in the affirmative.

Your full written statements, of course, as most of you know from previous experience here, will be submitted on the record and accepted, so we will ask that your oral remarks stay as close as you can to 5 minutes and give us a little synopsis of what you have to say.

Mr. Pendleton, I know that you and Mr. Bertoni come as a team, and I understand that you will be presenting remarks and Mr. Bertoni may not. In that case, we will give you a little leeway on the 5-minutes, as we will for all the witnesses in any regard. I thank you and the Government Accountability Office for your fairness in your report and the depth of your work. I would ask you at this point in time to proceed with your testimony.

STATEMENTS OF JOHN PENDLETON, ACTING DIRECTOR, HEALTH CARE, U.S. GOVERNMENT ACCOUNTABILITY OFFICE, ACCOMPANIED BY DANIEL BERTONI, DIRECTOR, EDUCATION, WORKFORCE, AND INCOME SECURITY, U.S. GOVERNMENT ACCOUNTABILITY OFFICE; MAJOR GENERAL ERIC SCHOOMAKER, COMMANDER, WALTER REED ARMY MEDICAL CENTER; MICHAEL L. DOMINGUEZ, PRINCIPAL DEPUTY UNDER SECRETARY OF DEFENSE, PERSONNEL AND READINESS, U.S. DEPARTMENT OF DEFENSE; AND PATRICK W. DUNNE, REAR ADMIRAL, RETIRED, ASSISTANT SECRETARY FOR POLICY AND PLANNING, U.S. DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF JOHN PENDLETON

Mr. PENDLETON. Thank you, Mr. Chairman.

Mr. Chairman and members of the subcommittee, I am pleased to be here today as you continue your oversight of DOD and VA efforts to improve health care and other services. As the situation in Walter Reed came to light earlier this year, the gravity and im-

plications of many longstanding issues became clear. I visited Walter Reed last month, as I know many of you have, and learned first-hand from many of the soldiers there just how far the system still has to go.

I am pleased to be joined by my colleague, Dan Bertoni, who leads our disability work at GAO.

Mr. Chairman, I would like to ask Dan to make a few comments, because he is our disability expert.

Mr. TIERNEY. That is fine.

Mr. PENDLETON. I will provide an overview first and then turn it over to Dan to focus on disability.

Mr. TIERNEY. That is fine. Thank you.

Mr. PENDLETON. Please take note that the findings that we are presenting today are preliminary, based in large part on ongoing reviews. Much of the information is literally days old, and the situation is evolving rapidly.

Efforts thus far have been on two separate but related tracks. First I will cover the Army's service-specific efforts; then I will cover the collective DOD/VA efforts.

The Army is focused on its issue through its medical action plan. The centerpiece of that plan is the new Warrior Transition Units. The Army formed these to blend active and reserve component soldiers into one unit and to improve overall care for its wounded warriors.

While these units have been formed on paper, many still have significant staff shortfalls. As of mid-September, just over half of the total required personnel were in place in these units; however, many of those personnel that were in place had been borrowed, presumably temporarily, from other units. Ultimately, hundreds of nurses, enlisted and officer leaders, social workers, and other highly sought after specialists, like the mental health professionals that will help with TBI and PTSD, will be needed.

The Army told us it plans to have all the positions filled by January 2008, and it is planning to draw these personnel from both the active and reserve component, as well as from the civilian marketplace. Filling all the slots may prove difficult. As I think everyone knows, the Army is stretched thin due to continuing overseas commitments.

Furthermore, the military must compete in a civilian market that will pay top dollar for many of these health professionals. This is an area that we intend to monitor closely as we continue our work.

Now if I could I am going to briefly describe the broader efforts.

Through the newly created Senior Oversight Committee, DOD and VA are working together to address the broader systemic problems. One of the key issues being taken on by the Senior Oversight Committee is improving the continuity of care for returning service members. In plain English, this is about helping the service members move from inpatient to a less-regimented outpatient status, and navigate within and across two entirely different departments, DOD and VA, as well as possibly out to the private sector to obtain needed care. This can be quite complex.

To improve continuity, the Dole/Shalala Commission recommended that recovery plans be crafted to guide care for seriously

injured service members and that senior-level recovery coordinators be put in place to oversee those plans.

DOD and VA intend to adopt this recommendation, but key questions remain unanswered. For example, it is unclear exactly which service members will be served by this recovery coordinator, and without an understanding of the proposed population it is impossible to answer other fundamental questions, like how many recovery coordinators will ultimately be needed.

It is also unclear how the Army's efforts will be synchronized with the broader efforts. This is important so that service members do not have too many case managers, potentially resulting in overlaps and confusion.

Mr. Chairman, given the complexity and urgency of these issues, it is critical for top leaders to ensure the goals are achieved expeditiously; however, careful oversight will be needed to ensure that any gains made in the near term are not lost over time.

That concludes my part of the statement. With your permission, Dan will focus on disability.

[The prepared statement of Mr. Pendleton follows:]

United States Government Accountability Office

GAO

Testimony

Before the Subcommittee on National Security and Foreign Affairs, Committee on Oversight and Government Reform, House of Representatives

For Release on Delivery
Expected at 10:00 a.m. EDT
Wednesday, September 26, 2007

DOD AND VA

Preliminary Observations on Efforts to Improve Health Care and Disability Evaluations for Returning Servicemembers

Statement of John H. Pendleton, Acting Director
Health Care

Statement of Daniel Bertoni, Director
Education, Workforce, and Income Security

GAO-07-1256T

September 26, 2007

GAO
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Highlights

Highlights of GAO-07-1256T, a testimony before the Subcommittee on National Security and Foreign Affairs, Committee on Oversight and Government Reform, House of Representatives

DOD AND VA

Preliminary Observations on Efforts to Improve Health Care and Disability Evaluations for Returning Servicemembers

Why GAO Did This Study

In February 2007, a series of Washington Post articles disclosed troublesome deficiencies in the provision of outpatient services at Walter Reed Army Medical Center, raising concerns about the care for returning servicemembers. These deficiencies included a confusing disability evaluation system and servicemembers in outpatient status for months and sometimes years without a clear understanding about their plan of care. The reported problems at Walter Reed prompted broader questions about whether the Department of Defense (DOD) as well as the Department of Veterans Affairs (VA) are fully prepared to meet the needs of returning servicemembers. In response to the deficiencies reported at Walter Reed, the Army took a number of actions and DOD formed a joint DOD-VA Senior Oversight Committee.

This statement provides information on the near-term actions being taken by the Army and the broader efforts of the Senior Oversight Committee to address longer-term systemic problems that impact health care and disability evaluations for returning servicemembers. Preliminary observations in this testimony are based largely on documents obtained from and interviews with Army officials, and DOD and VA representatives of the Senior Oversight Committee, as well as on GAO's extensive past work. We discussed the facts contained in this statement with DOD and VA.

To view the full product, including the scope and methodology, click on GAO-07-1256T. For more information, contact John H. Pendleton at (202) 512-7114 or pendletonj@gao.gov; or Daniel Bertoni, at (202) 512-7215 or bertonid@gao.gov.

What GAO Found

While efforts are under way to respond to both Army-specific and systemic problems, challenges are emerging such as staffing new initiatives. The Army and the Senior Oversight Committee have efforts under way to improve case management—a process intended to assist returning servicemembers with management of their care from initial injury through recovery. Case management is especially important for returning servicemembers who must often visit numerous therapists, providers, and specialists, resulting in differing treatment plans. The Army's approach for improving case management for its servicemembers includes developing a new organizational structure—a Warrior Transition Unit, in which each servicemember would be assigned to a team of three key staff—a physician care manager, a nurse case manager, and a squad leader. As the Army has sought to staff its Warrior Transition Units, challenges to staffing critical positions are emerging. For example, as of mid-September 2007, over half the U.S. Warrior Transition Units had significant shortfalls in one or more of these critical positions. The Senior Oversight Committee's plan to provide a continuum of care focuses on establishing recovery coordinators, which would be the main contact for a returning servicemember and his or her family. This approach is intended to complement the military services' existing case management approaches and place the recovery coordinators at a level above case managers, with emphasis on ensuring a seamless transition between DOD and VA. At the time of GAO's review, the committee was still determining how many recovery coordinators would be necessary and the population of seriously injured servicemembers they would serve.

As GAO and others have previously reported, providing timely and consistent disability decisions is a challenge for both DOD and VA. To address identified concerns, the Army has taken steps to streamline its disability evaluation process and reduce bottlenecks. The Army has also developed and conducted the first certification training for evaluation board liaisons who help servicemembers navigate the system. To address more systemic concerns, the Senior Oversight Committee is planning to pilot a joint disability evaluation system. Pilot options may incorporate variations of three key elements: (1) a single, comprehensive medical examination; (2) a single disability rating done by VA; and (3) a DOD-level evaluation board for adjudicating servicemembers' fitness for duty. DOD and VA officials hoped to begin the pilot in August 2007, but postponed implementation in order to further review options and address open questions, including those related to proposed legislation.

Fixing these long-standing and complex problems as expeditiously as possible is critical to ensuring high-quality care for returning servicemembers, and success will ultimately depend on sustained attention, systematic oversight by DOD and VA, and sufficient resources.

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today as you examine issues related to the provision of care and services for our returning servicemembers. In February 2007, a series of Washington Post articles disclosed troublesome deficiencies in the provision of outpatient services at Walter Reed Army Medical Center, raising concerns about the care for returning servicemembers and conditions at Army facilities across the country. Deficiencies at Walter Reed included poor living conditions, a confusing disability evaluation system, and servicemembers in outpatient status for months and sometimes years without a clear understanding about their plan of care or the future of their military service.

The reported problems at Walter Reed prompted broader questions about whether the Department of Defense (DOD) as well as the Department of Veterans Affairs (VA) are fully prepared to meet the needs of the increasing number of returning servicemembers as well as veterans. Several review groups were tasked with investigating the reported problems and identifying recommendations. In February 2007, the Secretary of Defense established the Independent Review Group, which reported its findings in April 2007.[1] In March 2007, the President established both the Task Force on Returning Global War on Terror Heroes and the President's Commission on Care for America's Returning Wounded Warriors, commonly referred to as the Dole-Shalala Commission. The Task Force reported its findings in April 2007[2] and the Dole-Shalala Commission reported its findings in July 2007.[3] In August 2007, the President announced that he had directed the Secretaries of DOD and VA to study and implement the recommendations made by the Dole-Shalala Commission. See appendix I for a summary of selected findings from each of the review groups.

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

[2]Task Force on Returning Global War on Terror Heroes, *Report to the President* (April 2007).

[3]President's Commission on Care for America's Returning Wounded Warriors, *Serve, Support, Simplify* (July 2007).

The three review groups identified common areas of concern, including inadequate case management to ensure continuity of care;[4] confusing disability evaluation systems; the need to better understand and diagnose traumatic brain injury (TBI) or post-traumatic stress disorder (PTSD),[5] sometimes referred to as "invisible injuries;" and insufficient data sharing between DOD and VA of servicemembers' medical records. Problems in these areas have been long-standing and the subject of much past work by GAO.[6] For example, we have reported that major disability programs, including the VA's disability programs, are neither well aligned with the 21st century environment nor positioned to provide meaningful and timely support.[7] Specifically, challenges exist related to ensuring timely provision of services and benefits as well as interpreting complex eligibility requirements, among other things. In January 2003, we designated modernizing federal disability programs as a high-risk area.[8]

In response to Walter Reed deficiencies reported by the media, the Army took several actions, most notably initiating the development of the Army Medical Action Plan in March 2007. The plan, designed to help the Army become more patient-focused, includes more than 150 tasks for establishing a continuum of care and services, optimizing the Army Physical Disability Evaluation System, and maximizing coordination of efforts with VA. According to the Army, most of the tasks in the Medical Action Plan are to be completed by January 2008.

In May 2007, DOD established the Wounded, Ill, and Injured Senior Oversight Committee (Senior Oversight Committee) to bring high-level attention to addressing the problems associated with the care and services for returning servicemembers, including the concerns that were being raised by the various review groups. The committee is co-chaired by the Deputy Secretaries of Defense and Veterans Affairs, and also includes the

[4]Case management is a process for guiding a patient's care from one provider, agency, organizational program, or service to another.

[5]TBI is an injury caused by a blow or jolt to the head or a penetrating head injury that disrupts the normal function of the brain. PTSD is an anxiety disorder that can develop after exposure to a traumatic ordeal in which physical harm occurred or was threatened.

[6]See the end of this statement for a list of related GAO products.

[7]GAO, *Federal Disability Assistance: Wide Array of Programs Needs to be Examined in Light of 21st Century Challenges*, GAO-05-626 (Washington, D.C.: June 2, 2005).

[8]GAO, *High-Risk Series: An Update*, GAO-07-310 (Washington, D.C.: January 2007).

military service Secretaries and other high-ranking officials within DOD and VA. To conduct its work, the Senior Oversight Committee has established workgroups that have focused on specific areas including case management, disability evaluation systems, TBI and psychological health, including PTSD, and data sharing between DOD and VA.[9] Each workgroup includes representation from DOD, including each of the military services, and VA. The workgroups report their efforts and recommendations to the Senior Oversight Committee, which directs the appropriate components of DOD and VA to act. The Senior Oversight Committee was established for a 12-month time frame, which will end in May 2008.

Today, our remarks are based on preliminary observations drawn from our ongoing reviews as well as extensive past work. Our statement addresses the near-term actions being taken by the Army, as well as the broader efforts of the Senior Oversight Committee to address longer-term systemic problems that affect care for returning servicemembers, in the following four areas: case management, disability evaluation systems, TBI and PTSD, and data sharing between DOD and VA. We focused on efforts of the Army because it has the majority of servicemembers in Operation Iraqi Freedom and Operation Enduring Freedom, and, as a result the majority of returning servicemembers needing care and rehabilitation go to Army facilities. We also focused on the efforts of the Senior Oversight Committee because it was specifically established to address concerns about the care and services provided to returning servicemembers. Our testimony is based largely on documents obtained from and interviews with Army officials, including the Army's Office of the Surgeon General, and DOD and VA representatives of the Senior Oversight Committee. Specifically, we reviewed Army's staffing data related to the initiatives established in the Army Medical Action Plan. We did not verify the accuracy of these data; however, we interviewed agency officials knowledgeable about the data, and we determined that they were sufficiently reliable for the purposes of this statement. We visited Walter Reed Army Medical Center in August 2007 to talk with officials about how they are implementing the Army's Medical Action Plan and to obtain views from servicemembers about how the efforts are affecting their care. Our findings are preliminary and it was beyond the scope of our work for this statement to review the efforts under way in other military services or throughout DOD and VA. We discussed the facts contained in this

[9]Additional workgroups are examining the condition of DOD and VA facilities as well as issues about personnel, pay, and financial support systems, among others.

statement with DOD and VA, and we incorporated their comments where appropriate. We are conducting the work we began in June in accordance with generally accepted government auditing standards.

In summary, the Army took near-term actions to respond to reported deficiencies about the care and services provided to its returning servicemembers, and the Senior Oversight Committee is undertaking efforts to address more systemic problems. However, challenges remain to overcome long-standing problems and ensure sustainable progress in the four areas we reviewed: (1) case management, (2) disability evaluation systems, (3) TBI and PTSD, and (4) data sharing between DOD and VA.

- **Case management**: The Army has developed a new organizational structure—Warrior Transition Units—for providing an integrated continuum of care for its returning servicemembers. Within each unit, a servicemember is assigned to a team of three critical staff—physician, nurse case manager, and squad leader—who manage the servicemember's care. As of mid-September, 17 of the 32 units had less than 50 percent of staff in place in one or more of these critical positions. To facilitate continuity of care across departments, the Senior Oversight Committee is developing a plan to establish recovery coordinators to oversee the care of severely injured servicemembers across federal agencies, including DOD and VA. This action is being taken to address a recommendation by the Dole-Shalala Commission. Although initial implementation is slated for mid-October 2007, as of mid-September, the committee had not determined how many federal recovery coordinators will be needed. This is partly because it is still unclear exactly what portion of returning servicemembers these recovery coordinators will serve.

- **Disability evaluation systems**: The Army is pursuing several initiatives to help streamline the disability evaluation process for its servicemembers—for example, by reducing the caseloads of staff who help servicemembers navigate the system—and has taken steps to help mitigate servicemembers' confusion, such as providing additional briefings about the process and an online tool. To address more systemic concerns about the timeliness and consistency of DOD's and VA's disability evaluation systems, the Senior Oversight Committee is planning to pilot a joint DOD/VA disability evaluation system that may include variations of three elements: (1) a single, comprehensive medical examination; (2) a single disability rating performed by VA; and (3) a DOD-level retention board for adjudicating servicemembers' fitness for duty. The departments initially slated the pilot to begin on August 1, 2007, but the date has slipped as DOD and VA continue to review pilot options and take steps to address

key questions including those related to emerging legislative proposals and long-standing challenges.

- **TBI and PTSD**: To improve the care provided to servicemembers with TBI and PTSD, both the Army and the Senior Oversight Committee have efforts under way to improve screening, diagnosis, and treatment of these conditions. As part of the Army Medical Action Plan, the Army has established policies to provide training on mild TBI and PTSD to all its nurse case managers and psychiatric nurses, among others. As of September 13, 2007, 6 of the Army's 32 Warrior Transition Units had completed training for all of these staff. The Senior Oversight Committee has developed a policy for DOD and VA to establish a national Center of Excellence for TBI and PTSD that will coordinate the efforts of the two departments related to promoting research, awareness, and best practices on these conditions.

- **Data sharing**: DOD and VA have been working for almost 10 years to facilitate the exchange of medical information. The Army has service-specific efforts under way to improve the sharing of data between its military treatment facilities and VA. Also, the Senior Oversight Committee has developed a workgroup to accelerate data-sharing efforts between the two departments and to help provide for the data-sharing needs of other efforts being overseen by the Senior Oversight Committee. The need for DOD and VA to share patient data continues to be critical. For example, data sharing is important to the proposed recovery coordinators who will require timely and reliable patient information to ensure continuity of care across the many organizational seams in DOD and VA.

Given the importance of all these issues for providing appropriate and high-quality care to our returning servicemembers, it is critical for top leaders at DOD and VA to continue to implement as well as to oversee these efforts to ensure the goals of the efforts are achieved in a timely manner, particularly since there is an increasing need to provide care to servicemembers.

Background

DOD and VA offer health care benefits to active duty servicemembers and veterans, among others. Under DOD's health care system, eligible beneficiaries may receive care from military treatment facilities or from civilian providers. Military treatment facilities are individually managed by

each of the military services—the Army, the Navy,[10] and the Air Force. Under VA, eligible beneficiaries may obtain care through VA's integrated health care system of hospitals, ambulatory clinics, nursing homes, residential rehabilitation treatment programs, and readjustment counseling centers. VA has organized its health care facilities into a polytrauma system of care[11] that helps address the medical needs of returning servicemembers and veterans, in particular those who have an injury to more than one part of the body or organ system that results in functional disability and physical, cognitive, psychosocial, or psychological impairment. Persons with polytraumatic injuries may have injuries or conditions such as TBI, amputations, fractures, and burns.

Over the past 6 years, DOD has designated over 29,000 servicemembers involved in Operation Iraqi Freedom and Operation Enduring Freedom as wounded in action, and almost 70 percent of these servicemembers are from the Army active, reserve, and national guard components. Servicemembers injured in these conflicts are surviving injuries that would have been fatal in past conflicts, due, in part, to advanced protective equipment and medical treatment. The severity of their injuries can result in a lengthy transition from patient back to duty, or to veterans' status. Initially, most seriously injured servicemembers from these conflicts, including activated National Guard and Reserve members, are evacuated to Landstuhl Regional Medical Center in Germany for treatment. From there, they are usually transported to military treatment facilities in the United States, with most of the seriously injured admitted to Walter Reed Army Medical Center or the National Naval Medical Center. According to DOD officials, once they are stabilized and discharged from the hospital, servicemembers may relocate closer to their homes or military bases and are treated as outpatients by the closest military or VA facility.

Returning injured servicemembers must potentially navigate two different disability evaluation systems that generally rely on the same criteria but for different purposes. DOD's system serves a personnel management purpose by identifying servicemembers who are no longer medically fit for duty. The military's process starts with identification of a medical condition that could render the servicemember unfit for duty, a process that could take months to complete. The servicemember goes through a

[10]The Navy is responsible for the medical care of servicemembers in the Marine Corps.

[11]The system is composed of categories of medical facilities that offer varying levels of services.

medical evaluation board proceeding, where medical evidence is evaluated, and potentially unfit conditions are identified. The member then goes through a physical evaluation board process, where a determination of fitness or unfitness for duty is made and, if found unfit for duty, a combined percentage rating is assigned for all unfit conditions and the servicemember is discharged from duty. The injured servicemember then receives monthly disability retirement payments if he or she meets the minimum rating and years of duty thresholds or, if not, a lump-sum severance payment.

VA provides veterans compensation for lost earning capacity due to service-connected disabilities. Although a servicemember may file a VA claim while still in the military, he or she can only obtain disability compensation from VA as a veteran. VA will evaluate all claimed conditions, whether they were evaluated by the military service or not. If the veteran is found to have one or more service-connected disabilities with a combined rating of at least 10 percent,[12] VA will pay monthly compensation. The veteran can claim additional benefits, for example, if a service-connected disability worsens.

While Efforts Are Under Way to Respond to Both Army-Specific and Systemic Problems, Challenges Are Emerging

While the Army took near-term actions to respond to reported deficiencies in care for its returning servicemembers, and the Senior Oversight Committee is undertaking efforts to address more systemic problems, challenges remain to overcome long-standing problems and ensure sustainable progress. In particular, efforts were made to respond to problems in four key areas: (1) case management, (2) disability evaluation systems, (3) TBI and PTSD, and (4) data sharing between DOD and VA. The three review groups identified several problems in these four areas including: a need to develop more comprehensive and coordinated care and services; a need to make the disability systems more efficient; more collaboration of research and establishment of practice guidelines for TBI and PTSD; and more data sharing between DOD and VA. While efforts have been made in all four areas, challenges have emerged including staffing for the case management initiatives and transforming the disability evaluation system.

[12]VA determines the degree to which veterans are disabled in 10 percent increments on a scale of 0 to 100 percent.

Efforts to Improve Case Management for Servicemembers Under Way, but Human Capital and Other Challenges Are Surfacing

The three review groups reporting earlier this year identified numerous problems with DOD's and VA's case management of servicemembers, including a lack of comprehensive and well-coordinated care, treatment, and services. Case management—a process intended to assist returning servicemembers with management of their clinical and nonclinical care throughout recovery, rehabilitation, and community reintegration—is important because servicemembers often receive services from numerous therapists, providers, and specialists, resulting in differing treatment plans as well as receiving prescriptions for multiple medications. One of the review groups reported that the complexity of injuries in some patients requires a coordinated method of case management to keep the care of the returning servicemember focused and goal directed, and that this type of care was not evident at Walter Reed.[13] The Dole-Shalala Commission recommended that recovery coordinators be appointed to craft and manage individualized recovery plans that would be used to guide the servicemembers' care. The Dole-Shalala Commission further recommended that these recovery coordinators come from outside DOD or VA, possibly from the Public Health Service, and be highly skilled and have considerable authority to be able to access resources necessary to implement the recovery plans. The Army and the Senior Oversight Committee's workgroup on case management have initiated efforts to develop case management approaches that are intended to improve the management of servicemembers' recovery process. See table 1 for selected efforts by the Army and Senior Oversight Committee to improve case management services.

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

Table 1: Selected Army and Senior Oversight Committee Efforts to Improve Case Management

U.S. Army
• Established a new organizational structure for providing care to returning servicemembers that combines active duty and reserve servicemembers who are in outpatient status.
• Established a case management approach that includes a primary care physician, nurse case manager, and military squad leader who will coordinate the management of a servicemember's recovery process.
Senior Oversight Committee
• Developed policy requiring DOD and VA to establish a joint Recovery Coordinator Program no later than October 15, 2007, to integrate care and service delivery for returning servicemembers and their families. The recovery coordinators are to be provided by VA.
• Mapped the case management process across the military services and developed common roles and responsibilities for case managers for an integrated DOD and VA approach and joint standards of practice and training.
• Planning to develop DOD/VA oversight metrics to ensure accountability and continuous process improvement.

Sources: Army and Senior Oversight Committee.

The Army's approach includes developing a new organizational structure for providing care to returning active duty and reserve servicemembers who are unable to perform their duties and are in need of health care—this structure is referred to as a Warrior Transition Unit. Within each unit, the servicemember is assigned to a team of three key staff and this team is responsible for overseeing the continuum of care for the servicemember.[14] The Army refers to this team as a "triad," and it consists of a (1) primary care manager—usually a physician who provides primary oversight and continuity of health care and ensures the quality of the servicemember's care; (2) nurse case manager—usually a registered nurse who plans, implements, coordinates, monitors, and evaluates options and services to meet the servicemember's needs; and (3) squad leader—a noncommissioned officer who links the servicemember to the chain of command, builds a relationship with the servicemember, and works along side the other parts of the triad to ensure the needs of the servicemember and his or her family are met. As part of the Army's Medical Action Plan, the Army established 32 Warrior Transition Units, to provide a unit in every medical treatment facility that has 35 or more eligible

[14]The Warrior Transition Unit also includes other staff, such as human resources and financial management specialists.

servicemembers.[15] The Army's goal is to fill the triad positions according to the following ratios: 1:200 for primary care managers; 1:18 for nurse case managers; and 1:12 for squad leaders. This approach is a marked departure for the Army. Prior to the creation of the Warrior Transition Units, the Army separated active and reserve component soldiers into different units.[16] One review group reported that this approach contributed to discontent about which group received better treatment.[17] Moreover, the Army did not have formalized staffing structures nor did it routinely track patient-care ratios, which the Independent Review Group reported contributed to the Army's inability to adequately oversee its program or identify gaps.

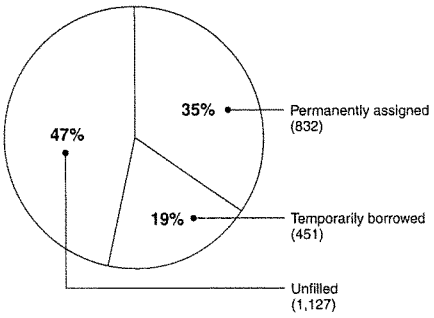
As the Army has sought to fill its Warrior Transition Units, challenges to staffing key positions are emerging. For example, many locations have significant shortfalls in registered nurse case managers and non-commissioned officer squad leaders. As shown in figure 1, about half of the total required staffing needs of the Warrior Transition Units had been met across the Army by mid-September 2007. However, the Army had filled many of these slots thus far by temporarily borrowing staff from other positions.

[15]The Army also established three Warrior Transition Units in Germany.

[16]Active-duty servicemembers were typically placed in Medical Hold units, while Reserve and National Guard servicemembers were placed into separate Medical Holdover units.

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

Figure 1: Status of Warrior Transition Unit Staffing, as of September 13, 2007



Source: GAO analysis of Army data

Note: Percentages do not add to 100 percent due to rounding.

The Warrior Transition Unit staffing shortages are significant at many locations. As of mid-September, 17 of the 32 units had less than 50 percent of staff in place in one or more critical positions. (See table 2.) Consequently, 46 percent of the Army's returning servicemembers who were eligible to be assigned to a unit had not been assigned, due in part to these staffing shortages. As a result, these servicemembers' care was not being coordinated through the triad. Army officials reported that their goal is to have all Warrior Transition Units in place and fully staffed by January 2008.

Table 2: Locations Where Warrior Transition Units Had Less Than 50 Percent of Staff in Place in One or More Critical Positions, as of September 13, 2007

		Critical positions		
Location	Total number of servicemembers at location[a]	Physicians	Nurse case managers	Squad leaders
Fort Hood, Texas	743		x	x
Fort Lewis, Washington	617	x	x	
Fort Bragg, North Carolina	586		x	
Fort Gordon, Georgia	546	x		x
Fort Knox, Kentucky	430			x
Fort Carson, Colorado	394	x	x	x
Fort Campbell, Kentucky	328			x
Tripler, Hawaii	237			x
Fort Stewart, Georgia	223		x	
Fort Riley, Kansas	209		x	x
Fort Eustis, Virginia	128			x
Fort Sill, Oklahoma	127			x
West Point, New York	99			x
Fort Leonard Wood, Missouri	78			x
Fort Wainwright, Alaska	51		x	
Fort Jackson, South Carolina	45		x	x
Redstone Arsenal, Alabama	4	N/A[b]	N/A[b]	x

Source: GAO analysis of Army data.

Note: Warrior Transition Units also include other positions, such as social workers, occupational therapists, and administrative staff.

[a]Total number of servicemembers includes those in outpatient care—assigned to a Warrior Transition Unit as well as in the Medical Evaluation Board process and who have not been assigned to a Warrior Transition Unit.

[b]No staff were authorized for this position.

The Senior Oversight Committee's approach for providing a continuum of care includes establishment of recovery coordinators and recovery plans, as recommended by the Dole-Shalala Commission. This approach is intended to complement the military services' existing case management approaches and place the recovery coordinators at a level above case managers, with emphasis on ensuring a seamless transition between DOD and VA. The recovery coordinator is expected to be the patient's and family's single point of contact for making sure each servicemember receives the care outlined in the servicemember's recovery plan—a plan to

guide and support the servicemember through the phases of medical care, rehabilitation, and disability evaluation to community reintegration.

The Senior Oversight Committee has indicated that DOD and VA will establish a joint Recovery Coordinator Program no later than October 15, 2007. At the time of our review, the committee was determining the details of the program. For example, the Dole-Shalala Commission recommended this approach for every seriously injured servicemember, and the Senior Oversight Committee workgroup on case management was developing criteria for determining who is "seriously injured." The workgroup was also determining the role of the recovery coordinators—how they will be assigned to servicemembers and how many are needed, which will ultimately determine what the workload for each will be. The Senior Oversight Committee has, however, indicated that the positions will be filled with VA staff. A representative of the Senior Oversight Committee told us that the recovery coordinators would not be staffed from the U.S. Public Health Service Commissioned Corps, as recommended by the Dole-Shalala Commission. The official told us that it is appropriate for VA to staff these positions because VA ultimately provides the most care for servicemembers over their lifetime. Moreover, Senior Oversight Committee officials told us that depending on how many recovery coordinators are ultimately needed, VA may face significant human capital challenges in identifying and training individuals for these positions, which are anticipated to be complex and demanding.

Efforts Are Under Way to Improve Disability Evaluation Processes, but Challenges Remain in Transforming the Overall System

As we have previously reported, providing timely and consistent disability decisions is a challenge for both DOD and VA. In a March 2006 report about the military disability evaluation system, we found that the services were not meeting DOD timeliness goals for processing disability cases; used different policy, guidance and processes for aspects of the system; and that neither DOD nor the services systematically evaluated the consistency of disability decisions.[18] On multiple occasions, we have also

[18]GAO, *Military Disability System: Improved Oversight Needed to Ensure Timely and Consistent Outcomes for Reserve and Active Duty Service Members*, GAO-06-362 (Washington, D.C.: Mar. 31, 2006).

identified long-standing challenges for VA in reducing its backlog of claims and improving the accuracy and consistency of its decisions.[19]

The controversy over conditions at Walter Reed and the release of subsequent reports raised the visibility of problems in the military services' disability evaluation system. In a March 2007 report, the Army Inspector General identified numerous issues with the Army Physical Disability Evaluation System.[20] These findings included a failure to meet timeliness standards for determinations, inadequate training of staff involved in the process, and servicemember confusion about the disability rating system. Similarly, in recently-issued reports, the Task Force on Returning Global War on Terror Heroes, the Independent Review Group, and the Dole-Shalala Commission found that DOD's disability evaluation system often generates long delays in disability determinations and creates confusion among servicemembers and their families. Also, they noted significant disparities in the implementation of the disability evaluation system among the services, and in the purpose and outcome of disability evaluations between DOD and VA. Two reports also noted the adversarial nature of DOD's disability evaluation system, as servicemembers endeavor to reach a rating threshold that entitles them to lifetime benefits. In addition to these findings about current processes, the Dole-Shalala Commission questioned DOD's basic role in making disability payments to veterans and recommended that VA assume sole responsibility for disability compensation for veterans.

In response to the Army Inspector General's findings, the Army made near-term operational improvements. For example, the Army developed several initiatives to streamline its disability evaluation system and address bottlenecks. These initiatives include reducing the caseloads of evaluation board liaisons who help servicemembers navigate the disability evaluation system. In addition, the Army developed and conducted the first certification training for evaluation board liaisons. Furthermore, the Army increased outreach to servicemembers to address confusion about the process. For example, it initiated briefings conducted by evaluation board

[19]For additional information on VA disability claims processing, see GAO, *Veterans' Disability Benefits: Long-Standing Claims Processing Challenges Persist*, GAO-07-512T (Washington, D.C.: Mar. 7, 2007); and GAO, *Veterans' Disability Benefits: Processing of Claims Continues to Present Challenges*, GAO-07-562T (Washington, D.C.: Mar. 13, 2007).

[20]Office of the Inspector General, Department of the Army, *Report on the Army Physical Disability Evaluation System*, (Washington, D.C.: Mar. 6, 2007).

liaisons and soldiers' counsels to educate servicemembers about the process and their rights. The Army also initiated an online tool that enables servicemembers to check the status of their case during the evaluation process. We were not able to fully assess the implementation and effectiveness of these initiatives because some changes are still in process and complete data are not available.

To address more systemic concerns about the timeliness and consistency of DOD's and VA's disability evaluation systems, DOD and VA are planning to pilot a joint disability evaluation system. DOD and VA are reviewing multiple options that incorporate variations of the following three elements: (1) a single, comprehensive medical examination to be used by both DOD and VA in their disability evaluations; (2) a single disability rating performed by VA; and (3) incorporating a DOD-level evaluation board for adjudicating servicemembers' fitness for duty. For example, in one option, the DOD-level evaluation board makes fitness for duty determinations for all of the military services; whereas in another option, the services make fitness for duty determinations, and the DOD-level board adjudicates appeals of these determinations. Another open question is whether DOD or VA would conduct the comprehensive medical examination.[21] Table 3 summarizes four pilot options under consideration by DOD and VA.

[21]On August 31, 2007, the Senior Oversight Committee directed DOD and VA to create by October 1, 2007 a single, standardized examination to be used by DOD to determine fitness for all seriously injured servicemembers and by VA to determine disability ratings, but it did not specify which agency will be responsible for conducting the examinations.

Table 3: Summary of Pilot Options under Consideration by DOD and VA

	Comprehensive medical examination	Single disability rating done by VA	DOD-level evaluation board
Option 1	Done by VA	Yes	Makes fitness determinations.
Option 2	Done by DOD	Yes	None. Services make fitness determinations.
Option 3	Done by VA	Yes	Adjudicates appeals of services' fitness determinations.
Option 4	Done by VA	Yes	Conducts quality assurance reviews of services' fitness determinations.

Source: GAO analysis of information provided by DOD.

Note: DOD and VA explored these options at pilot planning exercises conducted in August 2007, but are also considering variations of these options including combining portions of them. For example, one option may be to have DOD conduct comprehensive medical examinations and to have a DOD-level evaluation board make fitness determinations.

As recent pilot planning exercises verified, in addition to agreeing on which pilot option to implement, DOD and VA must address several key design issues before the pilot can begin. For example, it has not been decided how DOD will use VA's disability rating to determine military disability benefits for servicemembers in the pilot. In addition, DOD and VA have not finalized a set of performance metrics to assess the effect of the piloted changes. DOD and VA officials had hoped to begin the pilot on August 1, 2007, but the intended start date slipped as agency officials took steps to further consider alternatives and address other important questions related to recent and expected events that may add further complexity to the pilot development process. For example, the Senior Oversight Committee may either choose or be directed by the Congress to pilot the Dole-Shalala recommendation that only VA and not DOD provide disability payments to veterans. Implementing this recommendation would require a change to current law, and could affect whether or how the agencies implement key pilot elements under consideration. In addition, the Veterans' Disability Benefits Commission, which is scheduled to report in October 2007, may recommend changes that could also influence the pilot's structure. Further, the Congress is considering legislation that may

require DOD and VA to conduct multiple, alternative disability evaluation pilots.[22]

DOD and VA face other critical challenges in creating a new disability evaluation system. For example, DOD is challenged to overcome servicemembers' distrust of a disability evaluation process perceived to be adversarial. Implementing a pilot without adequately considering alternatives or addressing critical policy and procedural details may feed that distrust because DOD and VA plan to pilot the new system with actual servicemembers. The agencies also face staffing and training challenges to conduct timely and consistent medical examinations and disability evaluations. Both the Independent Review Group and the Dole-Shalala Commission recommended that only VA establish disability ratings. However, as we noted above, VA is dealing with its own long-standing challenges in providing veterans with timely and consistent decisions.[23] Similarly, if VA becomes responsible for servicemembers' comprehensive physical examinations, it would face additional staffing and training challenges, at a time when it is already addressing concerns about the timeliness and quality of its examinations. Further, while having a single disability evaluation could ensure more consistent disability ratings, VA's Schedule for Rating Disabilities is outdated because it does not adequately reflect changes in factors such as labor market conditions and assistive technologies on disabled veterans' ability to work. As we have reported, the nature of work has changed in recent decades as the national economy has moved away from manufacturing-based jobs to service- and knowledge-based employment.[24] Yet VA's disability program remains mired in concepts from the past, particularly the concept that impairment equates to an inability to work.

[22]H.R. 1538, as passed by the Senate on July 25, 2007, Sec. 154.

[23]To help address processing challenges, VA hired about 1,000 new disability claims processing employees since January 2007.

[24]GAO, *High-Risk Series: An Update*, GAO-03-119 (Washington, D.C.: Jan. 1, 2003) and *SSA and VA Disability Programs: Re-Examination of Disability Criteria Needed to Help Ensure Program Integrity*, GAO-02-597 (Washington, D.C.: Aug. 9, 2002).

Efforts Under Way to Improve Screening, Diagnosis, and Treatment for TBI and PTSD

The three independent review groups examining the deficiencies found at Walter Reed identified a range of complex problems associated with DOD and VA's screening, diagnosis, and treatment of TBI and PTSD, signature injuries of recent conflicts. Both conditions are sometimes referred to as "invisible injuries" because outwardly the individual's appearance is just as it was before the injury or onset of symptoms. In terms of mild TBI, there may be no observable head injury and symptoms may overlap with those associated with PTSD. With respect to PTSD, there is no objective diagnostic test and its symptoms can sometimes be associated with other psychological conditions (e.g., depression). Recommendations from the review groups examining these areas included better coordination of DOD and VA research and practice guidelines and hiring and retaining qualified health professionals. However, according to Army officials and the Independent Review Group report, obtaining qualified health professionals, such as clinical psychologists, is a challenge, which is due to competition with private sector salaries and difficulty recruiting for certain geographical locations. The Dole-Shalala Commission noted that while VA is considered a leader in PTSD research and treatment, knowledge generated through research and clinical experience is not systematically disseminated to all DOD and VA providers of care. Both the Army and the Senior Oversight Committee are working to address this broad range of issues. (See table 4.)

Table 4: Selected Army and Senior Oversight Committee Efforts to Improve Screening, Diagnosis, and Treatment of TBI and PTSD

U.S. Army
• Providing mild-TBI and PTSD training for social workers, nurse case managers, psychiatric nurses, and psychiatric nurse practitioners.
• Exploring ways to track incidents on the battlefield (e.g., blasts) that may result in TBI or PTSD.
• Examining procedures for screening servicemembers for mild TBI and PTSD prior to an involuntary release from the Army to ensure that servicemembers are not inappropriately separated for behavioral problems.
Senior Oversight Committee
• Developed policy requiring DOD and VA to establish a national Center of Excellence for TBI and PTSD no later than November 30, 2007.
• Establishing common educational and training materials and screening processes for mild TBI and PTSD, as well as consistent definitions for mild-TBI diagnosis.

Sources: Army and Senior Oversight Committee.

The Army, through its Medical Action Plan, has policies in place requiring all servicemembers sent overseas to a war zone to receive training on recognizing the symptoms of mild TBI and PTSD. The Army is also exploring ways to track events on the battlefield, such as blasts, that may result in TBI or PTSD. In addition, the Army recently developed policies to provide mild TBI and PTSD training to all social workers, nurse case managers, psychiatric nurses, and psychiatric nurse practitioners to better identify these conditions. As of September 13, 2007, 6 of the Army's 32 Warrior Transition Units had completed training for all of these staff.

A Senior Oversight Committee workgroup on TBI and PTSD is working to ensure health care providers have education and training on screening, diagnosing, and treating both mild TBI and PTSD, mainly by developing a national Center of Excellence as recommended by the three review groups.[25] This Center of Excellence is expected to combine experts and resources from all military services and VA to promote research, awareness, and best practices on mild TBI as well as PTSD and other psychological health issues. A representative of the Senior Oversight Committee workgroup on TBI and psychological health told us that the Center of Excellence would include the existing Defense and Veterans Brain Injury Center—a collaboration among DOD, VA, and two civilian partners that focuses on TBI treatment, research, and education.[26]

Efforts Under Way to Facilitate Data Sharing between DOD and VA

DOD and VA have been working for almost 10 years to facilitate the exchange of medical information. However, the three independent review groups identified the need for DOD and VA to further improve and accelerate efforts to share data across the departments. Specifically, the Dole-Shalala Commission indicated that DOD and VA must move quickly to get clinical and benefit data to users, including making patient data immediately viewable by any provider, allied health professional, or program administrator who needs the data. Furthermore, in July 2007, we reported that although DOD and VA have made progress in both their long-

[25]VA has a national Center on PTSD that was required to be established by the Veterans' Health Care Act of 1984. This center advances the clinical care and social welfare of veterans though research, education, and training of clinicians in the causes, diagnosis, and treatment of PTSD.

[26]In April 2007, VA established policy requiring all Operation Iraqi Freedom and Operation Enduring Freedom veterans receiving care within the VA system to be screened for TBI. Additionally, if the screen determines that the veteran might have TBI, then the veteran must be offered further evaluation and treatment by providers with expertise in this area.

term and short-term initiatives to share health information, much work remains to achieve the goal of a seamless transition between the two departments.[27] While pursuing their long-term initiative to develop a common health information system that would allow the two-way exchange of computable health data,[28] the two departments have also been working to share data in their existing systems. See table 5 for selected efforts under way by the Army and Senior Oversight Committee to improve data sharing between DOD and VA.

Table 5: Selected Army and Senior Oversight Committee Efforts to Improve DOD and VA Data Sharing

U.S. Army
• Army Medical Department is developing a memorandum of understanding regarding sharing of medical data between Army military treatment facilities and VA.
Senior Oversight Committee
• Developed policy requiring DOD and VA to develop a plan to execute a single Web portal to support the care and needs of servicemembers and veterans by December 31, 2007.
• Developed data sharing policies requiring DOD and VA to (1) develop a plan for interagency sharing of essential health images, such as radiology studies, by March 31, 2008; (2) ensure that all essential health and administrative data are made available and viewable to both departments, and requiring that progress be reported by a scorecard no later than October 31, 2008.

Sources: Army and Senior Oversight Committee.

As part of the Army Medical Action Plan, the Army has taken steps to facilitate the exchange of data between its military treatment facilities and VA. For example, the Army Medical Department is developing a memorandum of understanding between the Army and VA that would allow VA access to data on severely injured servicemembers who are being transferred to a VA polytrauma center. The memorandum of understanding would also allow VA's Veterans Health Administration and Veterans Benefits Administration access to data in a servicemember's medical record that are related to a disability claim the servicemember has filed with VA. Army officials told us that the Army's medical records are

[27]GAO, *Information Technology: VA and DOD Are Making Progress in Sharing Medical Information, but Remain Far from Having Comprehensive Electronic Medical Records*, GAO-07-1108T (Washington, D.C.: July 18, 2007).

[28]Computable data are data in a format that a computer application can act on—for example, to provide alerts to clinicians of drug allergies.

part paper (hard copy) and part electronic, and this effort would provide the VA access to the paper data until the capability to share the data electronically is available at all sites.[29]

Given that DOD and VA already have a number of efforts under way to improve data sharing between the two departments, the Senior Oversight Committee, through its data sharing workgroup, has been looking for opportunities to accelerate the departments' sharing initiatives that are already planned or in process and to identify additional data sharing requirements that have not been clearly articulated. For example, the Senior Oversight Committee has approved several policy changes in response to the Dole-Shalala Commission, one of which requires DOD and VA to ensure that all essential health and administrative data are made available and viewable to both agencies, and that progress is reported by a scorecard, by October 31, 2008. A representative of the data sharing workgroup told us that the departments are achieving incremental increases to data sharing capabilities and plan to have all essential health data—such as outpatient pharmacy, allergy, laboratory results, radiology reports, and provider notes—viewable by all DOD and VA facilities by the end of December 2007.[30] Although the agencies have recently experienced delays in efforts to exchange data, the representative said that the departments are on track to meet all the timelines established by the Senior Oversight Committee.

A Senior Oversight Committee workgroup on data sharing has also been coordinating with other committee workgroups on their information technology needs. Although workgroup officials told us that they have met numerous times with the case management and disability evaluation systems workgroups to discuss their data sharing needs, they have not begun implementing necessary systems because they are dependent on the other workgroups to finalize their information technology needs. For example, the Senior Oversight Committee has required DOD and VA to establish a plan for information technology support of the recovery plan to be used by recovery coordinators, which integrates essential clinical (e.g., medical care) and nonclinical aspects (e.g., education, employment, disability benefits) of recovery, no later than November 1, 2007. However,

[29]Officials from Walter Reed Army Medical Center told us that Walter Reed already has the capability to share this data electronically.

[30]DOD facilities in combat zones may not have this capability because they operate in a different environment with different informational technology capabilities.

this cannot be done until the case management workgroup has identified the components and information technology needs of these clinical and nonclinical aspects, and as of early September this had not been done. Data sharing workgroup representatives indicated that the departments' data sharing initiatives will be ongoing because medications, diagnoses, procedures, standards, business practices, and technology are constantly changing, but the departments expect to meet most of the data sharing needs of patients and providers by end of fiscal year 2008.

Concluding Observations

Our preliminary observations are that fixing the long-standing and complex problems spotlighted in the wake of Walter Reed media accounts as expeditiously as possible is critical to ensuring high-quality care for our returning servicemembers, and success will ultimately depend on sustained attention, systematic oversight by DOD and VA, and sufficient resources. Efforts thus far have been on separate but related tracks, with the Army seeking to address service-specific issues while DOD and VA are working together to address systemic problems. Many challenges remain, and critical questions remain unanswered. Among the challenges is how the efforts of the Army—which has the bulk of the returning servicemembers needing medical care—will be coordinated with the broader efforts being undertaken by DOD and VA.

The centerpiece of the Army's effort is its Medical Action Plan, and the success of the plan hinges on staffing the newly-created Warrior Transition Units. Permanently filling these slots may prove difficult, and borrowing personnel from other units has been a temporary fix but it is not a long-term solution. The Army can look to the private sector for some skills, but it must compete for personnel in a civilian market that is vying for medical professionals with similar skills and training.

Perhaps one of the most complex efforts under way is that of redesigning DOD's disability evaluation system. Delayed decisions, confusing policies, and the perception that DOD and VA disability ratings result in inequitable outcomes have eroded the credibility of the system. Thus, it is imperative that DOD and VA take prompt steps to address fundamental system weaknesses. However, as we have noted, key program design and operational policy questions must be addressed to ensure that any proposed system redesign has the best chance for success and that servicemembers and veterans receive timely, accurate, and consistent decisions. This will require careful study of potential options, a comprehensive assessment of outcome data associated with the pilot, proper metrics to gauge success, and an evaluation mechanism to ensure

needed adjustments are made to the process along the way. Failure to properly consider alternatives or address critical policy and procedural details could exacerbate delays and confusion for servicemembers, and potentially jeopardize the system's successful transformation.

Mr. Chairman, this completes my prepared remarks. We would be happy to respond to any questions you or other members of the subcommittee may have at this time.

For further information about this testimony, please contact John H. Pendleton at (202) 512-7114 or pendletonj@gao.gov or Daniel Bertoni at (202) 512-7215 or bertonid@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. GAO staff who made major contributions to this report are listed in appendix II.

Appendix I: Selected Issues Identified by Three Review Groups following the Reporting of Deficiencies at Walter Reed

In the aftermath of deficiencies identified at Walter Reed Medical Center, three separate review groups—the President's Commission on Care for America's Returning Wounded Warriors, commonly referred to as the Dole-Shalala Commission; the Independent Review Group, established by the Secretary of Defense; and the President's Task Force on Returning Global War on Terror Heroes—investigated the factors that may have led to these problems. Selected findings of each report are summarized in table 6.

Table 6: Selected Findings of Review Groups Reporting on Walter Reed Army Medical Center Deficiencies

Review groups	Findings
President's Commission on Care for America's Returning Wounded Warriors (Dole-Shalala Commission) (July 2007)	• A patient-centered recovery plan is needed for all seriously injured servicemembers. • Department of Defense's (DOD) disability and compensation systems need to be "completely restructured." • DOD and the Department of Veterans Affairs (VA) must work to aggressively prevent and treat post-traumatic stress disorder (PTSD) and traumatic brain injury (TBI) and reduce perceived stigma of both conditions. • Support for servicemembers' families must be strengthened, including expanding DOD respite care and extending the Family and Medical Leave Act for up to six months for spouses and parents of the seriously injured. • DOD and VA should work together to quickly share clinical and administrative data with each other. A "My eBenefits" page for servicemembers should be established. • DOD and VA must assure that Walter Reed Army Medical Center has the clinical and administrative staff it needs, until its closure in 2011.
Secretary of Defense's Independent Review Group on Rehabilitative Care and Administrative Processes at Walter Reed Army Medical Center and National Naval Medical Center (April 2007)	• Comprehensive care, treatment, and administrative services not provided to the outpatient in a collaborative manner at Walter Reed Army Medical Center. • Lack of clear, consistent standards for qualifications and training of outpatient case managers across the Army, Navy, and Air Force. • Lack of early identification techniques and comprehensive clinical practice guidelines for TBI and its overlap with PTSD, within the military health system, results in inconsistent diagnosis and treatment. • Serious difficulties administering the Physical Disability Evaluation System due to significant variance in policy and guidelines among the military services. The current process is cumbersome, inconsistent, and confusing to providers, patients, and families. • No common automated interface exists between the clinical and administrative systems within DOD and among the services, or between DOD and VA.
President's Task Force on Returning Global War on Terror Heroes (April 2007)	• DOD's and VA's disability evaluation systems are confusing, time consuming, and sometimes inconsistent among the services and between DOD and VA. • No formal agreements for how active duty servicemembers should be managed when they receive services from both DOD and VA. • No agreements on definition of case management, functions of case managers, or how DOD and VA case managers should transfer patients to one another to assure continuity of care. • Servicemembers with mild to moderateTBI can be particularly difficult to diagnose given the lack of easily visible symptoms. • While VA provides a comprehensive medical benefits package for enrolled veterans, the current paper and online versions of the required paperwork for certain benefits packages do not allow for identification of Operation Enduring Freedom / Operation Iraqi Freedom veterans. Further, the online application does not provide e-authentication or e-signature capabilities thereby requiring veterans to submit signed applications and complete the entire form, including some data they have already supplied VA.

Sources: President's Commission on Care for America's Returning Wounded Warriors, the independent Review Group, and the President's Task Force on Returning Global War on Terror Heroes.

Appendix II: GAO Contacts and Staff Acknowledgments

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Acknowledgment

In addition to the contact named above, Bonnie Anderson, Assistant Director; Michele Grgich, Assistant Director; Jennie Apter; Janina Austin; Joel Green; Christopher Langford; Chan My Sondhelm; Barbara Steel-Lowney; and Greg Whitney, made key contributions to this statement.

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Mr. TIERNEY. Thank you, Mr. Pendleton.

Mr. Bertoni, we would be interested to hear from you.

STATEMENT OF DANIEL BERTONI

Mr. BERTONI. Good morning, Mr. Chairman and members of the subcommittee. I am pleased to be here to discuss an issue of critical importance: providing timely, accurate, and consistent disability benefits to returning service members and veterans. Thousands of Operation Iraqi Freedom and Operation Enduring Freedom service members have been wounded in action, many of whom are now trying to navigate a complicated labyrinth of disability policies and often wait many months and even years for a decision.

Various commission reports have noted that overhauling the disability evaluation process is key to improving the cumbersome, inconsistent, and confusing bureaucracy facing injured service members.

My testimony today draws on our ongoing work and focuses on three areas: current efforts to improve the evaluation process; challenges to reforming the system; and issues to consider as DOD and VA press ahead on this important matter.

In summary, our prior work has identified longstanding weaknesses in DOD's and VA's disability programs, especially in regard to the timeliness, accuracy, and consistency of decisions. More recently, an Army Inspector General report noted similar problems with DOD's system, including a failure to meet timeliness standards, poor training, and service member confusion about disability ratings.

In response, the Army developed several near-term initiatives to streamline processes and reduce bottlenecks such as expanding training, reducing the case loads of staff responsible for helping service members navigate the system, and conducting outreach to educate service members about the process and their rights.

To address the more fundamental systemic issues, DOD and VA area also planning to pilot a joint disability evaluation system. The agencies are currently vetting multiple pilot options that incorporate variations of: one, a single medical exam; two, a single disability rating performed by VA; and, three, a DOD-level evaluation board for determining fitness for duty. However, at the time of our review, several key issues remain in question, such as who will conduct the medical exam, how the services will use VA's rating, and determining the role of the board.

DOD and VA recently completed a tabletop exercise of four pilot options using actual service member cases. While preliminary results showed that no single option was ideal, officials told us they were currently analyzing the data to determine which option or combination thereof would be most effective.

Although the pilot was originally scheduled for roll-out in 2007, this data slipped as officials continued to consider these important issues, as well as various commission report findings and pending legislation which could, in fact, affect the pilot's final design and implementation.

Beyond pilot design issues, DOD and VA face other challenges. Three of the options call for VA to conduct the medical exam as well as establish the disability rating. This could have substantial

staffing and training implementations at a time when VA, with 400,000 pending claims already, is struggling to provide current veterans with timely and quality services.

We are also concerned that, while having a single rating could improve consistency, VA's outdated rating schedule does not reflect changes in the national economy and the capacity of injured service members to work, thus potentially undermining the re-integration of returning warriors into productive society.

Going forward, DOD and VA must take aggressive yet deliberate steps to address this issue. Key program design and policy questions should be fully vetted to ensure that any proposed redesign has the best chance of success. This will require careful, objective study of all proposed options and pending legislation, comprehensive assessment of pilot outcome data, proper metrics to gauge progress of the pilot, and evaluation process to ensure needed adjustments are made along the way.

Failure to properly consider alternatives or address critical policy details could worsen delays and confusion and jeopardize the system's successful transformation.

Mr. Chairman, this concludes my statement. I am happy to answer any questions you might have.

Mr. TIERNEY. Thank you very much. Thanks to both of you gentlemen.

General Schoomaker, would you care to make some remarks?

STATEMENT OF MAJOR GENERAL ERIC SCHOOMAKER

General SCHOOMAKER. Mr. Chairman, Congressman Shays, distinguished members of the subcommittee, thanks for this opportunity to update you on the extraordinary and heroic acute care and rehabilitative and comprehensive support of our warriors and families being performed every day at Walter Reed Army Medical Center and throughout our Army. I am very proud to be here with you today sharing some of the many accomplishments of the clinicians, medics, technicians, nurses, therapists, uniformed and civilian Army, Navy, Air Force, full-time, volunteers—all of those who care for these most-deserving American warriors and their families.

Words, alone, really can't do justice to caregivers at Walter Reed Army Medical Center and their colleagues throughout the Joint Medical Force for what they do every day in really extremely demanding jobs. You have seen them yourself when you have been out to visit our hospitals. They are witness to much pain and suffering. The pace is constant and unyielding. But they recognize that we have the privilege to care for the best patients in the world, our young men and women who have given of themselves for our country.

Our patients, as you have seen, are an astounding group of warriors who inspire and amaze us every day. Their incredible spirit and energy drive our hospitals to the highest level of performance and invoke in our health care providers and staff a level of commitment and dedication to patients that is unparalleled, in my experience. I am constantly impressed with the quality and caliber of the health care team at Walter Reed and their unwavering focus on caring for these deserving warriors and their families.

I am always careful to point out to all visitors and to members of the public and to our elected officials that the quality of care, itself, was never in question at Walter Reed or any military facility. As you know, my Command Sergeant Major Althea Dixon and I joined the Walter Reed leadership team in early March. In fact, I took command shortly before you.

Our focus has been on ensuring that the warriors for whom we care get the very best medical care, the best administrative processing, and the best support services that are available. With worldwide support from the Army leadership and of trusted colleague Brigadier General Mike Tucker, a career armor officer, a former NCO, and a veteran of both Operation Desert Storm and Iraqi Freedom, who set out to correct identified deficiencies and provide the very best for our warriors and their families, we have received extraordinary support from the U.S. Army Medical Command, the entire Army, the senior Department of Defense leadership, and the Department of Veterans Affairs.

During the past 6 months we have identified problems and, where appropriate, we have taken immediate corrective actions. Many involved the creation of support services which were present at larger Army installations but weren't available at Walter Reed before the events of mid-February.

The specifics of these changes and the continuing improvements are outlined in my formal written statement for this hearing. Let me focus on several recent events and key people to highlight our progress.

First, I would like to talk about Staff Sergeant John D. Shannon. Many of you know Staff Sergeant Shannon is one of the first three soldiers who raised serious concerns about our care and support of soldiers like him. He lived in building 18. He appeared before this committee at a hearing held at Walter Reed in March. He has since met with you and members of your staff updating you on his concerns and progress, and, as you alluded to, Mr. Chairman, he recently was the subject of a newspaper cover story on continuing problems for our warriors in transition like him.

I regret that he declined to be with us today. He is in the midst of out-processing, and I trust that he won't take issue with my talking about him in an open hearing here to day.

We have endeavored to work closely with wounded warriors like Staff Sergeant Shannon to improve our system of care and administrative processes at Walter Reed, and, by extension, across the Army and the joint force, and into long-term care and continued rehabilitation within the Veterans Administration system. We immediately improved the housing conditions for all our warriors in transition who were in building 18 and any other accommodations that did not meet the highest standards of the Army.

We created a triad of a squad leader, a physician primary care manager, and a nurse case manager to ensure the well-being; provide comprehensive medical oversight; and ensure administrative efficiency, timeliness, and thoroughness in the care and rehabilitation and adjudication of physical disability for these warriors.

Regrettably, in Staff Sergeant Shannon's case we encountered a problem toward the end of his very lengthy acute treatment, rehabilitation, and processing of disability which resulted in misin-

formation and fear of unnecessary delays in his medical retirement. But his chain of command and the support systems embodied in the triad responded promptly to his call for help and he underwent all steps on schedule in his Physical Evaluation Board process, and he is now out-processing from Walter Reed and will be medically retired from the Army.

Ironically, Staff Sergeant Shannon, in conversations with him, did not realize that because the physical disability system and the Physical Evaluation Board are separated from our squad leaders, that he should not have gone to his squad leader to get help. In fact, that is exactly what we would have asked him to do, and we have used his example to re-educate people about how to get help within our system.

We truly appreciated his service and his sacrifice. It is our obligation, it is, frankly, our sworn duty to heal soldiers like Staff Sergeant Shannon.

Every warrior in transition and every family is a unique case and experiences unique challenges. We won't perform flawlessly always, but we are hard at work building a team of clinicians, military leaders, and case managers and experts in all aspects of medical benefits and physical ability adjudication to allow us to provide the very best possible care.

Finally, let me talk briefly about efforts to accelerate the transition at Walter Reed into a new Walter Reed National Military Medical Center at Bethesda and how our work on warrior care in the Army is being embraced by the entire joint medical community. Our transition is proceeding very well. Rear Admiral Promotable Madison of the Navy, who was recently appointed as the commander of the joint task force to combine medical military operations in the National Capital Region, strongly supports the future establishment of a warrior transition brigade at the future Walter Reed National Military Medical Center in Bethesda, and that may well serve as a model for the development of a joint service approach to caring for warriors in transition.

We are also encouraged by recent directions from the Deputy Secretary of Defense, Mr. Gordon England, in an August 29, 2007, memorandum that directs the service Secretaries to use all existing authorities to recruit and retain military and civilian personnel necessary for seriously injured warriors and directing the Secretaries to fully fund these authorities to achieve this goal.

In his memorandum, Secretary England directs the Secretary of the Army to develop and implement "a robust recruitment plan" to address identified gaps in staffing and sufficiently fund the Walter Reed budget to pay for these recruitment and retention incentives.

These efforts should help to stabilize the work force at Walter Reed and to ensure that our warriors will continue to be cared for by the best health care professionals in the world. I believe that the actions that we have taken in the last 6 months will ultimately make Walter Reed and the Army Medical Department stronger organizations, more adept at caring for warriors and their families.

We need to continue to address our shortfalls. We need to continue to focus on serving our warriors and families, and we will continue to improve.

Thanks for this opportunity to speak with the committee today and answer your questions.

[The prepared statement of General Schoomaker follows:]

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FINAL VERSION

STATEMENT BY

MAJOR GENERAL ERIC B. SCHOOMAKER
COMMANDING GENERAL, NORTH ATLANTIC REGIONAL MEDICAL COMMAND AND WALTER REED ARMY MEDICAL CENTER

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

UNITED STATES HOUSE OF REPRESENTATIVES

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WALTER REED PROGRESS REVIEW

SEPTEMBER 26, 2007

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Mr. Chairman, Congressman Shays, and distinguished members of the sub-committee, thank you for the opportunity to update you on the extraordinary and heroic acute care, rehabilitation and comprehensive support of Warriors and Families being performed every day at Walter Reed Army Medical Center (WRAMC). It is with great pride that I share with you the accomplishments of the hundreds of clinicians, medics, technicians, nurses, therapists, leaders and administrators—uniformed and civilian, Army, Navy and Air Force, full-time and volunteers—who care for these most deserving Warriors and their Families. The caregivers at Walter Reed have extremely demanding jobs. They are witnesses to much pain and suffering. The pace is constant and unyielding. But they are also privileged to care for the best patients in the world--young men and women who have given of themselves for their country. Our patients are an astounding group of Warriors who inspire and amaze us every day. Their incredible spirit and energy drive this installation and evoke in our health care providers and staff a level of commitment and dedication to their patients that is unparalleled. I am constantly impressed by the quality and caliber of the health care team at Walter Reed and their unwavering focus on caring for these deserving Warriors and their Families.

Since I joined the talented WRAMC Leadership team with my trusted Command Sergeant Major Althea Dixon in early March, my focus has been on ensuring that the Warriors for whom we care get the best medical care, the best administrative processing, and the best support systems available. With Brigadier General Mike Tucker, a career Armor officer, former Non-Commissioned Officer, and Operation Desert Storm and Operation Iraqi Freedom veteran at my side, and with countless other leaders throughout the organization, we have set out to correct identified deficiencies and provide the best of everything for our Warriors and their Families. Throughout this effort, we have received extraordinary support from the U.S. Army Medical Command, the

entire Army, the senior leadership of the Department of Defense and the Department of Veterans Affairs, as well as the United States Congress.

During the past 6 months, we have identified problems and, where appropriate, have taken immediate corrective actions. Many involved the creation of support services which are present at larger Army installations but were not available at WRAMC before the events of mid-February. Some of our early accomplishments included:

- Immediate relocation of Soldiers from Bldg 18 to the highest quality barracks space available in Abrams Hall on the WRAMC Campus
- Installation of telephone, cable television, and internet in each Warrior in Transition room
- Provision of Family Counselors who are available 24 hours-a-day/7 days-a-week
- Establishment of priority access to medical care and appointments for Warriors in Transition undergoing Medical Evaluation Boards (MEB) as a means of ensuring effective healing and medical care as well as expediting completion of Medical and Physical Evaluation Boards
- Establishment of a one-stop Soldier and Family Assistance Center (SFAC) that is centrally located in the Hospital providing all necessary services for family assistance, finance, and personnel actions
- Establishment of a "Warrior Clinic" providing Warriors in Transition and their Families improved access to care, continuity of rehabilitative care, and enhanced movement through the medical process.
- Establishment of a program to greet Family Members upon arrival at Andrews Air Force Base and civilian airports and escort them to WRAMC
- Implementation of Monday welcome briefs and Thursday town hall meetings for Soldiers and Families
- Distribution of informational handbooks and Warrior and Family Hotline cards to Soldiers and Families

- Elimination of the backlog of awards and decorations, in part by holding a series of frequent--now monthly—Purple Heart ceremonies in the Walter Reed auditorium attended by a standing room only audience of Soldiers, Families, hospital staff and fellow warriors
- Co-location of Department of Veterans Affairs Social Work Liaisons with Nurse Case Managers (NCM) to facilitate seamless transition of Warriors in Transition to Department of Veterans Affairs programs and services
- Employment of an Ombudsman to give Wounded Soldiers a source to resolve issues and combination of the Ombudsmen and Patient Representatives to form a Patient Advocacy Center
- Enhanced accessibility to the hospital dining facility for Wounded Warriors
- Creation of a Clothing Issue Point to issue new uniforms to Wounded Warriors

These early accomplishments of the first 90 days were the "easy victories." Although they required some innovative thinking and some bureaucracy busting, the solutions could be implemented quickly. These second 90 days have involved the same level of effort and innovation, but the results are less eye-catching. Nevertheless, tremendous progress has been made and we've built the foundation for long-term sustainable improvements to the system of caring for Warriors in Transition. Some of these accomplishments include:

- Attained sufficient staffing of Primary Care Manager (PCM), Nurse Case Manager, and Squad Leader (SL) personnel to meet the staffing ratios called for in the Army Medical Action Plan (AMAP) for these critical positions
- Piloted ***myMEB***, a web-based portal that became available Army-wide on July 9, 2007 to all Soldiers undergoing a MEB enabling them to track the progress of their MEB proceedings, as well as access a wealth of information to help them better understand the MEB process

- Served as a beta test site for a Staff Assistance Visit program designed to assist Warrior Transition Units Army-wide to become better able to execute their AMAP responsibilities
- Conducted a 2-day Certification and Training Seminar in Silver Spring, Maryland, June 16 and 17, 2007 for all 35 Warrior Transition Units. In addition, the training provided during this seminar has been established as a resident course at the Army Medical Department Center and School at Ft. Sam Houston in San Antonio, Texas
- Conducted training for Ombudsmen to help them cut through red tape to resolve concerns for Warriors in Transition
- Initiated behavioral health certification training developed by the Department of Veterans Affairs to train all Clinical Social Workers, Nurse Case Managers, Psychiatric Nurses, and Psychiatric Nurse Practitioners who care for Warriors in Transition
- Conducted Physical Evaluation Board Liaison Officer (PEBLO) performance training on the responsibilities of this pivotal position when it comes to efficient navigation of the Physical Disability Evaluation System

As you are all well aware, for the last several years the Walter Reed campus has been home to hundreds of Warriors in Transition—formerly known as Med Hold and Med Holdover Soldiers--and to hundreds of their Family members. We've been running what essentially amounts to a fully-occupied intermediate or step-down rehabilitation complex on the grounds of Walter Reed Army Medical Center without the structure, design, or manpower to support it. Individuals were putting forth Herculean efforts to patch things together and make it work. Platoon sergeants—many of whom were former patients or medics tasked with new roles--were responsible, on average, for the care and well-being of 55 Soldiers with illness and injuries-some unseen, such as behavioral health challenges and mild Traumatic Brain Injury. This was an enormous burden to place on one individual, especially when those in their

charge were in many instances facing significant, life altering medical concerns and decisions about their and their Families' future.

The most important step we've taken to address identified shortfalls is to establish the Warrior Transition Brigade (WTB) and to fully implement the concept of a triad of a Primary Care Manager (usually a physician), a Nurse Case Manager and a small unit Army leader or Squad Leader. The WTB is organized as a distinct unit of the WRAMC Command with its own Table of Distribution and Allowances and formal staffing structure that includes a strong Command and Control element at the brigade and company levels to provide dedicated leadership and direction to ensure Warriors in Transition and their Families receive the care and assistance they require. Squad leaders are responsible for no more than 12 Warriors to ensure that each warrior can get personalized, one-on-one attention on a daily basis. Each SL has a close working relationship with the NCM assigned to that squad. The SL and case manager work as a team in conjunction with the third member of the triad, the PCM. Each part of the triad has clearly delineated responsibilities to care for the needs of the Warrior. These responsibilities overlap enough to provide a safety net of support that will not allow any Warrior to fall through the cracks. I am convinced that the power of a fully-staffed WTB along with the synergy of the triad will generate enormous contributions to the well-being of our Warriors.

Another accomplishment that I'd like to highlight is the establishment of the Soldier Family Assistance Center at WRAMC. The family is an integral part of the recovery process for all our Warriors. We need to have support systems in place for Family members much like we do for the Soldiers. The SFAC is designed to support every need of our Family members. The staffing of an SFAC includes social workers, military finance and personnel experts, Morale, Welfare and Recreation specialists, liaisons to service organizations, and, most importantly, a caring person to listen to concerns. This is where we will escort our newly arrived Family members so that they can have a warm cup of coffee

and talk to a chaplain or counselor before seeing their Soldier for the first time. The SFAC is a concept that has worked with great success at Brooke Army Medical Center (BAMC) and we hope to expand upon that success with the establishment of a SFAC here at WRAMC.

We have also established a network of ombudsmen at WRAMC and 17 other Army hospitals to serve Warriors and their Families as independent resources and problem solvers. Ombudsmen work closely with Patient Advocates and are readily available and in regular contact with Warriors in Transition and their Families to determine areas where they can be of assistance to resolve concerns that may not have been solved by other means. Each ombudsman has been specially trained for his/her new role and has been given direct access to commanders in another effort to bust bureaucracy.

As with the example of the SFAC concept taken from BAMC and the triad concept borrowed from other installations, we have aggressively harvested best clinical and administrative practices from a variety of settings or are developing them de novo and are then standardizing them across the Army Medical Department. BG Tucker and the staff of the AMAP Cell identify and incorporate on an ongoing basis best practices found during Staff Assistance Visits, or identified by the various Task Forces and Commissions that have examined the care and assistance provided to Warriors in Transition and their Families. Our goal is to take advantage of these insights and ensure that the AMEDD remains on the cutting edge when it comes to providing world class care to our brave Soldiers and their Families.

Efforts to accelerate the transition of WRAMC to the new Walter Reed National Military Medical Center at Bethesda (WRNMMC) are proceeding well. RADM John Mateczun, USN, recently appointed as Commander of the Joint Task Force to combine military medical operations in the National Capitol Region, strongly supports the future establishment of a Warrior Transition

Brigade at the future WRNMMC that may well serve as the model for the development of a joint Service approach to caring for Warriors in Transition. Also encouraging is the recent direction provided by the Deputy Secretary of Defense, Mr. Gordon England in his August 29, 2007 memorandum directing the Service Secretaries to use all existing authorities to recruit and retain military and civilian personnel necessary to care for Seriously Injured Warriors, and directing the Secretaries to fully fund these authorities to achieve this goal. In this memorandum, Secretary England also directs the Secretary of the Army to develop and implement a "robust recruitment plan" to address identified gaps in staffing and sufficiently fund the WRAMC budget to pay for these recruitment and retention incentives. To ensure the success of this recruitment effort, Secretary England also directed that Dr. David Chu, the Under Secretary of Defense for Personnel and Readiness, develop with the Departments of the Army and Navy a "Guaranteed Placement Program" to maximize placement of WRAMC employees affected by the transfer of health care services under the Base Realignment and Closure process to the new Walter Reed National Military Medical Center or Dewitt Army Community Hospital. These efforts should help to stabilize the work force at Walter Reed and ensure that our Warriors will continue to be cared for by the best health care professionals in the world.

The recent opening of the Military Advanced Training Center (MATC) at WRAMC is yet the latest development in optimizing care and rehabilitation for our Wounded Warriors. The new, state-of-the-art $10 million dollar rehabilitation center for amputees, Traumatic Brain Injured and other Warriors in Transition with functional losses provides a dedicated 31,000 square foot facility where staff can focus on Service members who have lost a limb or an eye, their hearing, the ability to maintain their balance, orientation, or fine motor skills-but have never lost their fighting spirit or their Warrior Ethos. They are committed to restoring the capacity for these brave men and women to serve the Nation as Warriors or as productive citizens. The capabilities and even the specialized equipment of the MATC will be moved to the new WRNMMC when it is built.

I believe that the actions of the last 6 months will ultimately make Walter Reed and the Army Medical Department stronger organizations which are more adept at caring for Warriors and their Families. We need to continue to address our shortfalls, we need to continue to focus on serving our Warriors and their Families, and we will continue to improve.

I greatly appreciate the privilege to command this great Army medical institution and the opportunity to report on the progress we have been making at WRAMC these past six months. Thank you for holding this hearing and giving us the opportunity to share our accomplishments and to re-affirm our unyielding commitment to provide the best care available to all our Warriors and their Families.

Mr. TIERNEY. Thank you, General.

Mr. Dominguez.

STATEMENT OF MICHAEL L. DOMINGUEZ

Mr. DOMINGUEZ. Thank you, Mr. Chairman. Mr. Chairman, Congressman Shays, distinguished members of the committee, thank you for the opportunity to update you on the progress we have made improving the systems for support and care of our wounded, ill, and injured service members and their families.

I apologize for the tardiness of my written testimony, but trust that you will find within it the specific information you need in order to fulfill your oversight responsibilities.

I would like to use this opening statement to make four headline points: First, the issues that emerged at Walter Reed last February did, indeed, uncover systemic deficiencies in our care and support for the wounded, ill, and injured. We failed. We acknowledge that failure, and the senior leadership of the Defense Department is committed to correcting the system and repairing the damage. Secretary Gates has stated that, outside of the war, itself, he has no higher priority.

Next, it is absolutely clear to us that fixing this system requires a partnership with the Congress, with the various advisory committees, with the Nation's many charitable and service organizations, but first and foremost a partnership with the talented men and women in the Department of Veterans Affairs. Deputy Secretary Mansfield of the VA and Deputy Secretary England of Defense established the Senior Oversight Committee to forge that partnership. At my level, I believe I have spent more time over the last few months with Under Secretary Cooper and Assistant Secretary Dunne than I have spent with members of my own staff. We are jointly and cooperatively working this challenge.

Third, we have accomplished a great deal. That is documented in our testimony. We are doing more every day. In fact, only yesterday the two Deputy Secretaries endorsed a plan to pilot a substantive revision of the disability evaluation system which features a single comprehensive physical exam done to VA standards using VA templates and a single rating for each disabling condition, with that rating issued by the world-class professionals at DVA, and that rating decision being binding on the Department of Defense. Integrating DVA into DOD's administrative decisionmaking processes is evidence of the extraordinary level of cooperation we have achieved.

Four, while we have accomplished a great deal, there is still more to do. We will do everything we can within the realm of policy and regulation. Undoubtedly, we will seek legislation, but that legislation would be ground-breaking, changing the foundations of our current disability systems and changing fundamentally roles and responsibilities among Government agencies. We do not need from the Congress prescriptive legislation addressing the minutia of how we execute our responsibilities within current law. We do need and welcome your oversight of these areas through hearings such as this one and visits such as you conducted earlier this week. And when we have formed our ideas about fundamental changes, we will bring them to the Congress. In the meantime, we are making

changes, we are making them fast, and we won't stop until our wounded warriors have the support system they deserve.

Thank you. I look forward to your questions.

[The prepared statement of Mr. Dominguez follows:]

Prepared Statement

of

The Honorable Michael Dominguez
Principal Deputy Under Secretary of Defense
Personnel and Readiness

Before the

House Committee on Oversight and Government Reform
Subcommittee on National Security and Foreign Affairs

Topic
"Third Walter Reed Oversight Hearing: Keeping the Nation's Promise to Our Wounded Soldiers"

September 26, 2007

Not for publication until released by the committee

INTRODUCTION

SEAMLESS CONTINUUM OF SERVICES IN RECOVERY, REHABILITATION, AND REINTEGRATION OF WOUNDED, ILL, AND INJURED SERVICE MEMBERS

Mr. Chairman and distinguished members of this Subcommittee, thank you for inviting me to be here today. Last February, deficiencies at Walter Reed exposed systemic flaws in services to wounded, ill, and injured Service members and their families, and provided the impetus for us to take a comprehensive look at the full life cycle of treatment for wounded veterans returning from the battlefield. I am pleased to have an opportunity today to discuss the Department's progress improving the recovery, rehabilitation, and reintegration of our wounded, ill, and injured Service members.

When I last testified before this Committee in April, I indicated a number of review groups and task forces had been established, we were studying their work and recommendations, and we were on a fast track to develop and implement improvements. I am here today to tell you that much has been accomplished since then.

On May 3, 2007, the Departments of Defense (DoD) and Veterans Affairs (VA) jointly established the Wounded, Ill, and Injured Senior Oversight Committee (SOC). The SOC was established to ensure the recommendations of the various task forces and committees were properly reviewed, coordinated, implemented, and resourced. Under cognizance of the SOC, our two Departments have studied the issues, and are designing and implementing changes to our policies and programs. We have accepted and are working on all the recommendations from the Task Force to the President on Returning Global War of Terror Heroes and from the President's Commission on Care for

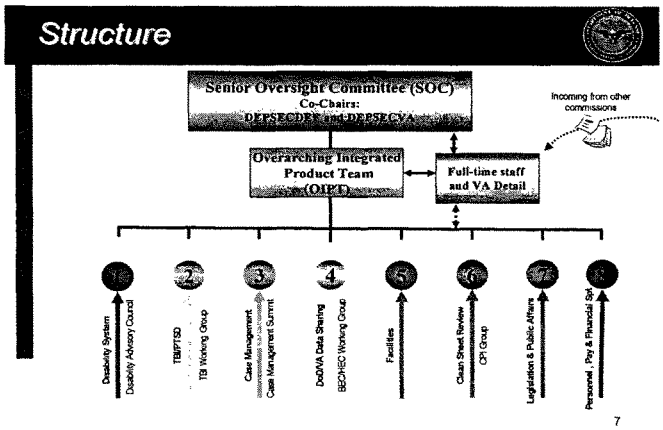
America's Returning Wounded Warriors. We also have accepted and are working on all but three recommendations from the Independent Review Group on Rehabilitative Care Administrative Processes at Walter Reed Army Medical Center and National Naval Medical Center, and all but one recommendation from the DoD Task Force on Mental Health. The four recommendations and reasons for their rejection are in Table 1, enclosed with this testimony.

Our work continues, however, and the SOC, co-chaired by the Deputy Secretary of Defense and Deputy Secretary of Veterans Affairs, continues to meet weekly to streamline, de-conflict, and expedite the two Departments' efforts to improve support of injured Service members' recovery, rehabilitation, and reintegration.

Senior Defense and Veterans Affairs officials serve on the SOC. This includes the Service Secretaries, the Chairman of the Joint Chiefs of Staff, the Service Chiefs, the VA Under Secretary for Health, the VA Under Secretary for Benefits, the VA Assistant Secretary for Policy and Planning, and the VA Deputy Assistant Secretary for Information and Technology. The driving principle guiding the SOC's efforts is the establishment of a *seamless continuum* that is efficient and effective in meeting the needs of our wounded, ill, and injured Service members/veterans and their families.

Supporting the SOC decision-making process is an Overarching Integrated Product Team (OIPT), composed of the Assistant Secretaries of Defense, the Military Department Assistant Secretaries for Manpower and Reserve Affairs, and other senior officials from DoD and VA. The OIPT reports to the SOC and coordinates, integrates, and synchronizes the work of eight Lines of Action and recommends sourcing solutions for resource needs.

The diagram below depicts the structure supporting the SOC. The Lines of Action, which have Senior Executive Service Co-Leads from both Departments, establish plans, set and track milestone, and identify and enact early, short-term solutions.



The Lines of Action and their goals are:

- **<u>LoA #1: Redesign the Disability Evaluation System</u>**

  Goal: *To develop a single, supportive, and transparent disability evaluation system.*

- **<u>LoA #2: Address Traumatic Brain Injury/Psychological Health</u>**

  Goal*: To provide Service members with lifelong standardized and comprehensive screening, diagnosis, and care for all levels of TBI and PTSD, in conjunction with education for patient and family members.*

- **<u>LoA #3: Fix Case Management</u>**

  Goal*: To coordinate health care, rehabilitation, and benefits, delivery of services and support that will effectively guide and facilitate Service members and their families through necessary processes.*

- **<u>LoA #4: Expedite Data Sharing</u>**

***Goal**: To ensure appropriate beneficiary and medical information is visible, accessible, and understandable through secure and interoperable information management systems.*

- **LoA #5: Facilities**

  ***Goal**: To provide Service members and families with the best possible facilities for care and recovery.*

- **LoA #6: "Clean Sheet" End-to-End Review**

  ***Goal:** To honor our Service members by providing wounded, ill, and injured personnel and their families the best quality care and a compassionate, fair, timely, and non-adversarial disability adjudication process – enabling Service members to return to the fullest, most productive and complete quality of life possible.*

- **LoA #7: Comprehensive Legislation and Public Affairs**

  Goal: *To coordinate the development of comprehensive legislation that will provide the best possible care and treatment for injured Service members and families. Additionally, to keep the public informed of significant accomplishments and events.*

- **LoA #8: Personnel, Pay, and Financial Benefits**

  Goal: *To provide compassionate, timely, accurate and standardized personnel, pay, and financial support practices for Wounded, Injured and to ensure appropriate data sharing, quality control, and support benefits.*

FEBRUARY IS LONG PAST

Facilities

I am pleased to report the living conditions disclosed last February at Walter Reed Army Medical Center's Building 18 are remedied and the outpatient housing conditions of our Wounded Warriors throughout the Department are improving every day. To ensure sub-standard facilities are identified and actions are taken to remedy them, a few weeks ago, the SOC approved new DoD Housing Inspection Standards for Medical Hold and Holdover Personnel.

These new approved Housing Inspection Standards require the Military Services to assign Medical Hold and Holdover Personnel to housing that meets or exceeds applicable quality standards and is appropriate for their medical condition, expected duration of treatment, dependency status (including non-medical attendants, if authorized), and paygrade.

The particular housing and associated amenities and services provided will be an integral part of a Service member's medical treatment plan. In addition, the chain of command will be responsible, in consultation with patients and their medical support team and case managers, to validate that every Medical Hold and Holdover Person is adequately housed in accordance with these new standards. If these standards cannot be met for a particular individual, installation commanders must notify their Service Headquarters. To ensure our facilities are maintained at this quality standard, periodic inspections will be conducted at least annually. 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 re-inspect the facility until the deficiency is corrected. And, finally, the Military Services will implement periodic and comprehensive follow-up programs using surveys, one-on-one interviews, focus groups, and town-hall meetings to learn how to improve Medical Hold and Holdover personnel housing and related amenities and services. We have implemented these new standards and are currently conducting inspections. In December, our inspection report on all DoD medical treatment and Medical Hold and Holdover facilities will be sent to Congress.

Data Sharing Between Defense and Veterans Affairs

We also have been making good progress on our information technology efforts to share medical information between the DoD and VA. We are committed to developing a seamless health information system for use within our Department and with DVA. Our long-term goal is to ensure appropriate beneficiary and medical information is visible, accessible, and understandable through secure and interoperable information management systems. Our short-term goal is to accelerate and improve data sharing among our two Departments. The SOC has approved initiatives to ensure health and administrative data are made available and are viewable by both agencies. For example, all DoD and VA sites are now able to view outpatient prescription data, outpatient and inpatient laboratory and radiology reports, and allergy information on patients treated by either Department. The Bi-Directional aspect of the system also allows for VA health data on Service members now to be viewed through the Armed Forces Health Longitudinal Technology Application (AHLTA) by DoD providers. Importantly, plans for a single Web portal to support the information needs of the Wounded, Ill or Injured Service members and their families should be ready in December 2007. This Web portal will allow users to access user-specific information about relevant programs, benefits and services available to them in both the private and public sector. Table 2 provides a summary of our progress sharing health data.

Care Management

We have received numerous recommendations from the various committees that have studied wounded warrior clinical and non-clinical care management issues, and we are committed to providing world class programs and services that improve significantly the delivery of quality and timely medical care to severely wounded Service

members/veterans and their families. We also are committed to eliminating bureaucratic hurdles and red tape, and creating a streamlined, efficient continuum of care. In particular, DoD, in partnership with the VA, is working to reduce the complexities of traversing our two care management systems through the creation of an integrated continuum of case management model.

Psychological Health and TBI

The DoD, in a collaborative effort with VA, has made great strides in addressing issues surrounding psychological health (PH) and traumatic brain injury (TBI) concerns across the full continuum of care. 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 military members, veterans, and families who deal with these important health conditions.

Since June 2007, a collaborative team of DoD and VA experts known as the "Red Cell" has worked to (1) create an integrated, comprehensive Department of Defense/Veterans Affairs program to identify, treat, document, and follow-up those who experience TBI or PH conditions while either deployed or in garrison; and (2) determine how to build resilience, both in people and in organizations, to prevent issues from developing and to reduce their impact if they do occur. In July, we received the report of the Mental Health Task Force, whose recommendations cover this same domain. Our report to the Congress addressing the recommendations of that Task Force has just been released, and is enclosed at the end of this testimony.

We have significant TBI and PH achievements. Using best practice guidance, behavioral health professionals are being integrated into the primary care setting for early identification of TBI and PH issues. Psychological health governance structures and trusted advisors to our commanders and senior leaders are being built at all levels, including embedding psychological health professionals into line units.

DoD and VA have partnered to develop clinical practice guidelines (CPG) for Post-Traumatic Stress Disorder (PTSD), Major Depressive Disorder, Acute Psychosis, and Substance Use Disorders. These guidelines help practitioners determine the best available and most appropriate care for PH conditions. In an effort to ensure that providers are trained in best practices, DoD also has been collaborating with VA in providing training in evidence-based treatment for PTSD.

To ensure Service members are appropriately screened for TBI, questions have been added to Post Deployment Health Assessment and Post Deployment Health Reassessment. Also, Post Deployment Health Assessment and Post Deployment Health Assessment Reassessment information is being shared between DoD and VA clinicians as part of an effort to facilitate the continuity of care for the veteran or Service member. Finally, identification and treatment for TBI have been enhanced through world-renowned TBI training to over 800 of our clinicians.

To ensure that there are appropriate staffing levels for PH, a comprehensive staffing plan for psychological health services has been developed based on a risk-adjusted, population-based model. In addition, to support and ensure appropriate staffing levels, DoD has partnered with the Department of Health and Human Services (DHHS) to provide uniformed Public Health Service officers in Military Treatment Facilities to

rapidly increase available mental health providers for DoD. Finally, we are programming over $900 million dollars to support PH and TBI prevention, treatment, and research to ensure that our services achieve and maintain excellence across the complete system of care.

To assist our children, we have expanded our Mental Health Self Assessment Program to include mental health education and suicide prevention training for children, parents and teachers in the DoD schools. We are also expanding the Emmy-nominated Sesame Street Workshop to help young children understand and manage the stress associated with having a deployed parent.

Our Senior Oversight Committee also has approved a national Center of Excellence for PH and TBI. It will include liaisons from both VA and DHHS, 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. This center will facilitate 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.

We have many more plans underway to continue the tradition of excellence that has characterized our military and veteran health system for decades. We are putting into place systems that will monitor quality and rapidly institutionalize new innovations and best practices as the science and practice of health promotion and clinical practice continues to advance. Our commitment to a consistent system of excellence will grow with time and experience, and our dedication to the fighting force and their families will not falter.

Disability Evaluation System

The Departments of Defense and Veterans Affairs are working closely to redesign and establish one Disability Evaluation System (DES) for use by Service members. A pilot program was explored via a "tabletop" exercise to ensure that no Service member would be disadvantaged by this new system, and that the Service member receives the high quality medical care, and appropriate compensation and benefits for the residuals of his or her disabilities incurred or aggravated by military service. An operational pilot program and schedule was just briefed to the SOC. If it is as successful as we plan, this pilot program will be expanded beyond the Washington Capital Region to become the DES system, worldwide.

The proposed new system is a much more efficient and due process friendly one. It will produce more consistent outcomes and, with DoD and VA working together as a team, the new system is a seamless, single process for users. We envision it cutting in half the time it takes for a Service member to go through the DES, from the time the member is referred for a Medical Evaluation Board (MEB), to the time the member is discharged from active military service and receives his or her first payment from VA.

An important improvement in this new system is that the Service member will only be required to have one medical examination to meet the requirements of both DoD and VA. Currently, a Service-specific medical examination is required for the purpose of determining a Service member's ability to continue on active military service based on the residual unfitting disability and the Service member's rank, rating, or military occupational skills, and a VA medical examination is also required for the purpose of evaluating the residual of the disability under the VA Schedule for Rating Disability, so a

percentage evaluation can be assigned to the disability. Under the current system, if Service members are found unfit and are separated or retired, they must complete the second VA exam to determine whether the claimed medical conditions are service-connected and represent impediments to full employment capability.

Under the proposed new system, the one medical examination collects information required by both Departments. Under this system, when the Service member transitions to civilian life, the VA already will have the information needed to immediately start paying the (new) veteran the appropriate amount of compensation for the residuals of his or her disability incurred or aggravated by military service.

This new DES will also allow the Services to ensure they have control over who is fit or unfit for further military service, and we would have a "one-stop shop" for the seamless transition of our wounded warriors from Solider, Airman, Sailor, or Marine to civilian life.

Financial and TRICARE Assistance

Another area where we have made great strides is offering a new premium-based health care plan called TRICARE Reserve Select (TRS). Beginning October 1st, our Reserve and National Guard members may enroll in this comprehensive plan which allows these members freedom to manage their own health care. TRS coverage is similar to TRICARE Standard and TRICARE Extra, but covered members and family members may access care from any TRICARE-authorized provider, hospital, or pharmacy – whether in the TRICARE network or not. TRS covered members may also access care at military treatment facilities on a space-available basis. They pay the same TRICARE cost-share and deductible as active duty family members.

The DoD has increased staffing levels for finance and other personnel at specific medical treatment facilities to ensure full support of the fiscal health of the Wounded Warrior. The Army and Navy have efforts underway to develop and implement methods to ensure appropriate staffing levels remain in place at both Walter Reed Army Medical Center and the Navy's facility at Bethesda throughout the upcoming Base Realignment and Closure (BRAC) 2005. These efforts include combined civilian hiring panels, standardized job classification/grades and DoD directives to maximize civilian medical professional recruitment and retention incentives.

Service members transitioning from military to civilian life can benefit from a collaborative effort between DoD and the Department of Labor (DoL). DoD recently uploaded the DoL Pre-Separation Guide which informs Service members and families of available transition assistance services and benefits at the click of a mouse. (http:\www.TurboTAP.org).

Another resource tool available to our transitioning Service members is the expansion of the PatriotExpress Loan program. The PatriotExpress 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.

Additionally, DoD expanded Wounded Warrior Pay Entitlement information on the Defense Finance and Accounting Service (DFAS) website and other organizations have linked to the website, and 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 website.

The Department has established better tracking capability and improved staffing for the DFAS Casualty Travel Pay Section. The travel voucher payment turn-around time has improved to an average of three processing days after receipt, down from a reported processing time in March 2007 of as much as 15 days.

The DoD and the VA have coordinated and are now sharing patient administrative data for active duty military personnel receiving care as inpatients in Veterans Affairs facilities. The two Departments continue to work toward a long-term solution of automatic data sharing between VA and DoD, which will ensure timely notification of patient status and ensure appropriate pay support.

The DoD and VA have shared information concerning Traumatic Injury Service members Group Life Insurance (TSGLI) and have implemented plans replicating best practices after the first year of this program. 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. The VA Insurance provider's payment time, upon receipt of an approved package, averages between 2 to 4 days. We have been successful using Congressional authority from the NDAA FY07 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 Service member is recovering.

WAY AHEAD

The work of the Senior Oversight Committee and its Overarching Integrated Product Team will continue. Both the SOC and OIPT are meeting weekly to review, coordinate, resource, and implement the recommendations of the various review groups

and task forces, and to integrate further the work being conducted by the OIPT lines of action. This work will expand to include the recommendations of both the DoD Inspector General's report on DoD/VA Interagency Care Transition, and the Veterans Disability Benefits Commission report, which are both due to present their findings and recommendations this next month.

The Departments of Defense and Veterans Administration also are solving problems through the use of policy and existing authorities. For example, our Deputy Secretary of Defense in August directed the Secretaries of the Military Departments to use all existing authorities (e.g., special pays, critical wartime accession bonuses) to recruit and retain military and civilian personnel to the limits authorized in current manning documents, required for care of our seriously injured warriors. These changes provide immediate improvement to the continuum of care for our wounded, ill, and injured Service members, and can be implemented by the Departments without the requirement for additional legislation.

As we continue to work through this complex system, we are learning and forming judgments as to what statutory changes will be necessary to improve the seamless continuum of recovery, rehabilitation, and reintegration of our wounded, ill, and injured Service members. We look forward to communicating these to Congress at the appropriate time, and working with Congress in pursuit of these legislative changes.

Thank you for this opportunity to provide information on the considerable progress we are making on improving the recovery, rehabilitation, and reintegration of our wounded, ill, and injured Service members.

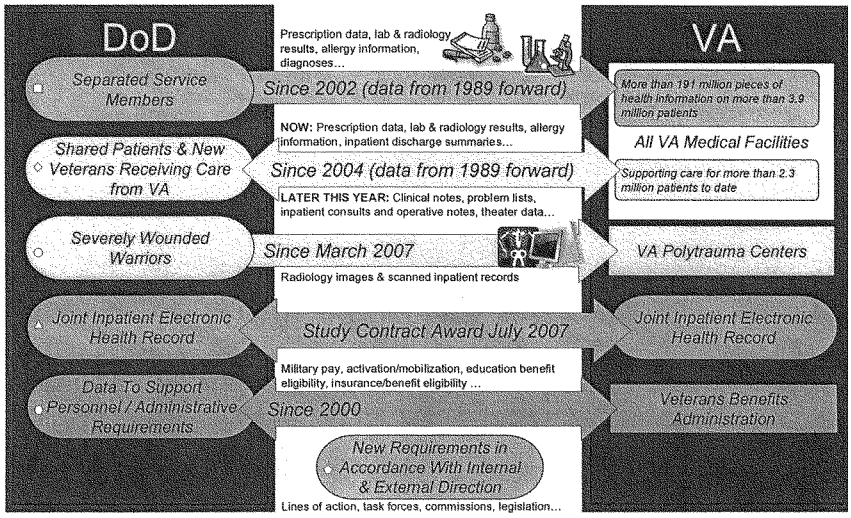
Table 1:

RECOMMENDATION(S)	DOD AND VA JOINT ASSESSMENT, RECOMMENDATION AND DETERMINATION
Independent Review Group (IRG)	
1. Conduct quality assurance review of all military services decisions of 0-20% disability and existed prior to military service (EPTS) cases since October, 7, 2001, to ensure fairness, consistency, and compliance with applicable regulations.	**1. Not Accepted.** The existing Board for Correction of Military Records (BCMR) process is fully responsive to this issue. The DoD Office of General Counsel process requires affected individuals to initiate the BCMR process. Joint Disability Review Board (JDEB) could review "selected" cases if needed for quality control.
2. Review Traumatic Serviceman's Group Life Insurance (TSGLI) to ensure coverage is expanded to include Post traumatic Stress Disorder (PTSD) to TSGLI	**2. Not Accepted.** PTSD is adequately covered through TSGLI's description of the loss of ability to perform activities of daily living resulting from specifically described physical and psychiatric conditions through which PTSD manifests itself.TSGLI standards are dictated by law. The VA completed a one-year review of TSGLI and does not support addition of PTSD to TSGLI.
3. The Secretary of Defense and all military service Secretaries should establish a program that returns previously deployed Reserve Component Service members back to an active duty status for Post-Deployment Reassessment and evaluation by medical professional, six months post demobilization.	**3. Not Accepted.** Several programs are now underway to determine the most appropriate way to meet reintegration needs of demobilized Guard & Reserve, including one program that authorizes involuntary recall, and another that brings the needed services to the member's hometown.There are alternative approaches to construct the post-deployment health reassessment for Reservists, including battle drills, targeted command emails, and leadership phone calls; all of which are less disruptive to our Reserve forces than being placed on mandatory active duty status, are as effective in obtaining the required information, and are already being conducted by the Services.
Mental Health Task Force (MHTF)	
1. DoD should ensure that covered TRICARE mental health services include V-codes related to partner relational problems, physical/sexual abuse,	**1. No action required.** Coverage for situational problems is currently available across the system through the fully funded *Military OneSource* program and other family

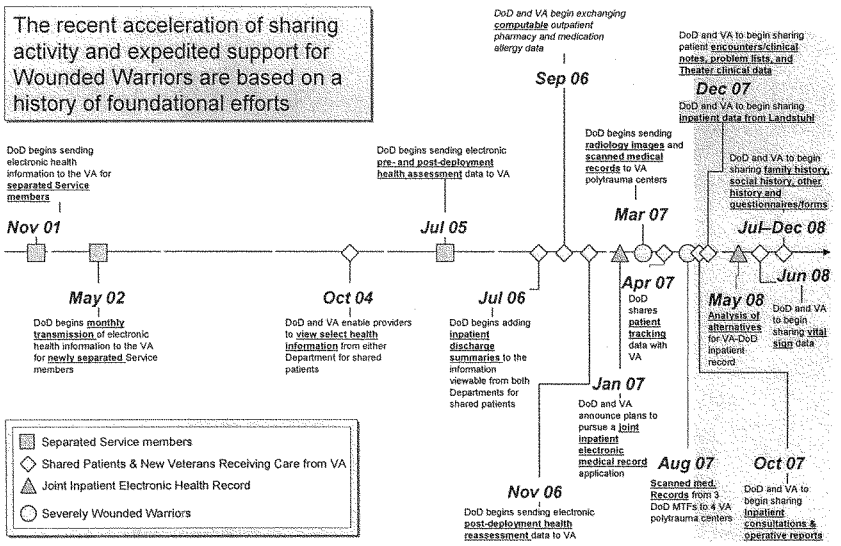
bereavement, parent-child relation problems, and other appropriate services.	support programs. Expanding TRICARE benefits would duplicate existing programs.

Table 2:

DoD/VA Electronic Information Sharing Focus Areas



DoD/VA Data Sharing – Milestones & Plans (Health)



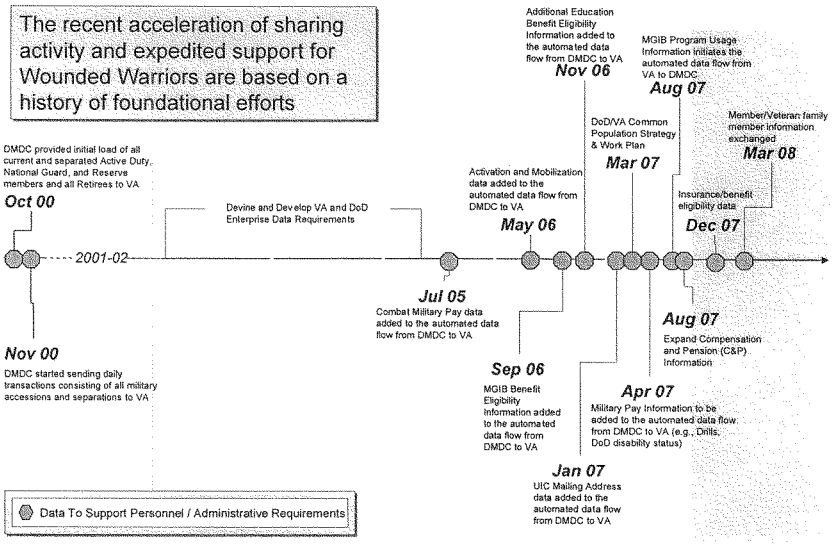
Electronic Health Data Sharing

Current Health Data Sharing	Available	Responds To
One-way push of data upon separation *	2002 - 2006	IRG, GWOT, PCCWW
Bidirectional, real-time view of pharmacy and allergy data, laboratory results, and radiology reports	2007	IRG, GWOT, PCCWW
Bidirectional, real-time view of discharge summaries	2007 – 11 DoD sites 2006 – all VA sites	IRG, GWOT, PCCWW
Bidirectional, real-time computable pharmacy and allergy data	2007 – 7 sites All DoD by Dec 2007	IRG, GWOT, PCCWW
One-way transfer of digital radiology images	3 DoD sites to 4 VA Polytrauma Centers	IRG, GWOT, PCCWW
Future Health Data Sharing	**Target**	**Responds To**
Theater clinical data	Dec 2007	IRG, GWOT, PCCWW
Bidirectional, real-time view of provider notes, procedures, and problem lists	Dec 2007	IRG, GWOT, PCCWW
Bidirectional, real-time view of vital signs	June 2008	IRG, GWOT, PCCWW
Bidirectional, real-time view of family history, social history, other history, questionnaires, and forms	Sept 2008	IRG, GWOT, PCCWW

* Pharmacy, laboratory, and radiology reports; allergy data, discharge summaries (from CHCS), consult reports, standard ambulatory data encounter, Pre- and Post-Deployment Health Assessment and Post-Deployment Health Reassessment

IRG	Independent Review Group
GWOT	Global War on Terror Heroes Report
PCCWW	President's Commission on Care for America's Wounded Warriors

DoD/VA Data Sharing – Milestones & Plans (Personnel / Administrative)



DoD/VA Data Sharing – Information Exchanges (Personnel / Administrative)

Personnel / Administrative Information	*2007*	*2008*
Initial Load of Current and Separated Active Duty, National Guard, Reserve, Retirees	√ (2000)	√
Daily Transactions of Military Accessions and Separations	√ (2000)	√
Combat Military Pay Data	√ (2005)	√
Activation and Mobilization Data	√ (2006)	√
MGIB Benefit Eligibility Data	√ (2006)	√
Education Benefit Eligibility	√ (2006)	√
UIC Mailing Address Data	√ (2007)	√
Expanded Military Pay Information	√ (2007)	√
Insurance/Benefit Eligibility Data	√	√
Member/Veteran Family Member Data		√

Appendix 1

DoD Response to Task Force on Mental Health Report

Mr. TIERNEY. Thank you.

I want to break protocol here a little bit because I don't generally do this, but I think my colleagues would share this. I hear the tenor in your voice about not wanting Congress to come in with prescriptive legislation, but you have to understand what makes it tempting for Congress to do that is the utter lack of urgency over a decade that we have sense with the Department of Defense and other agencies in the Government about getting this job done.

Nobody that I know of on this panel or anywhere else thinks about doing prescriptive legislation if we don't have to, but we oftentimes think about giving a foot right where it is needed to get things moved, and I will get into it further in my questioning and whatever. I am glad to see that you have a pilot program that you are finally focused on. We will talk about why it took forever to get there, relatively speaking, and things of that nature, and what legislation might be needed. But do understand that nobody here wants to be prescriptive, but the temptation is great when it takes too long a period of time to move from one point to another.

Mr. Shays, do you want to add a comment to that?

Mr. SHAYS. Just to say that is an opinion shared on both sides of the aisle.

Mr. DOMINGUEZ. Yes, sir, and, again, I acknowledge we failed, and fixing the problem is absolutely urgent and absolutely a top priority of our two departments' leadership and we commit to it, sir.

Mr. TIERNEY. Admiral Dunne.

STATEMENT OF ADMIRAL PATRICK W. DUNNE

Admiral DUNNE. Mr. Chairman, distinguished members of the committee, thank you for the opportunity to discuss the recent activities of the Department of Veterans Affairs to serve our Nation's veterans through improved processes and greater collaboration with the Department of Defense.

Over the past 7 months, I have had the privilege of being engaged in many activities dedicated to ensuring our returning heroes from OEF and OIF receive the best available care and services. I join my colleagues from VA and those from DOD in striving to provide a lifetime of world-class care and support for our veterans and their families.

On March 6th, the President established the Inter-Agency Task Force on Returning Global War on Terror Heroes. VA's Secretary Nicholson was appointed Chair, and I was proud to support him as the Executive Secretary. On April 19th the task force issued its report to the President. There were 25 recommendations to improve health care, benefits, employment, education, housing, and outreach within existing authority and resource levels. The report was unique in that it also included an ambitious schedule of actions and target dates. Thanks to outstanding inter-agency cooperation, 56 of 58 action items have been completed or initiated to date.

The results are having a positive impact. The Small Business Administration launched the Patriot Express Loan Initiative. This program, which has already provided more than $23 million in loans, provides a full range of lending, business counseling, and procurement programs to veterans and eligible dependents.

Other task-force-inspired initiatives will support seamless and world class health care delivery. VA and DOD drafted a joint policy document on co-management and case management of severely injured service members. This will enhance individualized, integrated, inter-agency support for the wounded, severely injured, or ill service member and his or her family throughout the recovery process.

To assist OEF/OIF wounded service members and their families with the transition process, VA hired 100 new transition patient advocates. These men and women, often veterans themselves, work with case managers and clinicians to ensure patients and families can focus on recovery.

VA also revised its electronic health care enrollment form to include a selection option for OEF/OIF to ensure proper priority of care.

Additionally, a contract was recently awarded for an independent assessment of in-patient electronic health records in VA and DOD. The contract will provide us recommendations for the scope and elements of a joint health record.

As you know, many recommendations have been issued lately which center around the treatment of wounded service members and veterans. To ensure the recommendations were properly reviewed and implemented, VA and DOD established the Senior Oversight Committee which has been discussed this morning, chaired by our two Deputy Secretaries.

In a collaborative effort with DOD, VA made great strides in addressing issues surrounding PTSD and TBI across the full continuum of care. The focus has been to create a comprehensive, effective, and individual program dedicated to all aspects of care for our patients and their families.

VA and DOD have partnered to develop clinical practice guidelines for PTSD, major depressive disorder, acute psychosis, and substance abuse disorders.

Our Senior Oversight Committee also approved a National Center of Excellence for PTSD and TBI.

Since 1992, VA has maintained four specialized TBI centers. In 2005, VA established the poly trauma system of care, leveraging and enhancing the expertise at these TBI centers to meet the needs of the seriously injured. The Secretary of Veterans Affairs recently announced the decision to locate a fifth poly trauma center in San Antonio, TX.

VA and DOD are also working closely to redesign the disability evaluation system. As Mike mentioned, a pilot program is being finalized to ensure no service member is disadvantaged by this new system and that the service member receives the high-quality medical care and appropriate compensation and benefits.

This proposed new system will be much more efficient, and I have provided additional details in my written testimony.

Over the last 4 years, VA has increased outreach and benefits delivery at discharge sites to foster continuity of care between the military and VBA systems and speed up VA's processing of applications for compensation. VBA also processes the claims of OEF/OIF veterans on an expedited basis.

Collaborating with DOD, we have accomplished a great deal, but there is still much more to do. We at VA are committed to strengthening our partnership with DOD to ensure our service members and veterans receive the care they have earned.

I would be happy to answer your questions.

[The prepared statement of Admiral Dunne follows:]

STATEMENT OF
THE HONORABLE PATRICK W. DUNNE
REAR ADMIRAL, U. S. NAVY (ret)
ASSISTANT SECRETARY FOR POLICY AND PLANNING
U.S. DEPARTMENT OF VETERANS AFFAIRS

BEFORE THE SUBCOMMITTEE ON NATIONAL SECURITY AND FOREIGN AFFAIRS
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM
U.S. HOUSE OF REPRESENTATIVES

SEPTEMBER 26, 2007

Good morning. Mr. Chairman and distinguished members of the committee, thank you for holding this hearing and providing the opportunity to discuss the recent activities of the Department of Veterans Affairs (VA) to improve benefits and services to our Nation's veterans through improved processes and greater collaboration with the Department of Defense (DoD).

The level of attention currently focused on our wounded service members and their families is unprecedented – and rightly so. Over the past seven months, I have had the privilege of being engaged in many activities dedicated to ensuring our returning heroes from Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) receive the best available care and services. I join my colleagues from VA and those from the Department of Defense in striving to provide a lifetime of world-class care and support for our newest generation of veterans and their families.

On March 6, 2007, by Executive Order, the President established the interagency Task Force on Returning Global War on Terror Heroes. VA Secretary Nicholson

was appointed to Chair the Task Force and I was proud to support him as the Executive Secretary. On April 19, 2007, the Task Force issued its report to the President. The Task Force made 25 recommendations to improve the delivery of federal services and benefits to returning service members. The Report contained recommendations in the areas of health care, benefits, employment, education, housing and outreach that could be achieved with existing authority and resource levels. The report was unique in that it also included an ambitious schedule of milestones and actions necessary to implement its recommendations. We continue to monitor implementation and I am pleased to inform you that, thanks to outstanding interagency cooperation, as of August 28, 56 of 58 action items have been completed or initiated.

The results of actions taken in response to recommendations in the Task Force Report are having a positive impact on the lives of service members, veterans, and their families. I would like to highlight some of the progress achieved.

In response to a Task Force recommendation, the Small Business Administration launched the Patriot Express Loan Initiative. This program provides a full range of lending, business counseling, and procurement programs to separating service members, veterans, spouses, survivors, and eligible dependents. This program has already approved more than $23 million in loans since it began in mid June.

Several initiatives have and will continue to support seamless and world-class health care delivery. VA and DoD have drafted a joint policy document on co-management and case management of severely-injured service members. The goal is to provide individualized, integrated, interagency and intergovernmental support for the wounded, severely-injured or ill service member and his/her family throughout the process of treatment, rehabilitation, and renewal. VA and DoD will work together to minimize fragmentation of Federal clinical and non-clinical services, improve the coordination of medical and rehabilitative care, and ensure access to all needed resources.

To assist OEF/OIF wounded service members and their families in navigating through the transition process, VA hired 100 new Transition Patient Advocates (TPA). These men and women, often veterans themselves, recognize the difficulty in understanding the many different programs and processes which come into play. VA TPAs work with VHA, the Veterans Benefits Association (VBA), and DoD, case managers and clinicians to ensure that patients and families can focus on recovery.

VA has also revised its electronic health care enrollment form to include a selection option for OEF/OIF to ensure proper priority of care.
Many advances are the result of improved records management and greater sharing and Information Technology (IT) interoperability with DoD. In response to Task Force recommendations, DoD and VA worked collaboratively to expand

access to service members' electronic health records by jointly developing the electronic capability to transfer digital radiographs from Military Treatment Facilities (MTFs) at Walter Reed, Bethesda, and Brooke to VA Polytrauma Rehabilitation Centers. The capability for electronic transmission of historical health care data from DoD MTFs to VA Medical Centers is complete in the domains of allergies, outpatient medications, laboratory results, and radiology. Additionally, a contract was recently awarded for an independent assessment of inpatient electronic health records in the Departments of Veterans Affairs and Defense. The contract will provide recommendations for the scope and elements of a joint electronic inpatient medical record.

In July of this year, the Report of the President's Commission on Care for America's Returning Wounded Warriors was issued. This Commission had a greater scope than the Task Force and was not constrained by existing authority and resources. In March, the Army Inspector General issued an inspection report on the Army Physical Disability Evaluation System detailing findings of military medical and personnel policies, procedures and services for wounded and injured Soldiers. There was also a report issued by the Secretary of Defense's Internal Review Group examining the conditions at Walter Reed Army Medical Center. In October of this year, the Veterans Disability Benefits Commission will issue its report and recommendations.

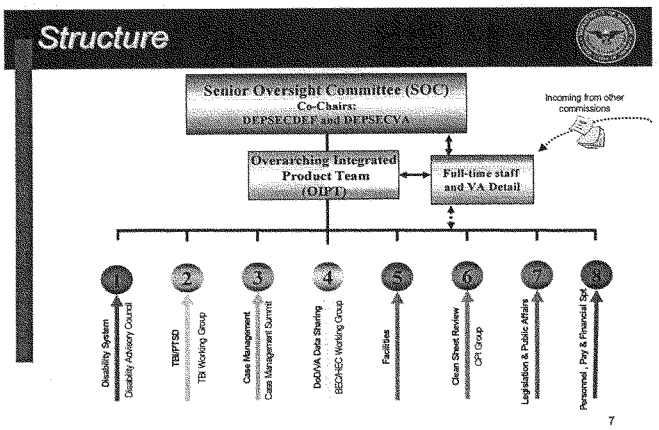
To ensure a seamless continuum of service to wounded, ill, and injured service members, the Departments of Veterans Affairs and Defense began an integrative effort, and established the Wounded, Ill, and Injured Senior Oversight Committee (SOC) on May 3, 2007. The SOC, composed of senior military and civilian officials from both Departments, was established for a 12-month time period, and was tasked to ensure the recommendations of the task forces and committees were properly reviewed, coordinated, implemented, and resourced. The Committee is co-chaired by the Deputy Secretary of Veterans Affairs and Deputy Secretary of Defense, and meets weekly to streamline processes, mitigate potential conflicts, and expedite the two Departments' efforts to improve support of injured service members' recovery, rehabilitation, and reintegration.

Senior Veterans Affairs and Defense officials serve on the SOC. This includes the Service Secretaries, the Chairman of the Joint Chiefs of Staff, the Service Chiefs, and VA's Under Secretary for Health, Under Secretary for Benefits, Assistant Secretary for Policy and Planning, and Deputy Assistant Secretary for Information and Technology. The driving principle guiding the SOC's efforts is the establishment of a seamless continuum that is efficient and effective in meeting the needs of our wounded, ill, and injured service members/veterans and their families.

Supporting the SOC decision-making process is an Overarching Integrated Product Team (OIPT), composed of the Under Secretary of Benefits, Assistant Secretary of Policy and Planning, and other senior officials from VA and DoD.

The OIPT reports to the SOC and coordinates, integrates, and synchronizes the work of eight Lines of Action and recommends sourcing solutions for resource needs.

The diagram below depicts the structure supporting the SOC. The Lines of Action, which have Senior Executive Service Co-Leads from both Departments, establish plans, set and track milestones, and identify and enact early, short-term solutions.



The Lines of Action (LOA) and their goals are:

- **LoA #1: Redesign the Disability Evaluation System**

  Goal: *To develop a single, supportive, and transparent disability evaluation system.*

- **LoA #2: Address Traumatic Brain Injury/Psychological Health**

  Goal*: To provide service members with lifelong standardized and comprehensive screening, diagnosis, and care for all levels of Traumatic Brain Injury and Post Traumatic Stress Disorder, in conjunction with education for patients and family members.*

- **LoA #3: Fix Case Management**

  Goal*: To coordinate health care, rehabilitation, and benefits, delivery of services and support that will effectively guide and facilitate service members and their families through necessary processes.*

- **LoA #4: Expedite Data Sharing**

  Goal*: To ensure appropriate beneficiary and medical information is visible, accessible, and understandable through secure and interoperable information management systems.*

- **LoA #5: Facilities**

  Goal*: To provide service members and families with the best possible facilities for care and recovery.*

- **LoA #6: "Clean Sheet" End-to-End Review**

  Goal: *To honor our service members by providing wounded, ill, and injured personnel and their families the best quality care and a compassionate, fair, timely, and non-adversarial disability adjudication process – enabling service members to return to the fullest, most productive and complete quality of life possible.*

- **LoA #7: Comprehensive Legislation and Public Affairs**

  Goal: *To coordinate the development of comprehensive legislation that will provide the best possible care and treatment for injured service members and families. Additionally, to keep the public informed of significant accomplishments and events.*

- **LoA #8: Personnel, Pay, and Financial Benefits**

  Goal: *To provide compassionate, timely, accurate and standardized personnel, pay, and financial support practices for Wounded, Injured and Ill to ensure appropriate data sharing, quality control, and support benefits.*

In a collaborative effort with DoD, VA has made great strides in addressing issues surrounding Post-Traumatic Stress Disorder (PTSD) and traumatic brain injury (TBI) concerns across the full continuum of care. 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 military members, veterans, and families who deal with these important health conditions.

Since June 2007, a collaborative team of VA and DoD experts known as the "Red Cell" has worked to (1) create an integrated, comprehensive Department of Veterans Affairs/Defense program to identify, treat, document, and follow-up those who experience TBI or PTSD conditions while either deployed or in garrison; and (2) determine how to build resilience, both in people and in organizations, to prevent issues from developing and to reduce their impact if they do occur.

VA and DoD have partnered to develop clinical practice guidelines (CPG) for PTSD, Major Depressive Disorder, Acute Psychosis, and Substance Use Disorders. These guidelines help practitioners determine the best available and most appropriate care.

Our Senior Oversight Committee also has approved a National Center of Excellence for PTSD and TBI. It will include liaisons from both VA and DHHS, 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. This center will facilitate coordination and collaboration between VA and the Military Services, promoting and informing best practice development, research, education and training.

As of the first half of FY 2007, approximately 250,000 returning veterans have sought care from VA medical centers and clinics. Of these, about 38 percent have received at least a preliminary diagnosis of a mental health condition, and 18 percent have received a preliminary diagnosis of PTSD, making it the most common, but by no means the only mental health condition related to the stress of deployment. Professionals with special expertise in PTSD are available in all medical centers to serve veterans with PTSD. Most are best served in outpatient programs, but for those with more severe symptoms, VA has inpatient and residential rehabilitation options across the country.

VA has taken several actions at multiple levels to promote the recruitment and retention of mental health professionals in the Veterans Health Administration (VHA). In February 2007, both an Education Debt Reduction Program and an Employee Incentive Referral Initiative began. The new mental health Education Debt Reduction Program currently provides up to $38,000 of education loan

repayment for qualified student debt. The Employee Incentive Referral program provides a bonus to VA employees who refer mental health providers who are hired into VA positions. These initiatives have already generated significant interest.

At the local level, opportunities have been developed for VA facilities to engage in local advertising and recruitment activities and to cover interview-related costs, relocation expenses, and provide limited hiring bonuses for exceptional applicants. VA has also established opportunities for supporting individual training and education activities for mental health employees, demonstrating an investment in staff can also have a positive impact on retention.

Rates of hiring have increased significantly in recent months, suggesting that the enhanced recruitment efforts are having a positive impact. Since FY 2005, VA has authorized 4,367 new Mental Health Enhancement positions. As of August 31, 2007, 81 percent of these positions have been filled.

In terms of treating TBI, VA offers comprehensive primary and specialty health care to our veterans, and is an acknowledged national leader in providing specialty care in the treatment and rehabilitation of TBI and polytrauma. Since 1992, VA has maintained four specialized TBI Centers. In 2005, VA established the Polytrauma System of Care, leveraging and enhancing the existing brain injury polytrauma expertise existing at these TBI centers to meet the needs of

seriously injured veterans and active duty service members from operations in Iraq, Afghanistan, and elsewhere. The Secretary of Veterans Affairs recently announced the decision to locate a fifth Polytrauma Center in San Antonio TX.

The Departments of Veterans Affairs and Defense are also working closely to redesign and establish one Disability Evaluation System (DES) for use by service members. A pilot program is being explored via tabletop exercise to ensure that no service member is disadvantaged by this new system, and that the service member receives the high quality medical care, and appropriate compensation and benefits for the residuals of his or her disabilities incurred or aggravated by military service. An operational pilot program should be completed in the second quarter of 2008. If it is as successful as we plan, this pilot program will be expanded beyond the Washington Capital Region to become the DES system, worldwide.

The proposed new system is much more efficient. It will produce more consistent outcomes and, with VA and DoD working together as a team, the new system is a seamless, single process for users. We envision it cutting in half the time it takes for a service member to go through the DES, from the time the member is referred for a Medical Evaluation Board (MEB), to the time the member is discharged from active military service and receives his or her first payment from VA.

An important improvement in this proposed system is that the service member will only be required to have one medical examination or series of medical examinations, depending on the severity of the potentially disqualifying conditions to meet the requirements of both DoD and VA. Currently, a Service-specific medical examination is required for the purpose of determining a service member's ability to continue on active military service based on the residual unfitting disability and the service member's, rank, rating, or military occupational skills, and a VA medical examination is also required for the purpose of evaluating the residual of the disability under VA's Schedule for Rating Disability, so a percentage evaluation can be assigned to the disability. Under the current system, if service members are found unfit and are separated or retired, they must complete the second VA exam to determine whether the claimed medical conditions are service-connected and represent impediments to full employment capability.

Under the proposed new DES system, the one medical examination process collects information required by both Departments. Under this system, when the service member transitions to civilian life, VA already will have the information needed to immediately start paying the veteran the appropriate amount of compensation for the residuals of his or her disability incurred or aggravated by military service.

Over the last four years, the Veterans Benefits Administration (VBA) service coordinators conducted more than 28,000 briefings attended by more than a million active duty and reserve personnel and their family members. Additionally, through the Benefits Delivery at Discharge program, service members at 153 military bases in the United States, Germany, and Korea are assisted in filing for disability benefits prior to separation. This fosters continuity of care between the military and VA systems and speeds up VA's processing of their application for compensation. Claims decisions can be completed prior to separation and veterans can begin receiving VA compensation payments, without delay, upon separation from the military. VBA also processes the claims of OEF/OIF veterans who apply for VA disability compensation or pension on an expedited basis.

In April 2007, Secretary Nicholson created a new Advisory Committee on OIF/OEF Veterans and Families to advise VA on ways to improve programs serving OEF/OIF veterans, their families, survivors, and care givers. The Committee is composed of OEF/OIF veterans, family members, survivors, and caregivers who have insight into how VA is responding to the unique circumstances of these veterans.

Thank you for providing me this opportunity to share with you recent activities in the Department of Veterans Affairs. I will be happy to answer any questions you may have.

Mr. TIERNEY. Thank you.

Typical of this institution, those are messages for votes coming up, I assume, on that. I will be able to get more information on that in a moment. What I think we will do is start with the questioning and then make a determination when we find out how many votes we have whether we will have to interrupt the meeting or whether we can try to continue on through.

I want to thank all of you for your testimony. Despite my interruption of Mr. Dominguez, I think we are trying to be helpful here in trying to move forward on this basis. If there was something in the tone or the comment that you made that struck a chord there amongst several of us here, but that had to do really with urgency. One of the things that we constantly have from all of the commissions and from all of the conversations with returning people is a sense that there has been a lack of urgency over time about dealing particularly with the rating system, with the evaluation system on that. When I look at how long it has taken for the Senior Oversight Committee to stand up and get going on this thing, the frustration is palpable. I was just making sort of a broad comparison to General Jones' work. He did the Independent Commission on the Security Forces of Iraq. He started in May 2007. They assembled teams, 20 prominent retired and active officers, police chiefs, Secretaries of Defense, etc. They have organized and attended syndicates. They focused on either discrete components or cross-cutting functional areas. They were all subject to review of the full committee. They traveled widely throughout Iraq, which for anybody is a seriously difficult prospect to do in the middle of a war. They interviewed hundreds of Iraqi officials, U.S. officials, visited sites, and did all that and filed their report in 4 months.

We are 7 months into this process, that we all admit is one of the major concerns that we have, and we are just now getting off the ground. So that is, you know, the lack of urgency that I think Members coming back from Iraq and Afghanistan sense and the Members here on this dais sense. Why has it taken so long to get going on that?

Now, I will let you answer that in the context of the first question I am going to ask. Now we have had the pilot program that you announced either yesterday or today, which is good. I am glad that is moving forward. We need to know from you a little bit more about that pilot program, what it entails, and does it address GAO's concerns in terms of personnel. I understand from your brief comments that it is going to be the Veterans Administration's standards and template on that, so that raises the questions, I think, that Mr. Pendleton or Mr. Bertoni raised about if you choose that, then you have difficulties with the process, itself, at VA.

The single disability evaluation should make it more consistent in disability ratings, but does it have enough people involved in the system? Are we going to have the personnel? Are we going to take into account the assistive technologies and disabled veteran's ability to work, have a new system for getting people that can be put into work out there and do something about the outdated rating system. Does it address that? And how long is this pilot program going to go? Why aren't we moving immediately into a final disposition of this, if you have done your table tops, you have had

your analysis, you have dealt with the experts, you have looked at the situation and have examined the data? How long is this pilot going to go? Why aren't we going right into just getting this done?

I suspect we will give you an opportunity to answer that.

Mr. DOMINGUEZ. Thank you for the question.

First let me say that if there was anything in my tone that was critical, I apologize for it. It was not intended to be.

The sense of outrage by the Congress and the American people is fully justified. Last spring in the demand for urgency, fully justified, 100 percent with it, I felt the boot had been appropriately applied, and I do want to say that we are moving urgently.

The SOC that meets for an hour a week, has been doing that in a decisionmaking forum.

Now, why it takes us a little longer to get going is that we are doing more than the report. In crafting our recommendations to the SOC on what we are going to do, we have to reach down into the organization and get those people who have an equity stake, who have a lot of knowledge and experience, and cause them all to try and work through this and come together, so it is very much managing an alliance as we work through the issues and come to grips with it.

And then I remind you again of the comments Mr. Bertoni made about, here is a bunch of the questions that have to be answered, and you have to have the evaluation plans and how you are going to do that. Those are the kinds of questions and the due diligence we have to put in place before we can launch a system.

So it does take some time to develop the details, to build that consensus, and to work through these issues.

I have to say that each of the military services feel an intense need to solve this problem themselves, so when I ride in there with Secretary Dunne saying, OK, stand back, guys, we are going to fix this, their immediate reaction is, prove it first before we let you hurt us more. This is justifiable on their part, as well. That is part of the confidence building process that we have to use.

Now, how this process will work, we will use the VA rating. The VA rating for the unfitting condition will be determinative, and the percentage that they put on that will dictate whether a person found to be unfit is separated or retired and the level of benefits, just as in the current system.

The pilot we are doing must stay within the context of the current law. That includes how the VA does their thing with the VA scheduled rating disabilities. The fact that it needs to be updated has been acknowledged by the Secretary. I will let Pat speak to that. But what we are going to be moving forward with is within the current context of law and what we can do by policy changes and by bringing the VA talent onto our side of the administrative processes.

Mr. TIERNEY. And how long do you project the pilot is going to be?

Mr. DOMINGUEZ. Sir, because this affects people, it is an administrative process that actually issues an outcome that affects benefits in for-real individuals, our first step is we are going to do the next thing beyond a table top, which is actually proof of concept where we walk people who have already been through the system and al-

ready been issued their benefits and their determinations, we are going to walk them back through this system and see how those two things compare. Then, notionally, in January 2008 we will actually start putting new cases through this.

There is also training associated with it in preparation for it. I don't, at the present, have a concept for how long that would work. We are going to do it in the Washington, DC, metro area first, within a few months, depending on the number of people who go through it and the outcomes, we could very well begin to scale it up across the Department shortly thereafter.

When and if fundamentally different legislation such as the ideas proposed by Secretary Shalala and Senator Dole come, then a lot of things would change based on that, so we have to re-evaluate how we do that.

Mr. TIERNEY. We will explore that a little further.

My time has expired.

Mr. Platts, would you care to ask some questions?

Mr. PLATTS. Thank you, Mr. Chairman. I appreciate your and the ranking member's leadership on this issue and the various hearings and visits to Walter Reed, and I want to thank all of our witnesses, both those on the front lines of trying to make these systems work, as well as the GAO colleagues and their important oversight work.

Mr. TIERNEY. Excuse me, Mr. Platts. I hate to do this to you, but there are only 6 minute left to vote.

Mr. PLATTS. OK.

Mr. TIERNEY. I know you want to record your vote. You have a choice. You can stay and I will stay with you, or we will both try to make it, or we could go and do the two quick votes and be back in 10 minutes.

Mr. PLATTS. Do you want to do that, Mr. Chairman?

Mr. TIERNEY. Fine. We are going to recess. I apologizes to our witnesses for the schedule around here, but we will take 10 minutes probably maximum and be back here.

Thank you.

[Recess.]

Mr. TIERNEY. The subcommittee will resume.

Mr. Platts, thank you for allowing us to interrupt you. I think it was a better way to proceed, and hopefully you will get your entire 5 minutes again starting now.

Thank you.

Mr. PLATTS. Thank you, Mr. Chairman.

Again, just let me reiterate to our witnesses my thanks to each of you for your efforts on behalf of our wounded warriors.

When we had our hearing earlier this year, the first hearing at Walter Reed, one of the common messages or two that I want to try to address in my 5 minutes quickly, one was the care, when provided, in the overwhelming instances was excellent, but the challenge was the coordination of that care, either within the DOD system or the transfer to the VA system, and then the second was the transfer of information from DOD to VA. I am going to try to address both of these.

Certainly, that has been the focus of the various studies or commissions that have been done, and specific to the Army with the

creation of the Warrior Transition Units. Then in the broader sense the SOC has talked about, I think what you are calling recovery coordinators to kind of oversee and be that one-stop person for wounded warriors and their family members.

My concern is, given that is so critical to these individuals, these soldiers getting to the right entity for their care and not being, as we had heard with Staff Sergeant Shannon and others, left to find their own way, the fact that we are now more than half a year along the path, and according to GAO report about half of these positions are unfilled, and even a good portion of those that are filled within the Army ranks are temporary, and then with the SOC recommendation it is still just a recommendation. We haven't even begun to implement this process.

So I guess if I can start with our two Secretaries first to the broad issue on the recovery coordinators, where we stand and what is the greatest challenge to getting this up and running and to making a difference. Then, General Schoomaker, if I can go to you on specific to the Army and the fact that we still have so many vacancies in these very critical positions.

Mr. DOMINGUEZ. Sir, I will start.

I think the first headline I have to tell you is that the Army has changed the situation on the ground in these hospitals. The triad of care that they are deploying through the Warrior Transition Units and stuff is changing the situation on the ground. That is the necessary and immediate response to soldiers in need.

Mr. PLATTS. I know that is the plan, but my understanding and I think from GAO is that only 13 of the 38 Army facilities actually have those fully staffed, those triads staffed. Is that incorrect?

Mr. DOMINGUEZ. I can't dispute the GAO data on it, because this plan and the triad and the requirement for it emerged in the Army's look internally at what they needed to do, and we have given them at the DOD level every support possible and every encouragement. In fact, the directive that General Schoomaker mentioned about, you know, hire everybody you need to hire, use every authority you have to do that in terms of this medical unit. So the situation on the ground has changed where the Army has been able to respond and been able to staff that. Again, challenges remain. More needs to be done. We are pouring all the gas on it we can.

That is also true with regards to the VA/DOD collaboration around information sharing and, in fact, people. There are people from both departments in each other's facilities actually coordinating and managing the transfer of patients and information when patients move back and forth between our systems, another great example of the partnership stepping up to the challenge and changing the situation on the ground.

At the more global level, at the SOC what we are again trying to do is trying to figure out, all right, what else needs to be done globally.

Mr. PLATTS. And specifically with recovery coordinators?

Mr. DOMINGUEZ. Yes, sir. That is one of the things that we are looking at now is the architecture of roles and responsibilities and how that all works together, because you don't want to disrupt this triad of care. You want to augment it and supplement it.

Mr. PLATTS. Right.

Mr. DOMINGUEZ. So what needs to be done, how do we do that, how do we introduce this new phase, what value-added does that new phase bring, and how do you connect them then with the triad of care that is going on? So you want to move carefully and deliberately, with urgency absolutely, and I hope to be able to have something definitive within the next few weeks about how we are sorting through the care recovery coordinator. In fact, part of that discussion will be at the SOC on October 2nd.

Mr. PLATTS. OK. Mr. Chairman, could General Schoomaker—if you could respond in specific to the triad approach and my understanding from the GAO information the number of vacancies, and your efforts, and what do you need from us, if anything, to help fill those positions?

General SCHOOMAKER. Yes, sir. I appreciate the question.

First of all, I think Mr. Pendleton made the comment earlier that the findings at GAO are preliminary and it gives us an opportunity to clarify and to better explain some of the data that are reported in this very thorough GAO study that we greatly appreciate.

First of all, warriors in transition, who are these people. It is important that you realize that the former terms of med-holdover don't exist any longer within the Army. We have taken all soldiers, active component soldiers and mobilized reserve component soldiers, National Guardsmen, Reservists, regardless of where they became injured, ill, whether they are combat casualties or whether they are, frankly, injured on a training base or develop a serious illness in the course of their service, we put them all together in a single unit we call Warrior Transition Units, and they are called Warriors-in-Transition.

The important thing is not where they got injured or ill; it is simply that they developed an injury or an illness as a consequence of their service and we want to treat them all the same.

We are at this point on the projected glide path to fully staff all Warrior Transition Units by the first of January. I hesitate to use the word incremental here because it has a bad sort of taste in our mouths now, but we are going as quickly as we can. The Army has been very, very aggressive about supportings, giving us full staff to provide the oversight of squad leaders, platoon sergeants, first sergeants, company commanders, battalion commanders for these units, and we are on a very good glide path to achieve the goal.

What the GAO heard about and does exist are not casualties of war. Every casualty evacuated out of the theater of operation or any major illness is immediately assigned to a Warrior Transition Unit and is given the term or label of a Warrior-in-Transition and is assigned to a unit that is staffed with a squad leader, platoon sergeant, company commander, and the like.

What we do have in the Army, however, and have always had, is about an equivalent sized, almost brigade-sized element distributed throughout our war fighter brigades, divisions, and corps, who have a medical illness or an injury that renders them at least temporarily unfit or unable to deploy. We now have a case-by-case negotiation with their commanders to bring them into the Warrior Transition Unit, to call these, to embrace them as Warriors-in-Transition and assign them.

That population is as yet unstaffed for cadre because we haven't identified them.

Mr. PLATTS. But you have prioritized those from the combat operations as far as the staffing, and now you are moving through the ranks?

General SCHOOMAKER. Yes, sir. If you go to every WTU across the Army right now, we are at over 50 percent cadre supplied. At Walter Reed, frankly, we are at 95 percent. Across the Army we are at about 65 percent across all Warrior Transition Units, and we are on that glide path to be fully staffed.

Mr. PLATTS. OK. Thank you, Mr. Chairman.

General SCHOOMAKER. Does that clarify?

Mr. PLATTS. Perhaps I will have a chance to followup if we have additional rounds. Thank you.

Mr. TIERNEY. Thank you.

Mr. Waxman.

Mr. WAXMAN. Thank you, Mr. Chairman.

I want to address this question to Under Secretary Dominguez. There have been reports about soldiers who, despite physical or mental health problems and against the advice of their doctors, have been ordered to redeploy to Iraq. We first heard this at our hearing on May 24th, and since then we have received additional reports from soldiers at Fort Benning and Fort Carson. These reports are extremely concerning, disturbing.

Do you agree that soldiers who are physically or mentally ill should not be deployed against the wishes of the doctors who are treating them?

Mr. DOMINGUEZ. Absolutely, sir.

Mr. WAXMAN. I understand there may be some gray area here. Some soldiers have illnesses that are not severe enough to prevent them from combat duty; others have mental illnesses that can be successfully treated with medication. In some cases, the soldiers may even want to return to their units. Has DOD put together a policy that governs these redeployments? How do you balance the needs of the soldiers, the unit, and the military as a whole?

Mr. DOMINGUEZ. Sir, we have given that a great deal of thought in these last several months. That is part of some of the work of the Mental Health Task Force. I would have to get back to you on the record with the policy that governs this. I do know that you are screened. People are screened before they redeploy. They are screened when they come back and then again before they go. People who have conditions that make them unable or unfit to serve in combat, in a combat theater, we have policies and practices in place where they should not be deployed.

Mr. WAXMAN. Well, under the policies, as I understand it, there is supposed to be a unit commander to have to get a waiver from Central Command before they can redeploy somebody, and we have one documented case at least from Fort Carson where a unit commander sought a waiver to redeploy a soldier who was on psychiatrically limiting medications and the waiver was denied. And then, despite this denial, the soldier was ordered to redeploy and subjected to disciplinary action when he could not. This seems to me like a clear violation of DOD policy. It was bad for the soldier, unquestionably. It couldn't have been good for the unit, either. The

soldier is not well enough to be in combat, he could present a real danger to his comrades.

Can you explain why it appears that DOD policy is not being followed with regard to redeployments of mentally ill soldiers at Fort Carson?

Mr. DOMINGUEZ. No, sir, I am not familiar with that particular case.

Mr. WAXMAN. Well, could you tell us what steps DOD is taking to ensure that the policies are followed? Are unit commanders who do not follow the policy subject to disciplinary action?

Mr. DOMINGUEZ. Sir, unit commanders who don't follow DOD policies, yes, are subject to disciplinary action.

Mr. WAXMAN. I know the military is greatly strained, that we have people who have been back and redeployments sometimes three or four times, but if we are going to redeploy people, at least we ought to make sure that they are well enough to be in a combat zone.

The other thing I wanted to ask you about is there are also credible reports of systemic problems at Fort Carson with regard to wrongful discharges of soldiers with psychiatric conditions. The military comes back and says, well, they have a pre-existing condition, and therefore they are not going to take care of them. They don't accept that this is a mental illness problem related to combat. NPR reported on a memo from the Director of Mental Health at Evans Army Community Hospital, and, according to reports, this memo was written to help commanders deal with soldiers with emotional problems, and NPR stated, "We can't fix every soldier, and neither can you. Everyone in life, beyond babies, the insane, the demented, mentally retarded have to be held accountable for what they do in life." And the memo goes on to urge commanders, "to get rid of the dead wood."

Are you familiar with that memo?

Mr. DOMINGUEZ. No, sir, I am not.

Mr. WAXMAN. Well, it appears this memo is advocating giving up on some of our mentally ill soldiers. That is certainly not a responsible approach. And this business of pre-existing conditions discharge, it means that the soldier is discharged dishonorably and they can't get access to mental health care that they require from the Veterans Administration. That doesn't make sense to me. It seems like if a soldier was healthy enough to be accepted into the Army, disciplinary problems that appear to be related to PTSD should not be blamed on pre-existing conditions. These soldiers should receive treatment, not blame.

I would like to get further reports from you on this issue. It is certainly not appropriate to discharge soldiers with PTSD via this pre-existing condition discharge. I would like to get from you for the record, because my time is up but I think we need to get this, the DOD policies that prevent soldiers from being inappropriately discharged for pre-existing conditions. If this is going on, it is certainly an outrage.

Mr. DOMINGUEZ. I am happy to provide that.

[The information referred to follows:]

CHARRTS No.: HOGR-02-026
House Government Reform Committee
Hearing Date: September 26, 2007
Subject: Third Walter Reed Oversight Hearing
Congressman: Congressman Waxman
Witness: HON Dominguez
Question: #26

Mental Illness and Discharges

Question: Please provide data for the Army as a whole, and for Fort Carson in particular, on the number of soldiers discharged for disciplinary reasons who have also been diagnosed with a mental health problem or a Traumatic Brain Injury since January 2005. Please provide copies of, and an explanation of, DOD policies and guidance for base commanders tasked with deciding whether a soldier should be discharged on disciplinary grounds or medical grounds when the disciplinary and medical problems are co-occurring. What steps is DOD taking to ensure that soldiers who are suffering from combated-related injuries or illnesses are not inappropriately discharged for disciplinary reasons?

Answer: The Department does not have a database to determine the number of Service members discharged Army-wide for disciplinary reasons who have also been diagnosed with some degree or type of mental health disorder, or with a traumatic brain injury. Fort Carson, however, conducted a narrower local records check of Service members facing administrative separations for disciplinary reasons who were also diagnosed with a mental health disorder that was at least a contributing factor to the conclusion that they did not meet medical fitness standards for retention. Thus, these Service members were eligible for full medical processing through the Medical Evaluation Board (MEB)/Physical Evaluation Board (PEB) process. Fort Carson identified 18 Service members facing administrative separations for misconduct who were also eligible for medical processing due, at least partially, to a mental health disorder. Of those 18, eight were allowed to process through the PEB, and ten were administratively separated for misconduct.

There is no DoD policy that specifically addresses the procedures for commanders considering whether to administratively separate Service members for disciplinary reasons when the Service members also have a medical condition that warrants MEB/PEB processing. Army regulations, however, directly address this situation.

Army Regulation 635-200, paragraph 1-32 (copy attached), establishes that disposition through medical channels takes precedence over administrative separation processing. When the appropriate medical treatment facility commander or other medical officer establishes that a soldier being processed for administrative separation does not meet the medical fitness standards for retention, then the case will be referred to an MEB. The administrative separation proceedings may continue, but the separation authority cannot take final action pending the MEB results.

If the MEB results indicate that referral to a PEB is warranted, then the medical treatment authority commander must furnish the approved MEB proceedings to the soldier's general court martial convening authority (GCMCA). The GCMCA may direct, in writing, that the soldier be processed through the PEB system when action under the Uniform Code of Military Justice (UCMJ) has not been initiated, when the medical condition is the direct or substantial contributing cause of the conduct that led to the misconduct, or when other circumstances warrant disability processing.

DoD does not have direct oversight of each such administrative separation, but is confident that procedures that elevate the approval authority to the GCMCA level provide the necessary protections. Commanders or others who do not follow these procedures are subject to the full range of administrative and disciplinary actions available under the UCMJ and applicable Service regulations. Service members who are being considered for such separations will generally be allowed to consult with or be represented by counsel and are afforded all due process. If appropriate procedures are not followed, then they may consult with the Inspector General or raise allegations against their commanding officers using the Article 138, UCMJ, process.

Section VI
Medical Processing
1–32. Separation and medical examinations

a. Medical examinations are required for soldiers being processed for separation under chapters 5 (see paras 5–3, 5–11, 5–12, and 5–17 only), 8, 9, 11 (see para 11–3*b* only), 12, 13, 14 (sec III only), 15, and 18. (See AR 40–501, para 8–23 and table 8–2.) Medical examinations incident to separation under other provisions of this regulation are not required but will be administered if requested in writing by the soldier. Separation will not be delayed for completion of the physical; however, the physical may be completed at a VA facility.

b. In addition to medical examinations, mental status evaluations conducted by a psychologist, or master level, licensed clinical social worker, are required for soldiers being processed for separation under chapters 13, 14 (sec III), or 15. A mental status evaluation is also required when a soldier being processed for discharge under chapter 10 requests a medical examination. The mental status evaluation will be documented in the soldier's medical records on SF 600 (Health Record-Chronological Record of Medical Care.)

c. Detailed information about the reasons for considering a soldier for separation will be provided to attending medical personnel to permit thorough understanding of the contemplated action.
(1) Medical personnel will not be used in an investigative capacity to determine facts relative to a soldier's behavior.
(2) Commanders referring a soldier for a mental status evaluation that is not required, as specified above, must comply with the provisions of DODD 6490.1 and AR 600–20.

d. Except as provided in paragraph 1–33*b*(2), specific responsibilities and procedures for conducting medical examinations and mental status evaluations will be prescribed in pertinent regulatory guidance issued by The Surgeon General.

e. Soldiers being considered for separation under paragraph 5–13 must have the diagnosis of personality disorder established by a psychiatrist or doctoral-level clinical psychologist with necessary and appropriate professional credentials who is privileged to conduct mental health evaluations for the DOD components.

f. A command-directed mental health evaluation performed in connection with separation under paragraph 5–17 will be performed by a psychiatrist, doctoral-level clinical psychologist, or doctoral-level clinical social worker with necessary and appropriate professional credentials who is privileged to conduct mental health evaluations for the DOD components.

Mr. DOMINGUEZ. If I might, I do want to call attention to Secretary Garon and Chief of Staff General Casey's efforts to train the Army on the challenges of combat stress. If you haven't seen or heard about the activity they initiated—and General Schoomaker can tell you a lot more—a superb effort of leaders to make sure that leaders throughout the Army understand the challenges of combat stress and how to deal with them. I think it is a laudable, commendable, superb effort by those two.

Mr. WAXMAN. Well, it doesn't seem to be getting through to the leaders at Fort Carson, so I think we need further reports on whether the Army is actually getting educated or whether more paper is just being generated.

Mr. DOMINGUEZ. Happy to do that, sir.

Mr. WAXMAN. Thank you, Mr. Chairman.

Mr. TIERNEY. Thank you.

Mr. Dominguez, we will expect some report back on those particular incidents that Chairman Waxman discussed in a reasonable time. We would appreciate that.

Mr. DOMINGUEZ. Yes, sir. Happy to do that.

Mr. TIERNEY. Thank you.

Mr. Turner.

Mr. TURNER. Thank you, Mr. Chairman.

I want to thank you again for all the work that you have done on this issue, both when the original issues came to light about the care that our soldiers were receiving, and your efforts on this committee have not only made a big difference, but have highlighted some solutions that we have been hearing today.

I serve on the Armed Services Committee, the VA Committee, and on this subcommittee, so I get three bites of the apple on this issue. I was very proud to listen to Senator Dole and Secretary Shalala deliver their recommendations to the VA Committee and, like many, are very appreciative of their work. They have looked to some real solutions and identifying real problems.

I want to echo the comments that others have made about the Medical Evaluation Board Processes at DOD, the VA, and the recommendations from Secretary Shalala and Senator Dole on the problems of the time for the process, the inconsistencies, and the lack of coordination between DOD and VA. I think they have some great recommendations.

So many times we look at the streamlining processes instead of, as they have recommended, collapsing processes and making them thereby more efficient. But in looking at the three different committees that I serve on, and the information that we receive and how we need to proceed, one of the things that this committee has continued to hear in this process of great concern is a sense between Reserve components, Guard, and active members that there is a disparity perhaps for Reserve and Guard members and the level of their care at the facilities, the resources that are brought to bear to assist them. They have told the committee that at times they feel like they are second-class citizens.

I know that each of you have a concern and a dedication to that issue, and I would like to give you an opportunity to respond to the feelings of disparity that they have, the issues that you do see

where there are disparities, and ways in which it might be addressed or ways in which you actively are looking to address it.

We will start with the General.

General SCHOOMAKER. You want to start with me, sir?

Mr. TURNER. Please.

General SCHOOMAKER. Well, sir, I would say right off the bat I think that their perceptions are real, and they are certainly justified. I think one of the failures that was alluded to by Mr. Dominguez earlier of the Department of Defense—and in the Army, we were guilty of the same—is that we put in place some structural solutions shortly after the first appointments of our Reserve component colleagues. We mobilized National Guard and Reserve elements, and when they returned or when they were injured or showed up at our deployment platforms with illnesses, we segregated them into two different populations, med-hold for active component soldiers and med-holdover units for the Reserve component soldiers. Now, that was done because there are differences between the two components when it comes to processing of disability and outprocessing in the Army and the like, the things that are more arcane than this General can understand, quite frankly.

But I think what that did, unfortunately, was create the impression, on both sides, ironically, both the active component and the mobilized Reserve component soldiers, that they were being treated differently.

Certainly we will continue to work on this misperception of the two groups by creating a Warrior Transition Unit and a single term to apply to all soldiers, they are all active duty soldiers. Whether they come out of the Reserve component, or they are active component soldiers like myself, they are all active duty soldiers that are serving the Nation, and, frankly, they are carrying a heavy load, and so we are trying in every way we can to break down that misconception.

Mr. TURNER. General, I appreciate your commitment to that. It is an important issue, and I know that everyone agrees with you on the need for your and other's success.

Would anyone else like to comment on the issue of things we need to look at?

Mr. DOMINGUEZ. Sir, if I might, yes, I believe the Army has changed the situation on the ground in the military treatment facilities at Army installations. We have a continuing challenge when we get Reserve and Guardsmen home, as they want to do fast, and then they may have trauma and challenges, particularly PTSD and the TBI, which sometimes emerge late after they have been demobilized back into their civilian communities. We have challenges trying to devise and deliver programs to help them with the tough, tough challenge of re-integration, because they are distributed all over the place. They are not concentrated at a military facility where we can get to them.

We are working through those challenges. Several activities right now are underway in terms of re-integration. Lots of work, thinking through with the VA how to reach those people in their communities at home and make sure they get care when they are back home, and lots of opportunities through TRICARE delivery organizations to make sure that they get treated. But it is a challenge

when we get them back home, making sure they get the care and support they need.

Admiral DUNNE. Sir, if I might also comment, in Secretary Nicholson's task force we also discovered that, with the Guard and Reserve, when they would go home and then try to do the post-deployment health reassessment, we found that it would be helpful if the local VA medical center was represented at those sessions, and so, as a result of the task force, we have taken that action to get from DOD the schedule of when those reassessments are taking place, and then we task the closest medical center to support those events and have VA experts available at those sessions.

So we are aware of potential problems, Guard and Reserve, and we are working hard to try to find solutions to the process to alleviate those.

General SCHOOMAKER. Let me add one additional comment to my earlier comments.

When we have looked very carefully at one of the critical steps in adjudication of disability for both Reserve component and active component soldiers, you need to understand, Congressman, we have not found any systemic evidence that the two are treated differently at that level. I think much of what you are describing is a perception at our facilities. What Mr. Dominguez said and what the Admiral said is exactly right—when they get back out to their communities, it is very hard for us to reach out and touch them, and we are working very actively to try to find the resources necessary to extend that care.

But certainly at the point of separation and adjudication of disability, Reserve component soldiers sit on the boards that adjudicate their disability, and we have found no evidence, in looking back at those adjudications, that there is any systemic bias.

Mr. TIERNEY. Thank you, Mr. Turner.

Mr. BERTONI. Excuse me. Can I offer up just a quick observation?

Last year we actually did a study for the Armed Services Committee where we were asked to look at disparities in the ratings system for Reservists and active duty. We did a very sophisticated analysis of outcomes, and it is true we couldn't find a real disparity between the ratings level between Army active service members and Reservists, but we did find that the Reservists were less likely to receive disability retirement benefits as well as lump sum benefits. The data was insufficient for us to determine the reasons for that. It just wasn't available.

We think a couple of things were going on. I think one of the things was the 8-year pre-existing condition rule. A Reservist entering the service in 1985 fulfilling all the obligations of his commitment or her commitment going on a 1-year tour of Iraq and Afghanistan, by 2005 that person would only have 6.9 years of creditable service and would fall within the 8-year pre-existing condition rule, so that is certainly a factor.

Generally, time and service would come into play also. If they didn't have the 20 years, they certainly wouldn't get the 20 years in that period of time based on based on Reserve status.

I testified before the Dole/Shalala Commission on this issue and brought forth a couple of points.

There are 26,000 service members assessed through DOD's system in 2006 or 2005. One in four of those was a Reservist, so not only do we have more Reservists making up a larger share of our military force, but we also have more Reservists coming in and seeking disability services, so I think we really need to look at our policies currently and whether they are serving the Reservists.

Mr. TIERNEY. Thank you.

Thank you again, Mr. Turner.

Mr. TURNER. Thank you, Mr. Chairman.

Mr. TIERNEY. Ms. McCollum.

Ms. MCCOLLUM. Thank you, Mr. Chairman. Thank you for the followup that you have been doing on this issue, because quite often it comes to light and then there is a lot of excitement and people are making plans, and then no one follows up to make sure the plans actually are implemented, so thank you so much for this hearing. I thank the gentlemen here today for their testimony.

I am not a stranger to the VA system. My father was a disabled vet. I am a regular fixture quite often at our VA facility in Minneapolis. I would like to commend the work that I have seen done in the poly trauma units, the lessons learned from the roll-outs as the units have gone through, the video linking with the families being present and the doctors speaking to one another with the patients. So there has been a lot of work done in there because basically you were starting from ground zero, so you could kind of invent the platform that you wanted to work off of using updated technology.

But that is not necessarily the case you see in the other parts of the VA system. One area, even in the poly trauma unit, that I am concerned about is the Department of Defense person that is assigned there to make sure that the flow of the paperwork goes forward. Most of that time that person is there for 3 months. It is not a career maker to be assigned to that unit, and so there even might be people who look at this as something that, if they can get transferred out of quickly, that they will. I think that service in that unit has a lot to offer for families.

The Marines, however, have decided to make this a priority, and the Marines that I have spoken with at our facility in Minneapolis are planning on being there for a year.

My comments now shift more to GAO. One of the things that we heard Mr. Dominguez say is, as we go through with the disparities rating, DOD is looking at moving forward with the VA disability rating. I turn my attention to page 17 of the GAO report, and there are two things on there I would like to have you comment on. One is the lack of confidence that our service men and women often have in the disability rating system, both in DOD and possibly VA. And second is the way in which the VA's rating system needs to be updated to reflect what is currently going on in today's labor market. Maybe if you could even comment, I had many people I case worked with, airline mechanics receive shoulder injuries, arm injuries, they were very concerned about their ability to return back to work and return back to work at a level which would allow them to move forward.

The other issue I would like to see addressed, and DOD and VA keeps talking about their plans. You folks did the study. I haven't

seen any budgets on how these plans are going to be implemented. I mean, we need to know. I serve on the Appropriations Committee. We need to know what we should be setting aside to appropriate to make these plans become a reality, both in the transfer of technology and what this is going to mean to staffing personnel.

Mr. Chairman, the buzzer is going off, but I would just also like to bring to the Chair's attention there is concern that traumatic brain injuries might lead to epilepsy for some of our service men and women later on in life, and my understanding is the VA, where they are in working with NIH to make sure that this is addressed and is not considered a pre-existing condition, ignoring that.

Thank you, Mr. Chair.

Mr. TIERNEY. Thank you very much, Ms. McCollum.

Mr. Lynch, do you have any objection? Mr. Hodes apparently has another meeting to go to and he has asked to ask a question before he leaves. Does that fit with your schedule, or do you also have a place to go?

Mr. LYNCH. Well, we have votes.

Mr. TIERNEY. We have two people to question before we go.

Mr. LYNCH. I'm sorry?

Mr. TIERNEY. We have both Mr. Hodes and you, will you be able to get your questions in before we go.

Mr. LYNCH. Yes. I have no problem.

Mr. TIERNEY. Great.

Mr. Hodes, please proceed.

Mr. HODES. Thank you, Mr. Chairman, and thank you for holding these hearings.

As you are all aware, these matters first came to prominence with articles about substandard care at Walter Reed that appeared in the Washington Post, and among the results of the articles and initial hearings was the testimony by Sergeant Shannon, who had lost an eye, suffered head trauma, and testified about languishing at Walter Reed for 2 years, and he talked about the difficulties he had had.

Now here we are in September, with all the attention that has been paid. We met Sergeant Shannon on Monday. He is back in the newspapers again. There was an article about his retirement papers having been lost, and he is now going to have to wait until December or January before he can retire.

The subcommittee went to Walter Reed on Monday, and we thank you, General Schoomaker, for briefing us and for telling us about your efforts. We had the opportunity to meet with a large group of soldiers in a room without brass, and we heard horror stories from them. They told of case managers who are unqualified, not doing their job, not up to the task. They told us of delays in pay or not receiving the awards due to them for their service to the country. They told about continuing to languish at Walter Reed for months or years. They told about continuing problems with scheduling medical appointments so that they were basically jerked back and forth about their scheduling. One soldier said to us sarcastically, "Walter Reed was the best place I have ever been incarcerated."

When we asked them whether they prefer to go back to Iraq or be in Walter Reed, nearly all of them said they wanted to go back to Iraq.

I have a constituent who turned to me to help him because he has been experiencing the same kind of thing on an ongoing basis, and I have been advocating for him within the system. He had to turn to his Congressman to advocate for him within this system.

The Army apparently will agree that Walter Reed's problems are a microcosm of those found throughout the Army. I would like to know first why are these horror stories still continuing as of our visit on Monday, No. 1?

No. 2, I would like to move on to questions about the case management system. But why are we still hearing this?

General SCHOOMAKER. Well, I think that is a difficult question. You met with 31 or 34 soldiers, I believe, on Monday when you went a self-selected group of soldiers, in large measure, who wanted to talk to you. We have 680 soldiers in that category right now at Walter Reed, and so you have seen a subset of the whole population.

I would venture to say that every one of the soldiers that you saw has an individual case with an individual set of family or personal problems and we have to work through each and every one of. This is a difficult time in the lives of all of these soldiers. We acknowledge the fact that we start off in a difficult position with them trying to establish trust and a relationship. They have gone into the Army, or in some cases they have gone overseas, and have come back not the same people that they went. We start at a disadvantage. We try to rebuild that relationship, but we aren't always successful in overcoming all of the problems these soldiers face.

All I can tell you, Congressman, is if you give me details about each and every one of them, we can address them through the devices that we have, acknowledging that we continue to seek solutions to this single adjudication process that has already been alluded to by our leaders within the DOD and the VA. That still represents and represented for Sergeant Shannon one of his hot button points, as they approach the final adjudication of their disability, it elicits enormous anxiety and resentment about their service and how we are treating them and how we as a Nation see their service.

If you give me details about any of those horror stories, sir, I will personally take them on.

Mr. HODES. Is it your testimony that the soldiers who we visited with on Monday are not representative of the active duty outpatient population at Walter Reed now?

General SCHOOMAKER. Yes, sir. I would have to say that is true. I was placed in that position to solve the problems of Walter Reed, and if at the end of this period of time, with all the efforts that we have put into it, if all of the soldiers at Walter Reed are characterized by what you just described, I would say that I have been a failure as a commander and I should be held accountable.

This is not the general rule. I can't say that every soldier is happy with what is going on in their lives. As I explained before, they start at a disadvantage. They have come back ill or injured.

They are going back into communities, some of them unable to resume their employment. But no, sir, I would not say that this characterizes the rule for our soldiers.

Mr. HODES. I see my time is up.

The only comment I would make, General, is I appreciate the task that you have undertaken in trying to reform the way things are done, but I suggest to you that if there is one horror story at Walter Reed, then there is room for accountability, and it should not be up to Congress to tell you who is having problems, but for you and your staff and the case managers to find out who is having problems and address them as quickly and completely as possible.

Thank you, General.

Mr. TIERNEY. Thank you, Mr. Hodes.

Mr. Lynch.

Mr. LYNCH. Thank you, Mr. Chairman.

I want to thank the panelists for attending, as well, helping the committee with its work.

I have a couple of questions, and they are related.

As previously noted by the GAO in its March 31, 2006, report, the Department of Defense grants each of the branches of the service considerable discretion in how it evaluates disability. That is with, one, respect to a determination of whether the service member is fit to duty, and second, with respect to the assignment of disability ratings. Specifically, each branch of the armed services manages its own physical disability evaluation system, which includes the MEB, the Medical Evaluation Board, and the PEB, the Physical Evaluation Board.

I asked the Department of Defense to send me the numbers on how each branch of the service handles these evaluations for disability. I was surprised. Well, maybe I shouldn't have been, but I was. When you take the Navy's numbers, and those include the Marines, they basically had determination rate of about 35 percent, either totally or temporarily disabled, 35 percent for the Navy. The Air Force has about 24 percent. The figure that really stood out to me was the Army. The Army has about 50 percent of all of the disability claims before it, and it approves only 4 percent. That is 4 percent compared to the other branches for permanent and then 15 percent for temporary disability.

Now I hear today from Mr. Dominguez that we are going to merge the standards of the DOD with that of the VA, and I think it was Mr. Bertoni who said earlier today the VA has a 400,000 case backlog. I know from my own personal experience dealing with my veterans back home in the Ninth Congressional District of Massachusetts that I have typically an 8-month waiting period before one of my vets can go see a doctor, a VA doctor. I am afraid of that, you merge two systems.

I associate myself with the remarks of Mr. Hodes earlier. We met with 30 to 35 soldiers at Walter Reed on Monday who were very, very unhappy, and the chief complaint, if I could generalize, was the mind-numbing bureaucracy that they have to deal with in getting treated with dignity and respect and having their cases resolved.

It varied. Some felt they shouldn't be there, they were fine, and they wanted to go back with their units. They wanted to go back

as war-fighters. Others were being held for more-extensive injuries. There were some amputees who certainly needed to be there, but also needed to have their cases dealt with in a more expeditious manner.

Given the different standards here, you have a military DOD system that evaluates a soldier based on their fitness for duty, given their rank and their responsibility. That is the DOD standard. The VA system is looking at their employability as a civilian and they are basing their disability evaluation on that standard.

When you merge these two, I am afraid you are going to discount the first, Defense Department disability based on their actual injuries, and you are going to moderate that because you are going to find some type of employability on the other end. I am just very concerned about the merger of these standards. I want our warfighters to be treated with the dignity and the respect that they deserve, but I have to raise a fair amount of caution here because of the two standards.

Let me throw it out to all of you. How do we basically, No. 1, eliminate the disparity between the Navy, the Marines, the Air Force, and the Army, and then at the same time reconcile the differences between the two standards, one a civilian standard and one a military standard in evaluating these disabilities?

Mr. TIERNEY. Mr. Lynch, if I can interrupt for a second, I am going to give you the option to pick one and ask them to answer in 30 seconds. You have 3 minutes to vote. We will come back and you will be the first to address them when we come back.

Mr. LYNCH. OK. I pick the first one.

Mr. TIERNEY. What is that?

Mr. LYNCH. We are going to come back?

Mr. TIERNEY. We are going to come back.

Mr. LYNCH. Why don't we come back?

Mr. TIERNEY. All right. Thank you all very much. Another 10-minute interruption for votes, and we will see if we can get there in 3 minutes or not. Thank you.

[Recess.]

Mr. TIERNEY. The subcommittee will resume.

Mr. Dominguez.

Mr. LYNCH. Would you like me to restate the question, Mr. Chairman?

Mr. TIERNEY. No, thank you, Mr. Lynch. It was a 5-minute question.

Mr. Dominguez, go right ahead.

Mr. DOMINGUEZ. Sir, let me first address how this process will work. The first is that there will be a single, comprehensive medical exam, and it will be done to standards using a template that the VA provides so that we can make sure we document the medical condition, each and every medical condition in it, so it is documented. So if there is an issue with a joint, then the circumstances around it and the degree of flexion of the joint, and those kind of things, are all documented so that the down-stream actions can all be taken and formed by that.

That exam will go to a PAB—Personnel Evaluation Board—which is military members who will use that information and look at the medical conditions, and bump that against the standards for

performance of a job within a unique individual's service and within a skill and within a grade and specialty. So the decisions then are being made based on a medical description against a service specified standards for this individual to do his or her job.

Once that evaluation board determines that the individual is unfit and will likely have to leave the service, that case file is then forwarded to the DVA rating examiners. It is only at that point that a rating is associated with the condition. That comes back to DOD for one decision only, which is, "Are you separated or retired?" That is how we would use it in our process. And, of course, the current law provides the degree of retirement pay you are entitled to. This is also a function of the degree of the disability above 30 percent. At 30 percent you are retired. Above that, it affects how much you are paid in your DOD retirement annuity.

Of course, you have all the appeal rights, etc., but that is how we would use it. So we are using medical information to make this military determination, and that determination is different by each service, because each service standard for what is required to do the job is different and unique.

You can be an airman with an injured back but not an infantryman, because you wouldn't be able to carry the rucksack, for example.

I hope that answers your question sir.

Mr. TIERNEY. Ms. McCollum, did you want to ask Mr. Lynch to yield?

Ms. MCCOLLUM. Yes. Mr. Lynch, would you yield?

Mr. LYNCH. I would. Yes.

Ms. MCCOLLUM. Explain to me how the National Guard gets figured into that, which was part of my questions that I had asked earlier. I am a highly trained airplane mechanic. I am called up, active duty. Let's say my shoulder is destroyed. I can't go back to work as an airline mechanic any more. What do you do for that individual?

Mr. DOMINGUEZ. Ma'am, there were two parts to the question. Assuming you were a National Guardsman airplane mechanic in the Guard and we found your condition unfitting and determined that you needed to be retired, just like any member of the armed forces, you would then be retired by the Disability Board. You would be given a retirement annuity based on the level of disability—in the pilot, again, assigned by a DVA rating panel. Then, by that time the VA will already have your records. They will have already determined the degree of disability. You would be then compensated——

Ms. MCCOLLUM. Excuse me, Mr. Chairman. I am not talking about somebody who was an airline mechanic and that was part of their job in the National Guard. We have people who are DOD employees who do an excellent job of maintaining aircraft to St. Paul/Minneapolis and Homeland Field in St. Paul. I am not talking about those. I am talking about the gentleman who was called up for active duty who works for Northwest Airlines and can't go back to work. What do you do for that individual?

Mr. DOMINGUEZ. Once they are retired from the DOD they then go to the DVA, and it is Admiral Dunne's challenge at that point.

Mr. TIERNEY. Nice hand-off, Mr. Dominguez. I have to hand it to you, that was good.

Admiral DUNNE. When the claim is filed and the medical condition is evaluated in accordance with the VA templates, not only the shoulder, but any other condition which the veteran identifies and we have a medical evaluation of is taken to the ratings schedule, and based on the ratings schedule the disability percentages are applied for that veteran for every item that they claim.

Mr. TIERNEY. Thank you.

Mr. Shays.

Mr. SHAYS. I thank you, Mr. Chairman, again for doing this hearing.

I am somewhat conflicted by the challenge that you have to face, General, and the others. When we came and met on Monday I felt that I was meeting with a representative group of traumatic brain injury soldiers, and others, dealing with some very real, as they said, mental issues. I didn't feel we were dealing with some of the other physical challenges. So to that extent I do agree it is not representative, but it is representative, it seems to me, of those who are dealing with brain injuries and so on.

On one side we had a group that was complaining that they weren't being discharged, and on the other side we had people who were afraid that someone might say something was wrong with them and they couldn't go back into the service.

I tried to put myself in the position of a doctor. If you believe that some are there because they are soldiers and Marines and others and they want to go back, but they may not be well enough to go back, I am struck with the fact that as a physician you have a difficult task. You have to try to see who is not qualified to go back and who need to be discharged, and neither side may like your outcome.

Now, the one thing that I was struck with, though, there was one physician in particular. One doctor that almost everyone there, anyone who came in contact with him—no one defended him—that he was disrespectful, biased against Guards and Reservists, and some said incompetent. We have heard complaints about this doctor by others, because our staff does extensive work. Evidently he seems to be a key player, and I have a feeling, General, that you may know which one this is because there is one who clearly gets a lot of complaints.

Without discussing the individual, what is the argument that he still is there?

General SCHOOMAKER. Well, first of all, let me just make it very clear, the two points you have made I think are very good ones. Virtually every soldier I have ever met in a military hospital, even our amputees under the most desperate circumstances, wants to go back to war, wants to go back where their colleagues are. It is heartbreaking to have to tell people that they cannot serve in the capacity that they came into the service, especially when they are leaving an active theater war.

It is very difficult to work with patients who have a variety of disabilities and problems that are going to keep them out of that. Frankly, that doesn't fall to the physician or to the medical commu-

nity. In general it falls to the line commander who is part of that equation.

Mr. SHAYS. It is difficult. I just want to interject myself. When you hear of people being there for a year, 18 months, you begin to think there clearly are some breakdowns there, I just want to say parenthetically.

General SCHOOMAKER. I mean, again, I am very careful about not making generalizations, because as I have said in many forums, every patient and every family is different.

One of our heroes is Retired General Freddy Franks, who came back from Vietnam and ultimately lost a portion of his leg. He was 21 months in an Army convalescent hospital at Valley Forge and returned to duty. He ended his service as a four-star general. He was the Corps Commander that took the Seventh Corps in the first Gulf war into Iraq. So every time I am given a timeline to hold a soldier to, I am always pointing out that is not fair.

Mr. SHAYS. What about this doctor?

General SCHOOMAKER. The doctor in question, his care has been looked at very carefully by other physicians in his practice, and his care objectively has always been determined to be appropriate. What I was led to believe was that he was taken out of the front line of caring for these patients.

I will have to go back, sir, and just confirm whether they are talking about prior events and encounters with him. What we have moved toward very, very firmly at Walter Reed and across the Army are dedicated, in a sense, institutionalized MEB doctors—Medical Evaluation Board doctors—whose specialty, in a sense, is to take care of the Medical Evaluation Board. But I will take that question and get back to you for the record.

[The information referred to follows:]

CHARRTS No.: HOGR-02-021
House Government Reform Committee
Hearing Date: September 26, 2007
Subject: Third Walter Reed Oversight Hearing
Congressman: Congressman Shays
Witness: Major General Schoomaker
Question: #21

Problem Doctor

Question: I asked a question during the hearing concerning one specific doctor about whom the Committee has heard serious complaints about since the beginning of our investigation in 2004. On Monday during our visit, most of the soldiers that we heard from had similar complaints. Can you please confirm the name of this doctor, and tell me why someone that has so many complaints about his treatments, evaluations and compassion is still on your staff? What will you do to address this?

Answer: There have been a number of vocal, persistent complainants regarding care received by Walter Reed's Orthopedic Medical Evaluation Physician, Dr. Harvey Cohen. He is a retired, non-operative physician who is an expert in the Medical Evaluation Board (MEB) process with decades of experience in evaluating and caring for Soldiers with orthopedic complaints.

Dr. Cohen can at times be blunt with Soldiers, and he has been criticized for not offering operative solutions to Soldiers with chronic musculoskeletal pain syndromes when he believes they are not indicated.

As part of the routine reprivileging process at Walter Reed, Dr. Cohen's peer review was completed on June 19, 2007 by the Chief of the Orthopedic Service. Upon examination by senior clinical staff, his privileges were granted as there were no trends that would indicate that Dr. Cohen's practice of orthopedic medicine did not meet the standard of care.

Since we first heard of complaints at the time of the *Washington Post* articles in February 2007, we have offered a second opinion to any Soldier who is dissatisfied with the care provided by Dr. Cohen. A handful of patients have requested and been afforded this second opinion. In addition, we initiated a "Customer Advocacy Program" in the Department of Orthopedics and Rehabilitation requesting patients complete an anonymous survey at the conclusion of their outpatient visit.

As of 10 October 2007, the Customer Advocacy Program continues in the Orthopedic Clinic in support of Warriors undergoing the MEB process. This program continues to be supported by all staff coming in contact with the transitioning Soldier. We continue to offer a customer satisfaction survey to each of these Soldiers. Since the inception of the program, 74 voluntary anonymous surveys have been filled out and returned to staff. Fifteen surveys expressed some degree of dissatisfaction with Dr. Cohen, but 11 of these concerned timeliness. We are addressing this with management of Dr. Cohen's appointment template. No other negative comments or indications have been noted, and the remainder of the reviews has been positive. Each passing month since the inception of the Advocacy Program has produced fewer completed surveys. There have been no instances where any of the other staff in the clinic have been asked to advocate/intervene for a Soldier during this time frame.

In addition, since February there have been two open contracts for non-operative orthopedic physicians to provide additional support to Dr. Cohen. We have been unsuccessful in filling these positions, and anticipate that even if they were filled, it would take 6-12 months to bring the physician to the level of expertise that Dr. Cohen possesses.

The MEB process at Walter Reed has recently been revamped with the development of an MEB Service where a specially trained MEB Physician "owns" the MEB process for an individual patient and in many cases provides the musculoskeletal and range of motion evaluations that are required by the MEB.

Mr. SHAYS. I see a yellow light, but let me ask this: In regards to the Board, there seemed to be tremendous fear on the Board. Is that simply because the Board basically plays God on what happens to these individuals?

General SCHOOMAKER. You are talking about the Physical Evaluation Board, sir?

Mr. SHAYS. Yes.

General SCHOOMAKER. Yes, sir. I think for the average soldier this is especially true. Ms. McCollum I think hit a very important point. I mean, soldiers come in. They are declared unfitting for the service and for the role that they play in the service, but they go back into other civilian roles. They can't go back. Maybe they come in and serve as an infantryman, but they are going to go back and walk a beat as a policeman or woman. What they face is what is going to be life for them now and their family.

They know that there is a threshold of 30 percent disability. The 30 percent disability renders them eligible for TRICARE healthcare benefits for themselves and for their family. Everybody knows within my hospital, and everybody within the Medical Evaluation Board system knows, about the 30 percent, but if the unfitting condition that renders you unfit to serve in whatever capacity you are that only gives you 10 or 20 percent, and by policy and by law, as I understand it, we are limited to that even if the VA later adjudicates all of the associated injuries or illnesses as giving them more than 30 percent. We are held to the unfitting condition, and so they may be separated with a single lump payment, and no healthcare benefits for their entire family that they would get if they reached the 30 percent disability rating.

I think that is going to remain a hot button item under any disability evaluation system that we have, and that has to be resolved.

Mr. SHAYS. Just an ending comment. Thank you, Mr. Chairman. That did come up continually about their health benefits. Their health benefits almost seemed more important than any financial benefit they get, and it may behoove us to look at that issue and see what kind of flexibility could take place.

Mr. TIERNEY. Thank you, Mr. Shays. And it was a point that came up again and again, and that adversarial nature is what results from that. I mean, I think that we are going to look at that as part of that, look and see whether or not on the other end coming out, whether something can't be done with healthcare, work on that.

Is there any member of the panel that would like to ask another question, that feels some business has gone unfinished from their perspective?

Ms. MCCOLLUM. Are they going to answer the questions that I asked before you started collectively gathering the questions?

Mr. TIERNEY. If you have another question you want to ask, or you don't feel was responded to, you could ask it here if you like.

Ms. MCCOLLUM. They didn't have an opportunity.

Mr. TIERNEY. Well go ahead and ask.

Ms. MCCOLLUM. I had asked about refreshing the VA's disability standards. The distrust that kind of exists between the servicemen and women with the Disability Rating Board, and I think that

came forward because most people get turned down the first time. That has been my experience quite often, and they are going through an appellate process and it is long and it is cumbersome. So you would need some suggestions on that.

And then the other question I had to kind of capsulate, so we can wrap up is: all of these plans and programs that have been put in place at the hospitals for the poly trauma unit, for having the case worker be there—and I am probably using the wrong term now—the Department of Defense person there, to help with the paperwork and to move things forward being there longer than 3 months. The budget being built in for all these new people that are being added as case workers, the money that is going to be needed to update these systems so that they are workable for transferrable records and make it seamless for the soldier, their families, and the doctors involved. I haven't seen a budget for that.

I have seen plans, lots of ideas, things being painfully implemented, in a slow process. But this Congress needs to have a budget so that we do it right, because I am assuming that the Department of Defense or the VA can't take this "all out of hide." These are big price-tag items, and I am on the Appropriations Committee, and to the best of my knowledge I haven't seen a budget for them. So I was asking for the gentleman here who conducted the review to let me know what they thought about that.

Mr. PENDLETON. We haven't seen the budget figures either. Our understanding is that the costs, the incremental costs, will be included as part of the President's budget. That is one of the initiatives of the Senior Oversight Committee, and you have representatives here. We have outstanding requests for that, but we honestly at this point don't know.

Ms. MCCOLLUM. Mr. Chair, could I ask DOD and VA? It has been ongoing. It has been 10 years since you have been going to integrate your records. Certainly you have a budget some place that we can look at, and look at today. Do you not?

Mr. DOMINGUEZ. The budget that supports the integration and the sharing of information in the medical organizations is funded. It is part of the budget that was submitted in 2008. It is in the TRICARE piece of the budget. I will get back to Dr. Fissells. We can try to pull that out for you for the record.

They will be certainly in the 2009 President's budget submission changes to that, because we will be accelerating those activities.

In the case of the standing up to Warrior Transition Units and those kind of staffing and those issues, because that happened in 2008 the DOD and the services took that "out of hide" in terms of reprogramming in 2008. There may have been something in the supplemental that helped us. In fact, the Congress appropriated a huge amount for TBI and PTSD—for which we are deeply grateful—which really did accelerate a lot of the thinking and the activity and our ability to respond to those crises.

But in the 2009 submission of the President's budget, we will make sure that these activities are called out to your attention when the President submits that budget to you.

Ms. MCCOLLUM. Mr. Chair, could I ask GAO then why weren't you able to get the budget numbers?

Mr. DOMINGUEZ. I was referring to future estimates for the new initiatives. I don't know that they have been created yet.

Mr. TIERNEY. Thank you.

Mr. Shays, do you have a couple of final questions?

Mr. SHAYS. First off, the GAO has really pointed out that DOD and the VA have been trying to work for 10 years to integrate and to share information, and there has to be a point where there is going to be some success here. The only thing I can conclude is it is just simply not a high priority.

I would like to ask GAO two questions: what do you believe are the greatest challenges to the implementation of each of the recommendations of the Dole/Shalala Report, and by each of them just give me some of the highlights, because we have been here very long? So what do you think are the greatest challenges to the implementation of these recommendations?

Mr. BERTONI. Of the Dole/Shalala Report?

Mr. SHAYS. Yes.

Mr. BERTONI. In hearing the VA testimony, I took down some notes. It looks as though they have gone with a single comprehensive exam done to VA standards using VA templates. So we call that the Dole/Shalala light option of the four that we looked at. All the other options had the VA doing the exam as well as the rating. So it looks like they are moving toward the Dole/Shalala portions that don't have to be addressed in legislation, which is a single exam and a single rating.

I think folks on both sides agree that is probably the way to go. They had the single exam, and had the single rating.

In terms of the two bureaucracies, I think there might be some push-back or concern as to who should actually have it in the end. I mean, changing management is going to be difficult. I think you need management support at the top. You need a plan. You need change agents within the agency to sort of convey to the troops and the bureaucrats that we are moving in this direction, and you need some early wins. If they go in this direction and implement the pilot, if they could show that they have substantially decreased timeframes, that is some early wins that can gain momentum. So that can help.

I am concerned that they may not be paying enough attention to accuracy and consistency, sort of the three-pronged issues that we have identified. If the system is not viewed as being accurate and consistent, we are back to service member distrust, congressional oversight, all these things that brought us here today. So that is certainly an issue.

Generally, getting in front of the implementation before considering all of the unanswered questions is of concern to us. We would be interested in seeing how they arrived at this decision—the data that drove that decision. In our view it should be a data-driven decision outside of the politics and other contexts.

I think, in general, again, large agency transformation is going to be difficult. This is larger than just re-engineering.

Mr. TIERNEY. Would you yield for 1 second, Mr. Shays?

Mr. SHAYS. Absolutely.

Mr. TIERNEY. Mr. Dominguez, would you have any objection to your department and Admiral Dunne sharing that information

with the Government Accountability Office so that they could do analysis, look at the data upon which you based your determination to go to this particular pilot program so that we, as a panel, could then in turn ask the Government Accountability Office to give us their assessment of that?

Mr. DOMINGUEZ. Yes, sir. We are happy to share with the GAO.

Mr. TIERNEY. We will ask the Government Accountability Office to take a look at then, and give us some idea then of what your views are toward that data.

Mr. BERTONI. Sure. And to date the information exchange has been very good. I must say that we have had a lot of cooperation. We have been riding herd as these things move forward and asking for information as it is being produced.

Mr. TIERNEY. Which is what we want.

Mr. BERTONI. And we intend to ask.

Mr. TIERNEY. And hopefully what this will continue to do is give us better insight as well.

Do you have any other questions, Mr. Shays?

Mr. SHAYS. I think Mr. Pendleton wanted to respond.

Mr. PENDLETON. Yes. We laid out in our statement the challenge of placing these recovery coordinators. Dole/Shalala recommended that these recovery coordinators come from the Public Health Service. The idea was that they be significantly high ranking and able to sort of break down bureaucracies, and I think not necessarily in either of the departments.

The decisions that DOD and VA have made, I think, are these are going to be placed in VA. That can work, but I think that is going to require careful lines of accountability and other things as it goes forward.

In terms of the information sharing, which you touched on, there has been some progress made. I think the most important thing that I saw in our review is there is a mark on the wall now. October 31, 2008, DOD and VA have committed to have all information viewable, administrative and health information. So there is now a mark on the wall for that.

I am not necessarily familiar with the history. There may have been previous marks on the wall, but there is one here.

In general, I think follow-through after the limelight fades, the spotlight fades, is what is going to be more important. These plans, many of them are quite solid, are well thought through. I think the continued accountability, oversight, and keeping track of how well these things are being implemented, is going to be key over the long haul.

Mr. SHAYS. I thank the gentleman.

Thank you, Mr. Chairman.

Mr. TIERNEY. Thank you.

We have no intention of letting down the oversight from this end of it, and I know each of the departments feels a responsibility to do their own oversight. So I hope we are going to err on the side of too much oversight as opposed to too little on that much to the chagrin of some out there maybe, but I think it behooves us all to do that.

Can either Admiral Dunne or Mr. Dominguez give me the answer as to why the decision was made to not use Public Health

Service Commission Corps, or similar people, instead of VA people as these recovery coordinators?

Admiral DUNNE. Sir, I think we are going to work with the Public Health Service as we put this recovery coordinator system together. Our two lead change agents, the two Deputy Secretaries of VA and Department of Defense, have signed out a memo which says that we are going to put together a program that will recognize that Public Health Service has a consulting role with this, be part of the evaluation, etc.

Mr. TIERNEY. But, it will not be the actual recovery coordinators. Is what you are saying?

Admiral DUNNE. The plan as put together now would have VA employees, new VA employees, being the recovery coordinators.

Mr. TIERNEY. What do you propose to be the chain of command in that? This recovery coordinator, as I understand it, is going to be above the triad of individuals that General Schoomaker has on bases.

Admiral DUNNE. Correct.

Mr. TIERNEY. And who are they going to report to, or does the buck stop with them? Are they the patient's advocate, or are they the department's advocate?

Admiral DUNNE. They are the patient's advocate, sir.

Mr. TIERNEY. And they get to make the final shot, or do they have to report up to somebody else?

Admiral DUNNE. They will be of a position description such that they have the seniority and the presence of mind to be able to understand the system and know when it is time to say, based on common sense, somebody needs to do something here and fix this problem. They will be coordinators.

Mr. TIERNEY. And they will have sufficient rank so that when they say, somebody will jump?

Admiral DUNNE. That is the intent. Yes, sir.

Mr. TIERNEY. OK. Thank you.

Admiral and Mr. Dominguez, the SOC is set to expire in May 2008. Are you going to be done by then?

Admiral DUNNE. Sir, we hope to have made significant progress by May 2008, but that date was picked back in May of this year as a goal. We are going to work toward that goal, but we still have the Joint Executive Council, which is a joint VA and DOD organization that will pick up the mantle and continue to follow through on anything that the SOC puts in place.

Mr. TIERNEY. Thank you.

Mr. DOMINGUEZ. Sir, if I might just add?

Mr. TIERNEY. Sure.

Mr. DOMINGUEZ. The SOC was envisioned and created as a crisis response organization to drive change fast. The changes that get implemented then will transition to the day-to-day oversight of this Joint Executive Council. That is where these changes will be institutionalized, implemented, and sustained for all time.

Mr. TIERNEY. Thank you.

We are going to have additional oversight hearings. It would be helpful for us to determine, and ask for your cooperation with our staff on this, on whether we ought to have individual hearings on specific aspects of the concerns raised by the Government Account-

ability Office—in other words, a hearing on disability evaluation and that process, a hearing on TBI and PTSD and that situation, one on data sharing, and one on the Warrior Transition Units and their staffing on those matters, or whether we will have another one in the aggregate.

Could each of you just, in a couple of words or less as we go down the line here, tell me when do you think would be an appropriate time for us to check back when we should be able to have answers to those, as to how we are proceeding, and a good idea that we are getting well along in our progress?

Mr. PENDLETON. On the issues relating to continuity of care, that is pretty much new work at GAO, and we haven't done a lot of tire kicking yet. We want to get out to some units and see what the impacts are of some of these staffing shortfalls. It would take us a couple of months probably to be able to give you much new on that.

Mr. TIERNEY. OK. And everything else?

Mr. PENDLETON. On the information and technology we have experts at GAO that have been working on that for a long time. I think they could come and have a hearing. They are following that actually quite closely, and we cribbed some of their work for this.

On the TBI/PTSD, we have a team following that as well. There was a mandate for us to look at that in the National Defense Authorization Act last year. That team is starting up, but much like the continuity of care work that we are doing, it is relatively new. Dan leads our disability specialty.

Mr. BERTONI. Out of 14 or 15 engagements I have had, I probably have eight right now that are VA or DOD looking at the benefits delivery, discharge system, vocational rehab for returning warriors, overlaps, and inefficiencies in the system. We are about to kick a job off on looking at the temporary disability retirement list for TBI patients and just a range of work that is relevant to what is going on here now. We have been doing it for a couple of months, and, of course, in 2, 3, 4 months if we were asked to come up and give you an interim report on any of those issues. We would be able to do that.

Mr. TIERNEY. Thank you.

Mr. BERTONI. And certainly a final report in 8 or 9, 10 months.

Mr. TIERNEY. Thank you.

So when should we next look at what is happening at Walter Reed and the other 29 facilities in terms of all of these overriding issues?

General SCHOOMAKER. Well, sir, one of our milestone events is going to be January 2008 when we say we will be fully operational and capable for the Army medical action plan. I would say any time after that we should be accountable for how we are doing.

Mr. TIERNEY. Thank you.

Mr. Dominguez.

Mr. DOMINGUEZ. Sir, my suggestion would be that we are ready now on the IT interoperability plans, what is going on, where we need to go. I think we are ready now on the PBI/PTSD. Again, ready now means to talk to you about where we are in this process. Lots of work in both of those in front of us, but we are ready now to explain them to you.

In terms of the disability evaluation system, we are not going to actually walk people through that until November. I would say in January is probably the right time again for you to take a deep dive into that and how it is working, because that is when we are actually going to startup the new system if all goes well.

Admiral DUNNE. Sir, I agree with my partner on the time lines.

Mr. TIERNEY. What a surprise. Thank you.

Let me just end. I want to make one last note with respect to General Schoomaker. We heard some comments earlier about a number of the soldiers with whom we met and their particular cases on that. I think in fairness we ought to note that they were just introduced to a new ombudsman's process as of last Friday, and you were kind enough to discuss it with us on the ride out to Walter Reed the other day. Maybe spend 1 minute at least telling us that there were three, I think, that you designated for Walter Reed, and what you would anticipate their role being, and whether they will be replicated, and when throughout the rest of the system?

General SCHOOMAKER. Thanks for giving me the opportunity to talk about that.

It distresses me, no question, to know that we have a single case within the hospital of a warrior in transition who is not pleased with his or her care and administrative oversight. We have tried to offer as many options for giving us candid feedback anonymously or directly with attribution from these soldiers. One of which is the ombudsman program. I think, sir, you had a great deal to do with this, and that is patterned after ombudsmen in other realms besides health care, a truly objective arbiter that looks at the system for the patient, looks at the system as a system and tries to figure out where are the points of weakness, where are the points of solution for that particular patient.

We are bringing those folks on. We are making them available to our patients in Walter Reed and across the Army.

Every soldier is also issued a 1–800 24/7 line that they can call and seek help for themselves or their families. We are very, very sensitive, especially in our Reserve component, about colleagues, their access to answers as symptoms may emerge, or as realizations about their disability, or potential disability emerge, access to information. That is available, too.

Mr. TIERNEY. Thank you very much.

I want to thank you. In fact, it was a previous member of my staff that brought up the ombudsman situation, and you were kind enough to accept the concept and work with him on that. He happened to be a veteran, himself. It is amazing to me the number of veterans that are following what is going on with the progress on this and feel very committed to it.

I thank each of you, gentlemen, for the commitment that you have made to helping us make sure that something is done. I think we are all disturbed. Everybody here is well intended. Everybody here is working hard at it. We may have some disagreements about whether it is fast enough, whether it might be done in a different way, or how we can improve it; but, nobody should doubt the commitment that has been made to get this resolved. I look forward to your cooperation, and we hope that together we will get this ex-

pedited. We will put to it the sense of urgency that is needed, and we will get the kind of treatment that our veterans deserve.

Thank you all very, very much and for suffering through the interruptions that we have had today, as well. Thank you.

[Whereupon, at 1:18 p.m., the subcommittee was adjourned.]