SEAMLESS TRANSITION: WHERE ARE WE NOW?

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

HOUSE OF REPRESENTATIVES

ONE HUNDRED NINTH CONGRESS

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SEAMLESS TRANSITION: WHERE ARE WE NOW?

WEDNESDAY, SEPTEMBER 28, 2005

U.S. House of Representatives,
Committee on Veterans' Affairs,
Washington, D.C.

The Committee met, pursuant to notice, at 10:39 a.m., in room 334, Cannon House Office Building, Hon. Steve Buyer [Chairman of the Committee] presiding.

Present: Representatives Buyer, Everett, Miller, Boozman, Evans, Snyder, and Michaud.

The Chairman. The hearing of the the House Veterans' Affairs Committee will come to order. The hearing will address Seamless Transition. The date is September 28, 2005.

First of all, I would like for everyone to know that I also sit on Energy and Commerce, and we are in the middle of a markup right now on an energy bill relative to expanding our refinery, storage, pipeline, and investigation with regard to potential gas price gouging, and that is occurring right now, and we're in an amendment process. So if I am called out, Mr. Boozman will take the chair.

Today's hearing will provide the Committee with an update on the Department of Veterans Affairs and the Department of Defense in their efforts to implement Seamless Transition.

Over the last year, myself and other distinguished members of this Committee, along with staff, have conducted numerous field and site visits at VA and military treatment facilities and military bases.

I am concerned that there is a significant disconnect between what Congress envisions, what the VA envisions, and what DOD policy makers envision, and what the three of us are initiating and what is actually taking place not only in Congress but also at all levels of the two departments.

Unfortunately, this disconnect that I will refer to, I believe, is coming at a significant cost to our taxpayers and, more importantly, to our soldiers, sailors, airmen, and Marines, Coast Guardsmen, and their families that have unselfishly served and sacrificed to our na-

tion.

It appears to me that the two departments continue to issue broad policy statements regarding Seamless Transition, VA-DOD sharing, and other initiatives, with little action on implementing congressionally mandated guidance from two different defense bills.

Although the term "Seamless Transition" is a relatively new word that is thrown around in this town, the concept was codified into law in 1982, when Congress passed the Veterans Administration and the Department of Defense Health Resources Sharing and Emergency Operations Act, often referred to as the Sharing Act. The Sharing Act created the VA-DOD Health Care Resources Sharing Committee to supervise and manage opportunities to share medical resources.

In 1996, the departments renamed the Sharing Committee the VA-DOD Executive Council.

In 2002, the departments administratively created the VA-DOD Joint Executive Council to provide oversight to the executive council on health care sharing.

In 2002, Congress amended Title 38 to mandate that the departments' under secretaries head the Joint Executive Council, and in 2003, Congress codified the Joint Executive Council into law. Congress directed the JEC to review all aspects of both departments to include plans for the acquisition of additional resources, especially new facilities and major equipment and technology, in order to assess potential opportunities for the coordination and sharing of resources.

Congress also directed the Secretary of Veterans Affairs and the Secretary of Defense, in section 721 of Fiscal Year '03, National Defense Authorization Act, to develop a joint strategic vision and a strategic plan to shape, focus, and prioritize the coordination and sharing efforts among the appropriate elements of the two departments. Section 721 also required them to incorporate the goals and requirements of the joint sharing plan into strategic and performance plans of each department under the Government Performance and Results Act, herein referred to as the GPRA.

Despite 20 years of congressional mandates for VA-DOD resource sharing, various name changes, other administrative actions, a presidential task force, the two departments are still operating, I believe, in separate worlds. Even though, yes, they are meeting, yes, they are talking, we are very anxious for some action.

Equally troubling, the two departments have been working in this exchange of patient health information electronically for now over seven years.

One of the largest and most far-reaching task force recommendation that VA and DOD developed and deployed this by 2005, the electronic medical records -- they asked that they be interoperable, bidirectional, and standards-based.

Currently, service members transitioning to veteran status must still make hard copies of their military medical records and hand-deliver them to the VA, because each department is proceeding separately with the development of its own respective health information system, VA's HealtheVet VistA, and DOD's Composite Health Care System II.

The estimated cost of these separate independent systems is approximately 1.2 billion and 3.8 billion respectfully.

In addition, the two departments differ in their legal interpretations of HIPAA, the Health Insurance Portability and Accountability Act, Privacy Rule.

Quite frankly, I believe that is unacceptable.

For these reasons, I have asked representatives from GAO and Health and Human Services to testify about their observations regarding HIPAA.

So, when I visited the polytrauma center in Minneapolis, I was disturbed when I heard that certain things couldn't be done because of HIPAA.

In addition, the Committee will hear testimony from experts in the field of health information technology.

Lastly, I want the Committee to hear firsthand from VA and DOD regarding their efforts to collaborate and coordinate policy, people, and resources to achieve the Seamless Transition.

Our service personnel and their families have faithfully and diligently served this nation well, providing for their benefits reflect the gratitude of a grateful nation.

It also serves to say thank you for your sacrifice and unselfish commitment in protecting America's cherished freedoms and liberties. I fully expect both departments to work together to fulfill this moral and legal mandate.

Unfortunately, I sincerely question the level of commitment by DOD on making Seamless Transition a priority. Simply put, this Committee invited Under Secretary Chu to appear here today. He declined.

According to his office, his schedule could not accommodate this important hearing. Equally telling, Secretary Chu's Assistant Secretary for Health Affairs, Dr. Winkenwerder, was equally not available to testify.

Given the importance of this issue, I am deeply troubled by both of them omitting their appearance here today, but I welcome the testimony of the Principal Deputy Assistant Secretary of Health Affairs and the Office of Personnel and Readiness.

It is more appropriate for this Committee, though, to hear from the Under Secretary Chu himself. After all, he serves as the legally appointed department head on the Joint Executive Council. His counterpart thought enough of this issue to appear.

I would like to now recognize the Ranking Member, the gentleman from Illinois, Mr. Evans.

MR. EVANS. Thank you, Mr. Chairman.

It is interesting that, after five recent hearings on this topic, why you must now ask DOD and VA to define what they mean by the term "Seamless Transition," as you did in their letters of invitation to this hearing. We should be asking each agency to demonstrate achievement based on measured performance. That said, VA and DOD have agreed on procedures to achieve a more seamless transition than what has been proposed.

They also have generally assured, for example, that the most seriously injured do not slip through the cracks in the medical system. We need to review performance to judge the real impact on veterans. Our efforts must appeal to a broad spectrum of our veterans needs.

Mr. Chairman, clearly, there is progress, but some of these issues continue to impede further process and development.

HIPAA, continues to impact information exchange between DOD and VA. We should strive to resolve this and other impediments, and I appreciate you holding the hearing. Both the Democratic and Republican caucuses, I think, are in session. Technically, we should not be, but we need to get moving on this issue and not wait for the problem with the attendance at our respective caucuses.

I yield back, Mr. Chairman.

THE CHAIRMAN. I associate myself with the comments of Mr. Evans and appreciate his cooperation so we may proceed.

At this point, I recognize Mr. Boozman for an opening statement.

MR. BOOZMAN. Thank you, Mr. Chairman, and I thank you and Mr. Evans for holding this hearing. It is such an important topic.

I would like to comment briefly about the subCommittee meeting that we had in New Hampshire a week or so ago. We had a field hearing, and Mr. Bradley was there, and Mr. Michaud, and it really went very, very well.

I was especially pleased with what we heard from our witnesses.

In a nutshell, New Hampshire is doing it right, and I hope the witnesses from the National Guard Bureau and other Federal agencies will export those best practices nationwide.

I think the first lesson that we took away from the hearing is involving the families of the soldier pre-, during, and post-deployment in a program of education and counseling that is very vital.

The second most important issue is that the Army must make several days of active duty drill time available to the returning Guard units to conduct this early intervention-type program.

Thirdly, the VA vet center system plays a key role in minimizing post-deployment de-mobilization readjustment issues, and we heard that, I think, over and over again, and fourth, the National Guard Bureau needs to impose these best practices across the nation.

The New Hampshire Guard has designed a program called Reunion and Entry for returning Guardsmen and their families. The program makes use of resources from VA vets, small business development centers, and state agencies such as the employment service and highway patrol.

Guard personnel involved included those from combat arms and support units. The program truly is excellent.

Col. Deb Carter deserves an awful lot of credit. She met with leaders from the 82nd Airborne, Marines, and Navy, determined best practices going into this.

They lined up the agencies to train 300 full-time staff and 500 family members in suicide prevention, PTSD, and access to resources, and as a result, again, their efforts have been very, very good.

The soldiers went through a five-day Army de-mobilization at Fort Dix, returned home. Then they were given the day off to unite with their families and were called to participate in a three-day tap featuring educational and stress-related issues, and I want to submit the rest of this to the record so we can go ahead and move on and get the testimony, but again, I really do want to compliment the New Hampshire group. I think they are doing an excellent job.

One of the problems that we have with the Guard units versus the regular units is that it's unlike coming back with your unit and it's kind of business as usual. These folks are going back to the civilian work place, and the transition is much more difficult, I think.

So, again, thank you, Mr. Chairman and Mr. Evans, for having the hearing.

Mr. Chairman, I would also like Col. Carter's statement from the field hearing to be made part of the record, so that others may learn from her experience.

THE CHAIRMAN. Hearing no objection, so ordered.

MR. BOOZMAN. Thank you.

[The attachment appears on p. 166]

THE CHAIRMAN. I would now like to yield to Dr. Snyder, and before I do that, let me thank you. I want to thank you and Chairman McHugh for the work that you did in the 2003 and 2004 defense bill, along with Lane Evans and others. I mean when you go through, and I had an opportunity to go in greater detail, exactly what you laid out to DOD and VA with regard to this issue, and you did it twice, and you have really -- it is a very fine product, and so, we're going to get into this today about what they have picked and chosen to follow and not follow, and so, I am really pleased that you are here.

Mr. Michaud?

MR. MICHAUD. Thank you very much, Mr. Chairman. I, too, want to thank you, Mr. Chairman, and Ranking Member Evans, for having this hearing.

It is extremely important that we do have that seamless transition.

We did have a very good hearing in New Hampshire, and I took a lot away from that hearing, and I appreciate Chairman Boozman for having it in New Hampshire, and I agree with -- associate myself with his remarks as far as what we heard in New Hampshire, and I look forward to hearing from both panels today, as far as the seamless transition.

I yield back the balance of my time.

THE CHAIRMAN. For the record, Dr. Snyder is the Ranking Member on the personnel Subcommittee of the House Armed Services Committee, and helped co-author the two provisions in the '03 and '04 defense bills referencing collaboration and DOD-VA sharing.

Mr. Miller, do you have an opening statement?

MR. MILLER. I will enter it in the record, Mr. Chairman.

THE CHAIRMAN. Your statement will be submitted for the record.

[The statement of Mr. Miller appears on p. 64]

THE CHAIRMAN. All members' statements may be submitted for the record and have three days to do so.

At this point, we will recognize our first panel, Ms. Cynthia Bascetta, the Director of Veterans Health and Benefits Issues, United States Government Accountability Office; Ms. Linda Koontz, the Director of Information Management Issues, United States Government Accountability Office; Dr. Jonathan Javitt, the former presidential appointee to the President's Information Technology Advisory Committee, Health Care Delivery and Information Technology SubCommittee; and Dr. Peter Dysert, the Chief Medical Information Office, Baylor University Medical Center.

I would ask our witnesses to limit their oral testimony to five minutes.

Do each of you have a written statement?

They have all nodded their head in the affirmative, and I will ask that your written statement will be made part of the official hearing record, and I will ask all members to hold questions until the panel has completed, and I now recognize the first panel.

We may proceed first with Ms. Bascetta.

STATEMENTS OF MS. CYNTHIA BASCETTA, DIRECTOR, VETERANS HEALTH AND BENEFITS ISSUES, U.S. GOVERNMENT ACCOUNTABILITY OFFICE; ACCOMPANIED BY MS. LINDA KOONTZ, DIRECTOR, INFORMATION MANAGEMENT ISSUES, U.S. GOVERNMENT ACCOUNTABILITY OFFICE; JONATHAN JAVITT, M.D., M.P.H., FORMER PRESIDENTIAL APPOINTEE, PRESIDENT'S INFORMATION TECHNOLOGY ADVISORY COMMITTEE (PITAC), HEALTH CARE DELIVERY AND INFORMATION TECHNOLOGY SUBCOMMITTEE; AND PETER DYSERT, M.D., CHIEF MEDICAL INFORMATION OFFICER, BAYLOR UNIVERSITY MEDICAL CENTER

STATEMENT OF MS. CYNTHIA BASCETTA

MS. BASCETTA. Thank you, Mr. Chairman, and members of the Committee.

I am pleased to be here today to discuss our ongoing review of VA's efforts to collaborate with DOD to ensure a seamless transition to VA health care for service members. DOD recently reported that more than 15,000 OEF/OIF service members have been wounded in combat, and both the Congress and the President have urged the departments to ensure that service members experience a smooth transition to VA's health care system.

I would like to make two points today.

The first is that VA has instituted policies, procedures, and outreach efforts designed to provide OEF/OIF service members with timely access to health care. We will be evaluating the effectiveness of VA's actions in our ongoing work.

Since 2002, VA has taken important steps, some at the direction of this Committee, to improve service members' transition.

The Secretary's April 2003 memorandum, for example, authorized VA to give service members who sustained combat injuries priority access to VA health care.

Three subsequent directives put additional transition-related policies in place.

One requires each VA medical facility to designate a clinically trained combat case manager to coordinate care.

A second directive requires each medical facility to designate a point of contact to receive and expedite transfers from MTFs to VA medical facilities, and a third directive expanded the scope of care at certain facilities to create four polytrauma rehabilitation centers.

Notably, these centers provide psychological treatment for family members and use high-technology prosthetics to maximize the recovery of service members with severe and disabling trauma.

Besides these directives, VA and DOD jointly established a program to place VHA social workers at selected MTFs to coordinate

the transfers from military to VA health care for service members. VBA benefit counselors are also located in the MTFs to assist in filing claims for disability compensation, vocational rehabilitation, and other VA benefits.

In addition, vet centers hired 50 peer counselors in 2004, and VA is planning to hire 50 more this year to provide outreach in home communities for those veterans in need of readjustment services, including counseling, employment assistance, and other social services.

The second point I would like to make today concerns a vital transition issue involving the sharing of health care information between DOD and VA.

While progress has been made since we last testified on this issue about four months ago, the absence of specific data sharing procedures continues to hinder VA's efforts to obtain needed health information from DOD.

Specifically, we have been tracking the progress VA and DOD have made in sharing health information. On the positive side, VA officials told us that DOD is expected to transmit deployment health assessment data to VA monthly beginning in October 2005.

This routine data sharing will be useful to VA clinicians, who will be able to access the data in the course of treating OEF/OIF service members who arrive at the VA for care.

The data includes, for example, service members' answers to questions about potential exposures to toxic substances and psychological injuries that could benefit from mental health services. But, at this time, DOD does not have plans to transmit the same health assessment data for National Guard and reserve members, who, as you know, comprise about 35 percent of the OEF/OIF forces.

VA officials told us that it would be helpful to receive individual health assessment data in aggregate form, in addition to the individual data, to plan for the needs of current service members who may seek VA health care. Sharing this information would be consistent with the President's task force finding that comprehensive health data is essential for VA to forecast and prepare for changes in the demand for health care services.

Another shortcoming is the lack of a data sharing agreement on the specific types of health information that will be exchanged and when the information will be shared for those who may transition to VA health care.

VA and DOD signed an MOU in June this year, but it does not constitute an agreement for the routine sharing of health information.

For example, VA officials still do not receive a list of service members undergoing a physical evaluation board for separation from the military.

With this information, VA believes it would be better positioned to make appropriate transfers to VA health care prior to discharge and

to reduce the chance of interruption in medical treatment plans.

DOD officials told us they are working on a policy directive to do this, and I was informed this morning that it was signed yesterday.

Mr. Chairman, this concludes my remarks, and I would be pleased to answer questions that you or the other members may have.

[The statement of Ms. Cynthia Bascetta appears on p. 66]

THE CHAIRMAN. Thank you very much.

Ms. Koontz?

STATEMENT OF MS. LINDA KOONTZ

MS. KOONTZ. Mr. Chairman and members of the Committee, I am pleased to participate in today's discussion of the efforts of the Departments of Veterans Affairs and Defense to make transition of active duty personnel to veteran status as seamless as possible.

One goal of these efforts is for the two departments to be able to exchange patient health information electronically, and ultimately, to have interoperable electronic medical records.

Sharing of medical information can help ensure that active duty military personnel and veterans receive high-quality health care and assistance with disability claims, goals that, in the face of current military responses to national and foreign crises, are more essential than ever.

As you know, for the past seven years, VA and DOD have been working to achieve these capabilities, beginning with a joint project in 1998 to develop a government computer-based patient record.

As we have noted in previous testimony, the departments achieved a measure of success in sharing data through the one-way transfer of health information from DOD to VA. However, the longer-term objective of virtual medical record is more complex and challenging, and potentially much more rewarding. For example, the data in the virtual medical record are to be computable. That is, they are not just displayed as in a paper record. Computable data are powerful. They can trigger actions alerting clinicians of a drug allergy, for instance, or of a significant change in the vital signs, such as blood pressure.

To achieve this longer-term objective, the departments have much work still to do.

In the past year, VA and DOD have built on their previous efforts and begun to implement applications that exchange limited electronic medical information between the departments' existing health information systems. These applications were developed through two information technology demonstration projects.

The first application, bi-directional health information exchange, enables the two-way exchange of health information on shared patients.

The departments have implemented this application at five sites, where it is being used for rapid exchange of information on shared patients, specifically pharmacy data, drug and food allergy information, patient demographics, and laboratory results.

The second application, laboratory data sharing interface, allows the departments to use each other's laboratory resources.

It enables them to rapidly send and receive lab orders and results, all electronically. This application has been implemented at six sites.

The two applications have significant benefits, according to the departments, because they enable lower costs and better service to patients by saving time and avoiding errors.

Since our last report on the department's efforts to achieve a virtual medical record, VA and DOD have taken several actions, but the departments have not yet achieved the two-way electronic data exchange capability originally envisioned.

They have implemented three recommendations that we made in June 2004.

They have developed an architecture for the electronic interface between DOD's clinical data repository and VA's health data repository, which are to contain the medical record information that will be accessed by the department's next-generation systems.

They established the VA-DOD Health Executive Council as the lead entity for the interface project, and they established a joint project management structure to provide day-to-day guidance for the initiative.

However, the department's project management plan for the interface development is not yet sufficiently detailed.

Moreover, the departments have experienced delays in their efforts to begin exchanging computable patient health data, and they have not yet fully populated their data repositories with the information that they intend to exchange.

In summary, Mr. Chairman, developing an electronic interface that will enable VA and DOD to exchange computable patient medical records is a highly complex undertaking that could lead to substantial benefits.

VA and DOD have made progress in the electronic sharing of patient health data in their limited near-term demonstration projects.

They have also taken an important step toward their long-term goals by improving the management of the program to develop the all important interface between the two data repositories.

However, the departments still face considerable work and significant challenged before they can achieve their long-term goals.

This concludes my statement. I would be happy to answer questions at the appropriate time.

[The statement of Ms. Linda Koontz appears on p. 82]

THE CHAIRMAN. Thank you, Ms. Koontz.

Dr. Javitt?

STATEMENT OF JONATHAN JAVITT, M.D., M.P.H.C

DR. JAVITT. Thank you, Mr. Chairman. Thank you for inviting me back to this Committee.

You have asked me to bring your Committee up to date on mature, scaleable private sector technologies for two-way health data interchange.

Now, I have founded and directed publicly-traded companies that deliver electronic health solutions. I have served as the senior executive of Fortune 100 companies that deliver such solutions, and my family's financial security is tied to the premise that the private sector can ultimately construct and deliver e-health solutions that save money while they are saving lives and suffering.

Despite my private sector credentials and experience, it is my duty to tell you that the current comprehensive electronic health environment of the Veterans Health Administration surpasses any capability available today on the planet, whether in the private sector, other departments of the U.S. Government, or the highly profiled activities of other countries.

Let me be clear that I am speaking only about VistA CPRS and not about VA's personnel or financial management software initiatives.

I offer that opinion as one who strongly supports President Bush's policies, including those expressed in OMB Circular A76, and who is proud to have been commissioned by the President to lead the PITAC's Committee on health care and the report on revolutionizing health care through information technology.

The Committee I chaired was composed entirely of individuals from the private sector, including former senior Microsoft and Oracle executives, the chairmen of computer science and electrical engineering at two prestigious universities, and we received extensive input from the entire IT community.

I will admit that our initial working assumption was that the VA approach to e-health, using MUMPS and other less-than-mainstream technologies, must be an example of government waste and inefficiency.

Instead, after examining the VA's achievement on paper, in testimony, and in numerous sites of care, we concluded that the VA had built something unique, something that should be considered a national treasure and a resource to be leveraged into the private sector.

I had the honor of accompanying President Bush and senior members of his administration to examine the electronic health records system of the VA and their capabilities for health data interchange.

On that occasion, the president noted information technology hasn't really shown up in health care yet, but it has in one place, in one department, and that's the Department of Veterans Affairs.

Notably, Medicare administrator Mark McClellan, himself a physician and a conservative economist, who served on President Bush's Council of Economic Advisors, came to the same conclusion in urging that the VA system be adopted by medical care givers across the country as a low-cost means of entering the e-health world.

As I understand the issue before this Committee, there should be no question about whether the Veterans Health Administration has used homegrown information technology to create a miraculous transformation in our ability to move health care information where it needs to go. A pile of scholarly articles several feet high attests to the fact that medical errors occur in fewer than one in 10,000 prescriptions in veterans hospitals, compared to one in five prescriptions in paper-driven private sector hospitals. The article from the New England Journal that I have submitted to you documents that our nation's veterans receive higher-quality care than is received under Medicare for conditions such as diabetes and heart disease, to name two of 12 conditions.

Other studies point to the demonstrated improvements in diabetes management, care for patients with congestive heart failure, smoking cessation, cholesterol reduction, pneumonia, and influenza vaccination, and other health outcomes among Americans' veterans that far surpass comparable measures in the private sector.

The VA system is remarkably stable and secure. Most recently, the Department of Health and Human Services in the civilian sector has been forced to allocate hundreds of millions of dollars to reconstructing health records destroyed in the wake of Hurricane Katrina. In contrast, it took the Veterans Health Administration less than 100 hours of staff time to safely transfer all records from the disaster zone to Texas. They would have done it electronically instead of by magnetic media had the regional private sector-run telecommunications infrastructure remained viable.

Your Committee has heard testimony on this subject from former Secretary Principi and a host of others, and yet a parade of contractors from private sector interests come before you regularly and ask that you fix what is not broken in favor of the principle that small government is better than big government and that the private sector, given sufficient resources, will provide better quality, more efficient, lower-cost solutions than government employees. Despite the fact that these contractors have not yet built a viable distributed electronic health record that spans institutions, either in the private sector or for the Department of Defense, they will certainly promise to deliver on spec, on time, and on budget for the VA.

As the article from the IEEE that I have brought you documents,

such massive contractor-led Federal software projects are likely to fail.

In fact, an honest look at the origins of the current CPRS program of the VA will readily discern that CPRS was born out of the ashes of a failed contractor-driven attempt to build a VA medical records system.

In general, I believe in small government and out-sourcing, just as I believe in basic principles of aerodynamics.

However, when I watch an aerodynamically implausible bumblebee fly across my back yard, my first impulse is not to legislate it out of existence.

There are exceptions to every rule, and the electronic medical records system of the VA is a notable exception to the principles of OMB Circular A76.

The irony of this all is that card-carrying IT professionals would call the dedicated professionals within the VA dangerous amateurs, in the same way that the executives of major computer companies that no longer exist spoke with derision about Jobs, Wozniak, and Gates. To an IT professional, there is nothing fundamentally different about computerizing the traffic control system of London, England, and computerizing the English national health system, except that the Brits, after spending $10 billion, are finding out that there are substantial differences.

In short, the answer to locating the best technology for two-way health data interchange is to look no further than the information technology apparatus of the Veterans Administration, and to continue to encourage and to demand two-way data interchange with the Department of Defense, and to lower whatever barriers can be lowered by congressional mandate that exist in HIPAA.

I would advise this Committee to continue careful, thoughtful, and aggressive oversight to make private sector resources available to help the VA implement mainstream solutions that may be more scaleable than some of the current solutions built of necessity, and to allocate funds to leverage the pioneering concepts and solutions of the Veterans Health Care Administration into the private sector. To do anything else would be a disservice to our veterans and ultimately to our nation.

Thank you.

[The statement of Jonathan Javitt, M.D., M.P.H., appears on p. 104]

THE CHAIRMAN. Thank you, Dr. Javitt.

Dr. Dysert?

STATEMENT OF PETER DYSERT, M.D.

DR. DYSERT. Yes.

Chairman Buyer, Ranking Member Evans, and members of the Committee, thank you for the time to be here today to share my perspective and relay to you some of the experiences I have had in the private sector trying to successfully computerize clinical care.

My written remarks are a matter of record, so I am not going to bore you with repeating those, and I am also not going to sit up here and read to you kind of my position. What I would like to do is take the five minutes you have granted me to have a conversation with you from my perspective as somebody who is really in the middle of a $140 million project of trying to convert our hospital from being paper-based to electronic-based.

Let me start my remarks by telling you I am not going to use very technical terms, because in my opinion, a lot of these projects have kind of sunk to the level of pure technology, and words like transmission and interfaces and things like that have shifted the focus of these projects to a technical level in taking them away from the very human dimension of both the people who use the systems and the people who receive the care delivered by care providers.

First of all, just some general observations about computer application designs.

From my perspective, the rationale for making investments in technology is not at a feature and function level.

It is the ability of the application to support work flow, and the focus, in return for investment in technology, should be primarily focused to achieving efficiencies and improvements in productivity.

When you look at a project, those should be the words you should be hearing played back to you. What's this going to do to provider efficiency and productivity? Because then it gives you the context to ask a very non-technical and simple question: How effective can a computer system be when it takes an inherently mobile professional like a physician or a nurse, forces them to sit down at a computer terminal after the fact, and document work they've already done? In my opinion, there is a very important link in this goal for safety and quality that's related to efficiency in productivity.

The reason quality pays and the reason technology is a wise investment in supporting quality -- it will only deliver if it improves the efficiency and the productivity of the people trying to deliver care.

The second point I will make is most existing technology solutions in health care are architected around computable or structured data, when, in reality, the practicalities of care involves all four information types of free text, data, speech, and image, and any successful solution needs to incorporate to the same level of value all of the information types.

The human interface design, again around productivity and efficiency, is a very important consideration. Most physicians in my world tell me that any time a computer application relegates the interchange from their perspective to one of a clerk-type activity, that's the -- they didn't go to medical school to be a clerk. They went to medical school to be a physician.

So, any time you transform the human interaction for care providers to one of being a clerk and documenting work they have already done, it is the best and most legitimate reason for providers of care to push back from using that technology.

I would like to close my remarks -- and again, I have given you in my written testimony kind of the blueprint that we followed on a technology level, and there are probably terms you do not understand, but I will just tell you, if you are not hearing these terms played back to you as you look at investing in future solutions, then I think you are not buying the right product.

The points I want to make are central.

Number one, efficiency and productivity, the value for the investment in technology needs to return in that space, and it will deliver quality.

The whole concept of seamless and integration does not need to be bi-directional, does not need to be transmitted or any of those types of things, it needs to put the center of that, the human facet, and concepts like access need to become important.

Can I, through a browser link, simply get access to information in another system, and do not leave it to the technologist to integrate the data, but remember, I have got a brain, and cognitively, the whole idea of seamlessness needs to put the human user in the center of the discussion and relegate the technology terms to something technology people talk about.

It needs to be focused on terms like access. Can I access this information?

For example, if you have invested in creating a system to support all the VA hospitals, are all the records basically accessible, do not need to be moved or transmitted? Can we use internet families of technology to answer and access that kind of information?

I would close my technology comment by saying that why in the world would anybody building a health care platform today ignore the success and the capabilities, the scaleability of the internet family of technologies? I think if the internet and the browser has done one thing, they have taken the role of the computer and moved it from something purely technical people saw value in so that us non-technical types see value in the computer using browser and internet technology, and I would just encourage this Committee to look forward and look at its investments and thing of things like inter-operability and communication in terms of things like access.

Can the user access this information?

The last principle I would leave you with is one I try to operate against every day.

Perfect is the enemy of good.

Thank you very much for your valuable time and the opportunity to testify, and I would be glad to take your questions.

[The statement of Peter Dysert, M.D. appears on p. 107]

THE CHAIRMAN. Perfect is the enemy of good.

Well, it is an inquisitive statement. I guess it is why I am so bothered that the torte lawyers have sort of moved America away from negligence to comparative negligence to now strict liability standards in almost every jurisdiction, you know.

I am sorry. That is what I was thinking by your statement.

Let me thank both of you, actually the entire panel, in particular -- I have heard from the ladies quite a bit, so let me just be complimentary to my other two witnesses, okay, for a second.

It is refreshing.

It is what we hope to expect when we ask people to testify before a congressional panel, not that I agree with everything that you said, but you stated your opinions, and you stated them professionally, and that is refreshing to me, and I am sure to my colleagues that were listening to you, because what you are sharing with us is helpful, and I appreciate that.

We get that from the General Accounting Office. We do not always get that from witnesses, and I just want you to know, personally, for me, it is very refreshing.

Since you went last, Dr. Dysert, you had mentioned that IT must deliver on efficiency and productivity. If I may, I would add a preposition to it.

IT must deliver on efficiency and productivity to improve safety and quality patient care.

You concur, right?

DR. DYSERT. I agree, but I think --

THE CHAIRMAN. So that the -- well, let me just say this. So that the development of that system -- the computer is just a tool. It is an enabler to achieve greater standards and quality of care, right? Isn't that what we are trying to do here --

DR. DYSERT. Yes, sir.

THE CHAIRMAN. -- and trying to achieve?

I do not think anyone has an -- I agree, doctors go to medical school, and you do your job, and to deliver on that quality patient care, part of this is when you are able to put down on the record your diagnosis and the prognosis in a manner that everybody understands, it sure helps the care givers, the follow-on or collaborative care givers, pretty important in seamlessness.

DR. DYSERT. It is called communication and collaboration.

THE CHAIRMAN. Yeah.

DR. DYSERT. It is not a technical term of interfacing.

THE CHAIRMAN. Well, all right, all right, all right. I am not going to quibble about words, even though I am a lawyer and love to do that, but all right.

Dr. Javitt, in your written statement, you indicated that the VA should not be allowed to continue ad hoc development and selective adoption of the VA health record at the regional or division level, and that IT budget authority should be centralized. You kind of get my attention.

Could you please explain and expand on your recommendations?

DR. JAVITT. I think we have reached a point of maturity within the Veterans Health Administration that we know what works in VistA CPRS. The whole country knows that we need to get to standardized medical terminology, and you have got a solution that demonstrably works, where the President of the United States looks at this, looks at what he can see at our universities, and says this is extraordinary, and yet, we still have some culture within the VA that allows people who direct regional-level operations to say I will implement this part but not that part, we will use this terminology but not that terminology.

So, I think Congress could save a good bit of taxpayer money and further improve the care within the VA by giving the Under Secretary of Health and at central headquarters within the Veterans Health Administration, not outside the health administration, but within the top-level doctors at the VA, the authority to have one seamless electronic health record that is implemented the same way in every VISN.

I would like to just take a moment to echo some of what Dr. Dysert said, because his points about the need for economic efficiency and the need for much more creative human computer interfaces are actually points one and point seven of the PITAC report to the President.

Clearly, it is a waste of time to have a nurse read a patient's temperature on a thermometer and put it into the computer. We really need the R&D allocations to have thermometers that talk to computers, to have blood pressure cuffs that talk to computers, to free physicians and nurses and other medical personnel from clerical tasks, so they can spend their time actually working with, talking to, and taking care of their patients, but that is sort of the next frontier once we have stabilized an e-health environment where the most basic level can move seamlessly across the country, and it is a critical frontier, because at the end of the day, putting a computer and a screen between the doctor and a patient does nothing to contribute to the quality of that doctor-patient relationship.

THE CHAIRMAN. All right.

I turn to the two doctors here for a moment.

You, Dr. Dysert, are developing a system -- and I would submit that you are in a luxury. The reason I use the word "luxury" is that, with the DOD and VA, we have a patient that is moving rapidly through a system of care, and how do we move that patient through that system of care rapidly and touching a new doctor so many times, from the combat aid station to the combat support hospital, MEDEVAC to Landstuhl, brought to the United States, from the United States sent to a polytrauma center, in a matter of weeks.

This is not the luxury of you receiving your patient and you getting to know everything about your patient. So, this issue about seamlessness is extraordinarily important in our health system.

So, I wanted you to know that I am taking your words and your counsel, and I do not know if I can -- I am trying to figure out how I do that overlay onto our challenge.

If you have any comments based on what I said, I invite them.

Dr. Dysert. Yes, Mr. Chairman, if you would allow me.

The whole idea of referral of patients -- we represent a quaternary, tertiary care hospital that gets many patients sent to us from rural communities for care.

One of the central themes that led us to deciding that we would build our platform on internet families of technology was simply the personal experience that we all have today of being able to seamlessly access information anywhere in the world if it is known and in a computer system with relative ease.

I will not discount the importance of systems being able to exchange data at machine levels through interfaces and other technologies.

The good news is there is a great growing family of tools kits built the internet family uses every day to exchange information.

I guess our point was -- and back to my "perfect is the enemy of good content" -- is that while we develop at a system level the interfaces -- and these things take time -- we felt it was better to provide the human direct access through the browser-based technology to getting at the answer, and let me give you a very specific example.

We have a number of different types of digital radiology systems in our health care environment.

Our approach, while we looked at the technical possibilities of making them all a single system, was to provide through a browser a link and a secure sign-on that would allow a physician to access all those radiology systems while the technology types figured out a way to get them to talk together at a technology level.

We thought it was better not to wait on the technology at an interface level to deliver access, because it's one of the biggest challenges physicians face in clinical decision-making, is simply having access to information that's already known about the patient, and my point about contrasting technology-based interfaces with the human ver-

sion of that -- and that's access -- is we think you do it every day in your private life; we do not think health care should be any different.

So, while we develop at a technology level the ability to data exchange, we have tried to use internet families of technology to provide access for the human to that information, because it already exists.

Does that address your question?

THE CHAIRMAN. My compliments to the VA, Secretary Mansfield, Dr. Pearl, and what you have done in your collaboration with the military health delivery system. Great. But what good is it when I take the patient -- the patient is taken from Landstuhl to Minneapolis and he does not have his records?

What good is it if we are going to develop that type of system and hand-off, and if we could get to this enabling system; see what I mean?

Every person along the way -- if you are the receiver at the polytrauma center, and five other doctors at five other sites have already touched your patient, you sure need to know what they have done, and you do not even have a record. Little frustrating for you, isn't it, a little challenging? Unnecessarily challenging, right? That is why we are here today, and it is not just that particular reason. I just want to let you know that, as we develop these systems, your counsel is important, but I just want you to know our challenges here are great. Let me yield now to Mr. Evans, and I am anxious to hear from Dr. Snyder soon.

MR. EVANS. Mr. Chairman, thank you.

Are the five sites sharing bi-directional information and six sites sharing laboratory data doing so under local agreements or in comprehensive national agreements?

DR. JAVITT. Could I hear the question again, please?

MR. EVANS. Are the five sites sharing bi-directional information and six sites sharing laboratory data doing so under local agreements or in comprehensive national agreements?

DR. JAVITT. I think that one is outside of my specific competence, but if it could be re-focused --

THE CHAIRMAN. Counsel, will you read this?

MR. SISTEK. Yes.

The question is directed towards GAO and regards the five sites that are now sharing bi-directional health information and the six sites sharing laboratory data. Are these sites doing this sharing agreement under local agreements, between the local VA and DOD facilities, or is there some sort of over-arching and national agreement?

THE CHAIRMAN. Thank you, Mr. Evans.

MS. KOONTZ. Thank you.

My understanding, that these are at multiple sites, and the agree-

ments extend beyond just a single location.

MR. EVANS. I yield back the balance of my time.

THE CHAIRMAN. Mr. Boozman?

MR. BOOZMAN. [Presiding] Yes.

Again, I appreciate you all being here. We had the opportunity to have you in earlier in a very informal session. I think we really learned a lot.

You mentioned that one of the problems we have got is that the records are not -- they are kind of -- some physicians are doing -- are recording in one way, and others are recording in any other way, so it is incomplete.

In the private sector now, because of Medicare and insurance plans and things, you really do not have that problem like you used to, because their attitude is, if it is not written, you do not get paid for it, and so, physicians are careful to document, you know, the things that they need to do for the level of exam and what they are doing.

We do not really have the hammer like that in the VA system. Again, that is a pretty big hammer. You know, if they review your case and they say, well, you did not do that, and all the ones like this, you are not getting paid for.

I guess, you know, kind of the challenge is how do we -- I mean, you know, what hammer do we have to get that done?

DR. JAVITT. With all due respect, Mr. Boozman, from what I have seen, the consistency in the documentation of computerized medical records within the VA is far more consistent and comprehensive than it is within the civilian sector.

I am currently an expert witness in a major health care fraud case in the State of Vermont brought by the U.S. Attorney there that involves consistency of medical records in the civilian sector, and the variability there, and the standards -- is extraordinary, and the standards there are practically non-existent, and it is true that, certainly, Medicare audits can be used as a club to encourage better documentation, but as long as documentation is done on paper, there will be as many ways of documenting as there are doctors and nurses out there practicing, whereas when I talk about differences in nomenclature from one VISN to another, I am talking about very technical differences that only matter not because you can't understand what the doctors in one VISN meant versus what the doctors in another VISN meant, but because in order for the data to become computable, in order for us to be able to apply the kind of medical decision rules that save lives every day -- for instance, identifying the patients who have had a heart attack but are not getting better blockers, the patients who are on blood thinners but may not have gotten the appropriate test to make sure those blood thinners are safe -- in order to be able to go the next generation of medical decision making and patient safety, you need nomenclature that is computable from one place to another,

and that is the next challenge within the VA. The private sector, to the extent that it is still based on paper, cannot even begin to talk about that challenge.

MR. BOOZMAN. Okay. Very good.

The other thing is the -- as we try and work -- and again, I am not a -- I have trouble with e-mail, but as we try and communicate, you know, as you said earlier, that it is communicating and things back and forth with our computer systems, what system do we use?

Do we dump all the information into a warehouse-type thing and then get it from that? I mean is that the system that we are trying to get up and running, or how are we approaching that?

MS. KOONTZ. Well, ultimately, in terms of VA's and DOD's long-term goals, what they hope to have is standardized data in each of their two data repositories which hold the data, and they will make -- and I now hesitate to use this word, but there will be an interface between these two repositories that will allow the information to be exchanged. So, yes, there is basically pools of data which will be standard to avoid the problems in, you know, interpretation, so we record it the same way, and also, as Dr. Javitt said, to make it computable.

MR. BOOZMAN. I know some of the -- like immigration, the border guards and things, you know, they have problems in having to collect a lot of data from a lot of agencies. They have been able to do that recently, or have a pilot project going on where they are able to interface that data, and the people still have ownership of their data without the central pooling.

So, is the technology -- is it leap-frogging ahead where -- I mean do we need to look at that? That makes more sense than giving up your data.

Do you understand what I am saying?

MS. KOONTZ. I do understand what you are saying. Not being familiar, though, with the specifics of that particular instance, it is difficult for me to comment about, you know, a particular situation like that, but --

MR. BOOZMAN. But are you familiar with that type of technology that is available?

MS. KOONTZ. No, I am not familiar with that kind of technology, no.

MR. BOOZMAN. Okay.

DR. JAVITT. I think, in the U.S., we have the tools. Secretary Thompson was prescient in licensing the vocabulary for the whole country, and Secretary Principi endorsed that. It is a very simple problem.

If two doctors are talking and one says crushing sub-sternal chest pain and the other one says angina, each of those doctors knows that they are describing the same entity, or likely to be, but two computers talking to one another do not know that those are the same entities. So, it is just a matter of standardizing nomenclature and standard-

izing vocabulary in ways that we already know how to do but having the discipline to implement.

MR. BOOZMAN. Okay. Thank you.

DR. DYSERT. Can I make one comment, Mr. Boozman?

MR. BOOZMAN. Yes, sir.

DR. DYSERT. On the whole issue of computability of information, and I think you are a physician, as well. You know, the transition for physicians from what I would represent to be an analog thought process to a binary decision tree of documentation is no small challenge, and the problem that I hear played back from physicians is things like computability and converting to structured data is something that is seen to largely create value downstream from the point of care.

The terms that resonate with providers of care when they are looking for a role of technology to serve in a meaningful way -- you have the terms I used before -- communication for the purpose of collaboration in the management of their patients.

What I hope the government will do and what we are trying to do now -- and it is a mighty challenge -- is to not lose sight of where the value is, and have a balance between downstream aggregated data for the purpose of looking at outcomes versus enabling the care providers up front to do what they do in medical practice, and that is communicate and collaborate.

DR. JAVITT. May I just take a moment to endorse what Dr. Dysert said but go one step further and point out that the world of natural language processing, the world of neuro-networks outside of medicine has progressed to where, with concerted R&D, we can have computers listen to one doctor say crushing sub-sternal chest pain, listen to another doctor say angina, and automatically code that to be the same thing. We do not have to force doctors to do things that are different from what they would like to do every day if we do this right.

MR. BOOZMAN. Mr. Snyder, you are up.

MR. SNYDER. I do not know who to direct this question to.

My understanding is that in the sequelae from Katrina in which VA patients were -- had to be evacuated from several of the VA facilities, that whatever facility they ended up at -- and I think many of them ended up at another VA hospital -- that the electronic transfer of their medical records worked, and it worked well. Do any of you have any knowledge of that or any comment on that?

DR. JAVITT. I did not see it happen firsthand. What I understand is that, had the local internet infrastructure not gone down, there would not have been a need for data transfer; the data would have actually been visible in whatever hospital these vets were evacuated to, but because of the failure of the internet infrastructure, VA was able to burn magnetic tapes and transport the magnetic tapes, so the records were preserved.

MR. SNYDER. Is it your understanding, also, that then that worked

well at the receiving facility? I mean it was essentially the same format, I would assume, at the receiving VA hospital?

DR. JAVITT. To the best of my knowledge, there is no veteran whose electronic medical records were lost in the process.

MR. SNYDER. That was my understanding.

We also have an occasion going on now where -- several members have done on a similar thing, but on one of my visits to Iraq where I visited a treatment facility at Camp Taji, and then we went to a hospital where we saw some -- that day -- some wounded soldiers from Arkansas, went to Landstuhl, and I visited with folks there, including another wounded Arkansan, who was unconscious at the time, and then he was subsequently moved to Walter Reed, where I visited with him there a week or so later, and then visited with him while he was still undergoing outpatient treatment when he was back in Arkansas at his home, and I may be wrong, but I don't think the system is quite as smooth as the VA, as we were talking about, but I have not had major complaints about the transfer of medical records in a system that very rapidly moves people in the war situation.

They feel very confident about moving people at quite severe levels of injury with all kinds of machinery and medication support and putting them on a plane and moving them.

I have not heard complaints about medical records transfers not working. Have you all heard anything about that, anything to the contrary within the military?

DR. JAVITT. The challenge you have is that CHCS1, which is the current level of implementation for military inpatient records, is not yet at a point where a lot of what doctors need, the images, the cardiograms, all of the, you know, thousands of tests that are critical for caring for a patient, can be transmitted through that system. It is not there yet.

So, you know, at some level, information --

MR. SNYDER. It has got to be a hard record of some kind, somebody carries an envelope.

DR. JAVITT. At another level, a lot of it has to be moved manually.

DR. DYSERT. Can I add to the comment? Would you mind?

MR. SNYDER. Sure.

DR. DYSERT. I think this is a very important consideration as the future gets looked at from a system perspective.

I applaud and I am certainly not here to criticize the efforts of the VA.

As has been said already, they are a leader in many respects.

I think, having not started a project over 20 years ago but started a project in the last couple of years, our approach is different, because we had a different set of tools to use to build our system.

I think a question and something I would look for in the future is why would we have records in one location at risk that needed to be

moved or accessed because they were physically associated with the application that supported patient care? I think the modern of families of technology gives you, at a national level, the ability to probably virtually store your records in more than one location without the need to physically transport and have a physical barrier to access.

MR. SNYDER. I think that is right.

The frustration, I think, for this Committee and the Armed Services Committee and other folks that follow this is we seem to have independent systems that work pretty well, but there just has been this frustration with why they can't do such a good job of communicating with each other, which I think is what GAO has been following and you all are referring to.

I trained at a couple of different VAs, both as a medical student and as a family practice resident, and I can remember when essentially the VA chart was pages and pages of illegibility, and 25 years ago, when I was a resident, I got in the habit of typing -- I would borrow the secretary's typewriter and type my admission notes, and it created a stir, because it was the only typed note in a medical record, in, you know, literally, for some of the patients, decades of illegibility, and then there would be this typed note, and so, we have moved from that, but we still have this issue of the two government entities.

What comments do you all have with regard to the fact that we talk about the military system and the VA system, as such, that are straightforward government -- I am sorry, I did not see my light -- government entities. The fact that Tricare -- so many of them are private providers -- where does that fit into this issue of sharing of medical information?

DR. JAVITT. I think, before getting into Tricare, you were asking about where is that gap between VA and DOD, and although I had no mandate to do so, I can honestly state that I led the first inspection of the VA's electronic medical records system by an Army surgeon general since that system has existed.

Gen. Peak came to look at the VA system for the first time approximately a year-and-a-half ago, and he found that that system was vastly different in its capability and vastly richer in its capability than his career staff had been telling him.

Now, fortunately, some of that career staff has now departed from the Department of Defense, and I have heard that there is a potential for more openness and more listening, but perhaps the most useful thing this Committee could do would be to bring the senior leadership of the Department of Defense's medical establishment together with the VA and make them look at each other's tools and see where there is room for sharing, and there is room for bilateral sharing. Some of the work that the Department of Defense has done in a structured outpatient note might have some value to the VA, but until somebody with, you know, three stars on his shoulders is willing to ignore what

he is hearing from professional staff and go look and go see, there is probably not much hope for the kind of sharing you are talking about.

The Tricare folks, unfortunately, are largely in an environment where they are going to get whatever care is available to them in the community.

It could be that Tricare could help facilitate the use of electronic medical records in places where Tricare comprises a large part of individual doctors' and hospitals' business, but in places where Tricare is just a small part of a doctor's business, Tricare has no more ability to help that doctor move to electronic medical records than any other insurance company does.

MR. SNYDER. I am not sure where my time is, Mr. Chairman. Thank you.

MR. BOOZMAN. Mr. Michaud?

MR. MICHAUD. Thank you very much, Mr. Chairman. This question is for the GAO.

In your written testimony, you stated that DOD is providing post-deployment health assessment information of individuals who have been discharged from the military to the VA. The assessment has self-reported responses that can help identify individuals at risk of PTSD.

To your knowledge, how is the VA planning to use this information, and will they use it to conduct targeted outreach to the veterans?

MS. BASCETTA. They plan to use the information in two ways.

First of all, for the information that is available now -- some of it was made available in July -- when a veteran or a service member comes to the VA for care, they have access to their post-deployment survey in their medical record, and they are supposed to be getting that monthly in October.

What they would like, in addition, is that information in the aggregate, so that they can look at what the potential demand for mental health services might be coming down the road and where those services might be needed especially if service members are going to be returning disproportionately to certain areas.

They do not have that aggregate information at this point.

MR. MICHAUD. Also in your testimony you state that DOD is not providing VA with the health assessment information for -- from reserve and National Guard members. These veterans actually represent roughly one in three of the OIF and OEF forces. Why is DOD not providing VA with this information, and how will this impact seamless transition for these veterans?

MS. BASCETTA. It obviously has a negative impact on the transition for Guard and reserve members. Honestly, we are not clear on what the reason is. It has something to do with the legal status of Guard and reserve members, as opposed to active duty members, and I think

if that were resolved, there is a solution to getting that information to VA, and I would encourage you to ask DOD that question.

MR. MICHAUD. I definitely will.

In your opinion, when one in three are reserve and National Guard members that are putting their lives on the line, and a lot of them have lost their lives in this war, why would we want to treat them less than we would for an active member because of a legal status?

Has GAO taken a position and has encouraged DOD to provide this information?

MS. BASCETTA. Yes, we would.

We would certainly not want to treat anyone differently who has, you know, put their life on the line in either of these conflicts.

In the transition assistance program, where we also noted in a report that we issued in May differences between the way the Guard and reserve and the active duty members were transitioned, received transition assistance, DOD, to its credit, has been working to assure that there is equal treatment of Guard and reserve members, and there are logistical difficulties, but they are certainly not insurmountable.

MR. MICHAUD. Thank you very much.

I yield back the balance of my time, Mr. Chairman.

MR. BOOZMAN. One thing that came up in the testimony with Dr. Snyder -- I know we did a good job of, you know, saving things and stuff, but were the digital x-rays -- were they lost?

DR. JAVITT. I do not have specific knowledge. I saw Dr. Kolodner in the room, and he probably knows the answer.

MR. SNYDER. Okay. Very good.

Dr. Dysert, the transfer of the digital x-rays really is not a problem. I know that people do that all the time.

DR. DYSERT. Well, again, I hate to get down at a word and semantic level, but the notion of transfer feels like it is a technology movement -- using technology movement of a file from one system to another, and I think it is the framework for my comment earlier: Perfect is the enemy of good. Sometimes there is an equally effective way and it is an access thought.

We are simply providing access to the information, creates value, without having to physically move at a system level, and the unfortunate thing with computer technology and interfaces -- sometimes they do require technical perfection to function in the exchange of information between systems versus you or I simply hitting a link that takes us to that PAX web viewer and you are able to see that image, even though it is resident on the original system. Nothing has been transferred at a system level. I am simply accessing where that image is. Does that make sense?

MR. BOOZMAN. Yes, sir, very much.

Ms. Bascetta, according to Dr. Jones' testimony, VA and DOD

signed a memorandum of agreement in June regarding the resolution of the HIPPA privacy rule. Are you familiar with the agreement, and in your opinion, to what extent does it resolve the untimely sharing of medical records between the two departments?

MS. BASCETTA. It does not resolve it at all, unfortunately. We testified about this in May, when we had a copy of the draft MOU, which is identical to the one that was signed in June.

The MOU essentially restates the circumstances under which DOD and VA can exchange individually identifiable health information, and it includes references to provisions of the HIPAA privacy rule, but it doesn't constitute a data sharing agreement, and that is what they really need to move to a seamless system.

They need to know exactly which individually identifiable information they are going to share, and they need to know the point in the process that they will share that information for service members.

It is interesting that they have apparently signed this directive to address the second part of the question, that at the point of the PEB, when, essentially, the military is pretty likely to medically discharge a service member, they are going to transfer information to VA, and that is important for the Veterans Benefits Administration, in particular, and probably is soon enough for them to get that information for processing disability compensation claims.

We still have questions about how the two departments could work together, could collaborate to determine even earlier points in the process for other service members who, for example, might need medical rehabilitation. You know, is there a way for VHA to access information more broadly about service members who may be in that need of VA medical care?

MR. BOOZMAN. I guess the next question would be, then, you know, since we are at this impasse again, how do we resolve that?

MS. BASCETTA. Well, there are a couple of options.

The presidential task force essentially recommended a few years ago that DOD and VA ask HHS to declare them a single health care system, and they said that if they were to do this, they could avoid what would otherwise be these cumbersome agreements that need to be put in place to be HIPAA compliant. In the JEC's annual report last December, they have a response to the task force's recommendation, and they essentially indicate that they do not need to do that, that they can handle their data sharing needs under HIPAA without going to HHS, but they have not done that, at least not to our satisfaction.

MR. BOOZMAN. I guess since we have got the inability to obtain the health information on the reserve and national guard members from DOD, what is the byproduct of that? How does that affect timely access for care to the service members involved?

MS. BASCETTA. Well, until some of the unique difficulties with in-

formation -- health information on Guard and reserve members are resolved, they will be at a disadvantage.

MR. BOOZMAN. Dr. Snyder?

MR. SNYDER. Help me with my ignorance on this, on the MOU. I do not understand how it is supposed to work. I guess in my naivete when we first started hearing about it, I was like you, Doctor, where I thought that you are talking about information being in a location someplace and the person shows up at a VA facility and that treating facility accesses that information.

If they are then transferred from Walter Reed and are getting some follow-up care at the VA, that facility accesses that information.

I do not understand the MOU. I mean it specifically talks about -- well, I do not understand how it is supposed to work according to this MOU.

If I am a patient, are we assuming that, for legal purposes, these are separate entities and that a person in the military can refuse to have information transferred to the VA?

MS. BASCETTA. Well, I suppose they could, but the way it works is that, right now, they are not considered a single entity, but that should not pose a barrier, and in the situation you just described, where someone is transferred from an MTF to a VA, there is no HIPAA problem, because under the continuity of care scenario, those records transfer. Under other situations, a service member could sign an authorization to have the records transferred. What we are talking about are -- and what DOD and VA are trying to negotiate are those situations in which a service member has not transferred to a VA facility but there is the potential for them to do that, and the issues that need to be worked out in those cases are what information VA needs to prepare for that patient and how soon they can get access to that information.

MR. SNYDER. So, a line in the MOU talks -- am I taking too much time, Mr. Chairman? Where it says -- the Department of Veterans Affairs' responsibilities -- and they both have responsibilities, which are about the same -- shall provide DOD Tricare with information necessary to provide medical treatment to veterans.

Okay. Information necessary, but then, down below, it says that -- shall provide a veteran or service member's information to DOD pursuant to prior written authorization by the service member.

Are those two in conflict, or am I missing something, where it says shall provide information necessary to provide medical treatment, and then, down below, it says the disclosure of information pursuant to prior written authorization.

What I am getting at is if you have a difficult patient -- I mean we are all difficult patients at some point -- somebody who is -- I will make up something -- abusing oxycodone or something, and wants to -- did that in military service, and now -- and that is in the medical

record, and now it is going to transfer to the VA. Can that person say no, I do not want my medical records to be accessed, I am not going to give you written authorization, or are we one entity in terms of providing treatment?

Ms. Bascetta. No, they are definitely not one entity at this point. That is what the task force recommended that they ask HHS, to declare them one entity, but certainly somebody could -- under the scenario you describe, they could refuse to have their medical record transferred, but the more -- that is not, you know, the kind of situation that has come up.

Mr. Snyder. No, I would think --

Ms. Bascetta. What has come up is that, in fact, if someone is being transferred under continuity of care, the VA can get the information that they need, and they do not necessarily need the entire medical record. They probably only need, at least in the immediate term, the record that is pertinent to that episode of care, and HIPAA does not pose a barrier in that situation.

Mr. Snyder. Which, if you believe in the concept of the total patient, would make some providers very apprehensive that I only want the information about the gun shot wound to his hand.

Ms. Bascetta. Right.

Mr. Snyder. I do not need the stuff about his antidepressants. I do not need the stuff about his suicidal gestures.

Ms. Bascetta. Right.

Mr. Snyder. That is, I would think, problematic.

Thank you for your indulgence, Mr. Chairman.

Mr. Boozman. Mr. Michaud?

[No response.]

Mr. Boozman. Thanks very much to the panel. We certainly appreciate your being here, and now we are going to move on to our second panel.

[Pause.]

Mr. Boozman. Thank you all very much for being here.

On the second panel, we have the Hon. Gordon H. Mansfield, Deputy Secretary, Department of Veterans Affairs; Dr. Stephen L. Jones, Principal Deputy Assistant, Office of Health Affairs, Office of Personnel and Readiness, U.S. Department of Defense; Maj. Gen Ronald G. Young, Acting Director, National Guard Bureau Joint Staff, National Guard Bureau; Col. Sheila Hobbs, Senior Patient Administrator, Office of the Surgeon General, United States Army; Ms. Susan McAndrew, Senior Health Information Privacy Policy Specialist, Office of Civil Rights, U.S. Department of Health and Human Services.

I would like for our witnesses to limit their oral testimony to five minutes, as your complete written statement will be made part of the

official record of the hearing. I ask that the members hold all questions until the panelist has finished.

Mr. Mansfield.

STATEMENT OF HON. GORDON H. MANSFIELD, DEPUTY SECRETARY, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY ADM. DANIEL L. COOPER, UNDER SECRETARY FOR BENEFITS; DR. MICHAEL KUSSMAN, DEPUTY UNDER SECRETARY FOR HEALTH; MR. JOHN BROWN, DIRECTOR, SEAMLESS TRANSITION OFFICE; DR. BARBARA SIGFORD, CHIEF, PHYSICAL MEDICINE AND REHABILITATION PROGRAM MANAGER, VETERANS HEALTH ADMINISTRATION; MS. KAREN OTT, VA/DOD LIAISON OFFICE; DR. STEPHEN L. JONES, PRINCIPAL DEPUTY ASSISTANT IN THE OFFICE OF HEALTH AFFAIRS, OFFICE OF PERSONNEL AND READINESS, U.S. DEPARTMENT OF DEFENSE; MAJ. GEN. RONALD G. YOUNG, DIRECTOR, NATIONAL GUARD BUREAU JOINT STAFF, NATIONAL GUARD BUREAU; COL. SHEILA HOBBS, SENIOR PATIENT ADMINISTRATOR, OFFICE OF THE SURGEON GENERAL, UNITED STATES ARMY; AND MS. SUSAN McANDREW, SENIOR HEALTH INFORMATION PRIVACY POLICY SPECIALIST, OFFICE OF CIVIL RIGHTS, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF HON. GORDON H. MANSFIELD

SECRETARY MANSFIELD. Thank you, Mr. Chairman, and members of the Committee, for this opportunity to appear before you.

I am here as one individual representing a agency that has 230,000 people. I am sitting here with representatives of an agency that has additional numbers.

So, you have the two largest agencies in the government sitting at this table. The VA is lucky, very lucky.

We have a single mission, and that is to take care of veterans, to take care of veterans' health care, to take care of veterans' benefits, and to give them repose in a national cemetery if they so wish, a national shrine that would honor their service.

These two big bureaucracies are charged with working together to take that individual, that young man or young woman who steps forward to become a member of the armed services, and we should recognize that, when that person steps forward, as they progress through a career in DOD, at some point in time they are going to become the responsibility of the Department of Veterans Affairs.

For these two agencies to work together, as the Chairman mentioned earlier, we have a bureaucratic entity, the Joint Executive

Council, and I would mention here that the goals for that council, as evidenced in their latest strategic plan and report that came here to this Congress, include leadership, commitment, and accountability, high-quality health care, seamless coordination of benefits, integrated information sharing, efficiency of operations, and then goes on to joint contingency readiness capabilities and other issues.

I think, rather than read the statement -- I request that my official statement be included in the record and Iwill talk about some issues, as I mentioned, two big bureaucracies.

So, how do we make this work?

Again, I would tell you that, from the VA's perspective, our one unique mission is that veteran and recognizing who and what they are, and we are required to take care of them.

The Executive Council, in providing leadership, looks at things at a high level, and let me talk about some of the issues that we are dealing with right now, some of which have been covered here.

For example, we know that there is concern here on the Hill, as there is in our agency and at DOD, about the issue of PTSD.

So, that issue has been a subject of discussions both off the record and on the record with the senior leadership, but I can tell you right now that we are tracking -- keeping track of the OIF/OEF veterans, 393,407 that have been separated, how many of those come from National Guard or how many come from active duty, how many of those have asked for or are seen for readjustment counseling service, how many have been evaluated or treated for PTSD, and how many have ongoing treatment, and that is a subject matter that this council, at its senior level, has been able to look at, deal with, and try and get the message out all the way to the field that this is an important issue.

Benefits: The fact that these individuals coming into service at some point in time are going to be veterans is important. We have an effort underway to make sure that not just OEF and OIF but all members leaving the service are seen, are given an opportunity to be briefed on what those benefits are, how they can be accessed, and how VA can assist them.

Medical facilities: We're doing an awful lot of work. As has been mentioned here in the area of seamless transition, as the Chairman mentioned and other members mentioned, the road from Iraq or Afghanistan to Landstuhl to Walter Reed to a VA hospital is one that we have spent a lot of work, energy, and effort on in the last few years to make sure that this works.

Then in the areas, for example, as mentioned, in the records area, HIPPA has come up and some questions have been asked.

It has been up and down the line a number of times, questions asked about what are the ability to withhold information or what are the ability to exchange information, what are the points where information stops, what is the information that can be asked for and

required.

We have moved forward to the point where we have had general counsels from HHS and general counsels from DOD and general counsels from the VA sitting down at a table and talking about how do we handle this, and we have got an agreement now at that high level, but we still need to move it down to the bottom line.

There is a piece of legislation, S. 1182, I believe it is, on the other side, that deals with this issue, and it would resolve it once and for all by saying that health care information can be moved back and forth between DOD and VA. I would make the point, seeing the red light, Mr. Chairman, that I do believe that Dr. Chu and myself and the members of the Joint Executive Council, the subCommittees on health care and the subCommittees on benefits, have done a lot of work. We have tried to get the message out that we have to make this work, have tried to get the message out that that person coming on duty from day one is going to be a veteran, and we need to consider that, and we need to make sure that the effort is there to ensure that the benefits, as you mentioned, sir, that have been earned by that service member are delivered in a timely and accurate manner. We are making sure that we take care of these young men and women, and I think that I can say that we have done, over the course of the last year, the last two years, the last three years, a better job than had been done in the past, but I would also say that we still have a long run to go. There is, I see, a commitment by VA and DOD to travel together down that road, and we are working on that.

Thank you very much.

[The statement of Secretary Gordon H. Mansfield appears on p. 120]

THE CHAIRMAN. [Presiding] Thank you, Secretary Mansfield.

Secretary Jones?

STATEMENT OF DR. STEPHEN L. JONES

DR. JONES. Thank you, Mr. Chairman.

Mr. Chairman and distinguished members of the Committee, thank you for inviting us to meet with you today. It is my honor to represent the Military Health System. I am especially pleased with the opportunity to discuss how we work together with the Department of Veterans Affairs to streamline the transition from military to veterans health care for our service members and their families. With your approval, I will summarize for you my written statement, touching on some of the noteworthy defense programs and assuring you of our commitment to work with the VA to meet the needs of our service members and their families as they move back to their civilian lives.

We have endeavored to encompass and integrate the many steps involved with transitioning from the battlefield to military hospitals to hometown communities. We have accomplished much, but we know that we can do more.

Many of our transition initiatives with the VA support recommendations found in the President's task force to improve health care delivery for our nation's veterans. These recommendations align into three broad categories: medical care and disability benefits, transitioning to home and the community, and sharing of service member personnel and health information.

Each of these areas, military medicine plays a role. Let me offer just a few examples.

Under medical care, by any measure, our war fighters who need medical treatment are receiving exceptional treatment and care by a dedicated health professional. One such example is the Army's collaborative program with the VA's polytrauma rehabilitation center, which you are familiar with, Mr. Chairman, which is a boots-on-the-ground program to aid in our severely injured service members who need assistance during the long recovery and rehabilitation program.

This program, an Army liaison officer at each of the polytrauma centers works with VA personnel to support service members and their families in addressing a broad array of issues such as travel, housing, and military pay, and Col. Hobbs is here from the Office of the Army Surgeon General, who can address specific questions that you may have, sir.

In the transition process, the DOD-VA Seamless Transition program features VA social workers and benefits counselors assigned to eight military medical facilities around the country to guide service members through the transition process.

The VA staff briefs service members while still on active duty about their VA benefits, including health care and disability compensation claims.

They also enable the smooth transfer of care to VA medical centers located near the service member's home and then maintain contact with patients to ensure success of the discharge plan.

Another example is the free counseling provided under the transition assistance program and the disabled transition assistance program.

Both DOD and VA counselors offer extensive information on numerous issues, to include health coverage and insurance programs, as well as a full range of benefits available to them.

To ensure we meet the particular needs of our reserve component members who transition and who are disabled and transition back to civilian life, we established an interagency demobilization working group which works to improve the process.

One of the policy changes that they are considering recommending is mandating attendance at the VA benefits briefings, and I might mention, Mr. Chairman, I was up at Fort Drum yesterday and was pleased to see, with the VA counselors, are in the same building, that the medical clinical there, with the Fort Drum soldiers, as they seek health care.

Another transition initiative created within DOD is military severely injured center established in February 2005 to operate on a 24/7 toll-free hot line for service members and families.

The mission of the center is, quote, "to prepare severely injured service members to return to duty or to reintegrate successfully into their home towns." To meet this mission, this center assists injured service members to achieve the highest level of functioning and quality of life by offering advice and help and a full spectrum of benefits, connecting the service members and their families with helpful resources in solving problems.

Currently, the center's health care managers, case managers, are working on more than 1,200 active cases. Issues of top concern are financial resources, education, employment, and family services.

This center, in concert with those operated by the individual services, provides a greater resource to cut through administrative obstacles and help ease the transition to civilian life.

Mr. Chairman, we have materials outside on the table and have additional materials on this military severely injured center that is available for you, and I see I am getting a red light, too. If I could have two more pages here, I would appreciate it.

Under information sharing, which has been discussed here considerably this morning, is the third category of interest.

We in the defense believe that sharing of necessary information is absolutely critical to an effective and transparent transition process.

Again, together with the VA, we have made significant strides.

Today, we have a memorandum of agreement that governs the sharing of protected health information and other individually identifiable information, and as I understand some of the discussions this morning, we were unaware of some of these difficulties, and we would like to work with the GAO and others to try to address some of these issues and attempt to solve the problems as quickly as we can.

The Bi-directional Health Information Exchange operations in Seattle, and being tested in El Paso, enables near real-time sharing of outpatient prescription and demographic data between DOD and VA for patients treated in both health care systems.

Inter-operability between our clinical data repository and VA's health data repository is getting much closer.

We routinely share with the VA service member contact information when they separate from military service. It may not be as timely as needed sometimes, but we are sharing that data.

While there are some discrepancies in this process, I understand that technical changes made last year resolve many of those problems. The next step in this effort will result in sharing the member's name, Social Security number, unit ID, current location, contact information, and a brief explanation of medical condition. Sharing this information with the VA at an earlier point in the transition process will allow expedited delivery of benefits to transitioning service members and reduce the chance of overlooking a particular individual.

With the VA, we will continue to enhance our electronic information sharing structure in order to further enhance seamless transition for all who move from military service to civilian communities.

Mr. Chairman, I would just like to emphasize what Secretary Mansfield stated.

We are committed at DOD to working with the VA in meeting the goals which you have expressed in your statement this morning, and we have many people throughout the agency working. We have people assigned with authority to try to -- and points of contact to work on the various issues, and I think, with good will and open communications, we are trying to do that.

We appreciate your Committee holding this hearing. We appreciate your outstanding support for our American heroes, and we will be happy to answer any questions at your convenience.

[The statement of Dr. Stephen L. Jones appears on p. 140]

THE CHAIRMAN. All right.

For the witnesses and my colleagues, we are going to have to recess for about 15 minutes.

We have a vote on the motion to instruct on the Department of Homeland Security appropriations act, thereby followed by adoption of the rule on the Department of Justice appropriations authorization act.

So, the Committee will be in recess for 15 minutes. I apologize to my colleagues for not giving a witness from the low country of South Carolina 10 minutes because of his dialect.

DR. JONES. I apologize.

[Recess.]

THE CHAIRMAN. The Committee will come back to order.

I would ask unanimous consent to strike the word "speech" that was used right before the break and insert the word "dialect."

Hearing no objection, so ordered.

I had no objection with regard to your speech that you gave.

It is just the dialect of the low country is a little slower than what perhaps I was used to and calculated. The word "tea" in Indiana has one syllable, not three.

Let me now turn to Maj. Gen. Young for testimony.

STATEMENT OF MAJ. GEN. RONALD G. YOUNG

MAJ. GEN. YOUNG. Mr. Chairman, distinguished members of the Committee, thank you for the opportunity to speak with you today about these vitally important programs.

Today the National Guard has over 78,000 soldiers and airmen mobilized around the world for the global war on terrorism, over 325,000 since 9/11.

That is why the transition assistance program is so critically important to our efforts to take care of service members and their families.

The information received during TAP briefings and the opportunity to enroll in these vital benefits programs has long-lasting effects on our men and women in uniform, their families, and their communities.

The effectiveness of transition assistance holds implications for the long-term health of our entire organization. Transition assistance must be comprehensive, a continuum of care that begins before the service member deploys, continues while he or she is away, and follows through after their return. TAP must provide a seamless transition from active duty back to the citizen soldier environment and thereafter.

That is why the National Guard Bureau fully supports the recommendations contained in the recent GAO report and why we support programs such as the New Hampshire reunion and reentry program.

The National Guard plans to continue to build on pilot programs like the one in New Hampshire. Many of the decisions made during the transition assistance program process are family-based, as opposed to individual choices. This necessitates that the service member be united with his or her family during the process.

In addition to the pressing need for the delivery of TAP information at or near the home station, there exists a need for more effective follow-through support in the period immediately following demobilization.

To be truly effective, this follow-on support requires close coordination by TAP representatives at the state and local levels. The New Hampshire model accomplishes this and much more.

While the efforts at the demobilization station are essential, New Hampshire experienced great success with local management and coordination with veteran centers and the VA hospital counselors in providing counseling and education to returning members and their families.

Returning soldiers testified that the one-on-one counseling which occurred during the additional transition days was very effective in

helping them identify and/or cope with their reintegration back into the local community.

This effort also educates the family on signs to look for when dealing with the stress and emotions of their service member's experiences. This coordinated effort makes it easy for the service member to seek and receive the help that they may need.

While New Hampshire should be applauded for their efforts, I would like to point out that there are other states, particularly Washington and New York, that are making great strides in their efforts, as well.

Now more than ever, taking care of soldiers and airmen must be our highest priority. Leveraging the benefits available to National Guard soldiers and their families through the transition assistance program is a key part of this commitment.

As I stated earlier this year, TAP is a readiness issue. The way we take care of service members and their families today will have a direct impact on how well we recruit and retain them in the future.

Working with the members of this Committee, I believe that the Guard, along with DOD, Department of Labor, and the Department of Veterans Affairs, as well as state and local agencies, can dramatically enhance the effectiveness of the transition assistance program and thereby improve the quality of life of our service members and their families.

I want to thank you again for the opportunity to be here today, and I look forward to your questions.

[The statement of Maj. Gen. Ronald G. Young appears on p. 151]

THE CHAIRMAN. Thank you very much.

Col. Hobbs?

STATEMENT OF COL. SHEILA HOBBS

COL. HOBBS. Mr. Chairman, distinguished members of the Committee, thank you for the opportunity to come before you to discuss invitational travel orders and support of family members of wounded and ill soldiers sent from VA medical centers and military treatment facilities.

This is an area we have recognized is in need of work, and we appreciate the opportunity to share with you our systemic improvements.

An invitational travel order is a mechanism used by the Army to cover transportation and sustainment costs. A non-medical attendant order is a particular type of invitational travel order that allows family members of injured soldiers to travel from home or military treatment facilities or another medical treatment facility, including civilian and VA facilities.

Non-medical attendant orders are issued when the medical author-

ities determine that a non-medical attendant is in the best interest of the patient. They are normally issued when patients are unable to travel alone due to physical or mental disability.

The orders are issued and funded by the military treatment facility responsible for providing care. Non-medical attendant orders authorize reimbursement for travel, lodging, and meals, but the extensions are possible if required.

Since the beginning of the global war on terrorism, the Army's Human Resources Command Casualty Branch has issued invitation travel orders to bring family members to the bedside of the injured soldiers while they are hospitalized.

Invitational travel orders differ from the non-medical attendant orders that are issued by the military treatment facilities.

In the past, there has been some overlap between the invitational travel orders used by Human Resources Command and the non-medical attendant orders used by the military treatment facilities.

Once the soldiers are transferred to the VA medical centers, human resources command no longer has visibility over the soldiers and the family members. When invitational travel orders expired, Human Resources Command was unaware of the situation.

Once this was identified, a systemic flaw, action was taken immediately to correct the process. Instead of extending the existing invitational travel orders by Human Resources Command to cover the soldiers and the family members at the VA medical facilities, the Army, MTFs, or military treatment facilities, are issued non-medical attendant orders to authorize family members' travel at the facility. This allows the military treatment facilities to transfer the soldier and the family members.

The military treatment facilities have the authority required to issue these orders upon request by the attending physician.

Although this is a new process, it has only been in place for about two months, we already are seeing improvements.

In addition, we have placed Army Medical Department representatives at four polytrauma centers to provide continuous support to our soldiers and family members.

The seamless transition of soldiers and their family members that are treated at the VA medical centers is an integral part of providing care to our soldiers. Non-medical attendant invitational travel orders are issued and tracked by the military treatment facilities will improve the transition.

Whether the soldiers are receiving care at the military treatment facilities or at the VA medical center, the Army is committed to providing world-class compassionate care to our wounded warriors.

Thank you for the opportunity to appear.

[The statement of Col. Sheila Hobbs appears on p. 156]

THE CHAIRMAN. Thank you very much.

Mrs. McAndrew?

STATEMENT OF MS. SUSAN McANDREW

MS. MCANDREW. Thank you, Mr. Chairman and members of the Committee.

I am pleased to be here today to help clarify the application of the HIPPA privacy rule to the transfer of medical information between the Departments of Defense and the Veterans Affairs.

Briefly, by way of background, the HIPPA privacy rule establishes for the first time a set of national standards for the protection of health information. These standards were issued in final form in December of 2000, and have been in operation widely since April of 2003.

They are relevant to today's hearings, because the health care programs of both DOD and Veterans Affairs are subject to the suite of HIPPA requirements, including the privacy rule.

I want to emphasize that the privacy rule has been carefully balanced to ensure that, while there are strong privacy protections for the health information of individuals, that those protections are not so strict as to interfere with the needed flow of information to provide individuals with quality access to care.

One of the ways in which this balance is most effectively evidenced is in the provisions in the rule that make clear information is able to flow freely from provider to provider for the treatment of the individual.

There has been discussions here in terms of the service member that is being transported and sees many doctors in the course of coming from overseas back to the United States and is in this -- is passed from facility to facility. The privacy rule, in fact, anticipates that and does allow that patient's treatment information to follow with him as he moves from one care setting to another, and I believe the GAO also made clear that, for that kind of treatment, the provision of treatment, there is really no HIPPA issue with regard to the VA's access to information in order to accomplish that.

I would also emphasize that our definition of treatment is quite broad, and it does also cover the provision of related services, as well as the direct provision of care, the coordination of that care, consultation with other providers, and referrals to other treatment settings, so that an individual, if there is a transfer of the treatment of a soldier from a DOD medical facility into the VA's system, that treatment information can flow, and that is permitted, clearly, by the HIPPA rules.

I wanted also to emphasize that there is one other provision of the HIPPA privacy rules that was intended to expressly recognize

the need for the transfer of medical information as an active duty service member makes the transition to veteran status, and there is an express provision in the HIPPA privacy rule that does allow this information to be shared by DOD to VA upon the separation or discharge of the active duty service member, and the VA can use that information to determine the individual's eligibility for entitlement to veterans' benefits.

When the privacy rule was being drafted, we were aware of the transfer programs in effect at that time as between the two departments.

Through the comment period, we heard that there were no real objections to the transfer of this information and that it was being protected both within DOD and within VA, and so, there was an express provision to allow that program to continue unimpeded.

As part of my statement for the record, I have included the actual regulatory provisions that are most relevant to this, and some of the regulatory discussion of this particular transfer provision, and so, I -- that is there in the record for reference, and I just want to say that we do appreciate the opportunity and the careful attention that both departments have been paying both to the achievement of the seamless transition of this information, as well as attention to the privacy interests at stake in the individual's information and that they have found solutions consistent with the privacy rule in order to have the seamless transition go forward, and I would be glad to answer any questions that you or the Committee members may have.

[The statement of Ms. Susan McAndrew appears on p. 159]

THE CHAIRMAN. Thank you very much for your appearance before the Committee, Ms. McAndrew.

This is going to be a very good discussion, and I am going to yield as much time as Dr. Snyder would like to have, because there is a good overlay here between the two of us, in his work on the personnel Committee of Armed Services. I realize that we are dancing within your jurisdiction on armed services, but this is all about our seamlessness, and I also have oversight on the health subCommittee on Energy and Commerce with regard to Health and Human Services, and it just makes me stand on end when I go out into the field and I hear someone at the local level saying, well, I can't because of HIPPA, and I just go crazy, and so, your appearance here -- I was paying very close attention to the two principals at the table while you were testifying.

The purpose of your testimony was not just for me. It is for both of you, both of the two secretaries here, and that is the reason I wanted Secretary Chu here. So, please convey that to him, and also Secretary Winkenwarder, because they are in very responsible positions, and they can send it down line.

We should not be hearing I can't because of HIPPA. We have just heard -- okay? I have not heard that, Secretary Mansfield, from the -- well, strike that.

I did hear at the VA facility with regard to -- in Minneapolis -- with regard to these records, but I just want to make sure that the two principals are comfortable with what you have just heard.

Do both of you acknowledge and are comfortable with what you just heard?

SECRETARY MANSFIELD. Yes, sir.

THE CHAIRMAN. All right.

Secretary Jones?

DR. JONES. Yes, sir.

THE CHAIRMAN. All right.

Maj. Gen. Young, it is my understanding that the National Guard Bureau has entered into a memorandum of agreement with the Department of Veterans Affairs regarding transition assistance. Could you please provide the Committee with more details on the nature of the agreement, in greater detail?

MAJ. GEN. YOUNG. Yes, sir, Mr. Chairman. We started working with the Department of Veterans Affairs at the National Guard Bureau back in 2004, when Secretary Principi was still there, and after Secretary Principi left, we formed a joint working group, or during that time-line, we formed a joint working group, and it has continued and still continues today to work on the seamless transition between the two departments.

We signed a memorandum of agreement, the two under secretaries for health administration and benefits administration, Dr. Perlan and Mr. Cooper, signed that memorandum, and then Gen. Blaum signed it on May the 19th out in Omaha, Nebraska, in front of all the adjutants general from around the country.

THE CHAIRMAN. So, he did this on his own initiative?

MAJ. GEN. YOUNG. Yes, sir. Well, Gen. Blaum and Secretary Principi started the discussions, and then it followed through in the new administration over at Department of Veterans Affairs, and it came to conclusion with the signing ceremony out at Omaha, Nebraska, on May the 19th.

Now, what that memorandum of agreement does -- it commits both of the departments to various things, one of them being establishing two offices, a seamless transition office, and at National Guard Bureau, we have appointed a program manager, and hired him even before the signature on the two documents.

It establishes that the two departments will establish mutually beneficial opportunities to exchange and educate and train our families and our service members about the benefits with VA, because it is a complex system, and guardsmen, as you know, until after 9/11, now that we have got over 300,000 veterans, did not play into that

system too much. So, now, with this many veterans, it is absolutely critical that they understand all their entitlements, all their benefits, and how to get that seamlessly without much difficulty.

Part of the agreement -- on National Guard Bureau's behalf, we took out of hide about $5 million from our other programs to establish state benefits advisors at every state, at the joint force headquarters level.

So, we are in the process of hiring the remaining -- to have 54 state benefits advisors at the joint force headquarters level, sir, not only to take care of Guard families but all families and all service members that are back in a state and need some assistance in getting their VA benefits.

That program, I believe, because of some of the initial states that, early on, took it out of hide and hired that person, they are getting lots of business, and I believe that in the future we are going to have to add to that one-or-two-person office to help take care of all the work load.

In addition, sir, as part of our effort at National Guard Bureau, we have across the country over 400 family assistance centers.

We have 92 wings and wing family program coordinators. We have 54 state family program directors.

Each of those entities, when you add them all together with our state benefits advisors, accounts to about 600 different service areas out there, service centers, that we can assist families and service members. So, we are in the process of bringing their level of expertise up to a higher level as it relates to veterans affairs, their benefits, and their entitlements.

So, this has been a mutually very beneficial relationship and agreement, and we think it is paying great dividends.

THE CHAIRMAN. Now, I realize you do not have operational control over various state adjutant generals. So, do we have a patchwork going on out there, a quilt, or how is this on the implementation?

MAJ. GEN. YOUNG. Sir, when we were out at Omaha, of course, all the adjutant generals -- I spoke to all the chiefs of staff, who were there at the same time, about the New Hampshire model.

I had seen it earlier and been briefed on it, and the experience in New Hampshire with 900 returning soldiers has been just absolutely phenomenal, and the continuation of care and counseling that they have received is going to pay great dividends in the future for those families and stuff.

So, we are sharing that model at Guard Bureau, and I am also the J1, the personnel officer, at National Guard Bureau. I believe that model is the best we have in the country, but I do not want to say that the other adjutant generals are not doing the same types of things.

In Ohio, where I am from, the adjutant general there has worked very closely with the Department of Health and Human Services.

He has worked with several other state agencies, the governor's office, and they have a program very similar, but the uniqueness of what happened in New Hampshire was that they went to the First Army commander, and they were able to get five additional days of Title 10 active duty service once they returned from the demobilization station, which was up at Fort Dix, and they were able to keep them on active duty, bring them home, have a very short welcome home ceremony with the leadership, give them a day off with their families immediately when they got home, and then bring them in for three days' worth of activities.

The first day, they broke their groups down into three different groups. The first day was a group of more of administrative details, checking over all the records, the pay records, all those types of things.

Day two was a day at the VA hospital that the VA conducted, actually giving them VA physicals, enrolling them and getting them enrolled in the program at that very setting, going through one-on-one counseling, and sir, you know that soldiers are macho-type people, male or female. They do not like to admit a weakness, especially to military superiors. The one-on-one counseling provided at the VA hospitals and the opportunity to meet with -- at the vet centers with a veteran and talk issues brought many things out that our service members, their commanders, their senior NCOs did not even know was going on with those individuals, and in some cases do not even know it today because it is protected-type communication.

THE CHAIRMAN. You said this was funded out of hide. What was the money taken from?

MAJ. GEN. YOUNG. It was funded out of hide, sir.

THE CHAIRMAN. The money was taken from what?

MAJ. GEN. YOUNG. Well, sir, what they did in -- sir, I can't talk all the particulars about exactly where they took the money from.

They had -- with the global war on terrorism, our states have some additional money for active duty special work-type days.

THE CHAIRMAN. What type of an account was the money taken from?

MAJ. GEN. YOUNG. Well --

THE CHAIRMAN. If you don't know the answer today, you can submit it for the record.

MAJ. GEN. YOUNG. Yes, sir, I will

THE CHAIRMAN. All right.

MAJ. GEN. YOUNG. I will do that.

THE CHAIRMAN. To you and to your team -- and please extend to the chief of the Guard Bureau that this is leadership, when you take an initiative and you do something like this, and I want to compliment the VA for signing this agreement.

My question is where is the rest of DOD?

Secretary Jones, we know what the Guard Bureau is doing, and they have entered this agreement, they have taken initiative.

So, where is the Department of Defense?

DR. JONES. Well, Mr. Chairman, as Secretary Mansfield stated, our agreements are all centered around the joint planning process that we have underway, and as alluded to, we have six major goals, 21 objectives, and I think it is, 125 specific action items.

As part of the presidential management agenda, 10 of those objectives are green; 11 of those objectives are yellow, which means we need additional work. I am pleased to say none of them are red.

So, I mean 123 action items, sir -- I mean I think a lot of activity is going on.

Now, whether we are being as successful as we would all like to be in, as you say, bringing those to fruition, the answer would be no, but a lot of good hard work is going on between the two agencies to try to reach the ultimate goal.

THE CHAIRMAN. Well, the gentleman to your left, in his opening statement, referred to the Executive Council as bureaucratic. Would you agree with that?

DR. JONES. I would like to think not, sir, but I mean we are two large organizations.

THE CHAIRMAN. Well, if that is happening, you are the principals responsible, right?

DR. JONES. Yes, sir.

THE CHAIRMAN. If you recognize that, you have got to somehow cut through it to perfect change, right?

DR. JONES. Yes, sir, and we are trying to do that. I have been here less than a year, and I enjoy going to work every day, because as you know, we are working on important things.

THE CHAIRMAN. I don't mean to put you in an awkward position, Dr. Jones.

My question really dealt more on the personnel side, and that is not your level of expertise, and again, that is why we wanted Secretary Chu here.

DR. JONES. Yes, sir.

THE CHAIRMAN. My last question dealing with the Guard -- and then, Dr. Snyder, I am going to yield to you -- is a key to the successful transition during the demobilization the ability to use the drill time.

I think that is what we have learned on the reserve component side, especially in your ramp-up, and then as you also return home.

The New Hampshire guard was authorized several drill days immediately after their return home, and I would like to know, though, whether or not this is a Guard policy -- is this a Guard Bureau policy, or is this one that each state is using based on their own resources?

COL. HOBBS. Sir, it is more a each-state initiative using their own resources.

The five days, sir, immediately after demobilization for the New Hampshire model was all Federally funded Title 10 man days, and as you know, our soldiers are on a transition leave period anyway, and depending on one year boots on the ground and 18-month mobilization orders, that can extend out to about 45 days, but First Army allowed them to stay and not be on leave for five extra days when they got back to home station. So, that was all Federally funded.

Now, they come back to drill at about the 60-day mark. So, they come back to their IDT status about 60 days after they return from a deployment.

So, other states have the same opportunity to go to the Army commanders and ask for that same type of program, and I have no reason to believe that it would not be allowed.

THE CHAIRMAN. Mr. Snyder?

MR. SNYDER. Thank you, Mr. Chairman.

Ms. McAndrew, I wanted to have you explain the memorandum of understanding for me, please, with regard to data sharing.

Is this the first memorandum of understanding, or does this replace something that was there before?

MS. MCANDREW. Actually, we are not a party to the memorandum of understanding, and I just saw it for the first time today at the hearing.

MR. SNYDER. So, when you testified just a while ago that information can be freely provided provider to provider, I thought you were stating that based on your understanding of what is in the memorandum of understanding.

MS. MCANDREW. No. That was one of the provisions in the rule itself, the standards itself.

MR. SNYDER. The HIPPA standards.

MS. MCANDREW. Right.

MR. SNYDER. So, you have not read the -- so I have got a fresh mind there to explain this language, then, since you have not looked at it before. It says here the Department of Veterans Affairs shall provide DOD with information necessary for DOD to provide medical treatment to veterans. That is consistent with what you said, correct, that information can flow freely from provider to provider.

MS. MCANDREW. Right. I would interpret that as referencing the ability to use and disclose protected health information in order to provide treatment to the patient.

MR. SNYDER. What I don't understand, then, is where this provision comes into effect, where it says that Veterans Affairs shall provide a veteran or service member's information to DOD pursuant to prior written authorization by the service member.

MS. MCANDREW. That is another means by which information nay be used and disclosed. They are not mutually exclusive.

The way the privacy rule is structured, it identifies uses and disclo-

sures of identifiable health information, where the entity, the covered entity may make those uses and disclosures without the individual's agreement.

Where they want to make a use or disclosure that is not within one of those express permissions in the rule, they can do it provided they obtain the individual's written authorization to make that use or disclosure with the information.

MR. SNYDER. You said earlier that it is a very broad --

MS. MCANDREW. Treatment is a very broad --

MR. SNYDER. It is very broad.

MS. MCANDREW. -- definition, because I mean the purpose the individual is coming to a covered entity, a health care provider, is to be treated, and we did not want the privacy protections, which really are to keep that information confidential within the health care system, to interfere with the doctor's ability to be able to use the information to treat the patient or to consult with others as necessary to make sure that the patient gets the best quality of care.

MR. SNYDER. Secretary Mansfield, I was not here when you -- I had to step out for a few minutes. I was not here when you gave your opening statement, but in your written statement, you state that the whole concept of seamless transition came about to help the OIF/OEF returning servicemen and veterans and women transition seamlessly, but aren't we really like the end of about a -- or in the middle of a 20-plus-year process of trying to have DOD and VA work better together for providing the services?

SECRETARY MANSFIELD. Yes, sir, you are correct. As the Chairman stated in his opening statement, that goes back to the '80s.

MR. SNYDER. Yes.

SECRETARY MANSFIELD. I think what I was trying to say in the statement -- and excuse me if it didn't come across -- was that the current focus on the seriously injured that are in military treatment facilities has been treated by us in the concept of a seamless transfer in that system, although the big picture--seamless transition--has been there, and we have attempted to work on it for a longer period of time, and that involves whether you have been in Iraq or Afghanistan or anywhere and are departing the service.

MR. SNYDER. In your opening statement -- I assume your opening statement, like every other opening statement from the administration, went to OMB first before it came here?

SECRETARY MANSFIELD. Yes, that is the process, procedure --

MR. SNYDER. Yes.

SECRETARY MANSFIELD. -- and requirement.

MR. SNYDER. I understand.

I have difficulty finding, you know, the future challenges and where the problems are. I am always suspicious those kind of get buffed away when they go through the OMB process, but could you give

me a list of what you see as the obstacles ahead of you in the area of medical records, you know, all those kinds of issues where -- that you see as being a challenge for both -- you can join in, too, Dr. Jones, if you like -- where you see the challenges ahead of us, particularly ones where you think there may need to be congressional help?

SECRETARY MANSFIELD. If you go back to the document I did refer to in my comments, sir -- it is the Joint Executive Council annual report.

MR. SNYDER. Right.

SECRETARY MANSFIELD. I talked about the goals, leadership, commitment, and accountability. That is a requirement to start with, and as I indicated, we need that at the top to be able to force these issues down through these two massive bureaucracies to make sure that people everywhere, at every level and position in these organizations, understand that the importance of the organizations rests on those individuals that come into DOD, raise their right hand, go on active duty, and then at some point in time are going to become veterans. We need to recognize that as the starting point, and then we need to work together to move the information on those folks across that spectrum of care, maybe sometimes even back and forth, to make sure that we have the information available to ensure health care in one sense and benefits in the other sense, and that's the first requirement.

MR. SNYDER. So, you are saying that is still a problem.

SECRETARY MANSFIELD. Well, I am saying it's still something that we have to focus on and make sure that we make it work.

The Chairman, at a previous hearing -- and I wasn't here, although I read it -- made a comment about an issue, IT. I think he said what we have to deal with here is the commitment of leadership to get the job done, and that is the first starting point that has to be done for all of this stuff, and we are making the point that it is bureaucratic, but it is the nature of how these organizations work, that we put this organization together, and we have to make the bureaucracy work, but sometimes, at the top, we have to know when to reach out and go around the bureaucracy and find out what is going on down at the bottom and then make a corrective action, bring it back up to the top.

A good example of that is the dental care issue that we had, mostly involving National Guard and reserve troops that came through our reporting process at VA, where all of a sudden it started spiking, and I was looking at it for a couple of months, then I had them go and do a review, and found out folks were getting treated before they went overseas with -- I don't know what you call it. They were extracting teeth and then sending them over for a year's duty, no care over there, coming back, requiring extensive treatment, but at double the numbers that we had projected we would have to deal with.

So, we had to reach around that, find out what was going on, get our dental -- our medical professionals involved in that. They came up with a report. We brought it back to this council, and we had the problem solved.

We now have a better understanding of what the requirements that DOD has to do with the money that they are being given to do it and what we have to do in that process.

So, it requires the leadership to be involved, to be focused, and to keep looking always, not at these reports and these papers, down at those individuals that are standing there, those men and women that are serving, and recognizing, from my point, as I said, that they are going to become veterans, and we need to start as soon as we can to line it up, so that when they do become veterans, as soon as we can do it, we present them with the benefits that they have earned for the health care that they need.

THE CHAIRMAN. Will the gentleman yield to me for a second?

MR. SNYDER. Yes.

THE CHAIRMAN. On the dental, I think this Committee has to accept some responsibility, and let me extend an apology to the Veterans Affairs.

There are some unintended consequences by some action that we took on this Committee, and that we recognized after the first Gulf war that we were also going to have veterans coming back, we didn't know how they were going to be doing, and we wanted to make sure that the VA was open and accessible to them. An unintended consequence is that we did not anticipate that DOD would not take care of the dental services with regard to these individuals that were brought on active duty, Dr. Jones, and so, what happened is that DOD, who gets their payments through the supplemental -- we don't do supplemental on VA.

So, we are thinking, when we passed on the supplemental, that these call-ups and things are going to be taken care of out of DOD.

DOD does a cost shift and takes that -- these guardsmen and reservists and then -- dumping is a hard word, but you cost shift these individuals into the VA, and it was a struggle and was also a deficit for which we then had to make up, Dr. Jones.

I yield back to the gentleman.

MR. SNYDER. I think we were all surprised, too, by the number of Guard and reservists who were not medically fit for deployment at the time of their activation. This was like a couple of years ago, and it was a little over 20 percent were not medically fit for deployment, and I think the overwhelming majority of that was dental, and so, they did get fixed up so they could go, but my guess is that there was work to be done when they got back, and you all had to bear the burden.

I am not going to belabor it. My time is up, but I want to be sure I understood what you are saying.

Are you saying that we still are having a problem at the highest levels of leadership in terms of commitment to this process?

SECRETARY MANSFIELD. No, sir. I made the point early on, I believe, right now, we do have the commitment.

MR. SNYDER. All right.

SECRETARY MANSFIELD. It is just we have to make sure that we reach out and follow through and get it done. HIPPA is a good example.

I mean we are talking about patients in a bed that have come back from a war with serious wounds, and we have got general counsels at the departmental level sitting there talking about who can get the information to treat them. That is not the way we should be doing business.

MR. SNYDER. Well, I mean I think your point is a good one.

I mean I am coming in the middle of this, but the memorandum of understanding is not that old.

SECRETARY MANSFIELD. Well, sir, part of that, too, though, if you look at it, as a, you know, fellow brother at the bar, you have got a law that went on the books in April of 2003, and lawyers look at it, and they want to look at case histories and see how many decisions have been made and what it means, and they are looking at that while the doctor is looking at the patient in the bed, and we have to work our way through this, but you know, if it requires the highest level to deal with it, we need to deal with it, but it needs to, again, be forced back down through the system so everybody understands what they have to do, and it is not what they have to do, it is what they ought to be doing that we are talking about.

MR. SNYDER. Thank you, Mr. Chairman.

DR. JONES. Congressman, can I add on? I think the issue you brought up with the dental care is an issue of how the system does work, though. Dr. Mansfield called Dr. Chu, said he thought there was a concern. We brought that to the HEC, pulled together a joint Committee between the two agencies.

It was then briefed to the Health Executive Council, and we are continuing to work that issue now to make sure that we aren't dumping.

So, I mean that's an example of how the process, while it might not be perfect, is working.

We are able to surface problems and try to deal with those problems.

THE CHAIRMAN. Col. Hobbs, you are representing the Army Surgeon General's office here. Is that correct?

COL. HOBBS. That is correct, sir.

THE CHAIRMAN. What is your background?

COL. HOBBS. I am a patient administrator, sir, patient administration, medical records, sir.

THE CHAIRMAN. Are you Medical Service Corps?

COL. HOBBS. Yes, sir.

THE CHAIRMAN. Your prior assignment was what?

COL. HOBBS. Prior assignment -- I have worked at Walter Reed, the Office of the Army Surgeon General previously, and I am there now, sir.

THE CHAIRMAN. Is the Dental Corps a combat multiplier?

COL. HOBBS. Indeed, it is, sir.

THE CHAIRMAN. Indeed it is.

COL. HOBBS. It is, sir.

THE CHAIRMAN. I like that answer. Indeed it is.

That is a great answer, isn't it, Dr. Snyder? Indeed. Indeed it is.

COL. HOBBS. Yes, sir.

THE CHAIRMAN. No, I liked your answer. I loved the answer. So does Maj. Gen. Webb, he would probably like that answer, too.

We recognize that when soldiers go to war, they are focused on a lot of things, and it is doing the job and the mission, essential tasks at hand, saving a buddy, fighting, grabbing a meal when they can, and they are not brushing their teeth, and they come back with gum disease and dental problems.

Most of the guys pulled off the battlefield, dental. Is that right, Col. Hobbs?

COL. HOBBS. Yes, sir.

THE CHAIRMAN. Dental.

So, if we know that going in, Dr. Jones, we have got to know that going out.

So, if you said that you are working on it, if I were to, in the second week of October -- we are not going to be in session, and I go to one of the demobilization sites, what am I going to see?

Am I going to see guardsmen and reservists having gotten their dental taken care of on active duty prior to discharge, or am I going to see that these individuals were eager to get out of service, ended up with a physical assessment, and were informed that they can just get their dental at the VA? What am I going to find out?

DR. JONES. Well, for one, I hope that you would find out that we are being responsive and that we are making changes and that the system is working the way it is intended to work, and as you know, in the demobilization process, where you do have an individual, all of the boxes has to be checked, you go through the computer screen, and you sit with an individual who is then saying are you sure this is going, are you sure that all the information is in there that we need, are there any other concerns that you may have, and if there is dental concerns, hopefully we are going to be addressing them then, but I will be pleased to follow through with you, sir, and see where we are on October 2, if that is appropriate.

THE CHAIRMAN. You know, when it comes to medical ailments that that soldier may have, we don't discharge them and say just go to the

VA, all right? We try to hold them -- we take care of our own. It is the philosophy, it is the values, correct?

DR. JONES. Correct.

THE CHAIRMAN. Of all services.

DR. JONES. Correct.

THE CHAIRMAN. My only point is -- I will stop beating on this one -- dental needs to be included in that whole person holistic approach to medical care. Would you agree?

DR. JONES. Yes, sir.

THE CHAIRMAN. All right.

MR. SNYDER. If I might put on my family doctor hat, that is a problem that we have throughout health care in America, that years ago, decades ago, probably a century or two ago, we just separated this part of the -- the teeth from the body, and it plagues all kinds of people. It makes it difficult to control all kinds of diseases, that our insurance system handles teeth differently than it handles other things, and it is a problem, and I appreciate you pointing it out.

THE CHAIRMAN. Thank you.

Let me move to the issue on physical separation or separation physicals, assessments.

I have no interest in revisiting the quibble that Dr. Winkenwarder and I had, and we had to bring in, then, Ed Wyatt, who was with me when we wrote the law, to figure out exactly what all this is.

It is kind of interesting.

This comes down to, when I chaired Personnel, what I intended; Ed Wyatt, when he wrote it, what did he mean by what he wrote, and then he is having to implement -- I mean it was one of these kind of things we went through, and then there was a population at large, too, including military organizations and veterans service organizations, who also interpreted one way, and I just want to ask this. Do you think it is a good idea that we should make these mandatory, these separation physicals, or should we just keep them as assessments?

What is your counsel to the Committee? I am going to ask the two principals.

SECRETARY MANSFIELD. I will go back to my original comments, sir, which said that I think we need to start keeping track of these folks as soon as they raise their right hand, and go forward, and in the process of doing that, probably when they leave the military, I would definitely go for making it mandatory and then giving it to us directly, immediately.

THE CHAIRMAN. Dr. Jones?

DR. JONES. Sir, as you know, it is controversial within the medical community as to the cost involved and whether hands-on physicals are necessary, and at this point in time, of course, the decision is the assessment is satisfactory unless additional -- unless items come up

that need additional follow-through.

I guess I would stand by the position that we have now, sir.

SECRETARY MANSFIELD. Sir, I might have to add an amendment at the end that that was my personal opinion and probably not an administration opinion.

THE CHAIRMAN. Well, all right, I am going to get into this, because I authored some of this stuff, and you know, it goes back to a living history of first Gulf war, guys coming back, and ladies, gee, it was in their head, it really wasn't physical; oh, gosh, perhaps they really do have some concerns here.

We do compensation on undiagnosed illnesses, a lot of money put into research. Then my concerns about establishing a baseline, pretty important.

So, then, on the Armed Services Committee, we say, okay, we are going to do these physical exams; oh, I meant physical assessments. We don't want to delay mobilizations, okay, but it is really important that a baseline be achieved at some point, because part of this whole transition is into a benefits side.

So, if an individual, then, is discharged and all you have is a physical assessment, or you don't even have that, maybe that record is gone, then, years later, they come back, and now they file a claim on the VA, and we have no baseline.

So, when you say, oh, my gosh, I don't think we should do mandatory physical exams, because it is going to cost too much, really? Cost too much. To whom?

We here in Congress have a perspective in that the Federal dollar here is fungible, because we see it going into many different agencies and departments.

So, when you don't put that cost on us, but if we don't do it, then what cost are we putting on the VA later on, not only by processing multiple claims later on, without a baseline, and that is why I asked the question about mandatory. Right now, it is just voluntary.

So, let me ask Secretary Mansfield if I may turn to Adm. Cooper. May I?

SECRETARY MANSFIELD. Yes, sir.

THE CHAIRMAN. What is VBA's position on the utilization of the BDD physical exam process?

ADM. COOPER. I am not sure I understand. We are very strong -- and for the same reason you say -- by having people come into our benefits delivery at discharge, because we do get that baseline.

As you know, we signed an MOU to conduct the physical, primarily for the service persons themselves, either at a VA facility or at the military facility, whichever might be closer or more convenient, but the primary point is, even if they have a discharge physical, our requirements for a VA physical are a little more extensive, and quite specific.

THE CHAIRMAN. I apologize. My question really wasn't asked right. I kind of put two things together. You are very kind.

Let me take a step back. Let me ask it this way. If Congress were to mandate these physicals, separation physical, whether the individual may have a particular ailment, we are just saying if you are being discharged from the -- if you are going to be discharged from the United States military, you are going to get a physical, is that a good idea or not a good idea?

ADM. COOPER. I personally think it is a good idea.

I certainly got one when I left. I mean I was an officer and got the physical when I left.

I, frankly, honestly, was not aware that we were not doing it these days.

THE CHAIRMAN. Well, it is voluntary right now.

Isn't that correct, Dr. Jones?

DR. JONES. Yes, sir.

THE CHAIRMAN. It is voluntary. So, we are not setting a baseline for you.

ADM. COOPER. No, and that is the reason I am very strong for our BDD process, because that way, anybody who even thinks they might have a physical problem will come to us and we can get a good solid baseline physical, and thereby, 10, 15, 20 years later, if they come back in and say not only am I worse on that particular problem but I have this other thing, then we can go back and use that as a base.

THE CHAIRMAN. This BDD discharge is done at the military medical treatment facility?

ADM. COOPER. We have 140 sites around the country where we have people who take in the claims when the people come in and register, and then we will try to get them the physical at the closest place. We do on the military base or if a VA medical hospital is nearby, we will do it there. We have this MOU that I mentioned that allows, if discharge physicals were being done, for either one of those places to do it, and they would adhere to our more rigid physical requirements for the physical exam.

THE CHAIRMAN. I don't want to get too far out in front of the Disability Commission, but I think our quest here is to the soldier that has been injured or wounded in some capacity, and now he's facing his physical discharge, seamless -- I want to make sure we are all on the same sheet of music -- seamless transition would be that he gets a physical discharge and his rating is then immediate. Is that not the goal?

ADM. COOPER. That is the goal, absolutely.

Now, let me interject something here. So that the service person can get paid as soon as legally possible, it is important that we have that medical information on their disabilities before they get out, because it takes us a certain discrete amount of time to complete the

compensation process.

THE CHAIRMAN. Let me for a moment entertain a discussion with Dr. Snyder from the personnel Committee standpoint. I have not spoken with John McHugh about this. Have you touched on this issue at all? Maybe this is something we should have some further conversations about it.

MR. SNYDER. I have not had recent discussions with him either.

THE CHAIRMAN. With Chairman McHugh?

MR. SNYDER. Chairman McHugh. Maybe it might be one of those topics we would want to consider having a joint hearing.

THE CHAIRMAN. All right.

MAJ. GEN. YOUNG. Mr. Chairman?

THE CHAIRMAN. Yes.

MAJ. GEN. YOUNG. Could I share just a few observations from the 900 soldiers that went to the VA hospital --

THE CHAIRMAN. Absolutely.

MAJ. GEN. YOUNG. -- in New Hampshire that I think are kind of pertinent here?

Five points, sir.

Almost 50 percent of the 900 soldiers requested follow-up support after their initial counseling back in New Hampshire at the VA hospital one-on-one counseling session, 50 percent of them.

Now, they had just came from the demobilization station and the transition assistance program there and had checked all the blocks and came back to New Hampshire.

Second point: Almost half of the soldiers filed VA claims during the three-day process conducted back in New Hampshire.

One of every 10 returning soldiers received acute care through the VA emergency room while processing.

All soldiers were provided a safe environment to disclose medical issues, and 2 percent were actually retained on active duty in a medical hold status. So, they were not allowed to go off of active duty but were kept on active duty and sent back in a medical hold.

The last point is all soldiers completed a dental assessment through the VA, securing their dental benefits for the next two years. Just a couple of points there.

THE CHAIRMAN. Secretary Mansfield and Secretary Jones, after 20 years of working DOD-VA sharing issues to include seamless transition, seamless care, and all the resources allocated towards this effort, staff, time, and money, you know, I almost have to ask what do we show for our efforts?

Now, you gave your testimony, so I don't want to be too openly critical, and I know that we have military liaisons at the VA trauma centers, we have VA reps at Walter Reed in Bethesda, but I mean look at what remains, the recommendations out of the presidential task force, even, the medical records, the physicals, the sharing of

information between the two departments that, as we just discussed, that could benefit the soldier now or later on in life.

I guess let me just boil it down to where are we going from here? Tell me what is in front of you right now, between now and the next six months.

What is in front of the joint Committee?

SECRETARY MANSFIELD. Sir, I think that you have focused in again on the IT issue, and we had a hearing here not too long ago about that that I recollect, and we are moving forward on that.

That obviously is a big issue, one that we have not produced what we should have produced, one that we are -- we at the VA are moving forward to deal with, and I know one that DOD is also moving forward to deal with. It is again one of those issues that is going to continue to require high-level attention and management concern to make sure that it happens as required.

So, that is a key area, and the other issues here, where we are dealing with health care, as I mentioned, I think we can say that we are doing a good job in that area and we are moving towards doing an even better job.

The benefits area is also one where I think we have cooperated a lot more than we had in the past. We have got VA benefits counselors on Navy ships that are steaming home from battle areas. We have got them at, you know, hundreds of posts around the country and the world, preparing these soldiers for the transition, and we are continuing to work on those efforts, and I think, again, it comes down to focused leadership, dealing with the specific issues, making sure, again, as I said, that we do recognize that seamless transfer means from the start to the end, and that we just keep working on it, recognizing that we are here, you know, not for this report or not for the reams of paper that gets submitted -- we are here for that individual, as I said, that started out by he or she raising their right hand and moved forward, and they became a veteran, and we are required to take over and give them the medical care and the benefits that they have earned and needed, and we need to do it the best way we possibly can.

THE CHAIRMAN. Secretary Jones?

DR. JONES. Yes, sir, Mr. Chairman. I would echo Secretary Mansfield's remarks, and one issue that -- you asked what have we done.

The joint incentive fund, where, as you realize, we -- DOD puts in 15 million and VA puts in 15 million, and I know you have visited a lot of the VAs and a lot of the MTFs, and I haven't had a chance to visit as many as you, but I have had an opportunity to go to about five or six of them, and what impresses me is the creativity and the willingness and the people wanting to work together at the local level. So, I mean I think that fund allows us to capture some of the creativity and to remove some of the obstacles at the local level, where they

want to try to work together and make things happen in the local health care market.

So, you know, that is one specific issue.

Another issue I think we have made progress is in the joint purchasing, and as you are aware, just on the joint purchase in the pharmaceuticals, I think the estimate is that, together, we have saved over 420 million last year by combining the VA and the DOD, but I would echo --

THE CHAIRMAN. On what?

DR. JONES. Joint pharmaceutical purchases, sir.

THE CHAIRMAN. You don't even want to come close to that issue with me. You understand that, right?

DR. JONES. Yes, sir, but I would echo Secretary Mansfield's remark, and Mr. Duffy and myself are trying to go back, with others, on the strategic plan and to make sure that we are able to focus on those issues, on those elements that aren't moving forward, that, as you say, the bureaucracy is getting in the way, and to give that leadership focus so that we can move those forward and make sure that we reach resolution.

THE CHAIRMAN. It is just really unfortunate that you have created something out there, then sucked yourself in a lawsuit unnecessarily and going against things that I have actually written, which I wrote, and I intended to do. It just blows my mind that DOD would go out and do such things. I just can't even fathom nor even begin to comprehend.

DR. JONES. I understand, sir.

THE CHAIRMAN. I know. It is why we are in litigation.

In the GEC annual report, one of the objectives of strategic goal five, efficiency of operations, was identifying of collaborative opportunities for joint construction activity in 2007 to 2010 time-frame. According to the objective, the list of opportunities for joint construction was to be identified after the release of the BRAC list. Can you testify as to what is the status of the list?

SECRETARY MANSFIELD. The status of the BRAC list is that it is submitted to Congress by the President, waiting the 45-day time-line.

I would make the point, sir, that --

THE CHAIRMAN. No, the list of your opportunities of joint construction.

SECRETARY MANSFIELD. I am sorry. We are still waiting the BRAC decision.

We also have moved forward in the BRAC arena with the VA forming a senior-level task force, and that issue, with the BRAC being on the agenda at the last two meetings and scheduled to be on for a meeting when the final decision, whatever that is, is made, which is --

THE CHAIRMAN. All right. You are waiting until after the Congress

acts and the President signs, then you go. Is that what you are --

SECRETARY MANSFIELD. Yes, sir.

THE CHAIRMAN. Okay. That is fine. I just wanted to know where it is proceeding.

Dr. Kussman, may I ask you a question, if we can do musical chairs here?

How valuable is it to you to receive, if you could get them, the pre- and post-deployment physical assessments? Is that of any value to you?

DR. KUSSMAN. Yes, sir, it is of obvious value to us, as was mentioned, both from an aggregate point of view, looking at demographic issues, as well as the specific issue, because as the individual transitions from DOD to the VA, they may come to us at certain points, and having the information that is on the post -- particularly the post-deployment screen, would help the provider who is assessing that individual who comes to know what things that they mentioned that they -- symptoms they may have had or experiences they may have had during that deployment.

THE CHAIRMAN. Compare that value to the value of receiving a post-deployment and/or discharge examination. Compare the physical assessment to an examination.

DR. KUSSMAN. Are you asking me whether I think that the actual physical examination is needed for people both in the post-deployment or prior to discharge?

THE CHAIRMAN. I want to know if you think it is valuable to the VA if we were to mandate -- this Committee --

DR. KUSSMAN. I understand.

THE CHAIRMAN. -- mandate, in conjunction with the Armed Services Committee, mandates the discharge physical exam, I want you to be able to tell me your opinion. Is that valuable to us, or do you say no, we just -- the physical assessments are fine?

DR. KUSSMAN. Without trying to equivocate, I think, if you asked me about -- as a clinician, as a physician -- of whether I think that this is needed or not, I think that the literature shows very clearly that routine physicals, without symptom-directed indications, are not very valuable, particularly in young people.

Having said that, a thorough assessment that could result in the actual hands-on or physical exam is appropriate in those settings. Because if a certain person says they have back pain, then that should be evaluated, and if they say they can't hear, it should be.

But if they say they don't have anything and they are young, then the actual putting a stethoscope on the chest or poking the abdomen or doing a neurologic exam has been shown not to be very productive.

It is not matter of saving money. It is a matter of efficiency of evaluating people, that you do not find anything from it.

THE CHAIRMAN. Okay. That is fair enough. I asked you from a clinician standpoint, but now, when you couple that with the fact that, when somebody goes into the military, we, the government, accept responsibility over that person's body and mind, all right, so when we accept that responsibility and then when they discharge, we say unto them that our responsibility is to make you whole, if it is not, and we do that in some measurements.

Now, I mean there are some related measurements that I think would be pretty important -- hearing test, eye test, some basics out there that we don't even get from physical assessments -- and suppose, because we link this to what I have just described, outside of the clinician's point of view, establishing this baseline would be pretty important given our liability exposure.

DR. KUSSMAN. Yes, sir, and I think that, generally speaking -- and I would have to defer to Dr. Jones because I can't remember now, because I am getting old and retired five years ago, but there is a physical evaluation that is done on active duty people on a regular basis. I think it is every three to five years, or is it every five years? I can't remember exactly when it is. Five years. Okay.

So, there are repeated baselines for someone who stays in for an extended period of time -- hearing, blood pressure, eye exam, dental exam, and all those other things.

So, there is a track record of that repeatedly during a 20-year -- if you are only in for four or five years or three years, that probably wouldn't be repeated, but having said that, I would agree with you that there probably is a set of data that would be very nice to have, like a hearing test, because that is a very common thing that somebody complains about, and it would be nice to know that their hearing was fine when they transitioned.

Blood pressure might be a good thing to check, and so, I think that the thing that we probably ought to look at, or I would suggest to look at, -- from Mike Kussman's individual opinion is -- is to determine what data sets would be of great value longitudinally to track people but not necessarily doing everything to everybody.

THE CHAIRMAN. That is fair. Thanks.

Col. Hobbs, to what extent is the issue of ITOs and NMAs an issue of manpower or resources?

COL. HOBBS. Yes, sir. It is not an issue of manpower or resources. It is a process that we are working to continue to --

THE CHAIRMAN. So, it is an issue of leadership?

COL. HOBBS. It is the process that -- it is a process.

THE CHAIRMAN. Who commands the process?

COL. HOBBS. The leadership does command the process, sir.

THE CHAIRMAN. So, it is neither an issue of manpower or resources.

This is an issue of leadership.

Well, I am going to extend some compliments, because you identi-

fied a problem, and then took actions to correct the problem, right?

COL. HOBBS. Yes, sir.

THE CHAIRMAN. In the Army's evaluation of determining where some of the problems lie in regards to the ITOs and NMAs, was this -- I know you said a systemic problem. When you use that word "systemic," you are saying to me that, you know, Steve, this was not just isolated, this was not just regional, this was CONUS-wide or even worldwide. Is that what I am to interpret from the word "systemic" that you used in your opening testimony?

COL. HOBBS. Sir, I would say inconsistency throughout our system.

We would find that we would see the most problems where we have our larger volumes.

THE CHAIRMAN. Dr. Sigford, could you come forward? Would you state your background and credentials, please?

DR. SIGFORD. Yes, sir.

THE CHAIRMAN. Your full name.

DR. SIGFORD. Barbara Jean Sigford. I am a physician, physical medicine and rehabilitation, a physiatrist. I am chief of physical medicine and rehabilitation at the Minneapolis VA and also national program director for physical medicine and rehabilitation.

THE CHAIRMAN. Are you affiliated with the polytrauma center in Minneapolis?

DR. SIGFORD. Yes, I am.

THE CHAIRMAN. On my trip to the Minneapolis VA -- in particular, the polytrauma center -- I asked you what some of the problems you were having with some of the patients, and I appreciated your candor. You expressed some concern with regard to the medical records on patients from Landstuhl, Germany.

So, before you answer this question on this premise, will you, for the record, explain what the polytrauma center is, how many we have, what is the purpose of the polytrauma center?

DR. SIGFORD. Yes, sir. We have four polytrauma rehabilitation centers which were designated in February, our first meeting in --

THE CHAIRMAN. Where are they located?

DR. SIGFORD. I am sorry?

THE CHAIRMAN. Where are they located?

DR. SIGFORD. They are located in Richmond, Virginia; Tampa, Florida; Minneapolis, Minnesota; and Palo Alto, California.

Their purpose is to provide rehabilitation care for severely injured service members or National Guard, reservists.

THE CHAIRMAN. Now the purpose of the polytrauma center is what?

DR. SIGFORD. To provide rehabilitation care and associated medical care that is a continuing need after their transfer from a military treatment facility.

THE CHAIRMAN. So, these are active duty soldiers.

DR. SIGFORD. The majority are, yes.

THE CHAIRMAN. So, they are with you for a point in time, and then they transfer back to a military medical treatment facility or they could be potentially discharged on-site

DR. SIGFORD. That is correct.

THE CHAIRMAN. The issue on medical records -- can you tell me about it?

DR. SIGFORD. Our current access to medical records is through a paper copy of medical records. We do not have access to an -- through an electronic system for medical records. So, we rely on paper copies, hard copies of the medical records to provide the care for the individuals that are transferred to our facilities.

We receive that information either via fax or physically accompanying the service member when they arrive.

THE CHAIRMAN. These patients -- now we are getting in on the issue of seamless. We are going to go right down to it on patient care.

What kind of problems are some of the doctors running into when, all of a sudden, you receive that active duty patient and you do not have all the medical records? What is happening?

DR. SIGFORD. Well, I believe probably the example I gave you when you visited Minneapolis about the soldier who was transferred to us from Landstuhl was perhaps the most complex problem we have faced, and that was an individual who had had emergency surgery, abdominal surgery, in Landstuhl. Those records did not follow him to the military treatment facility and, thusly, did not follow him to the VA. We then had to use teleconferencing to receive the information we needed to provide the continued required care for his abdominal injuries, and I think that is probably the most complex situation, but we do follow up with phone calls and direct one-to-one conversations.

THE CHAIRMAN. These active duty liaisons that are at the four polytrauma centers -- pretty important?

DR. SIGFORD. Yes.

THE CHAIRMAN. Why?

DR. SIGFORD. They provide us with a military presence for individuals, our active duty individuals, which is greatly appreciated by the men and women who have served in the armed forces, as well as their families. They really appreciate having this military presence. They also are able to make connections back to the military treatment facility, often assisting us with accessing the information in medical records which may not have followed the individual directly, and then they are also able to help with benefits, the boarding process, the travel orders, invitational travel orders, and other processes like that in the seamless transition process.

THE CHAIRMAN. Having the opportunity to speak to some of the families, you know, they expressed some real concern. They were in an I don't know land, and VA extending support, Fisher House support

-- you have heard the testimony of Col. Hobbs, representing the Office of the Surgeon General, United States Army, and corrective action taken. What is happening on the ground, though? Are you able to testify with regard to that?

DR. SIGFORD. In terms of support to families?

THE CHAIRMAN. Support to the families.

DR. SIGFORD. I can speak mostly from my experience at Minneapolis, and that is we do have a Fisher House. We have a very active voluntary services program, many people who want to donate and support these families, and I believe, while I don't know the specifics at each of the polytrauma centers, each has developed their own programs individually and specific to their areas.

We have case managers who are assigned to the service members and their families to be at their disposal, to help problem solve and provide support.

We provide them with lodging, and often additional activities and amenities as needed.

THE CHAIRMAN. All right.

Seamless Transition is this large umbrella term. It is, isn't it? So many things are covered underneath it, and the structure is very large.

I know, Secretary Mansfield, you have an office dedicated, but it is for a limited scope, is it not? It is regarding the active being treated in your facilities and those with whom you may have contractual relationships with at large.

SECRETARY MANSFIELD. The office that Mr. Brown heads up is concentrated on the seriously injured active duty member that is coming from a military treatment facility.

THE CHAIRMAN. Okay.

Well, this is going to be -- the seamless transition issue, I just want all of you to know, is going to be a continuous dialogue.

I mean there are -- Secretary Mansfield, you have been around the block a few times, and so, you know that there are certain issues out there that are called maintenance issues, right, and you are aware of the interest of the full Committee on a bipartisan basis on the issue, not only of this Committee but also of the Armed Services Committee, and Dr. Jones, if you can please express up the chain to Secretary Chu with regard to our concerns about the two defense bills and implementation, we think it is important. I know there is a lot on your plate, and there is a lot of contingencies and a lot of things that you are doing, a lot of things that the nation calls upon you to do, and you are stretched pretty thin.

So, I am not here to beat up on you. I am just concerned, as you are, about the soldier and the sailor, the airman, Marine, the Coast Guardsman, and the reserve components, and they should never be caught in bureaucracies, right, and it is how we move them from one

system to the other.

So, we have got these systems that try to have their separate identities, yet there needs to be that cohesion, a system that is synergistically intertwined, pretty important, and figuring out how to do all that is not easy.

Let me shift gears.

Does anybody have anything they would like to comment with regard to the issues on seamless transition before I move into a separate, completely different area?

[No response.]

THE CHAIRMAN. No?

Hearing none, let me ask a question with regard to -- under this issue on seamless and collaboration, is there anything going on right now between DOD and VA with regard to Hurricane Katrina and Rita that I should know about with regard to collaboration between VA and DOD?

SECRETARY MANSFIELD. Sir, I would make the point that I think, although I would have to go back to the operations office and double-check, that we were collaborating at the point in time over the weekend, as required both under the plan and, as we usually do, informally, and had the VA, I think, can say we had our needs met as far as DOD goes.

DR. JONES. Mr. Chairman, one of the things that we were working on early, before the storm, was to move approximately 3,000 patients who were in hospitals or in nursing homes to other facilities who were not in harm's way, and of course, the VA military health treatment facilities, and of course, commercial hospitals, were used to move those patients very successfully, and so, that was one instance where the plan worked and we worked together, along with others in the community.

THE CHAIRMAN. All right.

I know this was not the subject area of this hearing. Congress is also a large organization, and we all have different responsibilities.

I also serve on the Katrina Committee, and I am going to ask that you also pass this word along that the time-lines of the response, pre-landfall and post-landfall, with regard to Hurricane Katrina is going to be important, and Congressman Thornberry of the Armed Services Committee is also on the Katrina Committee.

Our responsibility is to look at the facts, not about assessing blame.

We want to figure out who did what, when, where, and then we can get into the issues of what changes, if any, need to be made.

So, please recognize that I will be coming with regard to obtaining the facts from DOD, the Guard Bureau, equally, please extend this, and to the VA.

I will also be into the Coast Guard and the medical side on this one.

So, I know that, VA, you had standing up an operations center, and I am sure that you have got to have a paper trail here at the ops center, do you not, Secretary Mansfield?

SECRETARY MANSFIELD. Yes, sir. We have a chronological, you know, day-by-day report that comes out of that center. They are working right now on the lessons learned, which is a built-in part of our system, also.

THE CHAIRMAN. I just want you gentlemen to know that that tasking is coming, all right? So, this report has to be done by mid-February.

So, when I show up with a team, I don't want you to say, okay, we will get you the answers.

Please put together what is necessary, and we are going to have to do -- obviously, the logistical function on DOD is pretty important.

We are focusing this to your role and mission with regard to the national response plan, okay? That is where I am going with this, okay?

All right.

I want to thank you for coming. I want to thank you for your testimony.

Ms. McAndrew, thank you very much for coming here. The two principals have heard your testimony. That is extremely important, and please extend my regards to Lt. Gen. Kiley and Maj. Gen. Webb, all right?

Again, let me thank you for the leadership in the Guard Bureau and the VA for that memorandum; pretty important.

Dr. Jones?

DR. JONES. Thank you, sir.

THE CHAIRMAN. Thank you very much for being here.

This hearing is now concluded.

[Whereupon, at 2:24 p.m., the Committee was adjourned.]

APPENDIX

Honorable John Boozman
Hearing on Seamless Transition
September 28, 2005

Good morning. Mr. Chairman, thank you for holding this important hearing. We are here today to determine how good a job we are doing to ensure that as servicemembers leave the military, they are aware of and know how to access the various programs available to them.

As you know, last week, I chaired the Subcommittee on Economic Opportunity field hearing to examine the New Hampshire Transition Assistance Program to reintegrate members of the Guard following extended deployments to Iraq. I was very pleased that Mr. Bradley, and Mr. Michaud were able to join me at Pease AFB. And I was especially pleased with what we heard from our witnesses. In a nutshell, New Hampshire is doing it right and I hope the witnesses from the National Guard Bureau and other federal agencies will export those best practices around the nation.

The first lesson I took away from the hearing is involving the families of the soldiers pre-, during-, and post-deployment in a program of education and counseling is vital. The second most important issue is that the Army must make several days of active duty drill time available to the returning Guard units to conduct this early-intervention-type program. Third, the VA Vet Center system plays a key role in minimizing post-deployment demobilization readjustment issues and fourth, the National Guard Bureau needs to impose these best practices across the nation.

The New Hampshire Guard has designed a program call "Reunion and Reentry" for returning Guardsmen and their families. The program makes use of resources from VA, VETS, Small Business Development Centers, and state agencies such as the employment service and highway patrol. Guard personnel involved included those from combat arms and support units.

To design the program, Col Deb Carter, the NHG HR officer, met with leaders from the 82nd Airborne, Marines and Navy to determine best practices. Next, they lined up the agencies to train 300 full time staff and 500 family members in in suicide prevention, PTSD, and access to resources. They also got permission from the Army/NG Bureau to use several annual drill days to run the program. The soldiers went through the standard 5-day Army demobilization at Ft. Dix and returned home. Then they were given one day off to reunite with their families and recalled to participate in a 3-day TAP featuring education on stress-related issues, myths/expectations on reunion, strategies for success, and some of the usual briefings involving VA benefits, etc. They were also introduced to the 17 Vet Center staff assembled from throughout the 6 New England states and began 1:1 counseling sessions.

The lesson here is that there probably isn't anything really new here, but it's the packaging, inter-agency cooperation, and aggressive implementation that has made it a success. NHG officers believe their pro-active stance has significantly reduced post-deployment problems and are very confident that in the long run, the attention paid to these soldiers will result in higher retention and morale. To put that in bean-counter terms, that means lower recruiting, retention, and training costs that far outweigh the costs for Guard TAP.

Rep. Jeff Miller (FL-01)

Statement of Representative Jeff Miller
House Veterans Affairs Committee
Oversight Hearing on Efforts by the Department of Defense and Department of Veterans Affairs Regarding the Seamless Transition of Service Personnel from Active Duty to Veterans' Status
September 28, 2005

Thank you, Mr. Chairman.

Now, more than ever, it is imperative that we address the needs of our servicemen and –women who are returning home every day, patriots who felt the call of duty to protect our liberty. Our duty to them is to make their transition back to our society as seamless as possible. I am glad to see that it has been an initiative of this Committee and Administration to facilitate our service members' transition to civilian life, and very much look forward to hearing today about what successes we have had and how current and future needs will be addressed.

With five military installations in my district and one of the largest veteran populations nationwide, I constantly see the need to address veterans' transition to civilian life. Clearly, a great first step for this is with the cooperation of the Department of Veterans Affairs and the Department of Defense. By getting these two vastly important government organizations to work together toward this common goal, considerable progress will be made in showing our veterans that we are truly thankful for all that they have done for this great Nation. I have seen within my district examples of local level sharing between these two agencies and know that continued efforts in that direction will bring us closer to the realization of Seamless Transition as opposed to the concept that it has been for the past twenty years.

Our armed forces dedicate their lives to the strength and survival of our nation, and willingly place themselves in danger to secure peace and freedom. I look forward to working with my colleagues and the Administration to do our part to make sure that our nation's duty to you is done.

I look forward to receiving the testimony from the distinguished witnesses who are before us today. I thank each of for your service, and appreciate the information that you will provide. It's going to help us move significantly closer to achieving a long-overdue goal.

Thank you.

United States Government Accountability Office

GAO

Testimony
Before the Committee on Veterans' Affairs, House of Representatives

For Release on Delivery
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VA AND DOD HEALTH CARE

VA Has Policies and Outreach Efforts to Smooth Transition from DOD Health Care, but Sharing of Health Information Remains Limited

Statement of Cynthia A. Bascetta
Director, Health Care

GAO-05-1052T

September 28, 2005

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Highlights

Highlights of GAO-05-1052T, a testimony before the Committee on Veterans' Affairs, House of Representatives

VA AND DOD HEALTH CARE

VA Has Policies and Outreach Efforts to Smooth Transition from DOD Health Care, but Sharing of Health Information Remains Limited

Why GAO Did This Study

Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) servicemembers and those who are discharged from military service may receive health care from the Department of Veterans Affairs (VA). Since the onset of OIF and OEF, the Department of Defense (DOD) has reported that more than 15,000 servicemembers have been wounded in combat. Those who are seriously injured require comprehensive health care services and may be treated at either DOD or VA medical facilities. Because VA is expected to provide health care to many of the injured OIF and OEF servicemembers, concerns have been raised about the ease with which these individuals and their health care information transition from DOD's to VA's health care system.

This statement is based on GAO's preliminary work on "seamless transition" and focuses on (1) the policies and outreach efforts that VA has instituted to provide timely access to health care to OIF and OEF servicemembers and (2) the extent to which individually identifiable health information is shared systematically between DOD and VA. Since GAO's work is still in the early stages of review, the statement is limited to information gathered to date.

What GAO Found

Since 2002, VA has developed policies and procedures that direct its medical facilities to provide OIF and OEF servicemembers timely access to care. Most notably, VA

- assigned VA social workers to selected military treatment facilities in August 2003,
- directed VA facilities to designate combat case managers in October 2003, and
- directed the establishment of four VA polytrauma centers for OIF and OEF servicemembers in June 2005.

In January 2005, VA established the Seamless Transition Office to further improve coordination within the Veterans Benefits Administration and the Veterans Health Administration as well as between DOD and VA. In addition, VA has increased outreach efforts by providing OIF and OEF servicemembers who have been discharged with personal letters and newsletters, a Web site for health information tailored to OIF and OEF servicemembers, counseling services, and briefings on available VA health care services. GAO is in the beginning stages of reviewing VA's efforts to provide a smooth transition from DOD health care and has not yet evaluated the effectiveness of VA's related policies, procedures, and outreach initiatives.

An important issue associated with transitioning servicemembers to VA health care is the sharing of health care information between DOD and VA. The two departments have signed a memorandum of understanding for sharing individually identifiable health information, but the memorandum does not specify the particular types of individually identifiable health information that will be exchanged and when the information will be shared. The absence of specific procedures continues to hinder VA's efforts to obtain needed health information from DOD. Recently, DOD has begun to share certain health assessment information with VA on individuals who have been discharged from the military, and the transmitting of this information to VA on a routine basis is expected to occur in October 2005. However, according to VA officials, DOD is not providing health assessment information to VA for Reserve and National Guard members, who comprise 35 percent of the OIF and OEF forces.

www.gao.gov/cgi-bin/getrpt?GAO-05-1052T.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Cynthia A. Bascetta at (202) 512-7101 or bascettac@gao.gov.

Mr. Chairman and Members of the Committee:

Thank you for inviting me to share our work to date on the Department of Veterans Affairs' (VA) collaboration with the Department of Defense (DOD) to ensure that servicemembers are able to make a "seamless transition" from DOD health care to VA health care services. Servicemembers, under certain conditions,[1] and those who are discharged from service may receive health care from VA. On September 20, 2005, DOD reported that more than 15,000 servicemembers had been wounded during Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF).[2] Many return to active duty after they are treated, but those who are seriously injured require comprehensive health care services and may undergo a medical evaluation to determine their ability to stay in the military. Because VA is expected to provide health care for injured OIF and OEF servicemembers, including those who have been discharged, concerns have been raised about the ease with which these individuals transition from DOD's to VA's health care system.

My remarks today are based on preliminary work done on this issue and focus on (1) the policies and outreach efforts that VA has instituted to provide timely access to care to OIF and OEF servicemembers and (2) the extent to which individually identifiable health information is shared systematically between DOD and VA.

In conducting our review, we interviewed DOD, National Guard, Reserve, and VA officials and obtained documents on relevant policies, procedures, and VA outreach materials. Among these documents, we reviewed the June 29, 2005, memorandum of understanding (MOU) for the sharing of data between DOD and VA and the applicable law and regulations that govern the sharing of individually identifiable health information. In addition, we examined issues related to eligibility and medical staff roles and responsibilities. We also visited the two DOD medical facilities that receive and treat most of the seriously injured OIF and OEF

[1]Generally, VA supplements care that is not available from DOD or when the demand for such care cannot be met by DOD.

[2]OIF, which began in March 2003, supports combat operations in Iraq and other locations. OEF, which began in October 2001, supports combat operations in Afghanistan and other locations.

servicemembers and two VA medical centers that also treat them.[3] We did our work from May 2005 through September 2005 in accordance with generally accepted government auditing standards.

In summary, VA has developed policies and procedures that direct its medical facilities to provide OIF and OEF servicemembers timely access to care. VA has also increased outreach efforts by providing OIF and OEF servicemembers who have been discharged with personal letters and newsletters, a Web site for health information tailored to OIF and OEF servicemembers, counseling services, and briefings on available VA health care services. We are in the beginning stages of our review of VA's efforts to provide a smooth transition from DOD health care and have not yet evaluated the effectiveness of VA's related policies, procedures, and outreach initiatives. We are reviewing the implementation of these efforts in our ongoing work for this committee.

An important issue associated with transitioning servicemembers to VA health care is the sharing of health care information between DOD and VA. Currently, DOD does not have specific procedures for routinely transmitting to VA health information on servicemembers who are likely to be discharged from the military due to their medical condition. Recently, DOD has begun to share certain health assessment information with VA on individuals who have separated from the military, and the transmitting of this information to VA on a routine basis is expected to occur in October 2005. However, according to VA officials, DOD is not providing health assessment information to VA for Reserve and National Guard members, who comprise 35 percent of the OIF and OEF forces.

Background

Since the onset of OIF and OEF, over 1 million servicemembers have been deployed. As of the end of June 2005, more than 393,000 active duty, Reserve, and National Guard servicemembers from OIF and OEF have separated from active duty. Of these, over 100,000 have sought health care services from VA, including over 2,400 who received inpatient care at VA medical centers. The Reserves and National Guard account for about 54,000 of those servicemembers who sought health care services from VA. The three most common health problems have been musculoskeletal

[3]The DOD facilities were Walter Reed Army Medical Center and the National Naval Medical Center; the VA facilities were the Augusta VA Medical Center and the Richmond VA Medical Center.

ailments (primarily joint and back disorders), dental problems, and mental health disorders.

Servicemembers injured during OIF and OEF are surviving injuries that would have been fatal in past conflicts. In World War II, 30 percent of Americans injured in combat died; this proportion dropped to 24 percent for those injured in the Vietnam War and further dropped to about 10 percent for those injured in OIF and OEF. Many of the injured OIF and OEF servicemembers are returning with severe disabilities, including traumatic brain injuries and missing limbs.

About 65 percent of OIF and OEF combat injuries are from improvised explosive devices, blasts, landmines, and fragments. Of those injured personnel, about 60 percent have some degree of traumatic brain injury and may require comprehensive inpatient rehabilitation services to address complex cognitive, physical, and mental health issues resulting from trauma. Traumatic brain injuries may cause problems with cognition (concentration, memory, judgment, and mood), movement (strength, coordination, and balance), sensation (tactile sensation and vision), and emotion (instability and impulsivity). The Department of Health and Human Services' Centers for Disease Control and Prevention reports that an estimated 15 percent of persons who sustain a mild brain injury continue to experience symptoms 1 year after injury.

Initially, most severely injured servicemembers, including Reserve and National Guard members, are brought to Landstuhl Regional Medical Center in Germany for treatment. From there, they are transported to appropriate U.S. military medical facilities, with most of the seriously injured admitted to Walter Reed Army Medical Center or the National Naval Medical Center, both located in the Washington, D.C., area. Once these servicemembers are medically stabilized, many are relocated closer to their homes or military commands and continue recovering either on an inpatient or outpatient basis at a VA medical facility, a DOD military treatment facility (MTF), or DOD civilian provider.[4]

Those who have served, or are now serving, in OIF and OEF may receive care from VA for conditions that are or may be related to their combat

[4]DOD provides health care to beneficiaries through its TRICARE program. TRICARE beneficiaries can obtain health care through DOD's direct care system of military hospitals and clinics, commonly referred to as MTFs, and through DOD's purchased care system of civilian providers.

services for a 2-year period following the date of their separation from active duty without copayment requirements. Following this 2-year period, they may continue to receive VA care but may be subject to a copayment for their health care.

To ensure that servicemembers engaged in conflicts receive the health care services they need, Congress passed legislation in May 1982 that authorized VA to provide medical services to members of the armed forces during and immediately following wartime or national emergencies involving the armed forces in armed conflict.[5] The law authorized the Secretary of VA to give servicemembers responding to or involved in a war or national emergency a higher priority for medical services than all veterans, except those with a service-connected disability.[6] VA has established an enrollment system to manage veterans' access to care. This system includes eight priority categories for enrollment, with higher priority given to veterans with service-connected disabilities, lower incomes, or other recognized statuses such as former prisoners of war.

Separation from the military and return to civilian life may entail the exchange of individually identifiable health information between DOD and VA. The exchange of this information must comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)[7] and the HIPAA Privacy Rule, which became effective April 14, 2001.[8] The HIPAA Privacy Rule permits DOD and VA to share servicemembers' health information under certain circumstances, such as for continuity of health care treatment or if the individual signs a proper authorization.

[5]The Veterans' Administration and Department of Defense Health Resources Sharing and Emergency Operations Act, Pub. L. No. 97-174, §4(a), 96 Stat. 70, 74-75.

[6]A service-connected disability is an injury or disease that was incurred or aggravated while on active military duty.

[7]Pub. L. No. 104-191, 110 Stat. 1936 (1996).

[8]The HIPAA Privacy Rule applies to covered entities and specifies how individually identifiable health data may be used and disclosed by covered entities. See 45 C.F.R. § 164.500(a), 164.502 (2004). Covered entities are defined in the HIPAA Privacy Rule as health plans, clearinghouses, and certain health care providers. Both DOD's health care system and VA's health care system are covered entities. See 45 C.F.R. § 160.103 (2004). All covered entities had to comply with the HIPAA Privacy Rule by April 14, 2003, with the exception of small health plans.

VA Has Established Policies and Outreach Efforts Intended to Smooth the Transition from DOD Health Care

VA has taken several steps to provide OIF and OEF servicemembers with timely access to health care and information on health care services. These steps include setting policies and developing outreach efforts targeting OIF and OEF servicemembers.

Recent VA Policies Designed to Facilitate Transition to VA Health Care

Since 2002, VA has issued a memorandum and four directives addressing eligibility criteria and the health care needs of recently discharged servicemembers.[9]

- A September 2002 directive established policies and procedures for offering hospital care, medical services, and nursing home care to recently discharged servicemembers for a 2-year period, beginning on their discharge date, for any illness, without requiring proof of its link to military service.[10] Under this directive, these veterans are enrolled in the lowest priority category for service-connected veterans.
- In April 2003, when the President declared a national emergency with respect to the conflict in Iraq, the Secretary of VA issued a memorandum authorizing VA to give priority health care to servicemembers who sustained an injury, over veterans and others eligible for VA care, except those with service-connected disabilities.
- An October 2003 directive (1) provided instructions to VA employees for determining the eligibility of recent combat veterans to be enrolled for VA health care; (2) required each VA medical facility to designate a clinically trained combat case manager, usually a social worker or nurse, to coordinate all of the medical care and services provided to recent combat veterans by VA and non-VA agencies until the veterans no longer need care; and (3) required VA medical facilities to designate a point of contact—administrative staff, social worker, or nurse—to receive and expedite transfers of servicemembers from MTFs to VA medical facilities and coordinate with VA's combat case managers.[11]

[9]VA sometimes refers to individuals who served in combat after the Gulf War or during a period of hostilities after November 11, 1998, as "recent combat veterans". Our reference to discharged servicemembers includes deactivated Reserve and National Guard members.

[10]VHA Directive 2002-049, *Combat Veterans are Eligible for Medical Services for 2-Years After Separation from Military Service Notwithstanding Lack of Evidence for Service Connection*, September 11, 2002.

[11]VHA Directive 2003-061, *Combat Veteran Intake Processing and Software Implementation*, October 23, 2003.

- A June 2005 directive specified the dates of service and combat locations to determine whether recent combat veterans are eligible for health care services.[12]
- Another June 2005 directive expanded the scope of care at VA's four regional traumatic brain injury rehabilitation centers and redefined these facilities as polytrauma rehabilitation centers.[13] These centers' inclusion of psychological treatment for family members and rehabilitation services using high-technology prosthetics reflect VA's intention to provide more coordinated care for patients, including the growing number of OIF and OEF servicemembers with severe and disabling trauma.[14] The directive states that coordination of care, including intensive clinical and social work case management services,[15] is essential in these severe trauma cases, as patients transition from acute hospitalization through acute rehabilitation and ultimately to their home communities.

In addition to VA's directives, a joint DOD and VA program was established in August 2003 to assign VA social workers to selected MTFs to coordinate patient transfers between MTFs and VA medical facilities.[16] The social workers make appointments for care, ensure continuity of therapy and medications, and followup with patients to verify success of

[12]VHA Directive 2005-020, *Determining Combat Veteran Eligibility*, June 2, 2005. Both this and the October 2003 directive allow VA to provide health care services to a veteran without proof of combat service. If VA later determines that the veteran is not a recent combat veteran, VA will reevaluate the veteran's eligibility.

[13]VHA Directive 2005-024, *Polytrauma Rehabilitation Centers*, June 8, 2005. The four centers are located in Minneapolis, Minnesota; Palo Alto, California; Richmond, Virginia; and Tampa, Florida.

[14]Because of the high percentage of veterans from OIF and OEF who are surviving multiple massive injuries, Congress mandated that VA establish polytrauma rehabilitation centers for research, education, and clinical activities for servicemembers with complex combat injuries. See the Veterans Health Programs Improvement Act of 2004, Pub. L. No. 108-422, § 302, 118 Stat. 2379, 2383-86.

[15]Case management includes assessment of the individual's health care needs, care planning and implementation, referral coordination, monitoring, and periodic reassessment of the individual's care needs.

[16]Five MTFs were originally selected because they received most of the OIF and OEF casualties. The MTFs were Walter Reed Army Medical Center (Washington, D.C.), Brooke Army Medical Center (San Antonio, Texas), Dwight David Eisenhower Army Medical Center (Augusta, Georgia), Madigan Army Medical Center (Tacoma, Washington), and the National Naval Medical Center (Bethesda, Maryland). In 2004 and 2005, three additional MTFs—Darnall Army Community Hospital (Fort Hood, Texas), Evans Army Community Hospital (Fort Carson, Colorado), and the Naval Hospital Camp Pendleton (Camp Pendleton, California)—were added to care for returning OIF and OEF servicemembers.

the discharge. By mid-July 2005, the social workers had received 3,907 requests for transfer of care—almost two-thirds of them had been transferred to VA facilities; the rest were pending. Further, VA benefits counselors work with the social workers to inform servicemembers about VA benefits and to initiate paperwork for disability compensation claims, vocational rehabilitation and employment assistance, and other VA benefits.

Also in August 2003, VA created the Taskforce for the Seamless Transition of Returning Service Members. The taskforce, composed of senior VA leadership, focused on developing and implementing VA policies to improve the transition of injured servicemembers to civilian life. In January 2005, VA established the Seamless Transition Office to further improve coordination within the Veterans Benefits Administration and the Veterans Health Administration as well as between DOD and VA.[17] The goals of the Seamless Transition Office include improving communication, coordination, and collaboration within VA and with DOD with respect to health care; educating VA staff about veteran's health care and other needs; and ensuring that policies and procedures are in place to enhance the transition from servicemember to veteran. The Seamless Transition Office uses the taskforce in an advisory capacity.

To help ensure that VA staff assisting OIF and OEF servicemembers can be responsive to their health care needs, the agency created an internal Web site to provide a single source of access to VA policies, procedures, and directives for wounded, ill, and seriously injured servicemembers and veterans. According to VA, the internal Web site also includes a list of the points of contact at medical facilities and articles about transition-related activities.

VA Outreach Efforts to OIF and OEF Servicemembers

VA has instituted several outreach strategies to provide information about the health care services available to OIF and OEF servicemembers who have been discharged. These include the use of newsletters, personal letters, an external Web site, counseling services, and briefings on VA benefits and services.

[17]The Veterans Benefits Administration provides benefits and services, such as disability compensation, to veterans. The Veterans Health Administration's primary responsibility is the delivery of health care to veterans.

Using DOD rosters of OIF and OEF servicemembers who have separated from active duty, VA sends newsletters and personal letters with pertinent information to these new veterans. VA has sent three newsletters since December 2003, with information on benefits and health issues specific to OIF and OEF veterans. In addition, the Secretary of VA sends these new veterans a letter thanking them for their service to the country and informing them about VA health care services and assistance to aid in their transition to civilian life. The letter includes a toll-free number for obtaining information on VA health care and two brochures on VA health care as well as benefit information, including disability compensation, education and training, vocational rehabilitation and employment, home loans, and life insurance. In addition, the Secretary of VA has sent letters to all the Adjutants General and Chiefs of the Reserves to inform them of VA services and benefits.[18]

VA has also sought to improve access to health care information. It created a Web site that provides information specific to those who served in OIF and OEF, such as information on VA health and medical services; dependents' benefits and services; transition assistance; and benefits for active duty military, Reserve, and National Guard personnel.[19] In addition, VA developed a wallet-sized card with relevant toll-free telephone numbers and Web site addresses. VA officials reported that the agency has distributed 1 million copies of this wallet card.

VA has enhanced outreach to those who served in OIF and OEF and their families through its Vet Center Readjustment Counseling Service, consisting of 207 centers. Vet Centers function as community points of access by providing information and referrals to VA medical facilities. Additionally, they offer counseling, employment services, and a range of social services to assist individuals in readjusting from wartime military service to civilian life. VA reported that during 2004, it hired 50 peer counselors and placed them at Vet Centers where significant numbers of servicemembers were returning from OIF and OEF. According to a VA official, VA is in the process of hiring an additional 50 peer counselors.

Briefings are another form of outreach used by VA to inform OIF and OEF servicemembers about health care services.

[18]Each state has an Adjutant General overseeing all Army and Air Force National Guard units in the state.

[19]The Web site can be accessed through VA's home page at www.va.gov.

- From fiscal year 2001 through the third quarter of fiscal year 2005, VA held more than 30,800 briefings on VA benefits for more than 1.1 million servicemembers.[20] These briefings include about 3,700 predeployment and postdeployment briefings for about 230,000 activated Reserve and National Guard servicemembers.[20] VA held some of these briefings aboard the USS Constellation, the USS Enterprise, and the USS George Washington during the return of these vessels from the Persian Gulf to the United States.
- VA's staff from the Seamless Transition Office have given educational briefings on VA services and benefits to senior leadership in the National Guard and the Army Reserve. Under a May 2005 memorandum of agreement between VA and the National Guard, VA is in the process of making staff available to provide briefings to Guard units in each state.

Sharing of Health Information between DOD and VA Is Limited

An important issue in providing a smooth transition from DOD's to VA's heath care system is the sharing of individually identifiable health information. In its May 2003 report, the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans stated that "a seamless transition from military service to veteran status is especially critical in the context of health care, where readily available, accurate, and current medical information must be accessible to health care providers." The task force further stated that increased collaboration is needed between the departments for the transfer of personnel and health information. DOD and VA officials have told us that health information is being shared when injured servicemembers are transferred from DOD to VA medical facilities.[21] For OIF and OEF servicemembers who may potentially use VA services, DOD and VA share some types of administrative data, such as individuals' names and addresses; however, the sharing of health information between the two departments remains limited.

As we reported at a hearing in May 2005, DOD and VA did not have an agreement—after 2 years of discussion—that specifies what types of individually identifiable health information can be exchanged and when they may be shared.[22] Shortly after the hearing, DOD and VA signed an

[20]VA could not report how many of these were OIF and OEF servicemembers.

[21]The HIPAA Privacy Rule permits the sharing of health information for continuity of health care treatment purposes.

[22]GAO, *DOD and VA: Systematic Data Sharing Would Help Expedite Servicemembers' Transition to VA Services*, GAO-05-722T (Washington, D.C.: May 19, 2005).

MOU for the sharing of individually identifiable health information.[23] The MOU constitutes an agreement on the circumstances under which DOD and VA will exchange individually identifiable health information and includes references to provisions of the HIPAA Privacy Rule and applicable laws that permit sharing. The MOU does not specify particular types of individually identifiable heath information that will be exchanged and when the information will be shared. The absence of specific data sharing procedures continues to hinder VA's efforts to obtain needed health information from DOD.

For example, DOD does not have specific procedures to routinely provide VA with health information on servicemembers who have injuries or illnesses that preclude them from continuing on active duty and, as a result, are being evaluated by a DOD physical evaluation board (PEB) for separation from the military.[24] According to VA officials, if a list of these individuals were transmitted routinely to VA, it would enable VA to contact the individuals to make the appropriate transfer of health care to a VA medical facility before the individuals are discharged from the military. Such information could reduce the potential for interruption to these individuals' health care treatment plans. DOD officials told us that they are in the process of developing a policy directive that would establish procedures for sharing information with VA on servicemembers who are entering the PEB process, but they could not determine when this policy directive would become effective.

Recent progress in VA and DOD data sharing involves a health assessment questionnaire that DOD requires servicemembers to complete following deployment.[25] This document contains, among other things, self-reported information about a servicemember's potential exposure to toxic substances and includes four questions that can be used to identify individuals at risk of developing post-traumatic stress disorder. In July 2005, DOD transmitted to VA postdeployment health assessment data for

[23]VA signed the MOU in May 2005 and DOD signed it in June 2005.

[24]Military PEBs recommend whether servicemembers are physically unfit to perform their military duties and should be placed on disability retirement or discharged from military service.

[25]All servicemembers who are deployed outside of the United States for 30 or more days to locations without treatment facilities must complete a postdeployment health assessment questionnaire, DD 2796. DOD uses this questionnaire to determine the presence of any physical ailments or mental health issues commonly associated with deployments.

those individuals who have been discharged from the military. According to VA officials, DOD is expected to transmit these data monthly beginning in October 2005. For these individuals, VA clinicians will be able to access the data through VA's computerized medical record system when the individuals seek VA health care services. However, according to VA officials, DOD is not providing health assessment information to VA for Reserve and National Guard members, who comprise 35 percent of the OIF and OEF forces.

In addition to individual health information from the postdeployment questionnaire, VA officials state that the agency could use aggregate data from the questionnaire to plan for the needs of current servicemembers who may one day be eligible for health care and benefits from VA. This is consistent with an observation made by the President's task force that comprehensive servicemember health data are essential for forecasting and preparing for changes in the demand for health care services. Currently, the data from the individual postdeployment assessments are not accessible in a format that can be aggregated and manipulated to provide the desired trend information.

Mr. Chairman, this concludes my prepared remarks. I will be pleased to answer any questions you or other members of the committee may have.

Contacts and Acknowledgments

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Related GAO Products

Military and Veterans' Benefits: Improvements Needed in Transition Assistance Services for Reserves and National Guard. GAO-05-844T. Washington, D.C.: June 29, 2005.

Military and Veterans' Benefits: Enhanced Services Could Improve Transition Assistance for Reserves and National Guard. GAO-05-544. Washington, D.C.: May 20, 2005.

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Testimony before the Committee on Veterans' Affairs, House of Representatives

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COMPUTER-BASED PATIENT RECORDS:

VA and DOD Made Progress, but Much Work Remains to Fully Share Medical Information

Statement of Linda D. Koontz
Director, Information Management Issues

GAO-05-1051T

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Highlights

Highlights of GAO-05-1051T, a testimony before the Committee on Veterans' Affairs, House of Representatives

Why GAO Did This Study

For the past 7 years, the Departments of Veterans Affairs (VA) and Defense (DOD) have been working to exchange patient health information electronically and ultimately to have interoperable electronic medical records. Sharing medical information helps (1) promote the seamless transition of active duty personnel to veteran status and (2) ensure that active duty military personnel and veterans receive high-quality health care and assistance in adjudicating their disability claims. This is especially critical in the face of current military responses to national and foreign crises.

In testimony before the Veterans' Affairs Subcommittee on Oversight and Investigations in March and May 2004, GAO discussed the progress being made by the departments in this endeavor. In June 2004, at the Subcommittee's request, GAO reported on its review of the departments' progress toward the goal of an electronic two-way exchange of patient health records.

GAO is providing an update on the departments' efforts, focusing on (1) the status of ongoing, near-term initiatives to exchange data between the agencies' existing systems and (2) progress in achieving the longer term goal of exchanging data between the departments' new systems.

www.gao.gov/cgi-bin/getrpt?GAO-05-1051T.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Linda D. Koontz at (202) 512-6240 or koontzl@gao.gov.

September 28, 2005

COMPUTER-BASED PATIENT RECORDS

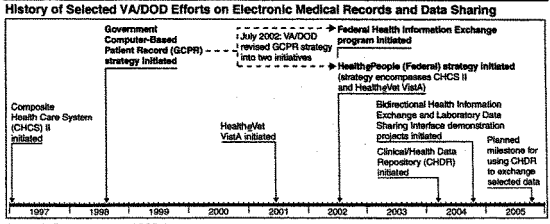
VA and DOD Have Made Progress, but Much Work Remains to Fully Share Medical Information

What GAO Found

In the past year, VA and DOD have begun to implement applications that exchange limited electronic medical information between the departments' existing health information systems. These applications are (1) Bidirectional Health Information Exchange, a project to achieve the two-way exchange of health information on patients who receive care from both VA and DOD, and (2) Laboratory Data Sharing Interface, an application used to electronically transfer laboratory work orders and results between the departments. The Bidirectional Health Information Exchange application has been implemented at five sites, at which it is being used to rapidly exchange information such as pharmacy and allergy data. Also, the Laboratory Data Sharing Interface application has been implemented at six sites, at which it is being used for real-time entry of laboratory orders and retrieval of results. According to the departments, these systems enable lower costs and improved service to patients by saving time and avoiding errors.

VA and DOD are continuing with activities to support their longer term goal of sharing health information between their systems (see figure), but the goal of two-way electronic exchange of patient records remains far from being realized. Each department is developing its own modern health information system—VA's HealtheVet VistA and DOD's Composite Health Care System II—and they have taken steps to respond to GAO's June 2004 recommendations regarding the program to develop an electronic interface that will enable these systems to share information. That is, they have developed an architecture for the interface, established project accountability, and implemented a joint project management structure. However, they have not yet developed a clearly defined project management plan to guide their efforts, as GAO previously recommended. Further, they have not yet fully populated the repositories that will store the data for their future health systems, and they have experienced delays in their efforts to begin a limited data exchange. Lacking a detailed project management plan increases the risk that the departments will encounter further delays and be unable to deliver the planned capabilities on time and at the cost expected.

History of Selected VA/DOD Efforts on Electronic Medical Records and Data Sharing



Source: GAO analysis of VA and DOD data.

Mr. Chairman and Members of the Committee:

I am pleased to participate in today's discussion on the actions taken by the Departments of Veterans Affairs (VA) and Defense (DOD) to promote the seamless transition of active duty personnel to veteran status. Among the two departments' goals for seamless transition is to be able to exchange patient health information electronically and ultimately to have interoperable[1] electronic medical records. Sharing of medical information is an important tool to help ensure that active duty military personnel and veterans receive high-quality health care and assistance in adjudicating their disability claims—goals that, in the face of current military responses to national and foreign crises, are more essential than ever.

For the past 7 years, VA and DOD have been working to achieve these capabilities, beginning with a joint project in 1998 to develop a government computer-based patient record. As we have noted in previous testimony,[2] the departments had achieved a measure of success in sharing data through the one-way transfer of health information from DOD to VA health care facilities. However, they have been severely challenged in their pursuit of the longer term objective—providing a virtual medical record in which data are computable. That is, rather than data being provided as text for viewing only, data would be in a format that the health information application can act on: for example, providing alerts to clinicians (of such things as drug allergies) and plotting graphs of changes in vital signs such as blood pressure. According to the departments, the use of such computable medical data contributes significantly to the usefulness of electronic medical records.

[1] Interoperability is the ability of two or more systems or components to exchange information and to use the information that has been exchanged.

[2] GAO, *Computer-Based Patient Records: Improved Planning and Project Management Are Critical to Achieving Two-Way VA–DOD Health Data Exchange*, GAO-04-811T (Washington, D.C.: May 19, 2004); *Computer-Based Patient Records: Sound Planning and Project Management Are Needed to Achieve a Two-Way Exchange of VA and DOD Health Data*, GAO-04-402T (Washington, D.C.: Mar. 17, 2004); and *Computer-Based Patient Records: Short-Term Progress Made, but Much Work Remains to Achieve a Two-Way Data Exchange Between VA and DOD Health Systems*, GAO-04-271T (Washington, D.C.: Nov. 19, 2003).

As of June 2004, when we last reported on this topic,[3] VA and DOD were continuing to define the data standards that are essential both for the exchange of data and for the development of interoperable electronic medical records. At that time, we identified weaknesses in the planning and management structure of the departments' program, and we recommended that the departments take a number of actions to address these weaknesses.

Also in 2004, in response to a mandate in the Bob Stump National Defense Authorization Act for Fiscal Year 2003,[4] VA and DOD initiated information technology demonstration projects focusing on near-term goals: the exchange of electronic medical information between the departments' existing health information systems. These projects are to help in the evaluation of the feasibility, advantages, and disadvantages of measures to improve sharing and coordination of health care and health care resources. The two demonstration projects (Bidirectional Health Information Exchange and Laboratory Data Sharing Interface) are interim initiatives that are separate from the departments' ongoing long-term efforts in sharing data and developing health information systems.

At your request, my testimony today will discuss the two departments' continued efforts to exchange medical information, with a specific focus on (1) the status of ongoing, near-term initiatives to exchange data between the agencies' existing systems and (2) progress in achieving the longer term goal of exchanging data between the departments' new systems, still in development, which are to be built around electronic patient health records.

In conducting this work, we reviewed the departments' documentation describing the two demonstration projects, including

[3] GAO, *Computer-Based Patient Records: VA and DOD Efforts to Exchange Health Data Could Benefit from Improved Planning and Project Management*, GAO-04-687 (Washington, D.C.: June 7, 2004).

[4] Pub. L. No. 107-314, §721 (a)(1), 116 Stat. 2589,2595 (2002). To further encourage on-going collaboration, section 721 directed the Secretary of Defense and the Secretary of Veterans Affairs to establish a joint program to identify and provide incentives to implement, fund, and evaluate creative health care coordination and sharing initiatives between DOD and VA.

business plans, budget summaries, and project status reports. We also reviewed documentation identifying the costs that the departments have incurred in developing technology to support the sharing of health data, including costs associated with achieving the one-way transfer of data from DOD to VA health care facilities, and ongoing projects to develop new health information systems. We did not audit the reported costs and thus cannot attest to their accuracy or completeness. We reviewed draft system requirements, design specifications, and software descriptions for the electronic interface between the departments' new health systems. We supplemented our analyses of the agencies' documentation with interviews of VA and DOD officials responsible for key decisions and actions on the health data-sharing initiatives. In addition, to observe the Bidirectional Health Information Exchange and Laboratory Data Sharing Interface capabilities, we conducted site visits to military treatment facilities and VA medical centers in El Paso and San Antonio, Texas, and Puget Sound, Washington. We conducted our work from June through September 2005, in accordance with generally accepted government auditing standards.

Results in Brief

In the past year, VA and DOD have begun to implement applications that exchange limited electronic medical information between the departments' existing health information systems. These applications were developed through two information technology demonstration projects: (1) Bidirectional Health Information Exchange is a project to achieve the two-way exchange of health information on shared patients,[5] and (2) Laboratory Data Sharing Interface is an application used to facilitate the electronic transfer/sharing of orders for laboratory work and the results of the work. The departments have implemented the Bidirectional Health Information Exchange application at five sites, at which it is being

[5] Shared patients receive care from both VA and DOD clinicians. For example, veterans may receive outpatient care from VA clinicians and be hospitalized at a military treatment facility.

used for the rapid exchange of specific types of information (pharmacy data, drug and food allergy information, patient demographics, and laboratory results[6] on shared patients). Also, the Laboratory Data Sharing Interface application has been implemented at six sites, at which it is being used for real-time entry of laboratory orders and retrieval of laboratory results. Although the data exchanged by these demonstration projects are in text form only (that is, they are not computable), the systems have significant benefits, according to the two departments, because they enable lower costs and improved service to patients by saving time and avoiding errors.

Since our last report on the departments' efforts to achieve a virtual medical record, VA and DOD have taken several actions, but the departments continue to be far from achieving the two-way electronic data exchange capability originally envisioned. The departments have implemented three recommendations that we made in June 2004: They have developed an architecture for the electronic interface between DOD's Clinical Data Repository and VA's Health Data Repository; they have established the VA/DOD Health Executive Council[7] as the lead entity for the project; and they have established a joint project management structure to provide day-to-day guidance for this initiative. Additionally, the Health Executive Council established working groups to provide programmatic oversight and to facilitate interagency collaboration on sharing initiatives between DOD and VA. However, VA and DOD have not yet developed a clearly defined project management plan that gives a detailed description of the technical and managerial processes necessary to satisfy project requirements, as we previously recommended. Moreover, the departments have experienced delays in their efforts to begin exchanging computable patient health data; they have not yet fully populated the data

[6] These data are text files providing surgical, pathology, cytology, microbiology, chemistry, and hematology test results and descriptions of radiology results.

[7] The VA/DOD Health Executive Council is composed of senior leaders from VA and DOD, who work to institutionalize sharing and collaboration of health services and resources. The council is cochaired by the VA Undersecretary for Health and DOD Assistant Secretary of Defense for Health Affairs, and meets every 2 months.

repositories that are to store the medical data for their future health systems. As a result, much work remains before the departments achieve their ultimate goal—interoperable electronic health records and two-way electronic exchange of computable patient health information.

Background

In 1998, following a presidential call for VA and DOD to start developing a "comprehensive, life-long medical record for each service member," the two departments began a joint course of action aimed at achieving the capability to share patient health information for active duty military personnel and veterans.[8] Their first initiative, undertaken in that year, was the Government Computer-Based Patient Record (GCPR) project, whose goal was an electronic interface that would allow physicians and other authorized users at VA and DOD health facilities to access data from any of the other agency's health information systems. The interface was expected to compile requested patient information in a virtual record that could be displayed on a user's computer screen.

In our reviews of the GCPR project, we determined that the lack of a lead entity, clear mission, and detailed planning to achieve that mission made it difficult to monitor progress, identify project risks, and develop appropriate contingency plans. In April 2001 and in June 2002,[9] we made recommendations to help strengthen the management and oversight of the project. In 2001, we recommended that the participating agencies (1) designate a lead entity with final decision-making authority and establish a clear line of authority for

[8] Initially, the Indian Health Service (IHS) also was a party to this effort, having been included because of its population-based research expertise and its long-standing relationship with VA. However, IHS was not included in a later revised strategy for electronically sharing patient health information.

[9] GAO, *Veterans Affairs: Sustained Management Attention Is Key to Achieving Information Technology Results*, GAO-02-703 (Washington, D.C.: June 12, 2002); and *Computer-Based Patient Records: Better Planning and Oversight by VA, DOD, and IHS Would Enhance Health Data Sharing*, GAO-01-459 (Washington, D.C.: Apr. 30, 2001).

the GCPR project and (2) create comprehensive and coordinated plans that included an agreed-upon mission and clear goals, objectives, and performance measures, to ensure that the agencies could share comprehensive, meaningful, accurate, and secure patient health care data. In 2002, we recommended that the participating agencies revise the original goals and objectives of the project to align with their current strategy, commit the executive support necessary to adequately manage the project, and ensure that it followed sound project management principles.

VA and DOD took specific measures in response to our recommendations for enhancing overall management and accountability of the project. By July 2002, VA and DOD had revised their strategy and had made progress toward being able to electronically share patient health data. The two departments had refocused the project and named it the Federal Health Information Exchange (FHIE) program and, consistent with our prior recommendation, had finalized a memorandum of agreement designating VA as the lead entity for implementing the program. This agreement also established FHIE as a joint activity that would allow the exchange of health care information in two phases.

- The first phase, completed in mid-July 2002, enabled the one-way transfer of data from DOD's existing health information system (the Composite Health Care System, CHCS) to a separate database that VA clinicians could access.
- A second phase, finalized in March 2004, completed VA's and DOD's efforts to add to the base of patient health information available to VA clinicians via this one-way sharing capability.

According to the December 2004 VA/DOD Joint Executive Council[10] Annual Report, FHIE was fully operational, and VA providers at all VA medical centers and clinics nationwide had access to data on separated service members. According to the report, the FHIE data

[10] The Joint Executive Council is composed of the Deputy Secretary of Veterans Affairs, the Undersecretary of Defense for Personnel and Readiness, and the cochairs of joint councils on health, benefits, and capital planning. The council meets on a quarterly basis to recommend strategic direction of joint coordination and sharing efforts.

repository at that time contained historical clinical health data on 2.3 million unique patients from 1989 on, and the repository made a significant contribution to the delivery and continuity of care and adjudication of disability claims of separated service members as they transitioned to veteran status. The departments reported total GCPR/FHIE costs of about $85 million through fiscal year 2003.

In addition, officials stated that in December 2004, the departments began to use the FHIE framework to transfer pre- and postdeployment health assessment data from DOD to VA. According to these officials, VA has now received about 400,000 of these records.

However, not all DOD medical information is captured in CHCS. For example, according to DOD officials, as of September 6, 2005, 1.7 million patient stay records were stored in the Clinical Information System (a commercial product customized for DOD). In addition, many Air Force facilities use a system called the Integrated Clinical Database for their medical information.

The revised DOD/VA strategy also envisioned achieving a longer term, two-way exchange of health information between DOD and VA, which may also address systems outside of CHCS. Known as Health*e*People (Federal), this initiative is premised on the departments' development of a common health information architecture comprising standardized data, communications, security, and high-performance health information systems. The joint effort is expected to result in the secured sharing of health data between the new systems that each department is currently developing and beginning to implement—VA's Health*e*Vet VistA and DOD's CHCS II.

- DOD began developing CHCS II in 1997 and had completed a key component for the planned electronic interface—its Clinical Data Repository. When we last reported in June 2004, the department expected to complete deployment of all of its major system

capabilities by September 2008.[11] DOD reported expenditures of about $600 million for the system through fiscal year 2004.[12]

- VA began work on HealtheVet VistA and its associated Health Data Repository in 2001 and expected to complete all six initiatives comprising this system in 2012. VA reported spending about $270 million on initiatives that comprise HealtheVet VistA through fiscal year 2004.[13]

Under the HealthePeople (Federal) initiative, VA and DOD envision that, on entering military service, a health record for the service member would be created and stored in DOD's Clinical Data Repository. The record would be updated as the service member receives medical care. When the individual separated from active duty and, if eligible, sought medical care at a VA facility, VA would then create a medical record for the individual, which would be stored in its Health Data Repository. On viewing the medical record, the VA clinician would be alerted and provided with access to the individual's clinical information residing in DOD's repository. In the same manner, when a veteran sought medical care at a military treatment facility, the attending DOD clinician would be alerted and provided with access to the health information in VA's repository. According to the departments, this planned approach would make virtual medical records displaying all available patient health

[11] DOD's CHCS II capabilities are being deployed in five increments. The first provides a graphical user interface for clinical outpatient processes, thus providing an electronic medical record capability; the second supports general dentistry; the third provides pharmacy, laboratory, radiology, and immunizations capabilities; the fourth provides inpatient and scheduling capabilities; and the fifth will provide additional capabilities as defined. According to DOD, the first increment has been deployed to 64 of the 139 DOD health facilities, representing over 6.9 million beneficiaries, or about 75 percent of the total 9.2 million beneficiaries.

[12] These expenditures represent acquisition costs for software development, test and evaluation, hardware acquisition, system implementation, and associated contractor personnel costs. They do not include government personnel or operations and maintenance costs.

[13] The six initiatives that make up HealtheVet VistA are the Health Data Repository, billing replacement, laboratory, pharmacy, imaging, and appointment scheduling replacement. This amount includes investments in these six initiatives by VA as reported in their submission to the Office of Management and Budget for fiscal year 2004.

information from the two repositories accessible to both departments' clinicians.

To achieve this goal requires the departments to be able to exchange computable health information between the data repositories for their future health systems: that is, VA's Health Data Repository (a component of Health*e*Vet VistA) and DOD's Clinical Data Repository (a component of CHCS II). In March 2004, the departments began an effort to develop an interface linking these two repositories, known as CHDR (a name derived from the abbreviations for DOD's Clinical Data Repository—CDR—and VA's Health Data Repository—HDR). According to the departments,[14] they planned to be able to exchange selected health information through CHDR by October 2005. Developing the two repositories, populating them with data, and linking them through the CHDR interface would be important steps toward the two departments' long-term goals as envisioned in Health*e*People (Federal). Achieving these goals would then depend on completing the development and deployment of the associated health information systems—Health*e*Vet VistA and CHCS II.

In our most recent review of the CHDR program, issued in June 2004,[15] we reported that the efforts of DOD and VA in this area demonstrated a number of management weaknesses. Among these were the lack of a well-defined architecture for describing the interface for a common health information exchange; an established project management lead entity and structure to guide the investment in the interface and its implementation; and a project management plan defining the technical and managerial processes necessary to satisfy project requirements. With these critical components missing, VA and DOD increased the risk that they would not achieve their goals. Accordingly, we recommended that the departments

[14] December 2004 VA and DOD Joint Strategic Plan.

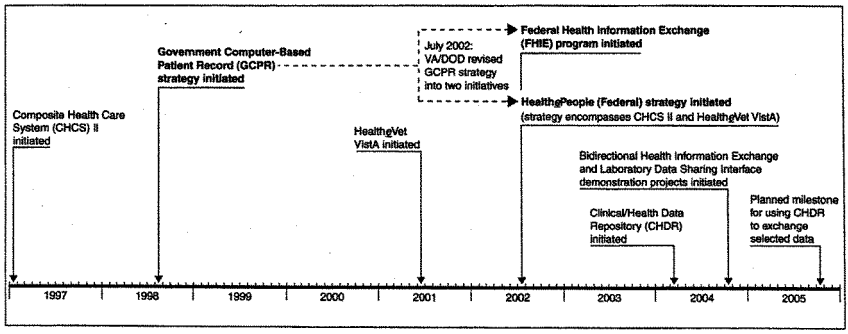
[15] GAO, *Computer-Based Patient Records: VA and DOD Efforts to Exchange Health Data Could Benefit from Improved Planning and Project Management*, GAO-04-687 (Washington, D.C.: June 7, 2004).

- develop an architecture for the electronic interface between their health systems that includes system requirements, design specifications, and software descriptions;
- select a lead entity with final decision-making authority for the initiative;
- establish a project management structure to provide day-to-day guidance of and accountability for their investments in and implementation of the interface capability; and
- create and implement a comprehensive and coordinated project management plan for the electronic interface that defines the technical and managerial processes necessary to satisfy project requirements and includes (1) the authority and responsibility of each organizational unit; (2) a work breakdown structure for all of the tasks to be performed in developing, testing, and implementing the software, along with schedules associated with the tasks; and (3) a security policy.

Besides pursuing their long-term goals for future systems through the HealthePeople (Federal) strategy, the departments are working on two demonstration projects that focus on exchanging information between existing systems: (1) Bidirectional Health Information Exchange, a project to exchange health information on shared patients, and (2) Laboratory Data Sharing Interface, an application used to transfer laboratory work orders and results. These demonstration projects were planned in response to provisions of the Bob Stump National Defense Authorization Act of 2003, which mandated that VA and DOD conduct demonstration projects that included medical information and information technology systems to be used as a test for evaluating the feasibility, advantages, and disadvantages of measures and programs designed to improve the sharing and coordination of health care and health care resources between the departments.

Figure 1 is a time line showing initiation points for the VA and DOD efforts discussed here, including strategies, major programs, and the recent demonstration projects.

Figure 1: History of Selected VA/DOD Electronic Medical Records and Data Sharing Efforts



Source: GAO analysis of VA and DOD data.

VA and DOD Are Exchanging Limited Medical Information between Existing Health Systems

VA and DOD have begun to implement applications developed under two demonstration projects that focus on the exchange of electronic medical information. The first—the Bidirectional Health Information Exchange—has been implemented at five VA/DOD locations and the second—Laboratory Data Sharing Interface—has been implemented at six VA/DOD locations.

Bidirectional Health Information Exchange

According to a VA/DOD annual report and program officials, Bidirectional Health Information Exchange (BHIE) is an interim step in the departments' overall strategy to create a two-way exchange of electronic medical records. BHIE builds on the architecture and framework of FHIE, the current application used to transfer health data on separated service members from DOD to VA. As discussed earlier, FHIE provides an interface between VA's and DOD's current health information systems that allows one-way transfers only, which do not occur in real time: VA clinicians do not

have access to transferred information until about 6 weeks after separation. In contrast, BHIE focuses on the two-way, near-real-time exchange of information (text only) on shared patients (such as those at sites jointly occupied by VA and DOD facilities). This application exchanges data between VA's VistA system and DOD's CHCS system (and CHCS II where implemented). To date, the departments reported having spent $2.6 million on BHIE.

The primary benefit of BHIE is the near-real-time access to patient medical information for both VA and DOD, which is not available through FHIE. During a site visit to a VA and DOD location in Puget Sound, we viewed a demonstration of this capability and were told by a VA clinician that the near-real-time access to medical information has been very beneficial in treating shared patients.

As of August 2005, BHIE was tested and deployed at VA and DOD facilities in Puget Sound, Washington, and El Paso, Texas, where the exchange of demographic, outpatient pharmacy, radiology, laboratory, and allergy data (text only) has been achieved. The application has also been deployed to three other locations this month (see table 1). According to the program manager, a plan to export BHIE to additional locations has been approved. The additional locations were selected based on a number of factors, including the number and types of VA and DOD medical facilities in the area, FHIE usage, and retiree population at the locations. The program manager stated that implementation of BHIE requires training of staff from both departments. In addition, implementation at DOD facilities requires installation of a server; implementation at VA facilities requires installation of a software patch (downloaded from a VA computer center), but no additional equipment. As shown in table 1, five additional implementations are scheduled for the first quarter of fiscal year 2006.

Table 1: Scheduled Rollout of BHIE at Selected DOD Facilities

Facility	Implementation date
Madigan Army Medical Center, Washington	October 2004
William Beaumont Army Medical Center, Texas	October 2004
Eisenhower Army Medical Center, Georgia	September 2005
Naval Hospital Great Lakes, Illinois	September 2005
Naval Medical Center, California	September 2005
Brooke Army Medical Center, Texas	First quarter, fiscal year 2006
Landstuhl Regional Medical Center, Germany	First quarter, fiscal year 2006
Bassett Army Community Hospital, Alaska	First quarter, fiscal year 2006
Walter Reed Army Medical Center, Maryland	First quarter, fiscal year 2006
Bethesda Naval Medical Center, Maryland	First quarter, fiscal year 2006

Sources: VA and DOD.

Note: VA facilities are sited near all the DOD facilities shown.

Additionally, because DOD stores electronic medical information in systems other than CHCS (such as the Clinical Information System and the Integrated Clinical Database), work is currently under way to allow BHIE to have the ability to exchange information with those systems. The Puget Sound Demonstration site is also working on sharing consultation reports stored in the VA and DOD systems.

Laboratory Data Sharing Interface

The Laboratory Data Sharing Interface (LDSI) initiative enables the two departments to share laboratory resources. Through LDSI, a VA provider can use VA's health information system to write an order for laboratory tests, and that order is electronically transferred to DOD, which performs the test. The results of the laboratory tests are electronically transferred back to VA and included in the patient's medical record. Similarly, a DOD provider can choose to use a VA lab for testing and receive the results electronically. Once LDSI is fully implemented at a facility, the only nonautomated action in performing laboratory tests is the transport of the specimens.

Among the benefits of LDSI is increased speed in receiving laboratory results and decreased errors from multiple entry of orders. However, according to the LDSI project manager in San Antonio, a primary benefit of the project will be the time saved by eliminating the need to rekey orders at processing labs to input the information into the laboratories' systems. Additionally, the San

Antonio VA facility will no longer have to contract out some of its laboratory work to private companies, but instead use the DOD laboratory. To date, the departments reported having spent about $3.3 million on LDSI.

An early version of what is now LDSI was originally tested and implemented at a joint VA and DOD medical facility in Hawaii in May 2003. The demonstration project built on this application and enhanced it; the resulting application was tested in San Antonio and El Paso. It has now been deployed to six sites in all. According to the departments, a plan to export LDSI to additional locations has been approved. Table 2 shows the locations at which it has been or is to be implemented.

Table 2: VA/DOD Facilities with LDSI Implementations

Facility	Implementation Date
Tripler Army Medical Center and VA Spark M. Matsunaga Medical Center, Hawaii	May 2003
Kirtland Air Force Base and Albuquerque VA Medical Center, New Mexico	May 2003
Naval Medical Center and San Diego VA Health Care System, California	July 2004
Great Lakes Naval Hospital and VA Medical Center, Illinois	October 2004
William Beaumont Army Medical Center, El Paso, Texas	October 2004
Brooke Army Medical Center, San Antonio, Texas	August 2005
Bassett Army Community Hospital, Alaska	Pre-implementation
Nellis Air Force Base, Nevada	Pre-implementation

Sources: VA and DOD.

VA and DOD Are Taking Actions to Achieve a Virtual Medical Record, but Much Work Remains

Besides the near-term initiatives just discussed, VA and DOD continue their efforts on the longer term goal: to achieve a virtual medical record based on the two-way exchange of computable data between the health information systems that each is currently developing. The cornerstone for this exchange is CHDR, the planned electronic interface between the data repositories for the new systems.

The departments have taken important actions on the CHDR initiative. In September 2004 they successfully completed Phase I of CHDR by demonstrating the two-way exchange of pharmacy information with a prototype in a controlled laboratory environment.[16] According to department officials, the pharmacy prototype provided invaluable insight into each other's data repository systems, architecture, and the work that is necessary to support the exchange of computable information. These officials stated that lessons learned from the development of the prototype were documented and are being applied to Phase II of CHDR, the production phase, which is to implement the two-way exchange of patient health records between the departments' data repositories. Further, the same DOD and VA teams that developed the prototype are now developing the production version.

In addition, the departments developed an architecture for the CHDR electronic interface, as we recommended in June 2004. The architecture for CHDR includes major elements required in a complete architecture. For example, it defines system requirements and allows these to be traced to the functional requirements, it includes the design and control specifications for the interface design, and it includes design descriptions for the software.

Also in response to our recommendations, the departments have established project accountability and implemented a joint project management structure. Specifically, the Health Executive Council has been established as the lead entity for the project. The joint project management structure consists of a Program Manager from VA and a Deputy Program Manager from DOD to provide day-to-day guidance for this initiative. Additionally, the Health Executive Council established the DOD/VA Information Management/Information Technology Working Group and the DOD/VA Health Architecture Interagency Group, to provide programmatic oversight and to facilitate interagency collaboration on sharing initiatives between DOD and VA.

[16] The completion of the pharmacy prototype project satisfied a mandate of the 2003 Bob Stump National Defense Authorization Act, Pub. L. 107-314, sec. 724 (2002).

To build on these actions and successfully carry out the CHDR initiative, however, the departments still have a number of challenges to overcome. The success of CHDR will depend on the departments' instituting a highly disciplined approach to the project's management. Industry best practices and information technology project management principles stress the importance of accountability and sound planning for any project, particularly an interagency effort of the magnitude and complexity of this one. We recommended in 2004 that the departments develop a clearly defined project management plan that describes the technical and managerial processes necessary to satisfy project requirements and includes (1) the authority and responsibility of each organizational unit; (2) a work breakdown structure for all of the tasks to be performed in developing, testing, and implementing the software, along with schedules associated with the tasks; and (3) a security policy. Currently, the departments have an interagency project management plan that provides the program management principles and procedures to be followed by the project. However, the plan does not specify the authority and responsibility of organizational units for particular tasks; the work breakdown structure is at a high level and lacks detail on specific tasks and time frames; and security policy is still being drafted. Without a plan of sufficient detail, VA and DOD increase the risk that the CHDR project will not deliver the planned capabilities in the time and at the cost expected.

In addition, officials now acknowledge that they will not meet a previously established milestone: by October 2005, the departments had planned to be able to exchange outpatient pharmacy data, laboratory results, allergy information, and patient demographic information on a limited basis. However, according to officials, the work required to implement standards for pharmacy and medication allergy data was more complex than originally anticipated and led to the delay. They stated that the schedule for CHDR is presently being revised. Development and data quality testing must be completed and the results reviewed. The new target date for medication allergy, outpatient pharmacy, and patient demographic data exchange is now February 2006.

Finally, the health information currently in the data repositories has various limitations.

- Although DOD's Clinical Data Repository includes data in the categories that were to be exchanged at the missed milestone described above: outpatient pharmacy data, laboratory results, allergy information, and patient demographic information, these data are not yet complete. First, the information in the Clinical Data Repository is limited to those locations that have implemented the first increment of CHCS II, DOD's new health information system. As of September 9, 2005, according to DOD officials, 64 of 139 medical treatment facilities worldwide have implemented this increment. Second, at present, health information in systems other than CHCS (such as the Clinical Information System and the Integrated Clinical Database) is not yet being captured in the Clinical Data Repository. For example, according to DOD officials, as of September 9, 2005, the Clinical Information System contained 1.7 million patient stay records.
- The information in VA's Health Data Repository is also limited: although all VA medical records are currently electronic, VA has to convert these into the interoperable format appropriate for the Health Data Repository. So far, the data in the Health Data Repository consist of patient demographics and vital signs records for the 6 million veterans who have electronic medical records in VA's current system, VistA (this system contains all the department's medical records in electronic form). VA officials told us that they plan next to sequentially convert allergy information, outpatient pharmacy data, and lab results for the limited exchange that is now planned for February 2006.

In summary, developing an electronic interface that will enable VA and DOD to exchange computable patient medical records is a highly complex undertaking that could lead to substantial benefits—improving the quality of health care and disability claims processing for the nation's military members and veterans. VA and DOD have made progress in the electronic sharing of patient health data in their limited, near-term demonstration projects, and have taken an important step toward their long-term goals by improving the management of the CHDR program. However, the departments face considerable work and significant challenges before they can achieve these long-term goals. While the departments have made

progress in developing a project management plan defining the technical and managerial processes necessary to satisfy project requirements, this plan does not specify the authority and responsibility of organizational units for particular tasks, the work breakdown structure lacks detail on specific tasks and time frames, and security policy has not yet been finalized. Without a project management plan of sufficient specificity, the departments risk further delays in their schedule and continuing to invest in a capability that could fall short of expectations.

Mr. Chairman, this concludes my statement. I would be pleased to respond to any questions that you or other members of the Committee may have at this time.

Contacts and Acknowledgments

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Testimony of Jonathan C. Javitt, M.D., M.P.H. before the Committee on Veterans Affairs, Subcommittee on Oversight and Investigations.

September 28, 2005

Mr. Chairman, distinguished members of Congress, I am honored to be invited back by your committee to testify on this area of critical national importance. You have asked me to bring your committee up to date on mature, scalable, private sector technologies for two-way health data interchange. I have founded and directed publicly traded companies that deliver electronic health solutions. I have served as a Senior executive of Fortune 100 companies that deliver such solutions. My family's financial security is tied to the premise that the private sector can construct and deliver e-health solutions that save money while they are saving lives and suffering.

Despite my private sector credentials and experience, it is my duty to tell you that the current, comprehensive electronic health environment of the Veteran's Health Administration surpasses any capability available today on the planet, whether in the private sector, other departments of the U.S. government, or the highly profiled activities of other countries. Let me be clear that I am speaking only about VISTA/CPRS and not about VA's personnel or financial management software initiatives.

I offer that opinion as one who strongly supports President Bush's policies including those expressed in OMB circular A76, and who is proud to have been commissioned by President Bush to lead the health subcommittee of PITAC and its report to the President on Revolutionizing Health Care through information technology.

The committee I chaired was composed entirely of individuals from the private sector, including former senior Microsoft and Oracle executives, the chairmen of computer science and electrical engineering at two of the nation's most prestigious universities, and received extensive input from the entire private sector IT community. I will admit that our initial working assumption was that the VA approach to e health, using MUMPS and other less-than-mainstream technologies must be an example of government waste and inefficiency. Instead, after examining the VA's achievement on paper, in testimony, and at numerous sites of care, we concluded that the VA had built something unique, something that should be considered a national treasure, and a resource to be leveraged into the private sector.(Exhibit A)

I had the honor of accompanying President Bush and senior members of his administration to examine the electronic health records system of the VA. On that occasion, he noted "Information technology hasn't really shown up in health care yet. But it has in one place, in one Department, and that's the Department of Veterans Affairs." Notably, Medicare Administrator Mark McClellan, himself a physician and a conservative economist who served on President Bush's Council of Economic Advisors, came to the same conclusion in urging that the VA system be adopted by medical caregivers across the country as a low-cost means of entering the e-health world.

As I understand the issue before this committee, there should be no question about whether the Veteran's Health Administration has used home-grown information technology solutions to create a miraculous transformation in the standard of medical care delivered to this nation's veterans. A pile of scholarly articles several feet high

attests to the fact that medical errors occur in fewer than 1 in 10,000 prescriptions in Veteran's hospitals, compared to one in five prescriptions in paper-driven private sector hospitals. This article (exhibit B) from the New England Journal of Medicine documents that our nation's veterans receive higher quality care than is received under Medicare for conditions such as diabetes and heart disease, to name two of twelve. Other studies point to the demonstrated improvements in diabetes management, care for patients with congestive heart failure, smoking cessation, cholesterol reduction, pneumonia and influenza vaccination, and other health outcomes among America's Veterans that far surpass comparable measures in the private sector.

The VA system is remarkably secure and stable Most recently, the Department of Health and Human Services has been forced to allocate hundreds of millions of dollars to reconstructing health records destroyed in the wake of Hurricane Katrina. In contrast, it took the Veteran's Health Administration less than 100 hours of staff time to safely transfer all records from the disaster zone to Texas. They would have done it electronically, instead of by magnetic media, had the regional private-sector run telecommunications infrastructure remained viable.

Your committee has heard testimony on this subject from former Secretary Principi, Under Secretary Perlin, Dr. Kolodner, and a host of others. Yet, a parade of contractors and private sector interests come before you regularly and ask that you fix what's not broken in favor of the principles that small government is better than big government, and that the private sector given sufficient resources will provide better quality, more efficient, lower cost solutions than government bureaucrats. Despite the fact that these contractors have not yet built a viable distributed electronic health record either in the private sector or for the Department of Defense, they will certainly promise to deliver on spec, on time, and on budget for the VA. As this article from the IEEE documents (Exhibit C), such massive contractor-led federal software projects are extremely likely to fail. In fact, an honest look at the origins of the current CPRS program of the VA will readily discern that CPRS was born out of the ashes of a failed contractor-driven attempt to build a VA medical records system.

In general, I believe in small government and outsourcing, just as I believe in basic principles of aerodynamics. However, when I watch an aerodynamically implausible bumblebee fly across my backyard, my first impulse is not to legislate it out of existence. There are exceptions to every rule and the electronic medical record system of the VA is a notable exception to the principals of OMB circular A76.

Recently, the journal Health Affairs asked me to examine and attempt to discern the basis of this success that is as improbable as the flight of the bumblebee or the success of the 1969 Mets. It stated my belief that the VA's success lies in the bottom up nature of its electronic health record.(Exhibit D) It was built by doctors and nurses whose focus was on the care of their patients and who realized that they could do so best through information technology. As a result, the VA has built a culture of dedicated professionals who stay up late at night, without any thought of financial remuneration, tweaking, improving, and inventing the next solution. They gather together annually to "sell" one another on their inventions, since their actual development budget is quite limited.

The irony is that "card carrying IT professionals would call these dedicated professionals dangerous amateurs, in the same way that the executives of many computer companies that no longer exist spoke with derision about Jobs, Wozniak, and Gates. To an IT professional, there is nothing fundamentally different between computerizing the traffic control system of London, England and computerizing the English National Health Service. Except that after investing more than $10 billion, the Brits are finding out it that top-down systems built by IT professionals with limited input by doctors and nurses can lead to unforeseen challenges.

No major health care delivery system has ever successfully had its Chief Information Officer functions—including development, implementation and user support—provided by a corporate IT organization, separated from the core constituency of those who use those functions every day.

The centralization of VHA's electronic health records program is likely to have a disastrous effect on the continued success of that program; which President Bush identified as the only place IT has really shown up in health care, a terrible effect on the morale of VA care providers; and on the system's productivity. Worst, it will damage the health of our nations Veterans to whom we owe so much.

In short, the answer to locating the best technology for two-way health data interchange is to look no further than the information technology apparatus of the Veterans Health Administration. I would advise this committee to continue careful thoughtful, and aggressive oversight, to make private sector resources available to help the VA implement mainstream solutions that may be more scalable than some of the current solutions built of necessity, and to allocate funds to leverage the pioneering concepts and solutions of the Veterans Healthcare Administration into the private sector. To do anything else would be a disservice to our veterans and ultimately to our nation.

Exhibits

Exhibit A. Presidents Information Technology Advisory Committee. Report to the President: Revolutionizing Health Care through Information Technology

Exhibit B-1. Jha AK, Perlin JB, Kizer KW, Dudley RA. Effect of the transformation of the Veterans Affaris Health Care System on Quality of Care. N Engl J Med 2003;348:2218-27

Exhibit B-2. Asch SM, McGlynn EA, Hogan MM, et. al. Comparison of Quality of care for Patients in the Veterans Administration and Patients in a National Sample. Ann Internal Medicine, 2004;141:938-945

Exhibit C. Charette, Robert N. Why Software Fails. IEEE Spectrum. www.spectrum.ieee.org/print/1685

Exhibit D: Javitt, Jonathan C. How to Succeed in Health Information Technology. Health Affairs, 2004, W4-321

TESTIMONY OF

DR. PETER A. DYSERT

CHIEF MEDICAL INFORMATION OFFICER
BAYLOR HEALTH CARE SYSTEM

BEFORE THE

UNITED STATES HOUSE OF REPRESENTATIVES

COMMITTEE ON VETERAN'S AFFAIRS

HEARING ON

THE STATUS OF SEAMLESS TRANSITION BETWEEN THE U.S. DEPARTMENTS OF DEFENSE (DOD) AND VETERANS AFFAIRS (VA)

September 28, 2005, 10:30 am
Cannon House Office Building
Room 334

Chairman Buyer, ranking member Evans, members of the Committee, I want to thank you for inviting me to participate in this important hearing. I am honored to have the opportunity to share with you thoughts on the potential for evolution of information technology in the health care system. Since the VA and DOD scale is so vast, the design and implementation of their systems will resonate in how the entire health system in our country evolves. I hope that my comments will give you some idea of how one major hospital system is tackling the problem today.

Mr. Chairman, my name is Dr Peter A Dysert. Currently I am the Chief Medical Information Officer for the Baylor Health Care System, a $2.7 billion dollar multi-hospital system serving the North Texas area. Baylor is a 102 year old, faith-based institution, with strong ties to the Baptist General Convention of Texas.

Last year, we provided more than $256 million in Community Benefits, at cost and not including bad debt. Baylor Health Care System is the corporate sponsor of 17 non-profit hospitals. Our flagship —Baylor University Medical Center (BUMC) is located in downtown Dallas. BUMC is a 1,000 bed teaching hospital, with a Level I trauma ED.

I have been in a technology leadership role since the mid 1980s and currently serve as the co-chair of a 140 million dollar clinical transformation effort which will convert the delivery of care in Baylor facilities from paper to computer. The project also includes providing an electronic medical record in physician offices across our system. We see our investment in clinical transformation as the next great innovation in delivering quality health care.

What I hope to provide you with today is a lens with which to view your current and future technology investments that support health care. I will begin my testimony with some observations and then finish with a review of our strategy.

As you are aware, companies are entering the field of building the technology systems with varying degrees of service. Here are some of the reasons why:

Observations

1) Computer application (program) design-
    a. Work flow support- most of the existing systems do a very poor job of supporting workflow (the way care is actually delivered). The computer program screens are mostly data entry in design, the functions they support represent clerk activities and require the user to sit and document work they've already done. This approach has a negative impact to the providers of care by eroding their productivity and efficiency. To nurses and doctors, these clerk type activities are not a value added function and it is not why they chose their professions. It is the major focus of legitimate resistance to the adoption of computers for patient care.
    b. Mobility- in the hospital setting, most care providers are mobile. The majority of current systems do not support mobility except via the use of wireless laptops displaying the same types of screens I described above.
    c. Data capture-one of the biggest opportunities for improving care and eliminating errors could be achieved if the computer systems automated data capture as a natural by product of doing the work. Technologies that could provide such a benefit are bar code, proximity recognition, biometrics, and voice recognition or natural language processing.
    d. Information types-Most commercially available systems for health care are designed principally to handle structured data. The realities are that a complete record must also accommodate, free text (unstructured data), sound, and image files. One of the historic challenges in computerizing the current processes of care is represented by this set of issues. The component of the current record known as the physician progress notes section has remained an Achilles heal for vendors. The reason is their applications attempt to force physicians to convert their "analog" cognitive thought processes and observations into a binary decision tree of predefined, structured observations.
    e. Human User interface design-the web browser has become the gold standard for the human user interface. It has proven to be very reliable,

platform agnostic, and require little to no user training. Traditional and many current product offerings have proprietary user interfaces and require a lot of training. In addition when changes are made to these proprietary applications, it typically requires a lot of work and training to support as well as a lot of effort to load the new applications on the user's computer. The web browser is the best version of a zero administrative client there is.

2) Computer systems architecture-
   a. Design-a global architecture design based on standards is required for the support of a reliable electronic health record. Most, if not all systems offered today are built on proprietary designs and in many cases outdated programming languages. As a result, these systems require expensive interface development in order for them to support the exchange of information with other systems. Interfacing as a means of exchanging data should be only one way of providing access to information contained in other systems. In my opinion, most people forget that simply making the information available to the user via a web browser without integrating the data at a systems or application level is in most cases is an acceptable solution. It can be accomplished in a lost less time and at a considerable savings in terms of cost.

The above observations are the reason the Baylor Health Care System has chosen a different approach for its electronic medical record. While we have solutions for most of these issues we are still in search of solutions for others.

The Baylor Approach

In 1997, members of Baylor Information Services (BIS) began meeting to explore the idea of using the Internet, a relatively new phenomenon in hospitals, as a medium for disseminating clinical patient information from the hospital where it resided in poorly interfaced main-frame host systems, to attending physicians and their office staff to

facilitate completion of the patient's office chart at their various Baylor-affiliated physician practices. Because of the ubiquity of the Web, it was thought that development of a browser-based Portal could be less expensive than that of an equivalent client-server product, and could be partially developed in-house by Baylor Internet programmers. This Portal would be cost effective to maintain because the only software required on the end-user's side would be a web browser, Internet access and a standard PC.

At the time, Baylor was spending in excess of $225,000 per year supporting a relationship with a vendor that had first automated Baylor's document delivery process. The vendor, working with hospital clients across the country, had created a way to capture patient information from main-frames by using virtual print queues and modems. In this process, the company would send the files out by modem to their off-site hub, and then relay the text files to physician offices. This extremely simple system was expensive to maintain because it required PC software on the Baylor network to process the files from the mainframes and client software in the physician offices.

In contrast, BIS began contemplating a Web system allowing for the ability to "grab" the patient files from the mainframes and send them out over the Internet to the physician practice Web browser. BIS' biggest concerns were how to parse the files themselves in order to determine which doctors were named in them, and how to send them securely over the Internet to the appropriate physician offices. BIS staff was confident it could be done, but lacked the knowledge to ensure strong security and confidentiality of data.

What followed was a three year design and implementation period where Baylor engaged a succession of software application vendors. The goal was to challenge these vendors to provide a Web-based solution that would fit Baylor's needs. At this time, Baylor worked with numerous vendors to confirm the concept and document the framework for building a solution.

From the beginning, the Baylor Portal team approached design of Portal features and functionality as a partnership with our physician user community. The Portal team has always sought input from key members of Baylor's medical staff. From the medicine and the surgery sides of the house, doctors have never been shy about sharing their hopes, concerns, or complaints for the Physician Portal. By going out to the physician's offices

and talking to their office staff, the Baylor Portal design team was able to get a holistic understanding of what the everyday patient information flow problems are for physician practices. In turn, they were able to design useful Web tools for physician practices and begin to solve long-standing problems regarding how information flows from the hospital to the physician practices.

Features & Functions

Highlights

All secure access protocols have been developed with key HIPAA, legal, and HIMD personnel.

Electronic Signature represents that biggest time savings tool on the current myBaylorEMR Portal.

The Portal Search functionality has been identified as the most popular way for physicians and staff to locate and review patient information.

Baylor Health Care System's chart scanning initiative coupled with the myBaylorEMR Portal is allowing Baylor to move to a completely paperless legal medical record.

Secure Access: Physician users are required to be active staff at a Baylor hospital and sign a confidentially agreement at the time of credentialing in order to get their Portal account information. The confidentiality agreement refers to language in the medical staff by-laws concerning consequences of misusing patient information. The confidentiality agreement also references "agents acting on their behalf," which implies that the physician is liable for patient information abuse by their office staff. Physicians are expected to initiate electronic requests office staff Portal accounts, so that a clear audit trail exists showing that the physician proxied his/her access to the office staff. There are different levels of access based on the user's defined role in the Portal. For example, physicians are able to see their own patients, as well as other patients by request, while office staff can only see their physician's patients. Hospital employee users can see currently admitted patients for their facility. All usage is logged and a nightly audit report is emailed to Medical Records and HIPAA department personnel. These access

procedures were originally developed with oversight from Baylor's HIPAA, legal and Medical Records departments.

Electronic Signature: This Web application gives the physician the ability to view, edit and sign dictated reports as well as scanned orders. This saves the physician a trip to the Medical Records department to sign the paper chart.

Census: The Physician Portal dynamically creates a list of the physician's current patients in the hospital, sorted by nursing unit. When the physician pulls it up he or she can click on the patient's name to see all the current documentation for that patient including lab results, pathology results, medical imaging interpretations, cath lab procedure transcriptions and all dictated reports from Medical Records.

Search: Physicians, their office staff, and approved hospital employees can look up patients based on their access level.

Clinical Document Viewer: This feature enables the physician or office staff user to view and retrieve patient documents from the hospital in the chronological order they are sent out, with most recent first. The user can manage the list of documents like an e-mail inbox. This application is most popular with office staff users responsible for maintaining their practice's office chart.

New Clinical Documents: This feature is part of the Portal's latest release; it shows the doctors a list of their patients against a grid of columns labeled Lab, Pathology, Radiology and Transcription. Hyperlinked numbers in those columns indicate how many documents the physician has not yet looked at. Clicking on the number creates a PDF file showing the documents indicated.

Scanned Chart feature: Baylor has an enterprise-wide strategy to electronically scan all paper charts once the chart has been closed, allowing the scanned chart to become the legal medical record as the paper version is destroyed. Baylor is using the Physician Portal as the primary means to access the scanned charts. When a treating physician wants to see a patient's chart from their last admission, all he or she has to do is look it up on the Portal.

Integrated PACSWeb access: As a result of working with Baylor's PACS vendor, the Portal development staff has been able to incorporate access to medical images seamlessly into the Physician Portal's patient visit screens.

Surgery Schedule Viewer and Case Monitor: A real-time surgery schedule viewer is available to surgeons, anesthesiologists and their respective office staffs.

Technical Architecture

Architecture Facts

Database agnostic, supporting all ODBC compliant data stores

Role based access methods leverage Microsoft Active Directory for Authorization.

Redundant load balanced server farm is utilized for high availability

N-Tier application design provides physical machine boundaries for added security/reliability

Highlights

Module reuse improves productivity when application functionality needs to be consistent across product boundaries

Microsoft Windows Server Systems and other Best of Breed technology solutions help maintain support costs

The myBaylorEMR Physician Portal developed at Baylor Health Care System was written using open industry standard protocols such as HTML, ODBC, HTTPS, XML, WSDL, SOAP, Web Services and product APIs where available. Cross vendor interoperability is achieved primarily through the use of Web Services when needed for myBaylorEMR integration. Interoperability definitions demand that the functionality of a web service interface behave consistently across:

Application boundaries, such as Lab systems and ADT systems

Application Platforms, such as Microsoft IIS, Apache Web Server, etc

Programming languages, such as .NET, C++, Java

Hardware platforms, such as mainframes and PCs

Database Platforms, such as Oracle, SQL Server, Informix, etc

Software Development Platform

The myBaylorEMR Physician Portal core engine is written entirely in .NET using the C# language. Microsoft IIS 6.0 web servers are used to deliver content to the browser. Microsoft Windows Server 2003 serves as the operating system for all server based infrastructure. The Microsoft BizTalk Server platform is used to facilitate data capture from legacy HIS systems.

Client Architecture

The myBaylorEMR Physician Portal is a secure web based application that is delivered to clients internal and external to the Baylor network. In an effort to be browser agnostic, no ActiveX controls were developed as part of the core services delivered via the Web. This architecture allows Baylor to deliver clinical patient information securely over the Web to affiliated physicians, allowing this information to be accessed anywhere and anytime. The availability of the myBaylorEMR Physician Portal allows Baylor to continue the vision of being the best place to give and receive safe, quality, compassionate healthcare.

Component Based Design Architecture

All applications developed for the myBaylorEMR Physician Portal are .NET modules. The design goal when creating this framework was to allow certain applications to span multiple products. For instance, there is a Surgery Schedule module that needs to be used by Physicians, as well as many other administrative non-clinical staff. Since non-clinical administrative staff has no access to the myBaylorEMR site, these modules were developed once, but are exposed multiple times via the portal framework to the corporate Intranet in the same role-based manner as is used on myBaylorEMR.

The modules developed on Baylor's Portal Framework must inherit from certain technical business object classes in order to compile correctly. These inherited classes ensure that HIPAA logging, Authentication, Authorization, UI Styles and Environment

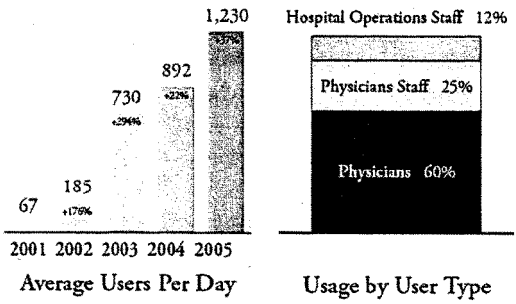
Settings are all consistent to produce the effective and secure user experience that staff has grown to expect.

Infrastructure Architecture & Design Approach

The myBaylorEMR Physician Portal systems architecture was developed using the Microsoft Windows Server System suite of products. This enabled the use of industry standard x86 server technology platforms as well as a standards based network and IP management solution from Cisco and f5 Inc. By utilizing this core set of technology, significant cost savings were realized while maintaining and achieving very high performance and high availability in the deployment model. Baylor's choice of these core technology vendors further enhanced this platform choice by bringing value added services and support to the deployment. By utilizing de facto and best of breed solutions available today, BIS is empowered to rapidly deliver performance, reliability, and scalability while maintaining acquisition and support costs relative to the established business model and design philosophy.

Metrics

Metrics Highlights



Usage Metrics

The average users per day values are reflective of increased physicians and staff adoption. To further compliment these statistics, BIS has tracked a downward trend of how long users are taking to complete their desired action on the site. In 2003 and 2004, on average a user would spend 13 minutes and 50 seconds on the site. In 2005 through

usability changes and enhanced functionality (in the Aug. 1 redesign of the site), the average visit length decreased to 10 minutes 36 seconds.

To further support the increased usability and adoption of the site, BIS has seen the number of pages used per visit increase over 100 percent, specifically in the viewing of clinical documents (to be detailed later). During 2003 and 2004, the average user viewed 10 pages per visit, in 2005 BIS has observed the average pages viewed rise greater than 22 pages per visit.

Physicians currently account for 60 percent of the total usage of the site, with 25 percent and 12 percent being from physician staff and hospital operations staff respectively.

Technical Measures

2003 page load time 7 seconds

2004 page load time 5 seconds

2005 page load time 2 seconds

During the MyBaylorEMR portal lifecycle, BIS has made yearly advances in the supporting infrastructure and technical components to increase performance. Leveraging faster server hardware, increasing the quality and performance of the code base and upgrading the network infrastructure has led to a 350 percent increase in site performance in a two year period.

Clinical Document Content

Average Clinical Documents Viewed Per Day

	2001	2002	2003	2004	2005
Average Views	87	603	2,876	4,035	5,303
% Change	--	692%	476%	143%	31%

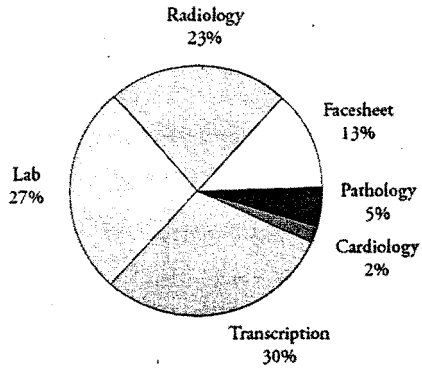
To get a feel for usage as it relates to the total number of clinical results processed, there are on average for 2005, 14,270 clinical documents uploaded daily to the data repository. Based on these numbers, BIS has approximately 37 percent of the total available clinical documents being viewed daily through the myBaylorEMR portal, this is an increase from 35 percent in 2004.

Metrics (Continued)

Types of Documents Being Viewed

During 2005, the percentage breakdown of documents viewed by type is:

Usage by Document Type



Supporting Information

myBaylorEMR Statistics Summary

	2001	2002	2003	2004	2005
Usage Metrics					
Users*	67	185	730	892	1,230
Pages Viewed**	-	-	10	10	22
Time on site**	-	-	13m 50s	13m 50s	10m 30s
Clinical Documents					
Documents viewed*	87	603	2,876	4,035	5,303
Document type:					
Transcription	-	-	-	-	30%
Lab	-	-	-	-	27%
Radiology	-				23%
Facesheet	-	-	-	-	13%
Pathology	-	-	-	-	5%
Cardiology	-	-	-		2%
Technical Measures					
Page load time*	-	-	7 sec	5 sec	2 sec

* Reporting averages per day ** Reporting averages per session

Metrics (Continued)

Growth & Adoption Summary

The myBaylorEMR Physician Portal has been a huge success at Baylor Health Care System. Strong Physician and Executive sponsorship of the portal vision, a need for enhanced access to clinical information and a corporate vision of being the best place to give and receive safe, quality, compassionate health care are all factors in this successful implementation of technology.

As the technical staff has grown at Baylor, staff has been able to introduce new features and functionality that continue to drive adoption. The technology choices selected, the strategic business partnerships with HIS vendors and the introduction of a Physician Workflow and A

Conclusion

Health care should follow the technology lead of all other major industries and customer service organizations around the world. The technological approach to the creation of an electronic medical record should be based on the internet family of solutions. These technology solutions are reliable, scaleable, and user friendly.

In addition we should not forget that when it comes to providing access to patient information for the providers of care, that serving it up via a browser and letting them do the integration in their head is a much more cost effective and timely way than building discrete point to point interfaces. I read that recent experiences during Hurricane Katrina validated this approach.

Mr. Chairman thank you for allowing me to be apart of this important dialogue; the VA and DOD will set the standard for the development of information technology. We must insure that the design is as forward thinking as possible to serve the citizens of our great country.

Statement of
The Honorable Gordon H. Mansfield, Deputy Secretary
Department of Veterans Affairs
Before the
Committee on Veterans' Affairs
United States House of Representatives

September 28, 2005

Mr. Chairman and Members of the Committee, I appreciate the opportunity to speak to you today about the progress the Department of Veterans Affairs has made in collaborating and coordinating with the Department of Defense to facilitate service members' transition to civilian life. These efforts are leading to improvements in health care and benefits delivery for our nation's veterans. I will speak to you of two major examples of this collaboration: 1) the seamless transition program and 2) the Joint Executive Council (JEC) governance process including implementation of recommendations by the President's Task Force to Improve Health Care Delivery For Our Nation's Veterans (PTF).

Under the leadership of Secretary Jim Nicholson, VA is determined to ensure that maximum efforts are undertaken to serve the needs of newly returning Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) service members. As co-chairs of the JEC, Dr. David Chu, the Under Secretary of Defense for Personnel and Readiness, and I are deeply committed to ensuring that DoD and VA fully leverage their collaboration to address the goals of the President's Task Force while meeting the needs of OIF/OEF service members. Let me share how this has been accomplished and the ongoing initiatives.

Seamless Transition

Mr. Chairman, the phrase "seamless transition" represents a set of clearly defined VA initiatives that are intended to ease the re-entry of those leaving active military service

and returning to civilian life by increasing awareness of, access to, and use of VA health care, benefits and services.

The term has been adopted by those in VA and in DoD to describe a set of specific short-term initiatives focused on providing seamless, high-quality health care and psycho-social support services to those young men and women who have been catastrophically disabled as a result of hostile actions associated with Operation Iraqi Freedom and Operation Enduring Freedom. These initiatives include intensive clinical case management in transferring the wounded from military treatment facilities to the most appropriate VA medical centers, including those VA facilities that are recognized as centers of excellence for specific clinical or rehabilitative services.

But looked at in a wider context, "seamless transition" is also a good descriptor for the myriad of programs and initiatives that we are attempting to institutionalize through the Joint Executive Committee, the Health Executive Committee, and the Benefits Executive Committee processes. VA and DoD are committed to enhancing collaboration in an effort to improve access to benefits; streamline application processes; eliminate duplicative requirements and correct other business practices that complicate the transition from active duty to veteran status. Seamless transition will be accomplished through joint initiatives that: ensure wide dissemination of information on the full array of benefits and services available to both VA and DoD beneficiates; enhance educational programming on eligibility criteria and application requirements; increase sites providing BDD services, improve the physical examination and claims processes; and develop interoperable information management systems necessary for the administration and management of beneficiary claims.

The Executive Council Structure

In accordance with President Bush's mandate to improve health care for veterans and military beneficiaries, VA and DoD have worked cooperatively in their efforts to remove barriers impeding interagency collaboration in order to improve access to high-quality health care and reduce the cost of furnishing services. With the recommendations of

the President's Task Force to Improve Health Care Delivery For Our Nation's Veterans in mind, the departments identified critical components to improve health care services to veterans and military beneficiaries through better coordination and improved business practices. Comprehensive strategies were developed to address identified impediments and institutionalize the VA/DoD partnership. In addition, VA has accelerated initiatives to streamline interagency activities that will ensure the seamless transition of service members to veteran status with particular emphasis on those returning from Operation Enduring Freedom and Operation Iraqi Freedom.

The Joint Executive Council (JEC

The Joint Executive Council (JEC) was formed February 2002 to provide overall support and guidance for the joint VA/DoD initiatives and to ensure high level attention from both Departments to maximize opportunities to improve service to our mutual beneficiaries. The JEC determined that the most effective way to increase and institutionalize collaboration between the departments was through the development of a Joint Strategic Plan (JSP). Through this forum, VA and DoD have achieved significant success in improving interagency cooperation in areas including health-care management and delivery and benefits coordination.

Approved by the JEC in April 2003, the JSP represented a significant step forward in institutionalizing VA and DoD collaboration. The JSP also reflected a review of past and current practices in VA/DoD sharing, Congressional direction, GAO reports and the findings of the PTF. The efficacy of having a single guiding document that established mutually agreed upon goals and milestones proved a very effective tool for managing this complex set of initiatives. VA and DoD now annually review and issue an updated, revalidated JSP that incorporates new initiatives and lessons learned from the previous year. The second JSP was signed in December 2004 and VA and DoD are currently reviewing the December 2004 plan for possible enhancements.

The Health Executive Council (HEC). Co-chaired by the VA Under Secretary for Health and the Assistant Secretary of Defense for Health Affairs, the HEC oversees the cooperative efforts of each agency's health care organizations.

Through the HEC, VA and DoD have worked closely to ensure coordination of health care services to our military members and newest veterans returning from Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF).

The HEC has charged work groups to focus on specific high-priority areas of national interest. Through these work groups, the departments have achieved significant success in improving interagency cooperation in key areas such as pharmacy, procurement, deployment health, clinical guidelines, contingency planning, graduate medical education, information management/information technology, financial management, joint facility utilization, and benefits coordination. A more detailed description of health care initiatives specific for returning OIF/OEF veterans will be discussed later.

The Benefits Executive Council (BEC). Co-chaired by the VA Under Secretary for Benefits and the Principal Deputy Under Secretary of Defense for Personnel and Readiness, the BEC is charged with examining ways to expand and improve information sharing, refine the process of records retrieval, identify procedures to improve the benefits claims process, improve outreach, and increase service members' awareness of potential benefits.

In addition, the BEC provides advice and recommendations to the JEC on issues related to seamless transition from active duty to veteran status through a streamlined benefits delivery process, including the development of a cooperative physical examination process and the pursuit of interoperability and data sharing.

VA signed a Memorandum of Agreement with DoD on November 17, 2004, that established a Cooperative Separation Process/Examination for separating service

members. This allows service members to begin the VA disability examination process up to 180 days prior to discharge through our Benefits Delivery at Discharge program and stipulates that consistent protocols are to be followed when one exam is to serve both as DoD's separation physical and to document VA disability claims. As of September, we have 91 locally signed Memoranda of Understanding with 42 in progress.

The "President's Task Force To Improve Health Care Delivery For Our Nation's Veterans" 2003 Final Report identified 23 specific recommendations for action to improve health care delivery to VA and DoD beneficiaries. Twenty of the recommendations were addressed in the VA/DOD Joint Executive Council Annual Report of December 2004/Appendix C entitled, "Department of Veterans Affairs/Department of Defense Response to the Final Recommendations." The document states that of these 23 recommendations, 18 had been fully supported by JSP objectives or by HEC work groups established to initiate action for full implementation.

Health Care Services

VA is well positioned to provide health care to returning OEF and OIF veterans. As the largest integrated health care organization in the United States, we can meet their needs through nearly 1,300 health care facilities throughout the country, including 721 community-based outpatient clinics that provide health care access closer to veterans' home communities. We also have 207 Vet Centers, which are often the first contact points for returning veterans seeking benefits and health care near their homes.

VA offers comprehensive primary and specialty health care to our enrollees, and the quality of our care is second to none. We are an acknowledged leader in providing specialty care in the treatment of such illnesses as post-traumatic stress disorder (PTSD), spinal cord injury, and traumatic brain injury (TBI). By leveraging and enhancing the expertise already found in our four TBI centers, VA created Polytrauma

Centers to meet the complex needs of certain seriously injured veterans from all parts of the country. This will be addressed in more depth later in my statement.

VA/DoD Electronic Exchange of Health Information

Our ability to provide care to returning OIF and OEF service members is optimized to the extent that we can obtain accurate health care information from DoD in the shortest time frame possible. In 2002, VA and DoD approved the Joint Electronic Health Records Interoperability Plan – HealthePeople (Federal). VA and DoD began implementation of Phase I of the plan, the Federal Health Information Exchange (FHIE) that same year. The FHIE supports the one-way transfer of electronic military health data on separated service members to the VA Computerized Patient Record System for viewing by VA clinicians treating veterans. Since FHIE implementation in 2002, DoD has transferred records for over 3.4 million unique patients to the FHIE repository. Approximately 1.4 million records have been viewed by VA clinicians and VBA claims examiners accessing FHIE data through an interface between it and the Compensation and Pension Records Interchange (CAPRI). In October 2004, VA and DoD began implementation of the Bidirectional Health Information Exchange (BHIE). BHIE supports the exchange of electronic pharmacy, laboratory, allergy and radiology text data between all VA facilities and select DoD facilities. Currently, VA and DoD are continuing to work on the bidirectional exchange of computable pharmacy and allergy information between the DoD Clinical Data Repository and VA Health Data Repository. This project, known as "CHDR", will support information exchange between next-generation health systems and will permit the departments to conduct drug-drug and drug-allergy checking in each other's systems.

VA's Seamless Transition

In January of this year, VA established a permanent Office of Seamless Transition (OST) dedicated to improving the process. Although the OST administratively reports to the Principal Deputy Under Secretary for Health, it is composed of representatives from the Veterans Health Administration (VHA), the Veterans Benefits Administration (VBA), two active duty Marine Corps Officers and one Army Officer. The OST now coordinates

all Departmental activities related to the provision of benefits and health care for those service members transitioning directly from Military Treatment Facilities (MTFs) to VA facilities.

Over the last 2 years, the seamless transition initiative has achieved many successes in the areas of outreach and communication, trending workload, data collection, and staff education. VA has worked hard with DoD to identify OEF and OIF veterans and to provide them with the best possible information and access to health care and benefits. In partnership with DoD, VA has implemented a number of strategies, policies, and programs to provide timely, appropriate services to returning service members and veterans – especially those transitioning directly from DoD MTFs to VAMCs. Members' ability to enroll for VA health care and file for benefits prior to separation from active duty is the result of the seamless transition process.

Liaisons and Benefits Counselors at DoD and VA

VA has assigned full-time social workers and benefits counselors to eight major MTFs, including Walter Reed Army Medical Center in the District of Columbia, National Naval Medical Center in Maryland, Brooke Army Medical Center and Darnall Army Medical Center in Texas, Eisenhower Army Medical Center in Georgia, Madigan Army Medical Center in Washington, Evans Army Medical Center in Colorado, and Naval Hospital Camp Pendleton in California. These VA social workers work closely with MTF treatment teams to ensure that returning service members receive information and counseling about VA benefits and services. They also coordinate the transfer of active duty service members and recently discharged veterans to appropriate VA health care facilities and enroll them into the VA health care system. Through this collaboration, we have improved our ability to identify and serve returning service members who have sustained serious injuries or illnesses while serving our country. VHA staff has coordinated almost 2,500 transfers of OEF/OIF service members and veterans from an MTF to a VA medical facility. VBA benefits counselors are also stationed at MTF's to provide benefits information and assistance in applying for these benefits. These counselors are generally the first VA representatives to meet with the veteran and family

members. In FY 2005, VBA benefits counselors will have interviewed more than 7,300 OIF/OEF service members hospitalized at MTFs.

Points of Contact at Regional Offices and Medical Centers

Each VAMC and VA Regional Office (VARO) has identified a point of contact (POC) to coordinate activities locally and to assure that the health care and benefits needs of returning service members and veterans are met. VA has distributed guidance on the role and functions of case management services to field staff to ensure that the roles and functions of the POCs and case managers are fully understood, and that proper coordination of benefits and services takes place.

Benefits Delivery at Discharge

Many of the OEF/OIF service members who are not seriously injured and therefore do not separate through one of the MTFs participate in VA's Benefits Delivery at Discharge Program (BDD). This program allows service members to begin the VA disability compensation application process as much as 180 days prior to separation. In most cases, disabled service members participating in the BDD Program begin receiving VA disability compensation benefits within 60 days of their separation from active duty, which serves to ease the transition from active duty to civilian status. To expedite claims processing for these service members, VA and DoD have agreed upon a single examination process, using VA's examination protocols, if an examination is also required by the military prior to separation. A memorandum of agreement to establish single examination procedures was signed by VA and DoD in November 2004. The BDD Program is currently offered at 140 military installations. In FY 2005, BDD sites have taken more than 35,000 claims as well as 30,000 claims in 2004.

Outreach

Outreach to service members is a vital responsibility of VA and VBA in particular. We have increased our outreach activities over the last several years to reach service members, not only when they are preparing to separate or retire from the military, but also upon their induction into service and during service.

VBA is working with DoD to ensure that all Military Entrance Process Stations (MEPS) give every inductee a copy of VA Pamphlet 21-00-1, A Summary of VA Benefits. It provides basic information about the VA benefits and services for which they will be eligible when they leave military service.

From FY 2001 through the 3rd quarter of the FY 2005, VBA military services coordinators have conducted more than 30,800 VBA benefits briefings, reaching a total of more than 1.1 million active duty service members. These briefings include 3,674 pre- and post-deployment briefings attended by over 228,300 activated Reserve and National Guard service members. During FY 2004 alone, VBA military services coordinators provided more than 7,800 benefits briefings to over 276,000 separating and retiring military personnel, including briefings aboard some Navy ships returning to the United States. As of June of this year, we had already provided more than 6,300 briefings to about 260,000 separating service members in FY 2005.

VA also actively participates in discharge planning and orientation sessions for returning service members. With the activation and deployment of large numbers of Reserve/National Guard members for the onset of military actions in Afghanistan and Iraq, VA, in collaboration with DoD, has greatly expanded outreach to returning Reserve/National Guard members and their family members. National and local contacts have been made with Reserve/National Guard officials to schedule pre- and post-mobilization briefings for their members at the unit level. Returning Reserve/National Guard members can also elect to attend the formal 3-day TAP workshops provided by DoL and VA personnel. Knowing that this is an optional program for the Reserve/National Guard, VA has developed strategies to brief family members while the service member is still deployed and has arranged time on the unit training schedule and during reunions and family day activities. In addition, the National Guard/Reserve Coordinator in the Office of Seamless Transition has conducted numerous briefings to senior National Guard and Reserve leadership informing them of benefits and services available from VA and discussing ways the organizations can

partner to better serve returning National Guard and Reserve troops. During the April 29, 2005 hearing before the Economic Opportunity Subcommittee, VBA provided more detailed information on the Transitional Assistance Program (TAP) and Disabled Transitional Assistance Program (DTAP). In addition, VBA has had the opportunity to attend a field hearing before this committee just this month in New Hampshire where TAP and DTAP were discussed.

Working with DoD, we developed a brochure entitled "A Summary of VA Benefits for National Guard and Reserve Personnel." The brochure summarizes the benefits available to this group of veterans upon their return to civilian life. We have distributed over a million copies of the brochure to all mobilization stations to ensure the widest possible dissemination through VA and DoD channels. It is also available online at:

http://www.va.gov/environagents/docs/SVABENEFITS.pdf,

I have these here today for distribution to the Committee.

Other outreach activities include the distribution of flyers, posters, and information brochures to VAMCs, VAROs, and Vet Centers. VA has, in fact, distributed more than 1.5 million brochures to DoD demobilization sites and USO's. VA produced and distributed one million copies of a VA health care and benefits wallet/pocket card. Due to popular demand, VA reprinted another 500,000 copies (available on line at www.va.gov/environagents/docs/WalletCard1B101817804.pdf). The card lists a wide range of VA programs, and provides relevant phone numbers and email addresses.

Last year, VA began sending "thank-you" letters together with information brochures to each OEF and OIF veteran identified by DoD as having separated from active duty. These letters provide information on health care and other VA benefits, toll-free information numbers, and appropriate VA web sites for accessing additional information. The first letters and information brochures were mailed in April 2004, and as of June 30, 2005, VA had mailed letters to more than 357,200 returning OEF/OIF veterans. In 2005, letters and educational "tool kits" were sent to each of the National Guard Adjutants General and the Reserve Chiefs explaining VA services and benefits.

VA has also developed and distributed educational videos (e.g., "Our Turn to Serve"), designed for VA employees and others involved in these critical outreach efforts. A second video was developed, entitled "We Are By Your Side," for returning Guard/Reserve members and their families to help them through the readjustment period upon returning home.

A critical concern for veterans and their families is the potential for adverse health effects related to military deployments. VA has produced a brochure that addresses the main health concerns for military service in Afghanistan, another brochure for the current conflict in Iraq, and one that addresses health care for women veterans returning from the Gulf region. These brochures answer health-related questions that veterans, their families, and health care providers have about these military deployments. They also describe relevant medical care programs that VA has developed in anticipation of the health needs of veterans returning from combat and peacekeeping missions abroad. These are widely distributed to military contacts and veterans service representatives; they can also be found on VA's website at www.va.gov/Environagents/page.cfm?pg=16).

Another concern is the potential health impact of environmental exposures during deployment. Veterans may have questions about their symptoms and illnesses following deployment. VA addresses these concerns through such media as newsletters and fact-sheets, regular briefings to veterans' service organizations, national meetings on health and research issues, media interviews, educational materials, and websites, like www.va.gov/environagents. One major initiative to educate VA and DoD healthcare providers is the Veterans Health Initiative (VHI). Through the VHI, VA has developed training programs for such topics as care of war wounded, TBI, and PTSD among others. Available on line at www.va.gov/VHI, this important educational material is also available as a CD-ROM, and has been distributed to VA and DoD Healthcare providers. Additionally, we have created a web page for VA employees on the activities of VA's seamless transition initiative. Included are the

points of contact for all VA health care facilities and VAROs, copies of all applicable directives and policies, press releases, brochures, posters, and resource information.

The Vocational Rehabilitation and Employment (VR&E) Service is actively participating with other organizations to strengthen our coordination and outreach efforts to disabled veterans. VBA counselors provide the DTAP briefings for service members cited earlier in my testimony. VBA also works within such service improvement workgroups as VA's Seamless Transition Coordination Office, the National Guard/VA Joint Workgroup, Army Disabled Soldier Support System Employment Workgroup, DoD/DoL TAP Steering Committee, Interagency Demobilization Working Group, the Military Severely Injured Joint Support Operations Center, and the Marines for Life.

VR&E has an ongoing partnership with the Department of Labor's (DoL) Veterans' Employment and Training Service (VETS). VR&E staff in 57 regional offices and more than 100 outbased VA offices works closely with DoL's Disabled Veterans Outreach Program Specialists (DVOPs) and Local Veterans Employment Representatives (LVERs) to assist job-seeking veterans. There are currently 71 DOL DVOPs and LVERs co-located in 35 VA regional offices and 26 outbased locations. This access can help to better integrate DVOPs and LVERs into the initial vocational evaluation process with the real goal of the best delivery of employment services.

As I have noted, separating and retiring service members also receive general information packages through the Veterans Assistance at Discharge System (VADS). All separating and retiring service members (including reserve/guard members) receive a "Welcome Home Package" that includes a letter from the Secretary, a copy of VA Pamphlet 21-00-1, *A Summary of VA Benefits,* and VA Form 21-0501, *Veterans Benefits Timetable,* through VADS. Similar information is again mailed with a 6-month follow-up letter. Separate information packages are also sent about Education, Loan Guaranty, and Life Insurance benefits.

Following a recommendation from GAO, DoD established the Interagency Demobilization Working Group, which includes VA, DoD, the military services, Department of Homeland Security, and DoL. The working group also has representatives from the Guard, Reserves, and the demobilization and personnel communities. The group will make recommendations to all Departments concerned on how to improve transition assistance and the demobilization process for the Guard and Reserve.

VBA continues to support the Military Severely Injured Center through on-site support by one VBA employee. The Operations Center, was established to case manage assistance to severely injured returning service members and their families. It is a multi-agency effort with on-site assistance available from the Departments of Veterans Affairs, Homeland Security and Labor.

Casualty Assistance - In-Service Deaths

Regional office Casualty Assistance Officers (CAOs) visit family members and assist them in applying for benefits. These visits are coordinated with military CAOs under an arrangement of the Casualty Advisory Board (CAB). The CAB's membership includes the Assistant Director for Veterans Services, Compensation and Pension Service, and representatives from DoD and the various military service departments.

The Dependency and Indemnity Compensation application process has been streamlined through the use of a special worksheet, and claims have been centralized to the VA Regional Office and Insurance Center in Philadelphia. The goal is to process all in-service death claims within 48 hours of receipt of all required documents. At the time of the initial visit, family members are in an acute stage of grief and are not always able to absorb and understand the full range of benefits available to them. To ensure that surviving spouses and dependent children are aware of all benefits, a six-month follow-up letter is also sent to surviving spouses reminding them of the benefits and services. VA offers bereavement counseling to parents, spouses, and children of Armed Forces personnel who died in the service of their country. Family members of

reservists and National Guard members are provided these same services. A special brochure, VA Pamphlet 21-02-1, *Benefits and Services for Survivors of Servicemembers Who Die on Active Duty,* is given to survivors.

Survivors' Benefits Website

The Survivors' Benefits Website was a BEC initiative for 2005, developed and activated by a cross-agency work group. It provides information on key issues for surviving spouses and dependents of military personnel who died while in active military service and to the survivors of veterans who died after active service. This website was successfully deployed July 19 and is receiving positive reviews from surviving spouses who work with other groups such as Gold Star Wives and Tragedy Assistance Program for Survivors (TAPS).

VA Health Care Utilization

Veterans who have served or are now serving in Afghanistan and Iraq may, following separation from active duty, enroll in the VA health care system and, for a two-year period following the date of their separation, receive VA health care without co-payment requirements for conditions that are or may be related to their combat service. Following this initial two-year period, they may continue their enrollment in the VA health care system but may become subject to any applicable co-payment requirements.

As of June 2005, VA had data on more than 393,400 OEF and OIF veterans who had separated from active duty. Approximately 26 percent of these veterans (101,300) have sought health care from VA as of June, 2005. Most of these veterans have received outpatient care, while only a comparatively small number (approximately 2,400) have had an episode of hospitalization. Reservists and National Guard members make up the majority of those who have sought VA health care (approximately 53,770, or 53 percent). Those who separated from regular active duty have accounted for 47 percent (approximately 47,500). However, among separated OEF/OIF veterans eligible for VA health care, a greater percentage of veterans of regular active duty (30 percent) have sought VA health care than have Reservists/National Guards personnel (23 percent).

OEF and OIF veterans have sought VA health care for a wide-variety of physical and psychological problems. The most common health problems have been musculoskeletal ailments (principally joint and back disorders) and diseases of the digestive system, with teeth and gum problems being the predominant complaints. In total, OEF/OIF veterans have accounted for only about two percent of our total veteran patients.

Mr. Chairman, VA is aware that there has been particular interest about mental health issues among OEF and OIF veterans and VA's current and future capacity to treat these problems, in particular PTSD. First, I want to assure the Committee that VA has the programs and resources to meet the mental health needs of returning OEF and OIF veterans. Second, in regard to PTSD among OEF and OIF veterans, I want to assure you that the PTSD workload that we have seen in these veterans has been only a small percentage of our overall PTSD workload. In FY 2004, we saw approximately 279,000 patients at VA health care facilities for PTSD and 63,000 in Vet Centers. Our latest data on OEF and OIF veterans indicate that as of February 2005, approximately 12,300 of these veterans seen as patients at VAMCs carried an ICD-9 code corresponding to PTSD. It is important to note, however, that this represents approximately 4.5%-5% of VA's overall PTSD population. Additionally, more than 3,500 veterans received services for PTSD through our Vet Centers. Allowing for those who have received services at both VAMCs and Vet Centers, a total of approximately 14,600 individual OEF/OIF veterans had been seen with actual or potential PTSD at VA facilities following their return from Iraq or Afghanistan. This figure represents only about three percent of the PTSD patients VA saw in FY 2004. It should be noted, however, that some of the 14,600 OEF/OIF veterans may include those with a provisional ("rule-out") diagnosis of PTSD who were being assessed for this disorder or other, unrelated disorders.

Post-Deployment Dental Care

VA has seen a significant increase in the number of OIF/OEF personnel who are being de-mobilized and seeking dental care from the VA. Because of early briefings on this emergent issue, I directed that dental care be made a priority on the JEC agenda for

resolution. The Assistant Under Secretary for Health for Dentistry and the Director/Dental Care Division, TRICARE Operations Division, TRICARE Management Activity (TMA) appeared before the JEC in June, 2005, to report on the significant increase in VA dental workload at a significant cost increase per patient Following the briefing, the Under Secretary of Defense for Personnel and Readiness directed that a working group be established to research this issue and standardize the process of completing the dental section of the DD-214 (Certificate of Release or Discharge from Active Duty). Additionally, I instructed that $10 Million in funding be provided for this patient group recognizing along with DoD- Health Affairs (HA) and the military services that funding for post-deployment dental care was an unfunded requirement that must be jointly addressed.

Subsequently, the HEC established a joint working group. They have determined the services may lack a standardized method of completing the DD-214 that can result in individuals without dental treatment needs receiving unnecessary dental examinations from VA facilities. This resulted in Dr. Chu's direction to the Services to review the DD-214 completion process. Accordingly, TMA Dental Division and VA dental will evaluate all patient visits from FY 2003-2005 to identify individuals by branch of service who received dental exams but did not require treatment. This process will continue through FY 2006.

Polytrauma Centers

One of the harshest realities of combat in Iraq and Afghanistan is the number of service members returning from Iraq and Afghanistan with loss of limbs and other severe and lasting injuries. VA recognizes that it must provide specialized care for military service members and veterans who have sustained severe and multiple catastrophic injuries. Since the start of OEF/OIF, VA's four regional Traumatic Brain Injury (TBI) Lead Rehabilitation Centers (located in Minneapolis, Palo Alto, Richmond, and Tampa) have served as regional referral centers for individuals who have sustained serious disabling conditions due to combat. These programs are specially accredited to provide comprehensive rehabilitation services and TBI services. Patients treated at these

facilities may have a serious TBI alone or in combination with amputation, blindness, or other visual impairment, complex orthopedic injuries, auditory and vestibular disorders, and mental health concerns. Because TBI influences all other areas of rehabilitation, it is critical that individuals receive care for their TBI prior to, or in conjunction with, rehabilitation for their additional injuries.

In accordance with section 302 of Public Law 108-422, VA is expanding the scope of care at these four centers to create Polytrauma Rehabilitation Centers (PRCs). The PRCs build on the capabilities of the regional referral centers but add additional clinical expertise to address the special problems that the multi-trauma combat injured patient may face. Such additional services include intensive psychological support treatment for both patient and family, intensive case management, improvements in the treatment of visual disturbance, improvements in the prescription and rehabilitation using the latest high tech specialty prostheses, development of a clinical database to track efficacy and outcomes of interventions provided, and provision of an infrastructure for important research initiatives. Per PL 108-422, certified rehabilitation nurses from VA will be assigned to Walter Reed Army Medical Center and National Naval Medical Center to initiate the assessment and coordination of care for active duty members with complex critical injuries. Additionally, the polytrauma centers address services for patients in the outpatient setting for ongoing follow-up care not requiring hospitalization. Existing rehabilitation outpatient clinical services have been enhanced to ensure that necessary services can be provided within easier access to the patient's home. To date, the four Polytrauma Rehabilitation Centers have treated 198 severely injured individuals.

VA/DoD Military Army Liaison Representatives

The Army Liaison Representative is a crucial uniformed member of the VA/DoD Polytrauma Rehabilitation Center (PRC) Collaboration. This representative functions as an integral member of the Polytrauma Rehabilitation Center team. The Army Liaison Collaboration is a joint service initiative and the Liaison functions as the hub in the military transition process for the seriously injured service member and their family

during the transfer of care from Military Treatment Facilities (MTFs) to VA. The Army Liaison represents the military and expedites the transfer of information and communication between MTFs and VA, between MTFs and family members and between VA, service members and family members. The presence of a uniformed liaison is very important in lessening feelings of abandonment from the military by both soldiers and family members during this critical transition period.

Nurse Recruitment & Staffing Project / Augusta VAMC and Eisenhower Army Medical Center

A successful joint staff recruitment project is ongoing between the Augusta VAMC and Eisenhower Army Medical Center (EAMC). Augusta VAMC is a two-division medical center that provides tertiary care in medicine, surgery, neurology, psychiatry, rehab medicine and spinal cord injury including a 30-bed Rehab Care Unit for active duty care. EAMC is a 300-bed hospital located at nearby Fort Gordon. EAMC relies on a satellite Human Resources (HR) Office. An opportunity was identified for August and EAMC to integrate HR processes and systems and integrate/share educational opportunities that enhanced EAMC's recruitment/hiring abilities and subsequently reduces their costs for contract nursing staff.

This collaboration has met or exceeded nearly all of its measures for success including the hiring and placement of RNs for the critical care internship program and the nursing float pool, as well as the integration of educational training programs.

VA/DoD Joint Collaboration in Certified Registered Nurse Anesthesia training.

The U.S. Army Medical Department Center and School of Certified Registered Nurse Anesthesia (CRNA) at Fort Sam Houston, TX and VA have been engaged in a collaborative training effort since 2004 to train CRNAs. The VA has graduated three CRNAs and has five students in the program at present.

Tuition being charged by the US Army for the VA students is less than $10,000 for the entire program in contrast to civilian programs that average $30,000 a year. VA

students receive an education that is compatible with VA patient needs including trauma and disaster training not available in civilian programs.

As a result of this program, VA has developed relationships with other DoD services for clinical site rotation including the placement of an Air Force CRNA student in the Tucson VA receiving case experience in cardiothoracic patients and the placement of Army CRNA students in the VA New Orleans, VA Brooklyn and VA San Antonio. Also as a direct result of our presence at the Army Medical Department Center & School we now have the first non-military training site for Army operating room technicians at the VA San Antonio.

VA/DoD Summit

On June 27, 2005, VA and DoD held a Seamless Transition Summit to discuss institutionalizing a coordinated transition process for service members and their families as they separate from active duty status and become veterans. The objective of the Summit was to understand the existing process; assess the degree of coordination or duplication; and develop recommendations to improve the information flow between VA and DoD. Recommendations from the Summit were analyzed and presented to the Health Executive Council (HEC) during its August meeting. The HEC recommended establishing a VA/DoD Joint Seamless Transition Working Group to monitor and report on seamless transition activities and initiatives. The working group would also be responsible for further development of the issues identified and recommendations offered by the Summit participants. The recommendation will be submitted to VA's Under Secretary for Health and DoD's Assistant Secretary of Defense for Health Affairs for approval.

Future Initiatives

- Although the seamless transition initiative was initially created to support service members who served in OEF/OIF, it is intended to become an enduring process that will support all service members who, as a result of injury or illness, enter the disability process leading to medical separation or retirement.

- VA continues to work with DoD to obtain a list of service members who enter the Physical Evaluation Board (PEB) process. The PEB list will identify those veterans who sustained an injury or developed an illness that precluded them from continuing on active duty and resulted in medical separation or retirement. The list will enable VA to contact these service members to initiate benefit applications and transfer of health care to a VAMC prior to discharge from the military.
- VA is strengthening its support system for veterans and their families to accommodate them in Fisher Houses and hotels as the veterans continue the rehabilitation process. VA's goal is to honor each new veteran and their family with compassion, dignity, and coordination of every service and support that can help to restore function. VA has made great strides in ensuring our veterans experience a smooth transition to civilian life. VA is committed to institutionalizing the seamless transition process as we continue to further increase collaboration with DoD.
- Finally, VA will continue to transform its culture to meet the expectations of our newest veterans and their families.

Conclusion

Meeting the comprehensive health care and benefit needs of returning OEF and OIF veterans who choose to come to VA is one of the Department's highest priorities. Mr. Chairman, this concludes my statement. My colleagues and I will be happy to respond to any questions that you or other members of the Committee might have.

THE HONORABLE STEPHEN L. JONES

PRINCIPAL DEPUTY ASSISTANT SECRETARY OF DEFENSE
FOR HEALTH AFFAIRS

BEFORE THE

COMMITTEE ON VETERANS AFFAIRS

U.S. HOUSE OF REPRESENTATIVES

SEAMLESS TRANSITION

September 28, 2005

NOT FOR PUBLIC RELEASE UNTIL
10:00 AM ON September 28, 2005

Mr. Chairman and distinguished members of the committee, thank you for the opportunity today to discuss the myriad initiatives and programs ongoing both within the Department of Defense (DoD), and in coordination with the Department of Veterans Affairs (VA) through the Joint Executive Committee structure to improve the transition process for Service members and their families. I will discuss some of the noteworthy programs DoD has already put in place to meet the needs of our Service members and families as they transition from Uniform Service back to civilian life. I also want to add, though, that we are aware that the process can be improved. DoD is committed to continuing collaborative efforts with VA to refine each Department's respective seamless transition programs to create a single continuum that encompasses and integrates all of the steps involved in transitioning from the battlefield to a Military Treatment Facility (MTF) veteran status and eventually back to the community.

The Department is working hard with seamless transition initiatives and programs to provide improved care for our injured and ill service members who have bravely served our Nation in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). These programs support the recommendations made in the Report of the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans and can be categorized in three general areas: 1) medical care and disability benefits, 2) transition to home and community, and 3) sharing Service member personnel and health information.

Medical Care

First, I want to highlight four key programs related to medical care in which DoD is working jointly with VA. The Army Liaison/VA PolyTrauma Rehabilitation Center

Collaboration program is a "Boots on the Ground" program stood up in March 2005 to serve severely injured service members who need a long recovery and rehabilitation period. These individuals are transferred directly from an MTF to one of the four VA PolyTrauma Centers, in Richmond, Tampa, Minneapolis, and Palo Alto. These Centers provide rehabilitative services for patients with traumatic brain injuries, amputations and other serious injuries. A non-commission officer is assigned to each of these four Centers, with an Army Office of the Surgeon General program manager detailed to the VA Office of Seamless Transition. The role of the Army liaison is primarily to work along with VA personnel in providing support to the family and the service member through assistance and coordination with a broad array of issues, such as travel, housing, and military pay. The liaisons have also played a critical role in the rehabilitation process by promoting resiliency in service members.

The next program is the DoD/ VA Joint Seamless Transition Program, established by VA in coordination with the Services, to facilitate and coordinate a more timely receipt of benefits for injured Service members while they are still on Active Duty. There are VA social workers and benefit counselors assigned at eight MTFs that serve the highest volumes of severely injured service members. This includes Walter Reed Army Medical Center, and the National Naval Medical Center in Bethesda, and six other DoD facilities. VA staff stationed at these MTFs brief service members about the full range of VA benefits including disability compensation claims and health care. They coordinate the transfer of care to VA Medical Centers near their homes, and maintain follow-up with patients to verify success of the discharge plan, and ensure continuity of therapy and medications. These VA case managers also refer patients to Veterans Benefits

counselors and Vocational Rehabilitation Counselors. As of August 2005, more than 3,900 patients have received VA referrals at the participating military hospitals.

The third area related to medical care entails the numerous initiatives within DoD designed to promote and provide treatment for the mental well being of all soldiers, sailors, airmen and Marines in the active, Reserve and National Guard components, as well as their families. Leadership, community programs, and dedicated helping professionals in garrison and in operational theaters form the core of mental health support for our service members and their families. This support is a continuum from community-based services, including buddy care, non-medical support resources, and chaplains; to command level involvement, monitoring morale, improving living conditions and supporting quality of life initiatives; to the full spectrum of clinical care and patient movement of the Military Health System for those with a need for more intensive support.

Some Service members, a minority, may develop chronic mental health symptoms. Experts from the Department of Veterans Affairs and Department of Defense co-developed clinical practice guidelines for acute stress, post traumatic stress disorder, depression, substance abuse disorders, medically unexplained symptoms, and general post-deployment health concerns. Local military or TRICARE providers (a benefit extended for up to 180 days post-deactivation for Reservists) treat affected Service members. VA also provides mental health services to OEF and OIF veterans who are no longer on active duty.

Service members are screened for mental health problems when they complete a preventive health assessment as part of DoD's overall Health Surveillance program—the

fourth key medical care program. Service members are also screened before they deploy, and before returning home from deployment, members complete a Post-Deployment Health Assessment. This assessment includes questions about acute stress, post traumatic stress disorder, depressions, substance abuse, and unexplained symptoms. Additionally, each of the Services is now in the process of implementing a Post-Deployment Health Reassessment to be conducted 3-6 months after returning home. Our experience has taught us that problems are not always apparent at the time service members are immediately returning home, but they may surface a few weeks or months later. We want to catch these problems, and help.

Transition to Home and Community

The second area in which DoD is working closely with VA involves those activities that occur at the point in the process where the actual transition takes place. I want to speak about three of these programs.

First is the Transition Assistance Program/Disabled Transition Assistance Program (TAP/DTAP). As an integral part of the pre-separation counseling program, VA counselors advise separating Service members on VA health care, compensation, VA home loans, Montgomery GI Bill, and Veterans' Group Life Insurance benefits. Additionally, the Department of Labor (DOL) provides employment workshops usually two and a half days in duration. This program has been successful at providing much needed information to Service members separating from Active Duty. However, the Department, as noted in the GAO report, "Military and Veteran's Benefits; Enhanced Services Could Improve Transition Assistance for Reserves and National Guard," recognizes there are inconsistencies in the delivery of VA Benefits Briefings for the

Guard and Reserves, and these inconsistencies vary from installation to installation. To ensure we have continuous improvement and meet the needs of our Reserve component, DoD established an Interagency Demobilization Working Group to address the numerous and complex issues associated with the TAP/DTAP. The working group is currently considering several policy changes including the impact of mandating attendance at VA benefits briefings.

Next, in November 2004, the Joint Executive Council signed a Memorandum of Agreement (MOA) to provide overarching implementation guidance for cooperative procedures for physical examinations for military separation and for VA determination of disability. This agreement streamlines the physical examination process without compromising the gathering of information that is critical for each department. This cooperative procedure also addresses the disadvantages of the previous procedures, in which a Service member might be required to unnecessarily undergo two physical examinations within months of each other, when separating from the military and when filing for VA disability compensation. Under this MOA, Service members can begin the claims process with VA up to 180 days prior to separation through VA's Benefits Delivery at Discharge (BDD) program. The MOA also delegates responsibility for implementing the program to the regional VA and DoD facilities. This policy is clear that the service member's convenience is to be considered in the evaluation of which entity has the available medical resources to conduct examinations. Since November 2004, 91 agreements to implement the cooperative procedures have been signed between VA and nearby military treatment facilities.

To enhance the Seamless Transition effort, the Military Severely Injured Center (MSIC), established in February 2005, operates a hotline center which functions 24 hours a day, seven days a week. The Center's mission is to assist injured service members and families achieve the highest level of functioning and quality of life by providing advice on the full spectrum of benefits, putting them in contact with these resources, and solving problems. Service members or family members can call a toll free number and speak to a care manager, who becomes their primary point of contact over time. The Center is working to coordinate outreach and referral services with Service-specific programs—the Army Disabled Soldier Support (DS3), the Navy Safe Harbor program, the Air Force Helping Airmen Recover Together (Palace HART) program, and Marine4Life. As of September 2005, care managers were working more than 1200 active issues. The most frequent request for assistance is related to financial and employment concerns. The DOL REALifelines program has been an integral component at MSIC in addressing employment issues. The second most frequent request is related to family services, such as travel arrangements or family counseling. DoD personnel are augmented by detailed employees from VA and the Transportation Security Administration.

Information Sharing

Mr. Chairman, the third key area that the Department of Defense is working in earnest with VA is in the transfer of Service member personnel and medical information. Information sharing between the two departments is absolutely critical to an effective and transparent transition process. In this vein, DoD and VA signed an MOA governing the sharing of Protected Health Information (PHI) and other individually identifiable information in June 2005—the so-called "HIPAA MOA."

DoD and VA are also pursuing several information management and technology initiatives to significantly improve the secure sharing of appropriate health information. These initiatives will enhance health care delivery to beneficiaries and improve the continuity of care for those who have served our country. The Bidirectional Health Information Exchange (BHIE) enables near real-time sharing of allergy, outpatient prescription and demographic data, and laboratory and radiology results between DoD and VA for patients treated in both DoD and VA. BHIE is operational in the Seattle, WA area, El Paso, TX and Eisenhower Army Medical Center, Augusta, GA. Deployment to additional sites in FY 2006 is being coordinated with the Service and the local DoD/VA sites. Site selection was based on support for severely wounded members of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF), number of visits for VA beneficiaries treated in DoD facilities, number and types of DoD medical treatment facilities, local sharing agreements, retiree population, and local site interest. In 2005, DoD plans to expand this capability to the Naval Hospital Great Lakes in Chicago, IL, the Naval Medical Center in San Diego, CA, the National Capital Area, the Landstuhl Regional Medical Center in Germany and to other DoD medical treatment facilities as well. DoD and VA can now facilitate care of the same Service member returning from OEF and OIF by sharing patient information.

Next is the Clinical Data Repository/Health Data Repository, which establishes interoperability between DoD's Clinical Data Repository and VA's Health Data Repository. The Departments successfully tested the exchange of computable outpatient pharmacy and allergy data in a laboratory environment in September 2004. This test

demonstrated the ability to do drug-drug and drug-allergy checking using outpatient pharmacy and allergy information from both Departments. VA and DoD are currently working to implement Phase 2 of the work between the Clinical Data Repository and Health Data Repository in a production environment. Like the prototype, Phase 2 CHDR also will support the exchange of outpatient pharmacy and allergy information, and drug-drug and drug-allergy checks in each other's next generation health information systems for DoD and VA, CHCS II and HealtheVet-VistA.

DoD has also successfully added the capacity to add electronic pre- and post-deployment health assessment information to the monthly patient information being sent to the VA. DoD completed an historical data pull in July 2005 that resulted in approximately 400,000 pre and post deployment health assessments being transmitted to the data repository at the VA Austin Automation Center. We expect to begin transmitting electronic pre and post deployment health assessment data monthly to the data repository in September 2005. VA is scheduled to have the capability to retrieve the data in November 2005. DoD has begun activities to add post-deployment health reassessment information to the data being sent to VA.

Finally, DoD is providing contact information on Service members when they separate. DoD began routinely providing VA rosters on Recently Separated OEF/OIF Veterans—Active Duty and Reservist Components in September 2003. The VA noted that some 12,000 of the initial 70,000 were still on active duty. Originally, proxy pay-files were used to identify individuals who were potentially deployed to OEF/OIF combat

theaters. In June 2004, a new process that more accurately identified those who deployed to OEF/OIF combat theaters and then separated from active duty was instituted, but that new process lost the ability to differentiate which individuals were OEF from those who were OIF. DoD continued to work closely with VA to get the rosters back on line and improve their usefulness. Since January 2005, the VA Office of Environmental Hazards reports that the accuracy of the DMDC OEF/OIF veteran rosters being provided is excellent, although theater specificity is still not available. The rosters for the VA will continue to be reviewed and are a regular agenda item at the DoD/VA Deployment Health Working Group.

The next step to close the gap between DoD benefits and VA benefits is to provide rosters to VA earlier in the transition process. To this end, DoD is developing a policy and specific business rules that will result in sharing the member's name, social security number, unit ID, current location, contact information, and a brief explanation of their medical condition via two rosters on OEF/OIF Service members. The first roster will contain information on Service members for whom a Medical Evaluation Board has referred them to a Physical Evaluation Board. The second roster will contain information on Service members who have been medically classified as Seriously Ill or Injured (SI), Very Seriously Ill or Injured (VSI), Special Category (SPECAT)—patients with loss of sight or limb, and/or paralysis, and lastly, Enabling Care Patients who have suffered amputations, traumatic head injury, eye injury, and post traumatic stress disorder. Sharing this information with the VA at a point earlier in the transition process will result in the expedited delivery of benefits to transitioning Service members and reduce the chance for anyone to fall through the cracks. By establishing the necessary information

sharing electronic structure we shall further ensure a seamless transition service for those we serve.

Mr. Chairman, this concludes my statement. I thank you and the members of this committee for your outstanding and continuing support of America's heroes--our Nation's Service members, veterans and their families.

STATEMENT BY

MAJOR GENERAL RONALD G. YOUNG
DIRECTOR, NATIONAL GUARD BUREAU JOINT STAFF

BEFORE THE

COMMITTEE ON VETERANS AFFAIRS
UNITES STATES HOUSE OF REPRESENTATIVES

FIRST SESSION, 109TH CONGRESS

ON SEAMLESS TRANSITION BETWEEN DEPARTMENT OF VETERANS AFFAIRS AND THE DEPARTMENT OF DEFENSE

SEPTEMBER 28, 2005

STATEMENT BY
MAJOR GENERAL RONALD G. YOUNG
DIRECTOR, NATIONAL GUARD BUREAU JOINT STAFF

Chairman Buyer, distinguished members of the Committee. My name is Ronald Young, Director, Joint Staff, National Guard Bureau. Thank you for the opportunity to speak with you today.

Today, we have 330,000 Army and 107,000 Air National Guard members of the National Guard serving our Country, States and Territories. During 2004 117,000 Reserve Component members were mobilized that met the minimum 180 days of active duty for full eligibility of benefits under the Transition Assistance Program.

Transition Assistance is a critically important component in our efforts to take care of Service members. We appreciate the opportunity to meet with you and review these programs. The information received during these briefings and the opportunity to enroll in these vital programs has long lasting effects on our men and women in the National Guard, their families and their communities. The effectiveness of Transition Assistance also holds significant implications for the long term health of our organization as a whole. The interest and concern by the President, Congress, Department of Defense and Senior Leaders within the Armed Forces for our men and women returning from difficult missions is reflected in these benefits and the timeliness of there receipt is critical to each member and their family.

Guard and Reserve personnel are entitled to participation in the Transition Assistance Program when they were mobilized The Transition Assistance Program was primarily focused on the transition of Active Component Service members to civilian life, but since more and more guard and reserve members have been mobilized of late, it has re-focused it objectives. It is very beneficial

to have these briefings, as some benefits require that the member apply before he or she leaves mobilized active duty status.

The need to spend effective time and limited resources in a comprehensive and efficient manner to determine the needs of service members during the course of their transition is critical. These types of programs are critical to ensuring our members and their families participate and help them determine the best next steps as they move back in to civilian life. As you are aware, there are really four components to TAP: the pre-separation counseling presented by the services; the VA benefits briefing; the Department of Labor's employment workshops; and the Disabled Transition Assistance Program (DTAP).The National Guard supports the initiatives planned or currently underway to improve the effectiveness of the Transition Assistance Program.

We face several leadership challenges as we execute the Transition Assistance Program for Guard members. While originally designed for the transition of Active Duty members to civilian life the program has evolved as more reserve and guard members are mobilized. There is an understandable interest both on the part of the Services and the members in demobilizing as quickly as possible in order that they may be returned to their families. As military leaders, we must work to educate our members about the availability and value of the Transition Assistance Program, which is currently administered at mobilization stations.

Transition Assistance Program managers must effectively educate National Guard members since the DoD compensation system depends, in part, on the use of benefits to leverage post-mobilization retention. As a result, the Guard leadership must ensure that our members fully understand that several important benefits are contingent upon continued service following demobilization.

The Transition Assistance Program briefings provide members with the opportunity to reintegrate with their families and avail themselves of all that Transition Assistance has to offer. In addition, the local Family Support Centers of the National Guard have arrayed a number of community based organizations and volunteer service organizations that create a significant synergy with the Transition Assistance Program. These organizations can compliment the VA, DOD and DOL programs.

The Department of Veterans Affairs (VA) has counselors that dissemination Veterans Affairs benefit information to members during the Transitional Assistance Briefings. It is especially important with regard to those members who have incurred disabilities during the course of their active duty. Of course VA works with disabled members while on active duty to help them apply for benefits that relate to disabilities incurred on active duty. Presently, the Employer Support of the Guard and Reserve (ESGR) benefits are included as a part of the Transition Assistance Program at the various demobilization stations.

Several pilot programs are currently underway to improve the administration of the Transition Assistance Program and the Disabled Transition Assistance Program. Of particular note are VA and DoD efforts to deliver Veterans benefits briefings during weekend drill periods following demobilization -- greatly enhancing the effectiveness of this program. The Department of Labor's employment assistance pilot programs in Minnesota, Oregon, and Michigan are exploring several means by which employment assistance can be provided to Guard members.

As noted earlier, while enhanced Service-member participation in the Transition Assistance Program is important for a host of reasons, it is also of critical importance to the National Guard from an organizational perspective. Retention of Guard members following mobilization is a critical component of the overall Guard strength management equation. Transition Assistance is a critical part of

this effort, because the current compensation strategy bases many incentives upon continuing service member participation. For example, participation in TRICARE Reserve Select, which provides one year of TRICARE coverage for every 90 days of mobilized service, is available to members who choose the remain in a Selected Reserve status. Similarly, the Reserve Education Assistance Program, which provides up to 80% of the benefits enjoyed under the existing Active Duty Montgomery GI Bill, is available to service members who choose to remain in the Ready Reserve.

Taking care of National Guard members must remain a high priority. Leveraging the benefits available to National Guard members and their families through enhanced administration of the Transition Assistance Program represents a key component in our commitment to the welfare of returning veterans and their families.

Working with the members of this Committee, I believe that the National Guard, working hand in hand with the leadership in the Departments of Defense, Labor and Veteran's Affairs, as well as state and local agencies, can continue to dramatically enhance National Guard members' quality of life and our personnel retention.

Thank you.

RECORD VERSION

STATEMENT BY

SHEILA A. HOBBS
COLONEL, UNITED STATES ARMY
SENIOR PATIENT ADMINISTRATOR
OFFICE OF THE SURGEON GENERAL

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

FIRST SESSION, 109TH CONGRESS

INVITATIONAL TRAVEL ORDERS FOR FAMILY MEMBERS OF ARMY PERSONNEL

28 SEPTEMBER 2005

NOT FOR PUBLICATION
UNTIL RELEASED BY THE
COMMITTEE ON VETERANS' AFFAIRS

Mr. Chairman and distinguished members of the Committee, thank you for the opportunity to come before you today to discuss Invitational Travel Orders and support of family members of wounded and ill Soldiers sent to VA Medical Centers from military treatment facilities. This is an area we recognized was in need of work, and we appreciate the opportunity to share our systemic improvements with you.

An Invitational Travel Order (ITO) is a mechanism used by the Army to cover transportation and sustainment costs for individuals. ITOs have a wide-variety of uses. A Non-Medical Attendant (NMA) order is a particular type of ITO that allows family members of injured Soldiers to travel from home or a military medical treatment facility to another medical treatment facility, including civilian and VA facilities. Even before the start of the Global War On Terror, the use of NMA orders was a fairly common practice. The authority for issuing NMA orders is clearly outlined in the Joint Federal Travel Regulation and Military Medical Treatment facilities are very familiar with the NMA process.

NMA orders are issued when medical authorities determine that a non medical attendant is in the best interest of the patient. They are normally issued when a patient is unable to travel alone due to physical or mental disability. The orders are issued and funded by the military treatment facility responsible for providing medical care. NMA orders authorize reimbursement for travel, lodging, and meals. They are not open-ended, but extensions are possible on a case-by-case basis.

Since the beginning of GWOT, the Army's Human Resources Command (HRC), Casualty Branch has issued ITOs to bring family members from their homes to the bedside of their injured Soldier while they are hospitalized in a military treatment facility. These ITOs are different from the NMA orders issued at military treatment facilities. In the past, there has been some confusion between ITOs issued by HRC and NMA ITOs issued by military treatment facilities. Once Soldiers were transferred to the VA facilities, HRC no longer had visibility of the Soldiers and family members. When ITOs

expired, HRC was unaware of the situation. Once this was identified as a systemic flaw, action was immediately taken to correct the process. Instead of extending existing ITOs by HRC to cover the Soldier's family member at the VA facility, Army MTFs are now issuing NMA orders authorizing family member travel to VA facilities. This allows the MTF to transfer the Soldier and family member to the appropriate civilian or VA facility for continued care without requiring HRC to amend the existing ITO or issue a new travel order. The MTF has the medical authority required to issue and extend the Attendant order as well as the patient tracking systems necessary to know where patients are located and when they will be transferred.

ITO and NMA orders for family members of Operation Iraqi Freedom and Operation Enduring Freedom casualties are funded using GWOT supplemental dollars. When the Soldier is discharged from a VA facility or medically separated or retired, funding of family member by the Department of Defense stops.

Although this new process has only been in place for two months, we are already seeing improved results. In addition, we have placed senior Army medical department representatives at the four VA Poly-Trauma Centers to provide continuous support to our Soldiers and their families. The seamless transition of Soldiers and their families from military treatment facilities to VA Centers is an integral part of providing care to our Soldiers. NMA ITO orders issued and tracked by MTFs will improve this important transition. Whether Soldiers are receiving medical care at an Army hospital or a VA medical center, the Army is committed to providing world-class, compassionate care to our wounded warriors and their families.

Thank you for the opportunity to appear before the committee.

Testimony
Before the Committee on Veterans Affairs
U.S. House of Representatives

Statement of

Susan D. McAndrew, J.D.

Senior Advisor for Health Information Privacy Policy
Office of Civil Rights
U.S. Department of Health and Human Services

For Release on Delivery
Expected at 10:00 a.m.
Wednesday, September 28, 2005

Introduction

Mr. Chairman and members of Committee, I am Susan McAndrew, Senior Health Information Privacy Policy Specialist, in the Office for Civil Rights. The Office for Civil Rights is the component of the U.S. Department of Health and Human Services (HHS) responsible for the implementation and enforcement of the Privacy Rule, issued pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). On behalf of Richard M. Campanelli, the Director of the Office for Civil Rights, I thank you for the invitation to testify today on the application of the Privacy Rule to the transfer of medical information between the Departments of Defense (DoD) and Veterans' Affairs (VA).

I am pleased to have represented the Office for Civil Rights at the July 14, 2005, roundtable discussion of these issues, hosted by Chairman Bilirakis and other members of the Subcommittee on Oversight and Investigations. My statement today will serve to enter into the hearing record the explanations and clarifications of the HIPAA Privacy Rule provided at the roundtable session. To that end, I am providing as part of my statement, the July 27, 2005, letter to Congressman Bilirakis from Mr. Campanelli which clarified selected areas of the Privacy Rule that were most relevant to the transfers of information between the DoD and VA.

Background

The *Standards for Privacy of Individually Identifiable Health Information* – better known as the HIPAA Privacy Rule – establishes, for the first time, a set of national standards for the protection of certain health information. In December 2000, HHS issued the Privacy Rule to implement the requirements of Health Insurance Portability and Accountability Act of 1996 (HIPAA). Those regulations were modified in a number of significant ways by further rulemaking in August 2002 to ensure the final Privacy Rule was workable and to avoid unintended consequences of certain provisions that would have impeded an individual's access to health care or prompt payment for those health care services. These federal privacy standards have been in operation for over two years and we are pleased to note that implementation has been smoother

than many expected, with the standards now becoming embedded as part of the daily practices of most health plans and health care providers across the nation.

The Privacy Rule standards address the use and disclosure of health information that is individually identifiable – called protected health information – by persons or entities that are subject to the HIPAA requirements – called covered entities. The Privacy Rule standards also give individuals certain rights with respect to their health information, including the right to receive notice from a covered entity about that entity's privacy responsibilities and practices and about the individual's other rights under the HIPAA Privacy Rule, the right to access and get a copy of their medical record and to ask to have that record amended if it is incomplete or incorrect, and the right to ask for accounting from the covered entity of certain disclosures of protected health information. The HIPAA Privacy Rule creates a uniform federal floor of privacy protections for health information; however, it does not prevent states or entities from adopting laws or practices that provide additional privacy protections.

The Privacy Rule is carefully balanced to ensure strong privacy protections without impeding the flow of information necessary to provide access to quality health are, and to that end, the Rule permits covered entities to share protected health information for core purposes – to treat the individual and to obtain payment for the health care service provided – without obtaining the individual's prior consent or authorization. In addition to treatment and payment functions that are critical to the provision of health care, the Privacy Rule also permits a limited number of other uses and disclosures of protected health information, without an individual's authorization, based on a determination of a compelling public interest need for identifiable health information for these purposes. For example, and subject to specific conditions or limitations that may apply to each public interest purpose, a covered entity may, without individual authorization, disclose protected health information as required by other federal or state law, for public health purposes, or for research. And, of course, the individual may authorize in writing any other use or disclosure of protected health information. The Rule provides for standards for authorizations to make sure that the individual's permission for a particular use or disclosure of his or her medical information is both informed and voluntary.

It is important to remember that the HIPAA Privacy Rule applies to persons or entities that are defined as "covered entities," including health plans, health care clearinghouses, and any health care provider that electronically transmit health information in connection with a transaction – such as billing a health plan for reimbursement for services – for which there is a HIPAA standard transaction and code set. By statute, both the health care program for active military personnel under title 10 of the United States Code and the veterans' health care program under chapter 17 of title 38 of the United States Code are considered to be health plans, and hence covered entities for purposes of the HIPAA Privacy Rule.

Key Privacy Rule Provisions

With this general background, I would like to turn to the specific provisions of the HIPAA Privacy Rule that will have the most direct impact on the transfer of medical information between the DoD and the VA. In the first set of uses and disclosures discussed below, it will be clear that the Privacy Rule does not create a barrier to the transfer of medical information when related to provision of health care to the individual or payment for the provision of such care. The second set of uses and disclosures directly relates to the sharing of information between the DoD and the VA, and within the VA, when active duty military personnel are transferring to veteran status. Taken together, these provisions allow protected health information to be used and disclosed in a way that promotes seamless transitions from DoD to VA.

Treatment and Payment

Treatment disclosures include covered health care providers using and disclosing protected health information for their own treatment purposes and health plans or health care providers disclosing individually identifiable health information for the treatment of the individual by others. Specifically, the Privacy Rule defines treatment to include the provision, coordination, or management of health care and related services by one or more providers, including the coordination or management of health care by a health care provider with a third party, consultation among health care providers relating to a patient, and the referral of a patient from one health care provider to another. The definition allows covered entities not only to provide

health care but also to offer or coordinate social, rehabilitative, or other services that are associated with the provision of health care. Thus, the Rule would allow the sharing of patient information between DoD and VA for purposes of treating individuals, including activities related to the continuity of care and services related to that care as the individual transitions from one health care setting or program to another.

In addition, a covered entity may disclose protected health information as necessary to determine or fulfill its responsibilities as a health plan for coverage and provision of benefits, and to furnish or obtain payment or reimbursement for health care provided to an individual. Thus, the Privacy Rule would allow the sharing of patient information between DoD and VA when health care is being provided in the facilities of one Department, but the other Department is responsible for the payment or reimbursement for those services.

Special Rules for Sharing Information by DoD and VA

In addition, in drafting the Privacy Rule, we recognized the legitimate need for the DoD and VA to share an individual's medical information as that individual transfers from active duty to veteran's status, even though the individual may not at that time be receiving health care services from the VA. The Rule permits DoD to disclose, without individual authorization, the protected health information of members of the Armed Services upon their separation or discharge from military service to the VA so that the VA may determine individuals' eligibility for or entitlement to veterans' benefits. In allowing this sharing of information we considered the benefits to individuals in receiving a timely determination of their eligibility for benefits under VA programs, the general support for the information transfer program that had operated without objection prior to the Privacy Rule, and the privacy protections afforded this information when transferred to the VA under the Privacy Act, or the Privacy Rule itself. In addition, this provision also allows the sharing of protected health information within components of the VA to determine eligibility for or entitlement to veterans' benefits.

These provisions afford DoD and VA have significant to improve the timeliness and efficiency of the transfer of medical information to prevent any lapse in coverage or disruption in services to active duty service members who are transitioning to veterans status.

Other Provisions

Based on our understanding of the purposes for which information will be shared between DoD and VA to provide to transition active duty military personnel to veteran status, the HIPAA Privacy Rule provisions discussed above should provide the necessary latitude to allow efficient flow of protected health information and promote a seamless transition from one healthcare system to another. In addition, other provisions of the Privacy Rule may also permit the exchange of information in particular circumstances. For example, covered entities may use and disclose protected health information without individual authorization as required by other law, including statutory and regulatory mandates. Further, as noted above, if a particular disclosure is not permitted by these or any other provision in the Privacy Rule, the components of DoD and VA that are subject to the Rule as covered entities may seek the individual service member's written authorization for the disclosure.

Closing

I trust this information will be helpful to the Committee in furthering its initiatives of providing service members a seamless transition between the healthcare systems of the DoD and VA. Attached to my statement is the regulatory text for provision that specifically addresses the sharing of information between the DoD and the VA for this purpose (45 CFR 164.512(k)(1)(ii)) and excerpts from the December 2000 preamble that discusses the Department's rationale and response to public comment on this provision. Other helpful information on Privacy Rule can be found at the Office for Civil Rights HIPAA Privacy web site at http://www.hhs.gov/ocr/hipaa, where the full regulatory text is available, as well as summary overview of the Rule and answers to over 200 frequently asked questions.

Again, we welcome the opportunity to explain how the HIPAA Privacy Rule operates to both protect an individual's health information, without impeding or delaying the delivery of health care. Mr. Chairman, this completes my prepared remarks and I will gladly answer any questions you or other members of the Committee may have at this time.

TESTIMONY OF

COLONEL DEBORAH L. CARTER

HUMAN RESOURCE OFFICER
NEW HAMPSHIRE NATIONAL GUARD

BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON ECONOMIC OPPORTUNITY

U.S. HOUSE OF REPRESENTATIVES

September 19, 2005

Mr. Chairman and Members of the Subcommittee: My name is Colonel Deborah Carter, Human Resource Officer for the New Hampshire National Guard, and I am honored to be here on behalf of the Adjutant General of the NH, Major General Kenneth Clark, to discuss the New Hampshire National Guard's "Reunion & Reentry" from combat program. I will overview the program, the partnerships, the results, and further challenges.

In 2004, the NH Army National Guard deployed 850 soldiers to Iraq and Afghanistan. Early in the deployments, the NHNG's vision on reentry was mostly ceremonial. However, that began to change as individual soldiers returned home for their two week R&R leave. Although it was the exception, we began to hear of soldiers drinking too much and having difficulty reconnecting with family members. In one case, a soldier spent the entire two weeks in his room and rarely spoke to his young wife and child. In addition, the NH Department of Health and Human Services reached out to offer preventative assistance because their data after Desert Storm showed increases in divorce, alcohol use, drug abuse, spousal abuse, child abuse, etc. As an organization, we

began to realize that the war isn't over just because the soldiers come home safely. With that understanding, the NHNG became committed to playing a very active role in the support of soldiers returning from combat.

With limited combat experience in recent history, the NHNG reached out to others with "multiple combat" experience such as the US Army's 82nd Airborne, the US Marines and US Navy to hear their experiences. The NHNG did not invent; we listened and tailored their "lessons learned" to our reserve force.

The challenges a reserve force faces upon returning from combat are different than active duty. Our soldiers and airmen are, in most cases, geographically separated from services, the command structure, and their battle buddies. Our goal was to build a life-cycle model for reentry and reunion that ensured "no warrior was left behind."

The NHNG "Reunion & Reentry" Program began before the soldiers left theater. Reserve commanders have limited ability to observe soldiers and reinforce resources of support when they return home. We trained approximately 300 full-time people and 500 family members in suicide prevention, post-traumatic stress and resources available. We were convinced these would be internal points of entry for support for many soldiers, and indeed in many cases, that is just what is occurring.

Once soldiers returned to the United States, they processed through Fort Dix, NJ or Fort Drum, NY for approximately 3-5 days. Upon returning to NH, they participated in a short ceremony and a day off with their families. After the day off, soldiers participated in a three-day process to ensure benefits were secured, counseling was provided, VA enrollment with medical and dental assessments was completed, and assistance was provided to unemployed soldiers through the Departments of Labor and

Employment Security – all occurring within days from leaving combat. In addition, all attended classes on stress related combat issues, myths/expectations on reunion, strategies for success, and interactive sessions about returning to family life and the civilian workplace.

The NHNG didn't have the resources to do it alone, so we asked the Manchester VA and Vet Center for help. The efforts of the Manchester VA and Vet Center in supporting National Guard soldiers returning from war is, in my definition, nothing short of a miracle. We asked for thousands of hours of support from both organizations, but with one small catch -- we couldn't tell them when we needed the support until about 48 hours out. Yet the VA and Vet Center pulled it off for 850 soldiers – the Manchester VA provided thousands of hours of short notice staff time for medical reviews, dental assessments, benefit briefings, emergency support and much more. The Regional Vet Center, using staff from six states, provided about 900 hours of counseling, again on little or no notice.

This type of support for returning veterans is unprecedented, and the NHNG and its partners have raised the bar nationally. I am constantly getting requests from other states that want to learn about NH's partnerships and model reentry program.

But the story doesn't end there. Governor Lynch put on a full court press called "Operation Welcome Home" -- a cross-departmental effort in support of returning troops and their families. Led by the Department of Health and Human Services, the effort included support from the Departments of Labor, Safety, Employment Security, Education, and Correction. "Operation Welcome Home" focused on statewide outreach to physicians, law enforcement, clergy, school counselors, and employers on the issue of

combat transition and potential support needed. Following one of the three outreach workshops for these "Natural Helpers," Maj Gen Clark said: "I had no idea that the community was as aware of this issue as we were. We thought we would be educating them and found that they had much to share with us as well. This partnership greatly enhanced the effectiveness of the "Welcome Home."

The overall results of the "Reunion & Reentry" Program have far exceeded our original expectations. Here are some of the results:

- All soldiers are introduced to local services within days of returning from combat.
- All receive mandatory introductory counseling through the local Vet Center, with each soldier being allocated an hour of initial counseling.
- 48% of soldiers requested follow-up support after the initial counseling.
- Overall, units involved in the most severe combat had the highest rate of requests for follow-up support.
- All soldiers met with local VA providers to learn about benefits.
- All enrolled in the VA during the NHNG three-day process.
- NHNG soldiers enrolled in the Hospital Primary Care at the VA at a rate of twice the national average.
- Almost half of the soldiers filed VA claims during the three-day process.
- One in every 10 returning soldiers received acute medical care through the VA emergency room while processing.
- All soldiers were provided a safe environment to disclose medical issues; 2% actually needed to be returned to active duty for appropriate treatment.

- All soldiers completed dental assessments through the VA, securing dental benefits for the next two years.
- All unemployed soldiers were assisted one-on-one by representatives from the Department of Labor and the Department of Employment Security.
- Over 10,000 "natural helpers" became involved in Governor Lynch's "Operation Welcome Home" initiative.
- Soldiers felt cared about and consistently shared that fact with the NHNG leadership.
- Many soldiers experiencing difficulty were and are reaching out for support early.

Vietnam Vets, upon hearing of the NHNG's attempt to better support returning soldiers, called us one-by-one to share with us their difficult stories and offer their advice. Many veterans told us stories of 25 or 30 years of losses, big losses, i.e. my wife divorced me, my kids don't have much to do with me, I drank way too much, I lost five jobs, I was in jail, I've been married four times, etc. These veterans weren't sharing for sympathy, but to let us know that if they had known more back then and had reached out for support early, they might not have lost so much.

That's what the NHNG believes -- we are not suggesting we have found the magic pill to eliminate PTSD and other issues of war, but we are aggressively educating and encouraging soldiers who struggle to reach out early for support. We believe early, mandatory counseling through an organization like the Vet Center, which knows and understands veterans, is the most profound way we are assisting soldiers upon reentry. It is about early intervention and not waiting 30 years to reach out.

As a military officer with expertise in human resources, I am well aware of the implications of the losses I just described. They manifest in the workplace through ineffective behavior, decreased productivity, and economic losses, if not resolved in a reasonable time and manner. Transitioning from a routine active duty tour is very different than reintegrating from combat. If soldiers do not transition from combat well, emotionally and physically, they will not be ready to address economic opportunities. They will instead be struggling to prevent economic loss.

STATEMENT BY

LTG THEODORE G. STROUP, JR., USA (RET)

VICE PRESIDENT

ASSOCIATION OF THE UNITED STATES ARMY

SUBMITTED FOR THE RECORD TO

COMMITTEE ON VETERANS AFFAIRS

HOUSE OF REPRESENTATIVES

109TH CONGRESS

STATUS OF SEAMLESS TRANSITION

BETWEEN

THE DEPARTMENTS OF DEFENSE AND VETERANS AFFAIRS

28 SEPTEMBER 2005

Biography of Lieutenant General Theodore G. Stroup, Jr., USA Ret.

Vice President, Association of the United States Army

General Theodore G. Stroup Jr. has served as AUSA's Vice President, Education, and Managing Director of the Institute of Land Warfare since January 1997.

At the time of his retirement from active service, General Stroup was serving as the Army's Deputy Chief of Staff for Personnel, having served in that position since 1994.

As a combat engineer, General Stroup commanded at all levels through battalion. His Vietnam service was from January 1966 to April 1967, during which he was a construction engineer in the U.S. Army Support Command, Vietnam; aide-de-camp to the commanding general of the 1st Logistics command; and commander of Company C, 864th Engineer Battalion (Construction). In Germany (1978-80), General Stroup commanded the 293rd Engineer Battalion (Combat Heavy).

Within the U.S. Army Corps of Engineers, he served as the Assistant Director, Civil Works, in Washington, DC (1981-1982), and as Commander of the U.S. Army Corps of Engineers District, Fort Worth, Texas, from July 1982 until January 1985. His staff duty includes service as an Engineer Personnel Management Officer, U.S. Army Military Personnel Center (1973-76). He then served as a manpower analyst in the Office of the Chief of Staff until January 1978.

General Stroup has also been assigned as Executive Officer to the Army Vice Chief of Staff (1985-86), and as Deputy Director of the Headquarters Reorganization Study, Army Reorganization Commission, under the Office of the Secretary of the Army.

General Stroup also served as Deputy Chief of Staff for Resource Management, U.S. Army Training and Doctrine Command, and as Director for Military Personnel Management in the Office of the Deputy Chief of Staff for Personnel. He also was Director for Program Analysis and Evaluation in the Office of the Chief of Staff.

General Stroup was commissioned through the U.S. Military Academy in 1962 and later served as a course director in the Academy's Military Science Branch (1968-71).

General Stroup is a licensed professional civil engineer in Texas and Pennsylvania. He holds a Master's degree in Civil Engineering from Texas A&M University, and a Master's in Finance and Economics from the American University, and is a graduate of the U.S. Army Command and General Staff College, Armed Forces Staff College and U.S. Army War College.

General Stroup's additional community and volunteer activities include: Member, USMA Association of Graduates Strategic Planning Committee; Vice President, West Point Society of Washington DC; Vice President, Class of 1962 USMA; Director, Army Historical Foundation; Director, Army Engineer Regimental Association; Fellow, Society of American Military Engineers; Chairman, USMA Bicentennial Committee, Washington DC area; Member, Personnel – Technology Committee – National Research Council of National Academy of Science; Member, Board of Advisors, Keller Graduate School, Chicago, Illinois; Member, American Society of Civil Engineers; Fellow, Inter University Seminar of Society and Armed Forces.

Neither General Stroup nor the Association of the United States Army has received any federal grants or contracts relative to the subject matter of this testimony during the current or previous two fiscal years.

Mister Chairman and Members of the Committee:

Thank you for the opportunity to present the views of the Association of the United States Army (AUSA) as it deals with the status of seamless transition between the Departments of Defense (DoD) and Veterans Affairs (VA). Both in personal testimony and through submissions for the record there exists a long-standing relationship between AUSA and the House Committee on Veterans Affairs. We are honored that we have been asked to express our views on behalf of our members and America's veterans.

The Association of the United States Army is a diverse organization of over 100,000 members – active duty, Army Reserve, Army National Guard, Department of the Army civilians, retirees and family members. An overwhelming number of our members are entitled to veterans' benefits of some type. Additionally, AUSA is unique in that it can claim to be the only organization whose membership reflects every facet of the Army family. Each October, at our Annual Meeting, our membership has the opportunity to express its views through the consideration and approval of resolutions

for the following year. These resolutions provide the base upon which the Association's leadership builds its legislative agenda.

AUSA is heartened that Congress has expressed a commitment to support America's veterans. Despite this, many are concerned that the declining number of veterans in Congress might in some way lessen the value this institution places on veterans and their service to the nation. We, at AUSA, do not share this opinion. AUSA is confident that you - well-intentioned, patriotic men and women – will faithfully represent the interests of America's veterans.

Our nation's service men and women deserve first class treatment and services before, during and after separation from military service. DoD and VA have critical, complementary roles in the transition process. Unfortunately, bureaucratic inertia and intramural priorities in DoD and the VA have slowed the pace of collaborative efforts towards the goal of "seamless transition".

Some of these efforts have been going on for decades with little or no substantive progress, in part because those responsible for action have come

to have low expectations. Time and again, progress has been stymied by a combination of a lack of leadership priority and oversight, management turnover, bureaucratic inertia, and technological backwardness.

With tens of thousands of veterans separating every year and upwards of fourteen thousand wounded Iraq and Afghanistan war veterans, improving the transition process must be made a major priority for both departments working together.

The President's Task Force final report on DoD - VA collaboration addressed the need to improve services and support for separating service members to ensure the receipt of timely, quality health care and other benefits. The PTF urged development of an interoperable, bi-directional electronic medical record, an electronic service separation document (DD-214), and enhanced post-deployment health screening among other initiatives. At this time when more than one hundred thousand service members are deployed in combat operations, the stakes are even higher – putting them at greater risk for long-term, service-connected health and disability problems.

In a recent report, *Vocational Rehabilitation; More VA and DoD Collaboration Needed to Expedite Services for Seriously Injured Service Members* (January 2005), the GAO recommends that VA and the DoD reach an agreement for VA to have access to information to promote recovery and return to work for seriously injured service members and to develop policy and procedures for regional offices to maintain contact with seriously injured service members.

Without systematic data from DoD, the VA cannot reliably identify all seriously injured service members or know with certainty when they are medically stabilized, when they are undergoing medical evaluation, or when they are medically discharged from the military. Patient tracking and quality and continuity in medical care then become bigger issues in achieving seamless transition goals.

AUSA is grateful that in the fiscal year 2005 National Defense Authorization Act (P.L. 108-375) Congress required DoD to do a better job of collecting baseline health status data through a formal medical readiness tracking and health surveillance system.

DoD and VA are gradually implementing a single separation exam at Benefits Delivery at Discharge (BDD) sites for active and reserve component members. But service-wide implementation at all 136 BDD sites has not been realized. AUSA recommends the Committee provide continued oversight to ensure that this important program is implemented promptly and effectively at all sites.

AUSA strongly recommends accelerated efforts to realize the goal of full and timely implementation of seamless transition activities, a bi-directional electronic medical record (EMR), enhanced post-deployment health assessments, implementation of an electronic DD214, additional family and mental health counseling services, and one-stop physical at time of discharge. Working with our partners in The Military Coalition, AUSA believes that more resources and senior leader commitment to seamless transition initiatives will allow them to move to complete implementation in a more timely fashion.

We encourage the positive steps toward mutual cooperation taken recently by the Department of Defense (DOD) and the VA. The closer we can come to a seamless flow of a service member's personnel and health files from

service entry to burial, the more likely it will be that former service members receive all the benefits to which they are entitled. AUSA supports closer DOD-VA collaboration and planning including billing, accounting, IT systems, patient records, but not total integration of facilities nor of VA/DOD healthcare systems.

AUSA strongly supports preservation of dual eligibility of uniformed service retirees for VA and DOD healthcare systems. We applaud Congress' opposition to "forced choice" in the past and encourage you to hold the line in for the future.

Your committee safeguards the treatment of America's veterans on behalf of the nation. AUSA knows that you take this responsibility seriously and treat this privilege with the gratitude and respect it deserves. Although your tenure is temporary, the impact of your actions lasts as long as this country survives and affects directly the lives of a precious American resource - her veterans. As you make your decisions, do not forget the commitment made to America's veterans when they accepted the challenges and answered the nation's call to serve.

Thank you for the opportunity to submit testimony on behalf of the members of the Association of the United States Army, their families, and today's soldiers who are tomorrow's veterans.

STATEMENT OF
ADRIAN M. ATIZADO
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
SEPTEMBER 28, 2005

Mr. Chairman and Members of the Committee:

On behalf of the Disabled American Veterans (DAV), thank you for the opportunity to submit our views for the record on the status of seamless transition between the Departments of Defense (DOD) and Veterans Affairs (VA). We commend the committee for holding today's hearing and its continued efforts to improve the delivery of benefits and services, which are especially important during the War on Terror when thousands of active duty, along with members of the Reserves and National Guard, will require transition services upon release from active duty.

Over two years has passed since the President's Task Force to Improve Health Care Delivery for Our Nation's Veteran's (PTF) issued it's final report. The DAV concurred with the PTF's findings on seamless transition, that there is a need for improving information sharing between the Departments, especially information relevant to deployments, occupational exposures, and health conditions. This data should follow a servicemember through his or her military career and be readily available to VA upon separation from the military. The PTF suggested expanded collaboration in order to identify, collect, and maintain specific data needed by both Departments to recognize, treat, and prevent illness and injury resulting from occupational exposures and hazards while serving in the Armed Forces.

The DAV believes that both VA and DOD have complementary and critical roles in ensuring servicemembers and returning combat veterans scheduled for discharge, receive prompt, comprehensive quality care and services from each agency. However, some of these efforts have been going on for decades with little or no substantive progress. Recent "seamless transition" initiatives have resulted in only modest improvements in service delivery. Time and again, progress has been stymied by a combination of a lack of leadership priority and oversight, bureaucratic inertia, and technological backwardness. Clearly, standardization and compatibility of information systems and medical records between VA and DOD will provide lasting improvements in health care delivery to veterans. The DAV, as with other veterans and military service organizations, believe these improvements are necessary and essential to ensure the health and safety of our troops, and we will continue to advocate for the development of an electronic DD-214, bi-directional medical records, expanded Benefits Delivery at Discharge activities, and a single separation physical.

The Departments have each taken positive steps to share data from their health information systems. The Federal Health Information Exchange initiative and the pharmacy data project are steps in the right direction. However, obstacles remain that will hinder the momentum of progress made toward the goal of a bidirectional health information exchange by next year. Despite a memorandum of understanding between the two agencies, there has not been any agreement on what types of individually identifiable health data can be exchanged and when the data can be shared.

The 2003 National Defense Authorization Act formally established the VA – DOD Joint Executive Council (JEC) structure to oversee benefits and health collaboration between DOD and the VA. The JEC also oversees development and implementation of the Joint Strategic Plan between DOD and VA. The mission of the JEC also includes identifying opportunities such as policy, operations, and capital planning to advance seamless transition initiatives.

Under the JEC, the Health Executive Council (HEC) is responsible for identifying changes in health care related policies, procedures and practices and assessing further opportunities for the coordination and sharing of health related services and resources. DAV believes that veteran and military service organizations have valuable insights to offer the JEC and HEC forums since our constituents are users of both the VA and DOD healthcare systems. DAV recommends the Committees aggressively oversee the actions of the JEC and schedule periodic joint hearings with the Armed Services Committees to assess progress on "seamless transition" initiatives.

Since the enactment of Public Law 107-103, the Veterans Education and Benefits Expansion Act of 2001, which provided that all active duty servicemembers would have the opportunity to attend the Transition Assistance Program and Disabled Transition Assistance Program (TAP/DTAP), the percentage of veterans who left military service without attending pre-separation counseling has greatly improved.

Still, a significant number of active duty personnel are unable to attend all components of TAP/DTAP because only the pre-separation counseling portion of the program is mandatory (with the exception of the Marine Corps, which has made attendance of TAP/DTAP mandatory for all components). Where attendance is not mandatory, many separating members miss valuable employment workshops due to difficulties in being excused from command responsibilities. While we are aware that DOD is considering a policy change that would mandate participation in all components, we believe that if mandatory attendance were a department-wide policy, members would not face tacit pressure from their superiors to return to work prior to completion of the entire TAP/DTAP program.

Additionally, problems with the TAP/DTAP involve Reserve and National Guard units. The sentiment is quite apparent among servicemembers that it would be unfair to extend demobilization periods merely to deliver TAP/DTAP programs. Members of National Guard and Reserve units have already sacrificed by being away from their homes and loved ones and are understandably eager to return to them as soon as possible. Furthermore, logistical planning by federal, state, and local entities is hindered due to national security concerns that prevent the release of information regarding unit deployment agendas continue to hamper progress in

providing TAP/DTAP. Reserve and National Guard Medical Hold Units are also overlooked for participation in TAP/DTAP.

In response, there are several pilot programs currently underway that involve administration of the TAP/DTAP at the state and local levels such as briefings during weekend drill periods following demobilization. Furthermore, we note successes of the New Hampshire National Guard as identified during the June 29, 2005, field hearing conducted by the House Committee on Veterans' Affairs, Subcommittee on Economic Opportunity on transition assistance for servicemembers returning from recent tours of duty. We learned during the hearing that soldiers were kept on active duty status for an additional 5 days to receive transition assistance. We look forward the lessons learned and best practices that can be gained from these activities.

The DAV believes that a mandatory single separation physical would provide improved health care information and greatly assist in early detection and prevention of more serious problems that would be encountered in the future. We commend VA and DOD with establishing over 50 memorandums of understanding between VA and DOD facilities and another 80 still in process to perform single separation physicals; however, with over 2,100 casualties, over 17,000 wounded since the war on terror began, and the projected numbers of National Guard and Reserve separations, the DAV is deeply concerned over the slow progress in this area.

DAV National Service Offices understand the importance of working with local National Guard and Reserve units that have been activated in support of the War on Terror. In some states, such as Florida, Ohio, as well as military facilities in Oklahoma, Texas, and Washington, DAV National Service Officers and Transition Service Officers have established strong working relationships with local units and provide outreach on a regular basis to ensure troops understand the benefits to which they are entitled. Last summer, the DAV was contacted by the National Guard Bureau requesting our assistance on a nationwide basis. We readily offered our help, agreed to a Memorandum of Understanding (MOU), and informed the Bureau that DAV NSOs would be promptly available upon notification of a unit's return and demobilization. Disappointingly, no further exchange has occurred since the MOU was signed, despite the DAV's repeated efforts to encourage such a relationship. The DAV remains willing to provide its services to National Guard and Reserve units on a nationwide basis.

The DAV sincerely appreciates this Committee's continued interest in providing a seamless transition for servicemembers entering veteran status. On behalf of our 1.3 million members, I thank you for the opportunity to submit our views on this important topic.

DISCLOSURE OF FEDERAL GRANTS OR CONTRACTS

The Disabled American Veterans (DAV) does not currently receive any money from any federal grant or contract.

During fiscal year (FY) 1995, DAV received $55,252.56 from Court of Veterans Appeals appropriated funds provided to the Legal Service Corporation for services provided by DAV to the Veterans Consortium Pro Bono Program. In FY 1996, DAV received $8,448.12 for services provided to the Consortium. Since June 1996, DAV has provided its services to the Consortium at no cost to the Consortium.

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FACT SHEET

BIOGRAPHICAL INFORMATION

ADRIAN M. ATIZADO
Assistant National Legislative Director
Disabled American Veterans

Adrian M. Atizado, a service-connected disabled veteran of the Persian Gulf War Era, was appointed Assistant National Legislative Director of the million-member-plus Disabled American Veterans (DAV) in August 2002. He is employed at DAV National Service and Legislative Headquarters in Washington, D.C.

As a member of the DAV's legislative team, Mr. Atizado works to support and advance federal legislative goals and policies of the DAV to assist disabled veterans and their families, and to guard current benefits and services for veterans from legislative erosion.

Mr. Atizado joined the DAV's professional National Service Officer (NSO) staff as an NSO Trainee at the DAV NSO Training Academy in Denver, Colorado in January 2000. He graduated as a member of Academy Class IX in May 2000 and was assigned as an NSO trainee to the DAV National Service Office in Chicago, where he served until his current appointment.

Mr. Atizado was born in Mountain View, Calif., and moved to Chicago at an early age where he was raised and attended public schools. He enlisted in the U.S. Navy in 1989. Following his initial training as a Navy Corpsman, Mr. Atizado's service included Company B and Battalion Aid Station Corpsman for the 1st Battalion, 1st Marine Regiment, 1st Marine Division at Camp Pendleton, Calif., as well as duties at the San Diego Naval Hospital.

In March 1993, while preparing for a second six-month deployment to the Western Pacific, Mr. Atizado sustained injuries in a vehicle accident that resulted in his disability. He was medically discharged from the Navy in December 1993, and spent an additional six months recuperating from his injuries after leaving the military.

Following his Navy enlistment, Mr. Atizado attended the University of Illinois in Chicago, where he earned his bachelor's degree in secondary education mathematics in 1999.

Mr. Atizado is a life member of DAV Chapter 36 in Chicago. He resides in Arlington, Va.

11/02

National Association for Uniformed Services

STATEMENT

of

NATIONAL ASSOCIATION FOR UNIFORMED SERVICES

on

The Status of Seamless Transition Between the Departments of Defense and Veterans Affairs

September 28, 2005

Presented for the Record
by

Rick Jones, Legislative Director
National Association for Uniformed Services

Chairman Buyer, Ranking Member Evans, and members of the Committee:

On behalf of the nationwide membership of the National Association of Uniformed Services (NAUS), I am pleased to offer our views to the Committee on Veterans' Affairs regarding the status of seamless transition between the U.S. Departments of Defense (DOD) and Veterans Affairs (VA).

For the record, NAUS has not received any federal grants or contracts during the current fiscal year or during the previous two years in relation to any of the subjects discussed today.

Mr. Chairman, NAUS applauds this Committee and its work in holding this important hearing. Providing a seamless transition for recently discharged military is critically important. It is especially important for servicemembers leaving the military for medical reasons related to combat, particularly for the most severely injured patients.

NAUS recognizes that progress is being made, but certainly we can all agree that there is ample room for improvement to ensure as smooth a transition as possible for our active duty and Reserve personnel as they leave the military healthcare system to enter VA's.

As you know, NAUS is a staunch advocate for providing veterans with appropriate care. These brave men and women did not fail us in their military service, and we, in turn, must not fail them in providing the care they need and *earned* through honorable military service.

Accordingly, our association's first priority is to help you, Mr. Chairman, and others in Congress to continue the necessary work toward an effective seamless transition. This effort is critical not only for those service members returning from Operation

Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) but also for all eligible veterans.

It is clear that some troops serving in OIF and OEF are returning home with injuries more serious than those who returned from previous conflicts. The new protective gear and body armor is helping to save lives but with worse injuries. While many injured in combat return to duty, others with more serious injuries are likely to be discharged from the military.

Independently, DOD and VA are doing a good job in caring for individuals wounded or injured in combat. However, reports indicate that distinct challenges in the continuity of medical care remain. In addition, related VA services such as physical rehabilitation, disability assessments and other earned benefits are not always smoothly coordinated.

To meet these challenges, one of the first things we need to develop is a computerized, electronic medical record compatible between the two Departments. This record would form the cornerstone of a working seamless transition initiative not only for the delivery of appropriate health care but for disability claims as well.

In this regard, NAUS is pleased to read a TRICARE Management Activity news release (No. 05-37) stating that displaced medical providers from Keesler Air Force Base, Biloxi, Miss., received immediate access to medical information of TRICARE beneficiaries evacuated due to Hurricane Katrina through the military electronic health record. The next step is to deploy similar data-sharing availability for incorporation of a fully interoperable healthcare system between DOD and VA.

There is a need to improve the system for handing over responsibility from DOD to VA for the continuance of medical care to those leaving service. To improve this exchange, the hand-off should include a detailed history of care provided and an assessment of what each patient may require in the future, including mental health

services. No veteran leaving military service should fall through the bureaucratic cracks.

Clearly, the Departments of Defense and Veterans Affairs must continue their work as a team to provide proper and seamless care for our soldiers and veterans. A bi-directional, interoperable, and standards-based electronic medical record, as the President's health care task force recommended in 2003, could greatly facilitate this effort.

It is our understanding that despite efforts to coordinate this exchange of information, DOD's stringent interpretation of HIPAA Privacy Rules continues to present a roadblock to completion of a successful inter-departmental partnership. Until this situation is sorted out, VA's priority efforts to serve the needs of OEF/OIF servicemembers face potential delays and interruptions in appropriate care as the individual moves from being a DOD patient to a VA patient. The administration should direct HHS, the department that implements HIPAA rules, to declare VA and DOD to be a single health care system to facilitate medical collaboration.

While DOD clearly requires its own medical care system, especially for in-theatre, deployment, and battlefield treatment, VA's system is widely recognized as one of the best, if not the best, integrated healthcare system in the world. Whole countries have adopted VA's award winning electronic medical record system. If it is necessary for Congress to do so, we recommend that DOD be directed to adopt a compatible technology to facilitate inter-operable transfers of electronic medical records.

Good communication between the two Departments means VA can better identify, locate and follow up with seriously injured servicemembers separated from the military. Much more needs to be done to ensure that returning OIF and OEF combat veterans receive a timely access to VA benefits and services.

And most important in the transition calculation is collaboration between DOD and VA. Ensuring on sharing information with VA at the earliest possible moment prior to separation or discharge. It is essential to completing a seamless transition of services.

In addition, NAUS believes DOD must ensure that all troops are given actual pre- and post-deployment medical examinations, not merely questionnaires. Such examinations would help identify troops who should not be deployed or who need help after returning home. They would be completed for all active duty personnel, as well as Guard and Reserve troops. Questionnaires are not sufficient to establish physical or mental fitness.

Another area that would enhance a seamless transition for our uniformed services is the further expansion of single-stop separation physical examinations. A servicemember takes a physical exam when he is discharged. In some cases, just days later another physical is taken to qualify for VA benefits. While progress is being made in this area, we recommend expanding VA's benefit delivery at discharge (BDD) program to all discharge locations in making determination of VA benefits before separation. This will allow more disabled veterans receive their service-connected benefits sooner.

NAUS would like to compliment VA and DOD for following through on establishing benefits representatives at military hospitals. This is an important step in providing a seamless transition. These VA points of contact offer medically separated service members information and improved access to VA care. In addition, these counselors can often reduce the amount of frustration inherent in the separation process for service members and their families. This type of service can smooth transition to civilian life.

In closing, NAUS calls on Congress to ensure adequate funding is available to DOD and VA to cover the expenses of providing for as seamless a transition as possible.

Taking care of veterans is a national obligation, and doing it right sends a strong signal to those currently in military service as well as to those thinking about joining the military.

Retired military and veterans can be among the best recruiters if they can report that "promises were kept" when their service was over. It can have the opposite affect, if veterans don't receive the promised benefits.

Mr. Chairman, NAUS appreciates the leadership of the members of this Committee to address seamless transition issues for the men and women of the Armed Forces and their families. We look forward in working with the Committee and thank you very much for the opportunity to present NAUS views on these important topics.

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Richard "Rick" Jones
Legislative Director
National Association for Uniformed Services (NAUS)

Richard "Rick" Jones joined NAUS as Legislative Director on September 1, 2005. As legislative director, he is the primary individual responsible for promoting NAUS legislative, national security, and foreign affairs goals before the Departments of Defense and Veterans Affairs, and the Congress of the United States.

Rick is an Army veteran who served as a medical specialist during the Vietnam War era. His assignments included duty at Brooke General Hospital in San Antonio, Texas; Fitzsimmons General Hospital in Denver, Colorado; and Moncrief Community Hospital in Columbia, South Carolina. At Moncrief Hospital, Rick was selected to assist in processing the first members of the all-volunteer Army.

Rick completed undergraduate work at Brown University prior to his Army draft and earned a Master Degree in Public Administration from East Carolina University in Greenville, North Carolina, following military service.

Prior to assuming his current position, Rick served five years as National Legislative Director for AMVETS, a major veterans service organization. He also worked nearly twenty years as a legislative staff aide in the offices of Senator Paul Coverdell, Senator Lauch Faircloth, and Senator John P. East. He also worked in the House of Representatives as committee staff for Representative Larry J. Hopkins and Representative Bob Stump.

In working for Rep. Stump on the House Committee on Veterans' Affairs, he served two years as Republican minority staff director for the subcommittee on housing and memorial affairs and two years as Republican majority professional staff on funding issues related to veterans affairs' budget and appropriations.

Rick and his wife Nancy have three children, Sarah, Katherine, and David, and reside in Springfield, Virginia.

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STATEMENT FOR THE RECORD

of

James B. King
AMVETS National Executive Director

before the

Committee on Veterans' Affairs
United States House of Representatives

on

The Status of Seamless Transition Between the U.S. Departments of Defense and Veterans Affairs

Wednesday, September 28, 2005, 10:00 am
334 Cannon House Office Building

Chairman Buyer, Ranking Member Evans, and Members of the Committee:

On behalf of National Commander Ed Kemp and the nationwide membership of AMVETS (American Veterans), I thank you for the opportunity to present a statement for the record to the Committee on Veterans Affairs regarding programs and issues dealing with the status of a seamless transition between the U.S. Departments of Defense (DOD) and Veterans Affairs (VA).

AMVETS has been a leader since 1944 in helping to preserve the freedoms secured by America's Armed Forces. Today, our organization continues its proud tradition providing not only support for veterans and the active military in procuring their earned entitlements but also an array of community services that enhance the quality of life for this Nation's citizens.

Mr. Chairman, with thousands of service members returning home from the Global War on Terrorism everyday, we must work together to ensure they are afforded the care and benefits they *earned* through honorable military service to this Nation. Many will return from battle with life-altering injuries and life changing experiences and will turn to VA for their health care needs. That is why it is so critically important that VA be funded at levels that will ensure all eligible veterans have access to and receive quality health care in a timely manner.

We greatly appreciate all the work you and the Committee have done in exposing VA's "underestimation" in FY06 medical services funding. You asked the Secretary and others some tough questions, and we hope that you will hold a joint hearing with the Appropriations Committee on the need to reform VA's budget forecasting methodology.

We are also appreciative of the quick response on part of the House in approving $1.5 billion in additional, emergency funds to VA so they can carry out their mission without interruption in service. But, as you know, the start of fiscal year 2006 is looming, and we urge you and your colleagues to work together in conference and quickly vote on a FY06 VA package so funding is not once again delayed. The men and women returning home cannot, and should not, be turned away from VA's door because of lack of timely funding.

AMVETS believes there is no greater responsibility of DOD and VA than to properly take care of returning soldiers, and to provide as many tools as possible to assist them in settling back into civilian life. The Departments of Defense and Veterans Affairs needs to intensify efforts to assure world-class services are provided to our military and veteran heroes returning from combat theaters. Providing timely, high quality care requires effective information sharing. In April 2003, the DOD and VA signed an agreement entitled, "Joint Strategic Plan," committing officials to significantly enhance the level of collaboration and dialogue at all levels between the two Departments. We are very concerned about the lack of progress, and on certain levels, the failure, of DOD and VA to meet many of the objectives outlined over two years ago.

While VA has taken several steps to expedite services to seriously injured service members, VA does not have complete and systematic data from DOD on those who may need vocational rehabilitation and other medical services. Furthermore, VA staff cannot confirm the completeness and accuracy of whatever little information they obtain from DOD. As a result, VA heavily relies on regional offices to develop information sharing techniques with local military treatment facilities to identify service members in need of treatment. This is not an effective way to manage a service member's health care needs and it consequently stifles DOD and VA's progress towards any seamless transition.

Complete, accurate, and timely information sharing is the key to ensuring a seamless transition. This fact is DOD and VA has been pursuing ways to share their information systems and create electronic records since 1998. Even with the 2003 joint agreement, Administration and Departmental efforts still seem to be largely uncoordinated and suffer from the failure to make seamless transition a high priority. This is far too long to be working on a solution to this problem, especially in the Information Age.

In order to provide a true seamless transition, AMVETS would respectfully recommend that the Committee seriously look at three problem areas that have not yet been fully resolved. These goals can only be accomplished through effective coordination and dialogue between DOD and VA. They are:

1. Making veterans basic service information contained in the DD-214 available electronically.
2. Making medical records, including pharmaceutical records, available electronically.
3. Documenting veterans' service history and environmental and occupational exposures.

We recognize that in order to achieve these goals, senior officials at both Departments need to get together and work towards common solutions. We believe the best and quickest way to accomplish the good-faith agreement between DOD and VA is to have a secretary-level order to ensure the Departments fully implement what they promised. Therefore, we recommend that Secretaries Rumsfeld and Nicholson provide the leadership and incentives necessary at this time to achieve the goal for improved coordination of benefits set out by the April 2003 agreement.

On a positive note, the VA Taskforce for the Seamless Transition of Returning Service Members has developed a number of training materials for staff, including a script and video for front line staff, to ensure that they can identify veterans in need of health services. But more needs to be done. Information relevant to a service member's deployment, occupational exposures and health conditions should follow the service member throughout their entire military career. Better recording, tracking, and reporting of data will improve the ability to understand the causes and origins of service-connected disabilities, assist in benefits determinations, and improve the overall health of veterans today and in the future. VA staff must also be properly trained to ensure policies and procedures are fully understood and in place so a seamless transition of health care and disability services are provided to the veteran.

Mr. Chairman, I will say that AMVETS believes DOD and VA are very capable of carrying out an effective seamless transition. When a service member separates from military service, the process for determining his or her eligibility for veterans' benefits should, and need to be, seamless, timely and accurate.

AMVETS appreciates the leadership of the members of this Committee to address needed improvements to a seamless transition for returning service members. We look forward in working

James B. King
AMVETS National Executive Director

James B. King was appointed national executive director of the nation's fourth largest veterans service organization on May 21, 2002. In this capacity, he administers the policies of the AMVETS, supervises its national headquarters operations and provides direction, as needed, to state and local components.

The U.S. Marine Corps veteran of 10 years joined AMVETS in 1969 after serving two combat tours in Vietnam with the 3rd Marine Division. A life member of AMVETS Post 4 in his hometown of Mount Vernon, Ill, Jim has served in leadership capacities on all levels of the organization.

He was elected AMVETS national commander for 1987-88, after serving consecutive one-year terms as national vice commander for membership and programs respectively. Prior to that time, Jim had served, most notably, as Department of Illinois commander and president of the state service foundation.

Long active in veterans' affairs on the state level, Jim also served as president of the Jefferson County, Ill., Veterans Assistance Commission and was appointed as a public member to the Illinois Agent Orange Study Commission. Additionally, he devoted much of his free time to serving as a Department of Veterans Affairs Voluntary Service representative at the VA medical center in Marion, Ill.

Jim and his wife Carol reside in Glen Burnie, Md.

AMVETS National Headquarters
4647 Forbes Boulevard
Lanham, MD 20706
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SERVING
WITH
PRIDE

September 28, 2005

The Honorable Steve Buyer, Chairman
Committee on Veterans Affairs
Cannon House Office Building
Washington, D.C. 20515

Dear Chairman Buyer:

Neither AMVETS nor I have received any federal grants or contracts, during this year or in the last two years, from any agency or program relevant to the September 28, 2005, full Committee hearing on the status of seamless transition.

Sincerely,

James B. King
National Executive Director

A M V E T S

NATIONAL
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An Independent Nonprofit Aerospace Organization

STATEMENT OF THE AIR FORCE ASSOCIATION

FOR THE RECORD

COMMITTEE ON VETERAN'S AFFAIRS

UNITED STATES HOUSE OF REPRESENTATIVES

SEAMLESS TRANSITION BETWEEN DOD AND VA

SEPTEMBER 28, 2005

The Air Force Association would like to thank the committee for holding this hearing today on an issue that is of great importance to our members. We all agree that military men and women who complete their term of service or retire from the military should receive timely access to VA benefits. However, inefficiencies centered around medical record keeping and information sharing have negatively disrupted the receipt of these earned benefits. To create a better system for the future, DoD and the VA need to rapidly deploy an interoperable, bi-directional and standards-based electronic medical record; a "one-stop" separation physical supported by an electronic separation document (DD-214); benefits determination before discharge; and information on occupational exposures from military operations and related initiatives.

The present inability to seamlessly transfer medical records between the Department of Defense and the Department of Veterans Affairs causes an immense amount of duplication, delay, wasted effort, and significant cost. Given the level of data processing expertise available to the United States Government, it is inconceivable that a seamless transfer of documents cannot be enacted. We further believe that the return on investment will be immediate, with considerable cost savings to be realized in the future.

Cost savings can also be realized if DoD and the VA can agree to utilize a single physical exam that will cover both retirement from the military and entrance into the VA system. Currently those entering the VA system with a disability rating must undergo a complete series of physical examinations after already having completed a similar series of examinations upon retirement. This duplication of testing and medical consultation is redundant, extraordinarily expensive, and further exacerbates the difficulty in securing appointments in a timely manner.

Others support these initiatives as well. At the conclusion of two years of work, Dr. Gail Wilensky, co-chair of the President's Task Force To Improve Health Care Delivery For Our Nation's Veterans stated:

> We're calling for a seamless transition from military to VA health care. Whether someone serves four years or 30 years in the military, there should not be long delays in receiving VA benefits. To make that transition seamless, VA and DOD should have electronic medical record systems that can communicate freely with each other. We're also calling for one standard separation physical exam and improved assistance to determine eligibility for disability compensation and VA health care.

The President's Task Force To Improve Health Care Delivery For Our Nation's Veterans released its final report in the summer of 2003. However, little progress has been made regarding these vitally important provisions. Two years of studying an important report with no action is unacceptable. Congress must take action now to effectively and efficiently provide for the benefits our service members have earned.

The Air Force Association's mission is to advocate for aerospace power and a strong national defense; to support the United States Air Force and the Air Force Family; and to promote aerospace education among the American people.

Founded in 1946, AFA is an independent, nonprofit organization with over 130,000 members and more than 200 chapters. Our members include Air Force enlisted, officers, civilians, Reserve and Guard, veterans, cadets, Civil Air Patrol and thousands of others.

TESTIMONY OF

JOHN M. KING

PRESIDENT

NATIONAL ASSOCIATION
OF
STATE DIRECTORS OF VETERANS AFFAIRS

BEFORE THE JOINT HEARING
OF THE
HOUSE VETERANS' AFFAIRS COMMITTEES

SEPTEMBER 28, 2005

Mr. Chairman, Committee members, as President of the National Association of State Directors of Veterans Affairs (NASDVA) I thank you for the opportunity to testify and present the views of our veteran directors in our Nation's states, commonwealths, and territories.

As the Nation's second largest provider of services to veterans, the role of state governments continues to grow. We believe it is essential fbr Congress to not only understands our role, but to ensure we have the resources necessary to carryout our responsibilities. The work of state governments is an extension of the Federal VA mission and our efforts, over $3 billion annually, supplement those of the Federal VA.

State Directors have consistently seen improvements in the effort to provide "seamless transition", designed to help service members successfully adjust to civilian life. Improvements include the designation of an Operation Enduring Freedom / Operation Iraqi Freedom Coordinator at each VA Regional Office and Veterans Integrated Service Network, and VA participation at Transition Assistance Program briefings. The coordination and collaboration with the State Directors of Veterans Affairs and State National Guards has improved. The National Guard is only two services (Army and Air), and the structure is easily discernible within the state - one TAG - one person in charge.

The Federal VA and the State Departments are working well to brief departing and returning National Guardsmen and the VA is following those briefings up with healthcare and claims processing. These efforts are producing positive results with our National Guard soldiers and airmen, but that is in part due to existing relationships between State Departments of Veterans Affairs and their Military Departments, and the geographic proximity of service members who typically serve in their home state.

However, Active Duty and Reserve service members often separate from the military in a state other than home of record. It is well-known that service members tend to minimize their physical and mental ailments as they transition out of military service, particularly in times of war, so their return home is not delayed. These soldiers return to their home state individually, by car or plane. Months after they return home, these veterans may recognize that they need help, but do not know where to turn. There are no established links between military transition points and the State Departments of Veterans affairs. Although Discharge Certificates (DD Form 214) are provided to State Departments of Veterans Affairs, these documents often have inaccurate addresses and have proven to be of limited help in actually locating veterans to offer assistance. These service members need to be informed of whom to contact once they are home. But more importantly, the State Departments of Veterans Affairs need information of who is returning to their states from all sources.

The Reserve components are especially difficult to reach. They are comprised of all five services under different chains of command of regional coverage, and the structures vary widely between services. Just for the Army for example, there is a number of Regional Readiness Commands that lead Army Reserve units in multi-state areas. Many reintegration programs are leaving out the Reserve Component because people don't understand them.

The inability of the Department of Defense (DoD) and the Federal VA to share information with one another and State Government is the single most significant barrier in providing effective "seamless transition" for our service members.

DoD does not provide the Federal VA or State Directors of Veterans Affairs with the names of all separating members of the armed forces, including those from the Guard and Reserve, so we can reach out and offer services. The DD214 received by State Departments of Veterans Affairs does not provide timely and accurate information to assist service members with the wide range of services that can best be coordinated by the State Departments of Veterans Affairs. These services go beyond what is provided by the Federal VA and include; immediate financial assistance, mental health counseling, housing, employment, transportation and more, and are best coordinated through State Departments of Veterans Affairs.

The Health Insurance Portability and Privacy Act (HIPPA) and other privacy laws are often excuses for not sharing information. However, State Governments are bound by the same laws and have the same legal obligation and liabilities as our partners in the Federal Government. Our recommendation is that Congress require DoD and the Federal VA to share information to facilitate effective outreach to all returning service members.

Other concerns expressed by both State Directors and Federal VA staff are as follows:

- The lack of an "Integrated Medical Records" between DoD and the Federal VA greatly impedes coordinated heath care and adversely affects the Veterans Benefits Administration in adjudicating timely and comprehensive claims.

- The Physical Evaluation Board does not share information with the Federal VA. For example, in Washington State, that resulted in a catastrophically injured veteran remaining at a pay level of Private for six months, rather than receiving disability pay. The difference is $1,600 a month verses $6,000 a month, without retroactive reimbursement.

- The transition of severely injured personnel from DoD treatment facilities to federal facilities appears to be working very well. More coordination with State Department of Veterans Affairs (names, addresses, phone numbers) while the member is in a Military Treatment Facility and when they are released would allow states to contact local resources to maintain support for them.

- DoD needs a seamless transition office like the Federal VA. The Military Severely Injured Center and Military One Source are reported as duplicating efforts because they are not well coordinated.

- Post deployment assessments could be more streamlined by creating a single standard assessment. When contracted out, these services need to be monitored to ensure consistency and accountability. Each branch of service has different practices.

- Many states recommend that TAP briefings become mandatory and/or that DoD have mandatory exit physicals. Too many service members are leaving without any exit briefing or assessments. Usually it is the prompting of a parent or spouse that gets the veteran to report to the primary clinic for assistance. Without the family support element, appointments are broken or never scheduled.

- Also, the military culture seems to have a chilling effect on seeking treatment in that we've had reports of cancellation of appointments after discussion with line command.

- It may be necessary to increase informational contact with families and, perhaps, awareness training and accountability for line command, especially at the unit level.

- Mental heath funding, although enhanced by Congress, still needs significant augmentation. Charles Hoge, M.D. of Walter Reed Army Hospital, and others, recently published an article *Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care.* New England Journal of Medicine 2004; 351: 13-22 finding that although high percentages report readjustment difficulties, the actual number of diagnosed with PTSD is lower. There are many who opine that Hoge's findings underestimate the level of need among our returning soldiers, since his sample is still on active duty and that the real rates of the emotional impact of war can not be known for some time *after* discharge from the military and actual homecoming.

For example, using the same screening tool as Hoge et al., screeners working with the Washington State National Guard are finding 90 day post-homecoming rates of readjustment and PTSD to be higher. The number of veterans returning from OIF/OEF that report "readjustment" difficulties is as high as 45%, based on Washington State data (see attached WA Statistics).

States should develop methods of early intervention, education and assistance to mitigate the long-term effects of readjustment difficulties in a way that maintains confidentiality to avoid stigmatization.

- Finally, there is much concern regarding the two year limit for healthcare for OIF/OEF veterans and how these veterans will be cared for when their two year window closes.

On behalf of the National Association of State Directors of Veterans Affairs, I appreciate the opportunity to provide this committee with our recommendations. It is our collective hope that the recommendations presented today will result in better service to all veterans. We have the utmost respect for the important work you are doing to improve support to veterans who answered the call to serve in the past and all of those standing in harm's way today.

FAMILY ACTIVITY DAYS
RESULTS MARCH – TO DATE

LOCAL	TOTAL	CLAIMS 21-526S FILED	READJUSTMENT REFERRALS	EMPLOYMENT ASSISTANCE	VHA ENROLLMENT / COUNSELING****	TRICARE BRIEFINGS
March 2005						
Ft Lewis	76	43	35	16		
July 2005						
Ellensburg	24	2	7	5	6	15
Camp Murray	46	17	6	10	13	25
July TOTAL	**70**	**19**	**13**	**15**	**19**	**40**
		27%	**19%**	**21%**	**27%**	
August 2005						
Spokane	142	10	83	13	0/50	142
Olympia	116	6	48	7	13/37	60
Moses Lake	110	10	54	26	25/35	80
Yakima	92	16	33	6	0/43	21
Snohomish	104	28	51	40	55/0	104
Bellingham	74	13	31	30	8/60	74
Longview	92	4	31	9	60/0	92
Kent	236	19	82	29	64/100	236
August TOTAL	**966**	**106**	**413**	**160**	**225/325**	**809**
		13%	**43%**	**17%**	**23%**	
September 2005						
Seattle (Sat)	176	60	77	30	91	176
Puyallup	111	6	40	45	30	111
Montesano	68	5	25	27	17	68
Centralia	60	0	22	16	0	60
Seattle (Sun)	118	30	96	1	105	118
Sept. TOTAL	**533**	**101**	**260**	**149**	**243**	
		19%	**49%**	**28%**	**45%**	
YTD Total	**1645**	**269**	**711**	**340**	**487**	**1382**
		17%	**43%**	**21%**	**30%**	

STATEMENT OF
PETER S. GAYTAN, DIRECTOR
VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION

TO THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

ON

THE STATUS OF SEAMLESS TRANSITION BETWEEN
THE DEPARTMENT OF DEFENSE
AND
THE DEPARTMENT OF VETERANS AFFAIRS

SEPTEMBER 28, 2005

STATEMENT OF
PETER S. GAYTAN, DIRECTOR,
VETERANS AFFAIRS AND REHABILITATION DIVISION
THE AMERICAN LEGION
TO THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
THE STATUS OF SEAMLESS TRANSITION BETWEEN THE
DEPARTMENT OF DEFENSE AND
THE DEPARTMENT OF VETERANS AFFAIRS

SEPTEMBER 28, 2005

Mr. Chairman and Members of the Committee:

Thank you for this opportunity to submit The American Legion's views on the status of seamless transition between the Department of Defense (DoD) and the Department of Veterans Affairs (VA). We commend the Committee for holding this hearing to discuss this important matter.

In a collaborative effort, DoD and VA have established a system of programs designed to facilitate "seamless transition" from the military to the VA healthcare/benefits system for active duty, guard and reserve personnel. This system allows VA direct access to health information in an effort to more immediately process eligible service members for compensation, expedite enrollment in the VA healthcare system, and to educate service members of their earned benefits. The available programs include Benefits Delivery at Discharge (BDD), VA outreach efforts, and military services briefings.

Origins of Seamless Transition

Well–publicized incidents in August 2003, detailed the difficulties veterans returning from Operations Iraqi Freedom and Enduring Freedom were experiencing in accessing VA benefits. In response, then Secretary of Veterans Affairs Anthony Principi created the Task Force for Seamless Transition of Returning Service Members with the charge to improve collaboration between VA and DoD, improve coordination of services, ensure VA staff is educated about seamless transition and ensure that appropriate policies and procedures are in place to enhance seamless transition. The Task Force was comprised of representatives from the Veterans Health Administration (VHA), the Veterans Benefits Administration (VBA), the Office of Secretary of Veterans Affairs, and DoD's Health Affairs Office.

First steps to improve collaboration included assigning VBA claims representatives at key Military Treatment Facilities (MTFs) to counsel service members and prepare claims, expansion of the Benefits Delivery at Discharge (BDD) program, development of a cooperative separation examination protocol, establishment of the Army's Disabled Soldier Support System (DS3) and development of VA/DoD data sharing initiatives.

To improve communication and coordination of services, two full–time VA social workers were assigned to cover Walter Reed Army Medical Center (WRAMC) and the National Naval Medical Center (NNMC) and points of contact (POCs) were established at each VHA facility. Full–time VA social workers were added at Brooke, Darnall, Eisenhower and Madigan Army Medical Centers and nurse/social work case OIF/OEF managers were appointed at all VHA facilities. POCs were established at all 57 VA Regional Offices (ROs). An email group was created for VHA social work liaisons, case managers and POCs to facilitate the rapid dissemination of information and a VA intranet web page was established. An OIF/OEF link was added to VA's public web site and pages were added on VA and DoD benefits and TRICARE and a National Guard and Reserve section was included.

The American Legion is pleased with initial efforts to ease the transition from military service. It is our hope that VA and DoD will continue to develop improved sharing programs that will ensure that transitioning servicemembers experience minimal obstacles while entering the ranks of America's veterans.

Disabled Soldier Support System

The Disabled Soldier Support System (DS3) is a new Army program established to provide severely disabled soldiers and their families with a system of advocacy and follow-up that provides personal support in their transition from military service to the civilian community. DS3 provides disabled soldiers and their families with an opportunity to connect with a participating Veterans Service Organization (VSO), such as The American Legion, which, in turn assists with the soldier's transition from the Army to include navigating the often-confusing landscape of VA benefits and entitlements.

As a part of the system, a voluntary partnership between VSOs and individual soldiers and their families is established. Injured soldiers who choose to participate in DS3 register through their Military Treatment Facility and are put in contact with an American Legion Service Officer who meets with the soldier and assesses his or her needs. The Service Officer also determines the soldier's likely geographical location after transition from the Army and assists in locating the closest VA facilities. Once the soldier is home, local American Legion Posts may provide volunteers to assist these soldiers in adjusting to their new life.

The Legion's National Veterans Affairs & Rehabilitation Division and National Security Division will continue to work with the Department of the Army in developing this plan and will provide guidance on post involvement in the local level of this important new initiative. The American Legion strongly supports DS3 and was actively involved in the planning and implementation of the program. To date National Headquarters has received 13 DS3 referrals from the Department of the Army. The referrals were subsequently forwarded to the appropriate Legion Department for local action. The American Legion applauds the Department of the Army for initiating the DS3 program and it is our hope that the other services will not only create similar programs, but will work together to ensure the success of each of their respective programs.

Benefits Delivery at Discharge (BDD)

BDD allows service members to be examined and file claims for VA benefits at, or near, time of discharge. In doing so, the number of days needed to process the claim is decreased considerably. Claims can be processed within 30 days, as opposed to the national average of 163 days. Since a VA physician administers the examination, VA gains immediate access to the service member's military medical information. There are currently 139 BDD sites nationwide.

The Veteran Benefits Administration (VBA), the Veteran Health Administration (VHA) and the Department of Defense (DoD) created a joint examination for service members leaving active duty. This joint protocol—called the Single Separation Examination Protocol—satisfies both DoD's discharge requirements and VA's compensation requirements. Of the 139 BDD sites, 28 utilize this protocol.

The American Legion fully supports the BDD Program and applauds VA and DoD for developing a smooth and effective benefits delivery process.

VA Outreach Effort

VA has benefits counselors and social workers assigned to the Walter Reed Army Medical Center (Washington, DC); Eisenhower Army Medical Center (Ft. Gordon, GA); National Naval Medical Center (Bethesda, MD); Brooke Army Medical Center (Ft. Sam Houston, TX); and Madigan Army Medical Center (Western Regional Medical Command, Tacoma, WA), military treatment facilities (MTF) where many severely wounded service members are sent. These benefits counselors and social workers assist service members and their families to ensure that service members receive information on VA benefits, arrange transfer of health care to VA facilities, enroll patients and track them as they transfer to the VA system.

Vet Centers

Vet Centers also conduct outreach efforts to include readjustment and family counseling. Vet Centers serve veterans and their families with professional readjustment counseling, community education, outreach to special populations, and work with community organizations. Today, 206 Vet Centers are located in communities throughout the United States, District of Columbia, Puerto Rico, Guam and the U.S. Virgin Islands. 65% of the 737–member clinical staff are veterans and of those over 40% are combat veterans.

In April 2003, the Secretary of Veterans Affairs extended Vet Center eligibility to veterans of Operation Enduring Freedom and later that same year extended eligibility to veterans of Operation Iraqi Freedom. In February 2004, the VA Under Secretary for Health authorized the Vet Center program to hire 50 OEF/OIF veterans to conduct outreach to their comrades from the Global War on Terrorism.

These outreach counselors are in 34 states and the District of Columbia. Additionally, on August 5, 2003, Vet Centers were authorized to furnish bereavement counseling services to surviving parents, spouses, children and siblings of service members who die while on active duty, to

include federally activated Reserve and National Guard personnel. As of January 31, 2005, Vet Centers had served 14,259 OIF/OEF veterans and families, either at Vet Centers or at Demobilization Sites 29 percent of which are PTSD clients.

Vet Centers are an invaluable resource to veterans and VA. Given the protracted nature of current combat operations, repeated deployments and the importance of retaining experienced combat service men and women in an all volunteer military, it is essential to promote the readjustment of service men and women and their families. The American Legion continues to be an unwavering advocate for Vet Centers and their most important mission.

Military Services Briefings

These briefings include separation and retirement seminars, pre- and post-deployment briefings, and the Transition Assistance Program (TAP) and Disabled Transition Assistance Program (DTAP). All military service briefings address VA benefits (compensation, education, vocational rehabilitation, employment, health care) and programs. Special emphasis on the VA compensation process, vocational rehabilitation and employment programs is made for service members separating due to medical problems. In fiscal year 2004, nearly 350,000 OIF/OEF active duty, National Guard and Reservists received over 8,600 pre–separation, TAP and DTAP briefings.

The American Legion remains concerned, however, that many of our servicemembers returning home from OIF/OEF duty are not being properly advised of the benefits and services available to them from the Department of Veterans Affairs and other Federal and State agencies. This is especially true of Reserve and National Guard units that are demobilized at hometown Reserve Centers and National Guard armories, rather than at active duty demobilization centers.

To assist in making sure that these servicemembers are aware of the services and benefits they have earned through their honorable service in the Global War on Terrorism, The American Legion has developed a *Welcome Home* brochure. This brochure outlines the basic entitlements and benefits available from VA and provides contact phone numbers and Internet websites from which servicemembers may obtain more information. The American Legion has distributed thousands of these documents at demobilization centers, Reserve Centers, National Guard armories and Transition Assistance Programs nationwide.

The American Legion Troop Support Services (TS2) Program

Combining three existing programs in an initiative called TS2, The American Legion has developed a pocket resource directory for both troops and their families. Packed with important information and contact telephone numbers, websites and e-mail addresses, the TS2 brochure was designed to fit easily into a desert BDU pocket for handy reference. It includes a wallet card with condensed information to carry during deployment while leaving the main resource guide at home with the family. To date 41,779 TS2 pamphlets have been mailed out to 56 American Legion Posts involved in distribution to our troops.

TS2 is based on three very successful programs of The American Legion –The Family Support Network, the Reconnect Program and Welcome Home Services. Just as our Legion mentors did for us when we went off to war, The American Legion will be there for our service men and women, and their families before, during their deployment, and after they come home.

Women Veterans

Many women, like their male counterparts, make the transition from active service back into their communities without faltering. The experiences they had while in the military go a long way to assist them in their careers and life goals. However, for some the transition is not as easy, depending upon their experiences and community support systems. Although most people leave active duty feeling good about the decision to "get out," transitioning from active duty can be a difficult time. Women veterans face unique challenges and conditions once they transition from active duty back into the civilian community. Women Veterans are entitled to the same VA and DoD benefits as their male counterparts based on their service eligibility. Readjustment Counseling is offered by the VA Vet Centers and medical facilities to assist veterans in readjusting to civilian life.

VHA reports that as of March 2004, among 20,255 women having served, 20.0% (4,045) have received health care from the VA. A higher percentage of OIF (21.1%) as compared to OEF (14%) served in both operations. A slightly higher percentage of separated women veterans have sought VA healthcare from both OIF (21% vs.16%) and OEF (14% vs. 11%) than the overall veteran population. Only .3% of women veterans had been hospitalized at least once in VA since separation. Eighty-eight percent women OEF and 60% of OIF veterans have been members of the Reserve/National Guard.

Women veterans present a wide range of both medical and psychological conditions; the most common conditions have been musculoskeletal, principally joint and back problems. In comparison to overall population of recent conflict veterans seeking VA healthcare, women veterans have experienced similar problems since deployment. Veterans Health Administration will continue to monitor health status of both OEF and OIF veterans using updated deployment lists provided by DoD.

DoD and VA must ensure that the unique needs of women veterans are not forgotten during their transition from military service.

Post Deployment Health Reassessment

DoD has created a post-deployment health reassessment to be implemented 3-6 months after the service members' return from areas of combat. This new assessment will focus on the adverse health effects —especially mental health difficulties like PTSD, and social readjustment issues— that the service members experience after attempting to resume their lives. It addresses the observation that many of these health effects may not manifest immediately. Some problems are not evident for months after the service member returns from combat duty.

The health information obtained from these reassessments is supposed to be used to improve communication between the health care provider and the service member and to help in assessing the service member's health. This program will be available to active duty, reserve and guard members through VA and TRICARE by the end of September 2005. All the services have submitted their respective implementation plans. The plan is to have a phased approach with adjustments made as needed.

The 1st Marine Expedition Force at Camp Pendleton, California was the first to test the program using an Internet–based version. However, technical problems with the electronic version subsequently lead to the need to test a paper version that also ran into some difficulties. The program has also been tested by a group of reservists in the Midwest with feedback expected in September 2005.

Coordinated efforts between DoD and VA are essential in ensuring the health and well being of all returning service members. Implementation is always the most difficult part of the process. It takes time, funding, and most of all, cooperative leadership to ensure service members reap the benefits of a good solid program.

Joint VA/DoD Electronic Data Sharing

The Joint VA/DoD Electronic Health Records Plan-HealthePeople. This overarching initiative guides activities and deliverables of VA and DoD sharing and will result in a "virtual" health record accessible by authorized users within DoD and VA. It will be comprised of a family of systems or converged applications between DoD and VA. The VA/DoD Health Executive Council (HEC), co-chaired by the VA Under Secretary for Health and the DoD Assistant Secretary of Defense for Health Affairs, is providing senior level executive oversight and management of the Departments' activities related to health systems interoperability. The HEC meets routinely to review and/or approve, when timely and appropriate, new and on-going initiatives or health IT sharing projects for coordination between VA and DoD.

The Clinical Data Repository/Health Data Repository (CHDR). This project seeks to ensure the interoperability of the DoD Clinical Data Repository (CDR) with the VA Health Data Repository (HDR) by FY 2005. CHDR is the effort to develop the software component services that will be used by the Composite Health Care System (CHCS II) CDR and the HealtheVet HDR to exchange clinical data in order to provide services in a seamless fashion to both TRICARE and HealtheVet beneficiaries. The Departments formed an active working group to lead this effort and are making significant progress toward building a prototype.

Lab Data Sharing & Interoperability (LDSI). This project will facilitate electronic order entry and results retrieval between DoD, VA, and commercial reference labs to maximize label resources and reduce costs. Phase One was successfully completed with the release of software that supports the ability of VA to initiate lab requests for filling at DoD labs. Development of software permitting DoD to initiate the request for filling at VA labs began December 1, 2003.

U.S. field commanders are aware that their responsibilities include Force Health Protection and this has become a major theme in military operations. The Congress has wisely seen to it that this theme extends to the highest reaches of the Pentagon and Department of Veterans Affairs.

The American Legion is confident that the goal of seamless transition will be achieved as the requisite technologies are developed and adapted. We also believe that this will serve to enhance the professionalism, prestige and pride-of-service of those men and women currently serving in the 21st Century All-Volunteer Military of this Nation and will encourage others to serve.

Although major strides have been taken to create a seamless transition from active duty, the decisions being made today by both DoD and VA will affect the current generation of servicemembers fighting to protect the freedoms of this country. The American Legion stands ready to assist this Committee as well as DoD and VA in understanding the needs of America's veterans well into the future.

★ WASHINGTON OFFICE ★ 1608 "K" STREET, N.W. ★ WASHINGTON, D.C. 20006-2847 ★
(202) 861-2700 ★

September 28, 2005

Honorable Steve Buyer, Chairman
Committee on Veterans' Affairs
335 Cannon House Office Building
Washington, DC 20515

Dear Chairman Buyer:

The American Legion has not received any federal grants or contracts, during this year or in the last two years, from any agency or program relevant to the subject of the September 28th hearing, concerning The Status of Seamless Transition Between The Department of Defense and The Department of Veterans Affairs.

Sincerely,

Peter Gaytan, Director
Veterans Affairs and Rehabilitaion Commission

BIOGRAPHY
PETER S. GAYTAN
DIRECTOR
VETERANS AFFAIRS AND REHABILITATION DIVISION

Mr. Peter S. Gaytan began serving as Director of the Veterans' Affairs and Rehabilitation Division in September 2004. Prior to serving as Director, he served as Principal Deputy Director of the Veterans Affairs and Rehabilitation Division and Deputy Director of the Legislative Division.

He attended Wesley College in Dover, Delaware where he earned a B.A. in Political Science. He is also a graduate of the Defense Information School, Fort Meade Maryland, and earned an Associate of Science Degree in Public Affairs from the Community College of the Air Force.

In 1991, he entered the United States Air Force. After completing initial training at Lackland Air Force Base, Texas, and Keesler AFB, Mississippi, he served as Military Protocol Liaison with the 436th Airlift Wing at Dover AFB, Delaware. While serving with the 436th Airlift Wing he worked with military, diplomatic, and congressional leaders. He coordinated all protocol requirements for NATO visits, repatriation ceremonies for the U.S. Army Rangers killed in Somalia and the memorial ceremony for Commerce Secretary Ron Brown and the passengers of the T-43A that crashed in Bosnia. While on active duty, he also served as Honor Guard Training Flight NCOIC where he provided final honors for more than 200 military funerals. He also served six years with the 512th Airlift Wing, U.S. Air Force Reserve as a Public Affairs Specialist.

During his military service, Gaytan received the Air Force Commendation Medal, Air Force Achievement Medal, Good Conduct Medal, and the Air Force Outstanding Unit Ribbon.

Originally from Norfolk, VA he and his wife, Kimberly currently reside in Washington, D.C.

Testimony

On Seamless Transition in Health Care

by Major General Robert W. Smith III

President, Reserve Officers Association

for the

U.S. House Committee on

Veterans' Affairs

September 19, 2005

Reserve Officers Association of the United States
"Preserving the Nation's Defense"

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The Reserve Officers Association of the United States (ROA) is a professional association of commissioned and warrant officers of our nation's seven uniformed services, and their spouses. ROA was founded in 1922 during the drawdown years following the end of World War I. It was formed as a permanent institution dedicated to National Defense, with a goal to teach America about the dangers of unpreparedness. When chartered by Congress in 1950, the act established the objective of ROA to: "...support and promote the development and execution of a military policy for the United States that will provide adequate National Security." The mission of ROA is to advocate strong Reserve Components and national security, and to support Reserve officers in their military and civilian lives.

The Association's 75,000 members include Reserve and Guard Soldiers, Sailors, Marines, Airmen, and Coast Guardsmen who frequently serve on periods of Active Duty to meet critical needs of the uniformed services. ROA's membership also includes officers from the U.S. Public Health Service and the National Oceanic Atmospheric Administration who often are first responders during national disaster and help prepare for homeland security. ROA is represented in each state with 55 departments plus departments in Latin America, the District of Columbia, Europe, the Far East, and Puerto Rico. Each department has several chapters throughout the state and is further divided into regional chapters. ROA has more than 450 chapters worldwide.

ROA belongs to The Military Coalition where it co-chairs the Tax and Social Security Committee. ROA is also a member of the National Military/Veterans Alliance. Overall, ROA works with 75 military, veterans and family support organizations.

DISCLOSURE OF FEDERAL GRANTS OR CONTRACTS

The Reserve Officers Association is a private, member-supported, congressionally chartered organization. Neither ROA nor its staff receive, or have received grants, sub-grants, contracts, or subcontracts from the federal government for the past three fiscal years. All other activities and services of the Association are accomplished free of any direct federal funding.

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Mr. Chairman and distinguished members of the Veterans Affairs Committee, on behalf of its 75,000 members, the Reserve Officers Association expresses its appreciation for the opportunity to present testimony on the issue of seamless transition of health care and how it potentially affects the 1.5 million men and women now serving in America's Reserve Components.

We thank you for the invitation to submit testimony. Traditionally, the associations that testify before this committee are the Veteran Service Organizations (VSO). Other veterans may be overlooked without ROA's testimony.

Actions taken by the Veterans' Affairs Committee can have a direct impact on retention in the Guard and Reserve. Providing adequate resources and authorities to support the current recruiting and retention requirements of the National Guard and Reserves is one of the top legislative priorities of the ROA. Health care treatment will be a measure used by RC members on whether they are willing to be recalled again.

Guardsmen and Reservists are unique because they are discharged from active duty but remain in military service. Their numbers are reported to Department of Veteran Affairs (VA) by the DoD, but the Reserve Component (RC) members' service obligation remains, and they can be recalled to additional active duty. RC members will be bouncing into and out of the VA System.

The seamless transition in health care involves Military Treatment Facilities (MTFs) and Veterans Health Administration (VHA) Hospitals, but also involves the TRICARE System. With every discharged veteran being offered two years of medical coverage by VHA, if TRICARE coverage fails to support returning Guardsmen and Reservists, they will turn to the VHA Hospitals for health care.

While ROA also watches the transition between Military and VHA, many of the Veteran Service groups will be testifying on the status of the seamless transition between DoD Military Treatment Facilities (MTFs) and Veterans Medical Centers. Our testimony addresses other issues.

ROA's focus:

Seamless transition under Military Treatment

Physical Screening of servicemembers is needed at demobilization sites to document the exit state of the individual. Medical Records of Guard and Reserve members are not maintained as completely as those members on Active Duty. Documentation is a key.

Completion of the Medical Review/Physical Evaluation Board for individuals with medical problems is essential, to document fitness for service and potential medical complications. Such documentation helps the Department of Veteran Affairs record and process claims.

The Risk: Health Insurance Portability and Accountability Act (HIPPA) states that a pre-existing condition will be covered when transitioning between insurance plans if an individual was "covered by previous health insurance (which qualifies under HIPAA as creditable coverage) and if there was not a break in coverage between the plans of 63 days or more." TRICARE is a qualifying plan.

If a member utilizes transitional health care over 120 days for an individual health insurance, or declines the employer's plan on the day of re-employment to continue on TRS, the demobilized service member may loose his or her USERRA or SCRA protection for a continuation of health care coverage. Should a waiting period exceed 63 days, pre-existing conditions of the member or family may not be covered.

Legislative Solution

Section 4317 of title 38 (USERRA) needs to include protections for returning RC member employees who elect TRICARE Reserve Select. Subsection (a)(1) of section 4317 of title 38, United States Code, should be amended by inserting after 'by reason of service in the uniformed services,' the following: 'or such person becomes eligible for medical under chapter 55 of title 10 by reason of subsection (d) of section of 1074 or 1076 of that title'.

Section 704 of the Servicemembers Civil relief act states in section (d) TIME FOR APPLYING FOR REINSTATEMENT- An application under this section must be filed *not later than 120 days after the date* of the termination of or release from military service. Suggested change 180 from 120 days and inclusion of "or upon completion of the person's eligibility for medical care under chapter 55 of title 10 by reason of subsection (d) of section 1076 of that title"

Conclusion

If TRICARE benefits aren't protected under USERRA and SCRA, members may only provide health care plans for family members, and turn to the Veterans Health Administration for their personal health care coverage. At a time when the VHA system is taxed by high demand, and health care costs are increasing, TRICARE benefits as well as Military and VHA medical coverage should be optimized.

The Reserve Officers Association thanks the House Committee on Veterans Affairs for the opportunity to submit testimony. We also thank you for your early actions to make corrections to the Servicemembers Civil Relief Act and USERRA by forwarding H.R. 2064, Servicemembers' Health Insurance Protection Act of 2005 to the House for a vote, where it passed. We hope our input can lead to additional corrections.

STATEMENT FOR THE RECORD OF

PARALYZED VETERANS OF AMERICA

BEFORE THE HOUSE COMMITTEE ON VETERANS' AFFAIRS

CONCERNING

THE SEAMLESS TRANSITION BETWEEN THE

DEPARTMENTS OF DEFENSE (DOD) AND VETERANS' AFFAIRS (VA)

SEPTEMBER 28, 2005

Chartered by the Congress of the United States
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EXECUTIVE SUMMARY

Electronic Medical Records and Data Exchange

- Electronic medical records must be interoperable and bidirectional.
- Allows for two-way electronic exchange of health information and occupational and environmental exposure data.
- Electronic records should include an easily transferable electronic DD214.

Disabled Soldier Support System (DS3)

- This has proven to be a very successful program.
- Its staff and budget is too limited to allow the program to be more successful.

Transition Assistance Programs (TAP/DTAP)

- VETS has been including more detailed employment training and education.
- Have also integrated the Small Business Administration.
- Programs also provide more information on Vocational Rehabilitation and Employment (VR&E) programs administered by the VA.
- Continue emphasis needed on TAP and DTAP at overseas installations.
- DTAP program has not been as successful.
    - Severely disabled veterans often fall through the cracks.

Licensing and Certification

- Licensure and certification creates a significant barrier to employment for transitioning servicemembers.
- VETS must coordinate with DOD and certifying agencies and organizations to provide a smooth transition for employment.
- VA recommends that a standardized licensure and certification requirement be adopted by federal and state agencies, and VETS must facilitate this process.

National Guard and Reserves

- DOD and VA seem ill-prepared to handle the large numbers and prolonged activation of Guard and Reserve forces.
- Greatest challenge is their rapid transition from active duty to civilian life.
- Lack of space and facilities and demobilization sites allows for limited contact between VA representatives and exiting servicemen and women.
- Also difficulty with separation physicals because they are currently not mandatory for separating Guardsmen and Reservists.
- PVA recommends that separation physicals be made mandatory for all separating servicemembers, including National Guard and Reserves.

- It is imperative that adequate funding be provided to VA to allow it to meet the needs of not only active duty veterans, but National Guard and Reservists.

Paralyzed Veterans of America (PVA) is pleased to have an opportunity to present our views on the status of seamless transition between the Department of Defense (DOD) and the Department of Veterans Affairs (VA). The transition of new veterans to civilian life is of such importance that it is one of the critical issues identified in *The Independent Budget* for FY 2006, published by AMVETS, Disabled American Veterans (DAV), PVA, and Veterans of Foreign Wars (VFW). PVA has not limited its focus to DOD and VA due to the many federal agencies that have an involvement in the transition of service members to civilian life.

PVA is an organization of veterans who are catastrophically disabled by spinal cord injury or disease. PVA has always been concerned about the ability of discharged service members, particularly those with spinal cord injuries or disease, to fully reintegrate into the civilian community as new veterans. Of greatest concern is whether or not these new veterans know of the benefits and opportunities provided by VA to assist them with their reintegration and the medical care available for them should they need it.

As servicemen and women return from Iraq and Afghanistan, the DOD and VA must provide these men and women with a seamless transition of benefits and services as they leave military service and become veterans. Due to the number of troops that are on "Stop-Loss"—a DOD action that prevents troops from leaving the military at the end of their enlistments during deployments—large numbers of troops rapidly transition to civilian life upon their return. This creates a number of problems for transition programs. The current transition from the DOD to VA is not completely seamless and is placing a hardship on new veterans trying to gain access to

VA. *The Independent Budget* Veterans Service Organizations (IBVSOs) believe that veterans should not have to wait to receive the benefits and health care that they have earned and deserve.

One of the greatest challenges has been the exchange of medical data. PVA believes the DOD and VA must develop electronic medical records that are interoperable and bidirectional, allowing for a two-way electronic exchange of health information and occupational and environment exposure data. We applaud the DOD for beginning to collect medical and environmental exposure data electronically while personnel are still in theater and this must continue. But it is equally important that this information be provided to VA. Additionally, these electronic medical records should also include easily transferable electronic DD214 information forwarded from the DOD to VA. This would allow VA to expedite the claims process and give the service member faster access to health care and benefits.

The departments have each taken positive steps to share data through the Federal Health Information Exchange initiative and the pharmacy data project; however, obstacles remain. PVA is not encouraged by reports that, in some instances, medical data gathered in theater and stored on electronic smart cards provided to the soldier are not even readable by other military medical facilities upon the service member's return. This does not bode well for an electronic system meant to exchange information between federal agencies.

PVA and other VSO's are not the only ones concerned about this exchange. In June 2004, the Chairman and Ranking Member of both this committee and the Armed Services Committee sent letters to Secretary Principi and Secretary Rumsfeld expressing concern with the current

transition of servicemen and women and indicating that "despite earnest desire by both the DOD and VA to provide each service member with a seamless transition, their efforts remain largely uncoordinated in important respects and suffer from the failure to make planning for transition a high priority for the Executive Branch."

The Independent Budget concurred with the President's Task Force (PTF) recommendation made in its report in June 2003, that "DOD and VA must implement a mandatory single separation physical as a prerequisite of promptly completing the military separation process." This will enhance collaboration by the DOD and VA to identify, collect, and maintain the specific data needed by both departments to recognize, treat, and prevent illnesses and injuries resulting from military service. This standardized physical is critical for active duty members leaving service, but may be even more critical for reservists who leave military service rapidly following demobilization.

PVA applauds the efforts of the DOD in establishing the Disabled Soldier Support System (DS3) implemented in the spring of 2004. This has proven to be a very successful program. It assists the most severely injured service members and their families' transition from military to civilian life. Unfortunately, its staff and budget is too limited to be as effective as it could be. With so many severely injured soldiers returning from the Global War on Terrorism, Congress must support and enhance this program.

In the last several years, DOD and VA have made good strides in transitioning our nation's military to civilian lives and jobs. There has been an increase in the coordination of DOD with

all federal agencies that impact this transition. The Transition Assistance Program (TAP) and Disabled Transition Assistance Program (DTAP) is generally the first service that a separating service member will receive. This is primarily handled by the Department of Labor's Veterans Employment and Training Service (VETS). These 3-day program workshops offer job-search assistance and related services at selected military installations both in the United States and overseas. DTAP was established for service members leaving the military with a service-connected disability and includes additional hours of individual instruction to help determine job readiness and address the special needs of disabled veterans.

Following the recommendations of Veterans Service Organizations, VETS began including more detailed employment training and education together with presentations by VA representatives in the TAP and DTAP. In addition, they began the inclusion of the Small Business Administration to help those veterans who may be interested in entrepreneurial opportunities. VA has also integrated information on Vocational Rehabilitation and Employment (VR&E) programs into both TAP and DTAP to inform new veterans. But more importantly, local military commanders, through the insistence of DOD, began to allow their soldiers, sailors, airman and marines to attend the programs well enough in advance to take greatest advantage of the program. These programs were provided early enough to educate these future veterans on the importance of proper discharge physicals and the need for complete and proper documentation. It made them aware of how to seek services from VA and gave them sufficient time to think about their situations and then seek answers prior to discharge.

The TAP and DTAP programs continue to improve. But challenges continue at overseas locations and with services and information for those with injures. PVA knows that service members are being informed of available programs from interviews conducted on recently injured individuals. But in many ways, there still seems to be disorganization and inconsistency in providing this information. Though individuals are receiving the information, the haphazard nature may allow some individuals to fall through the cracks. This is of particular risk in the DTAP program for those with severe disabilities who may already be getting health care and rehabilitation from a Department of Veterans Affairs (VA) spinal cord injury center despite still being on active duty. Because these individuals are no longer located on or near a military installation, they are often forgotten in the transition assistance process. DTAP has not had the same level of success as TAP and it is critical that coordination be closer between DOD, VA and VETS to improve this.

One area that continues to be a challenge for military personnel leaving military service is the ability to use skills learned during their service. Licensure and certification for those transitioning to the civilian workforce creates barriers to employment. With these credentialing standards based on traditional education and training methods, new veterans face an instant challenge to employment. This lack of civilian recognition of military schooling and experience makes the transition more difficult and reduces the veteran's ability to compete with their civilian peers.

There are a number of factors that have an impact on the ability of current and former military personnel to obtain civilian credentials. Civilian credentialing boards do not have adequate

knowledge of military training and do not, or will not, give proper recognition to military training and experience. There is a lack of clarity regarding the procedures for exchanging transcripts between military and civilian credentialing boards that creates undue barriers for military personnel.

PVA believes if DOD wants to support military personnel who have given so much during their service, it must do more to coordinate with VETS and certifying agencies and organizations. PVA recommends that a standardized licensure and certification requirement be adopted by the appropriate federal and state agencies, and that VETS must facilitate this process. Likewise, recently separated service members must be afforded the opportunity to take licensing and certification exams without a period of retraining.

Though the achievements of DOD and VA have been very good with departing active duty soldiers, there is a much greater concern with the large numbers of Reserve and National Guard soldiers moving through the discharge system. Both DOD and VA seem ill-prepared to handle the large numbers and prolonged activation of reserve forces for the Global War on Terrorism. The greatest challenge with these service members is their rapid transition from active duty to civilian life. Unless these soldiers are injured, they may clear the demobilization station in a few days. Little of this time is dedicated to informing them about veterans programs. Additionally, DOD personnel at these sites are most focused on processing soldiers through the site. Lack of space and facilities at these sites allow for limited contact with the demobilizing soldiers by VA representatives. Recent contacts with returning National Guard soldiers from Afghanistan to Fort Bragg, North Carolina demonstrated that VA representatives provided good and accurate

information, but were limited in their time. Only a few hours were available to provide guidance on VA benefits, healthcare and reemployment rights. These soldiers were strongly encouraged to complete their VA enrollment forms prior to leaving the demobilization station. VA representatives worked closely with the unit's chain-of-command to ensure soldiers were well prepared with information and also provided the opportunity for follow-up, providing business cards and information brochures.

The problem of separation physicals identified for active duty members is compounded when mobilized reserve forces enter the mix. A mandatory separation physical is not required for demobilizing reservists. Though the physical examinations of demobilizing reservists has improved in recent years, there are still a number of soldiers who "opt out" of the physicals, even when encouraged by medical personnel to have the physical. Though the expense, manpower and delays needed to facilitate these physicals might be significant, it would further enhance the ability of DOD and VA to deal with illnesses and injuries resulting from military service. We can not allow a recurrence of the lack of information that led to so many issues and unknowns with Gulf War Syndrome, particularly among our Guard and Reserve forces.

The Department of Defense and Department of Veterans Affairs have made progress in the transition process. Unfortunately, limited funding and a focus on current military operations interferes with providing for those service members who have chosen to leave military service. But if we are to insure that the mistakes of the first Gulf War are not repeated during this extended Global War on Terrorism, it is imperative that a truly seamless transition be created. With this, it is imperative that proper funding levels be provided to VA and the other agencies

providing services for the vast increase in new veterans from the National Guard and Reserves. This nation owes a great debt to all our service members and it is only fair that they be given every opportunity to be just as successful when they leave military service.

PVA appreciates the opportunity to submit a statement for the record. We would be happy to answer any questions that you might have. Thank you.

Information Required by Rule XI 2(g)(4) of the House of Representatives

Pursuant to Rule XI 2(g)(4) of the House of Representatives, the following information is provided regarding federal grants and contracts.

Fiscal Year 2005

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation — National Veterans Legal Services Program — $228,000 (estimated).

Paralyzed Veterans of America Outdoor Recreation Heritage Fund – Department of Defense -- $1,000,000.

Fiscal Year 2004

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation — National Veterans Legal Services Program — $228,000 (estimated).

Fiscal Year 2003

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation — National Veterans Legal Services Program — $228,803.

MILITARY OFFICERS ASSOCIATION OF AMERICA

STATEMENT for the RECORD

on

'Seamless Transition'

between the Departments of Defense and Veterans Affairs

submitted to the

HOUSE COMMITTEE ON VETERANS AFFAIRS

September 28, 2005

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One Powerful Voice.®

The Military Officers Association of America (MOAA) is pleased to submit this Statement for the Record concerning the transition of service men and women from active military service to veteran status and civilian life. MOAA is grateful to the Committee Chairman, Ranking Member and Members of the House Committee on Veterans Affairs for holding this important hearing.

MOAA does not receive any grants or contracts from the federal government.

Seamless Transition Road Map

Our nation's service men and women deserve first class treatment and services before, during and after separation from military service. DoD and VA have critical, complementary roles in the transition process. Unfortunately, bureaucratic inertia and internal priorities in DoD and the VA have slowed the pace of collaborative efforts towards the goal of "seamless transition."

Some of these efforts have been going on for decades with little or no substantive progress, in part because those responsible for action have come to have low expectations. Time and again, progress has been stymied by a combination of a lack of leadership priority and oversight, management turnover, bureaucratic inertia, and technological backwardness.

With tens of thousands of veterans separating every year and upwards of ten thousand wounded Iraq and Afghanistan war veterans, improving the transition process must be made a major priority for both departments working together.

In its final report, the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans (PTF) (May 2003) recommended a series of "seamless transition" initiatives. Together, these actions constitute a 'campaign plan' to implement the goal of seamless transition from active military service into veteran status. The PTF recommended the following:

- Single separation physical: "The Departments [of Defense and Veterans Affairs] should implement by fiscal year 2005 a mandatory single separation physical as a prerequisite of promptly completing the military separation process."
- Electronic Medical records: "VA and DoD should develop and deploy by fiscal year 2005 electronic medical records that are interoperable, bi-directional, and standards based."
- Privacy: "The Administration should direct the Department of Health and Human Services (HHS) to declare the two Departments to be a single health care system for the purposes of implementing HIPAA regulations."
- Electronic service record: "Upon separation, DoD should transmit an electronic DD-214 to VA."
- One-stop separation process: "VA and DoD should expand the one-stop shopping process to facilitate a more effective seamless transition to veteran status. This process should provide, at a minimum: 1) a standard discharge examination suitable to document conditions that might indicate a compensable condition; 2) full outreach; 3) claimant counseling; and 4) when appropriate, referral for a [VA] Compensation and Pension examination and follow-up claims adjudication and rating."
- Occupational and Hazard Exposure Data: "VA and DoD should expand their collaboration in order to identify, collect, and maintain the specific data needed by both Departments to recognize, treat, and prevent illness and injury resulting from

occupational exposures and hazards experienced while serving in the Armed Forces; and to conduct epidemiological studies to understand the consequences of such events."

- Servicemember Assignment-History Data: "By fiscal year 2004, VA and DoD should initiate a process for routine sharing of each service member's assignment history, location, occupational exposure, and injuries information."
- Joint Health Surveillance and Reporting: "The Departments [of Defense and Veterans Affairs] should: 1) add an ex officio member from VA to the Armed Forces Epidemiological Board and to the DoD Safety and Occupational Health Committee; 2) implement continuous health surveillance and research programs to identify the long-term health consequences of military service in high-risk occupations, settings, or events; and 3) jointly issue and annual report on Force Health Protection, and make it available to the public."

The record for accomplishment of the worthy goals set out by the PTF and numerous other study groups is mixed. With a nation at war, MOAA believes much more emphasis and additional resources must be applied from the top down to realize the vision of a "seamless transition" from military to civilian life. We offer the following observations on policy, procedures, and technologies supporting seamless transition objectives:

- **Oversight and Policy Coordination.** MOAA commends Congress for enacting legislation that established a formal coordination process between the Departments of Defense and Veterans Affairs. The DoD-VA Joint Executive Council (JEC) and its subordinate Benefits Executive Council (BEC) and Health Care Executive Council (HEC) have the potential to spearhead greater progress on seamless transition initiatives.

  The activities of these councils, however, appear to fly mostly below the radar. There is virtually no public record of the schedule, proceedings, or accomplishments of the Council with the rare occasional release of a press release to tout completion work that is later found to be suspect. One example is a press release announcing the creation of a single separation physical protocol. That may certainly have occurred at the policy level but a visit to Walter Reed or Bethesda Medical Centers reveals that a "one-stop" separation physical has still not been fielded.

  MOAA recommends greater transparency and oversight of the DoD-VA Joint Executive Council. We further recommend periodic joint hearings by the Armed Services and Veterans Affairs Committees to assess progress in collaborative DoD-VA activities associated with "seamless transition."

- **Benefits Delivery at Discharge (BDD).** MOAA commends VA for the establishment of approximately 135 – 140 BDD offices at military separation and transfer points. It's not clear, however, to what extent BDD services are available to the tens of thousands of demobilizing National Guard and Reserve servicemembers. MOAA and other Military Coalition partners are receiving disturbing reports of a continuing pattern of broken transition services for members of the Reserve forces. In one case, for example, a member of the Alaska National Guard was advised to forego medical treatment in a military treatment facility in Hawaii with the assurance that the VA would provide for his health care in Alaska. Now, apparently, his records are inadequate to substantiate

any future claim for service connection. There is no indication that BDD services were offered to him in Hawaii to document his case and enable him to submit a VA claim for disability prior to his separation.

MOAA recommends much more aggressive action to ensure that BDD services and military medical care are available to injured or ill National Guard and Reserve servicemembers who are serving on contingency operation orders.

- **Electronic Medical Records**. The VA has fielded a standard-setting electronic medical records system for its hospital facilities and outpatient clinic networks. Known as VISTA, the VA system has received high marks in the medical community and is being adopted by a growing number of civilian provider networks. VISTA permits the speedy retrieval of veterans' medical records throughout the VA health care system. The Department of Defense is now fielding a military electronic medical records system called CHCS II. DoD expects to complete CHCS II fielding in 2006. The question is whether VISTA and CHCS II can "talk to each other." Based on the glacial pace of fielding CHCS II, it would not surprise anyone that the issue of connectivity and compatibility of the military system with the VA system has not been addressed.

MOAA continues to strongly urge accelerated development of bi-directional, interoperable medical records between DoD and the VA.

- **Force Health Protection**. The National Defense Authorization Act for FY 2005 (P.L. 108-375) requires the Defense Department to do a better job of collecting baseline health status data through a formal medical readiness tracking and health surveillance system. DoD has developed procedures to conduct pre- and post-deployment health assessments. Time will tell whether the data being captured is adequate to support the care and treatment of deploying troops and to help substantiate claims for military and veterans' disability. MOAA observes that some versions of pre- and post-deployment questionnaires may have only marginal value for capturing substantive information. Some see them as not much more than a "check the block" exercise.

MOAA recommends a joint Armed Services and Veterans Affairs hearing to assess progress in tracking pre- and post-deployment health assessments of military personnel.

- **Medical Evaluation Board (MEB) / Physical Evaluation Board (PEB).** The Defense Department testified on 17 February 2005 before the House Committee on Government Reform regarding force health protection programs and how they affect wounded service members. The testimony included information on Service MEB and PEB activities. MEBs are not conducted until a "period of observation" or "time to heal" is completed. This period averages 121 days, but can vary considerably depending on the medical condition and healing process. Between 1 November 2003 and 2 February 2005, 15,485 Army soldiers had been evaluated for retention in the military. Of these, 65 percent were retained while 35 percent were released from the military. Army MEBs are currently taking up to 67 days to complete. The PEB is charged with making personnel decisions based on the input from the MEB. DoD requires a PEB in

peacetime to be completed within 40 days following an MEB. The average PEB completion time since Operations Iraqi Freedom (OIF) and Enduring Freedom (OEF) is 87-280 days. Taken together, the convalescence, MEB and PEB processes appear to average between about nine to 15.6 months' completion time for Army soldiers. DoD did not indicate how many National Guard and Reserve servicemembers were evaluated by MEB – PEB. DoD stated that "medical standards for service suitability are service-specific."

In testimony before the Veterans Disability Benefits Commission (15 September 2005), MOAA on behalf of The Military Coalition recommended the Commission conduct research on the MEB-PEB processes to ensure fair and equitable treatment of ill and injured service men and women. Mobilized National Guard and Reserve servicemembers who incur serious injuries or illness on military duty should be afforded full access to MEB – PEB.

- **Single Separation Physical.** MOAA remains concerned about known gaps in implementing a single separation physical. As indicated above, DoD and VA some time ago announced an agreement on a single separation physical protocol. Yet, at key medical treatment facilities (MTFs) like the Walter Reed Army Medical Center and the National Naval Medical Center neither facility has implemented a single, systematic process for a separation physical under a joint DoD-VA protocol. That being the case at the Army and Navy's premier medical facilities, it's unlikely that a single separation physical has been implemented elsewhere.

MOAA continues to urge Congress to direct the development and fielding of a single separation physical.

- **Electronic Service Record.** MOAA is mystified why an electronic service record has not been implemented. The technological requirements for an electronic DD-214 are rather straightforward. Privacy issues, if there are any, should have been resolved long ago through service member consent, if needed.

MOAA strongly supports the rapid development and implementation of an electronic service record (DD-214).

- **Seriously Wounded Transition Program.** DoD and VA have made commendable progress in improving services to injured and ill servicemembers. DoD has established a joint center to oversee care and services for injured and ill OIF and OEF servicemembers. The VA has assigned caseworkers to major military medical facilities that are providing care and rehabilitation services to seriously injured or ill troops. In a recent report, however, the GAO recommended better information sharing between DoD and VA on seriously injured service men and women: *Vocational Rehabilitation; More VA and DoD Collaboration Needed to Expedite Services for Seriously Injured Service Members* (January 2005). The GAO recommended that VA and DoD reach agreement whereby VA could access DoD information to promote recovery and return to work for seriously injured service members. GAO also recommended development

of policy and procedures for regional offices to maintain contact with seriously injured service members.

MOAA recommends continued emphasis on improving DoD – VA information sharing and outreach services for seriously wounded servicemembers.

- **Transition Assistance Program (TAP).** TAP services serve as the touchstone for "seamless transition" activities. MOAA on behalf of The Military Coalition (TMC) testified on TAP and Disabled Servicemember TAP (DTAP) at a 29 June hearing before the House Veterans Affairs Committee. TMC recommended the doubling of TAP resources to accommodate the growing number of Guard and Reserve members needing those services and the development of tailored TAP services in local communities for members of the Reserve forces.

MOAA supports increasing TAP resources for the increasing number of demobilizing Guard and Reserve veterans and development of hometown TAP services that address the needs of Guard and Reserve service men and women and their families.

Conclusion

MOAA is grateful to the Committee on Veterans Affairs for holding this timely and important hearing. As more and more men and women go into harm's way at home and abroad, it should be seen as an important government priority at the highest levels to ensure their ultimate transition to civilian life is accomplished in the most efficient, effective, and compassionate manner as possible. MOAA strongly agrees with the statement of the President's Task Force on DoD-VA collaboration: **"VA and DoD responsibility for veterans' health begins as soon as an individual enters the Armed Forces."** It follows that responsibility for determining service-related disabilities and determining government-provided benefits for separating servicemembers is a fundamental obligation of both departments towards those who have volunteered to wear their nation's uniform. Improving the policy, procedures and technologies that support "seamless transition" must be seen as a critical function of each department working collaboratively. To accelerate accomplishment of the vision of "seamless transition", ***MOAA urges Congress to direct a concerted "Manhattan Project" effort to ensure full and timely implementation of seamless transition activities: a bi-directional electronic medical record (EMR), enhanced post-deployment health assessments, implementation of an electronic DD214, additional family and mental health counseling services, and one-stop physical at time of discharge.***

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