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IMPLEMENTING THE WOUNDED WARRIOR PROVISIONS OF THE NATIONAL DEFENSE AUTHORIZATION ACT FOR FISCAL YEAR 2008

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

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IMPLEMENTING THE WOUNDED WARRIOR PROVISIONS OF THE NATIONAL DEFENSE AUTHORIZATION ACT FOR FISCAL YEAR 2008

WEDNESDAY, JUNE 11, 2008

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 10:21 a.m., in Room 334, Cannon House Office Building, Hon. Bob Filner [Chairman of the Committee] presiding.

Present: Representatives Filner, Brown of Florida, Snyder, Michaud, Herseth Sandlin, Mitchell, Hall, Hare, Salazar, Rodriguez, Donnelly, Space, Walz, Cazayoux, Buyer, Stearns, Moran, Brown of South Carolina, Boozman, Brown-Waite, Lamborn, Bilirakis, Buchanan, Scalise.

OPENING STATEMENT OF CHAIRMAN FILNER

The CHAIRMAN. We are going to open our hearing on Implementing the Wounded Warrior Provisions of the National Defense Authorization Act (NDAA) for Fiscal Year 2008. The Committee will come to order.

Mr. Scalise, it is customary for the new Members to be granted this opportunity to say a few words if you would like. We welcome you to our Committee and look forward to your participation.

OPENING STATEMENT OF HON. STEVE SCALISE

Mr. SCALISE. Well, thank you, Chairman Filner and Ranking Member Buyer. I appreciate the honor to serve on the Veterans' Affairs Committee and as well as my colleague, Mr. Cazayoux, who I served on the Legislature with, specifically in the New Orleans region.

All the parishes in my district were adversely affected by Hurricane Katrina, but our veterans hospital has been closed because of the damage that it took on from Hurricane Katrina. And so there are a number of issues I want to work on that involve all veterans across the country, but specifically the veterans in our region have been dealing with a number of extra problems because of the closure of that hospital.

And looking forward to working through those issues with you and the rest of the Members of this Committee. Thank you.

[The prepared statement of Congressman Scalise appears on p. 55.]

The CHAIRMAN. Thank you.

Mr. Cazayoux.

OPENING STATEMENT OF HON. DONALD J. CAZAYOUX, JR.

Mr. CAZAYOUX. Thank you, Mr. Chairman, Members, Ranking Member Buyer. I, too, am delighted and honored to be on this Committee and look forward to working with each of you to make sure that we take care of our veterans in an honorable way and make sure that we take responsibility for our men and women as they come back from fighting our wars.

And thank you very much, Mr. Chairman.

The CHAIRMAN. We thank you and we welcome you to the Committee.

I thank the witnesses for being in this hearing. Officially, we count that over 33,000 servicemembers have been wounded in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). I think we all know that due to the improvement in both battlefield medicine and incredible evacuation procedures and transportation, those who might have died in past conflicts are now surviving, many with multiple serious injuries such as amputations, traumatic brain injury (TBI) and, of course, post traumatic stress disorder (PTSD).

We have seen a lot of publicity on this and our apparent inability to predict all of this and have the resources in place to deal with it. We are trying to catch up and do that.

The Wounded Warrior provisions of the 2008 National Defense Authorization Act were intended to do just that. Many of them require the U.S. Department of Veterans Affairs (VA) and the U.S. Department of Defense (DoD) to collaborate to improve the care and management and transition of recovering servicemembers. The hearing today will explore the progress that the two Departments have made in implementing these provisions.

Thirty-two warrior transition units have been established in the Army to try to improve care management. Injured soldiers are now assigned a primary care manager, nurse case manager, and a squad leader to guide them to their recovery.

The rapid creation of these units appears to be a success. However, according to the U.S. Government Accountability Office (GAO), several challenges remain including hiring sufficient medical staff in a very competitive market, replacing temporarily borrowed personnel with permanent staff, and getting eligible servicemembers into those units.

In December of last year, the VA, in cooperation with DoD and the U.S. Department of Health and Human Services (HHS), established the Federal Recovery Coordinator (FRC) Program to coordinate clinical and nonclinical care for severely injured and ill servicemembers.

As of May of this year, there were only six field staff members working with the 85 patients at three sites. I want to look today at how effective this program has been and how it will be expanded to benefit more of our veterans.

As these veterans transition from the military health system to the VA system, they face the difficulty of navigating through two different and cumbersome disability evaluation systems. The current system is a source of stress and frustration for many veterans.

Last November, both DoD and VA jointly initiated a 1-year pilot program to evaluate a streamlined evaluation system. I hope they will be able to expand this program and today we will hear how that is going.

We all know that PTSD and TBI are considered to be the Doctor, signature injuries of this war.

According to a RAND Corporation report that came out in April, nearly 300,000 veterans of Afghanistan and Iraq are suffering from PTSD or major depression. Nearly 20 percent, according to the RAND figures and which, I think is a low number, reported a probable traumatic brain injury during deployment.

By the way, compare the 300,000 estimate, which again I think is low, with the official casualty number of 33,000 and there is not just a minor discrepancy between the two figures. I think we are going to ask the Pentagon to deal with these casualty figures in far more realistic terms, and we want to get your thoughts on that.

As we will hear, many veterans are not getting the care they need and deserve. Only 43 percent of those reporting probable TBI have been evaluated by a physician for brain injury. And only half of those who meet the criteria for PTSD or major depression sought help from a physician or mental health provider. This is simply not acceptable and we have to do better.

Again, last year, the Department of Defense established a Center of Excellence for psychological health and traumatic brain injury and I want to see how the VA and DoD are working together to conduct research in these areas and develop best practices.

Certainly an important component to improve continuity of care is development of an interoperable electronic health record, which would allow for the seamless transfer of medical information between the two Departments.

I think we have made some significant progress toward improving care and transition, but a lot of work needs to be done and that is what this hearing is about today. We look forward to an informative hearing.

Our first panel is from the RAND Corporation. Terri Tanielian and Lisa Jaycox will begin the discussion and then we will hear from the Department of Defense and Department of Veterans Affairs.

I want to say, before we start our hearing, that no matter where we stand on the war, we are united in saying that every man or woman that comes back from the war should get all the healthcare—the seamless healthcare—that they need and the benefits they have earned.

I will yield to Mr. Buyer, the Ranking Member, for his opening statement and any quick comments from the rest of our Members.

[The prepared statement of Chairman Filner appears on p. 53.]

OPENING STATEMENT OF HON. STEVE BUYER

Mr. BUYER. Mr. Chairman, I want to thank the witnesses for being here today to discuss the implementation of the Wounded Warrior provisions of the 2008 Defense Bill.

As you recall, these provisions, many of which were adopted in the Defense bill I drafted, received good input from Mr. Stearns and Mr. Miller, Mr. Brown, Mr. Boozman, along with Mr. Michaud,

Stephanie Herseth Sandlin, and, once again, we leaned on Dr. Snyder for his good work with the Defense Bill.

And, Mr. Chairman, you were also very supportive and spoke in support of them at the conference last year. So I want to thank you for your assistance.

I also am very cognizant. One thing I have learned about you, Mr. Chairman, and myself, is that sometimes we are not very patient and we are eager to get out there and be aggressive. And I want to thank you. That is what you are trying to do here. But when we put these together, we put in progress reports for a reason.

I almost cannot help but sense we are a month early with the hearing. I know that you are really eager to move out here, but there are eight DoD progress reports that were set forth in the Defense Bill.

Section 16 of the Bill required GAO to provide an assessment of the implementation of the Wounded Warrior provisions 6 months after enactment. Since that deadline is next month, the GAO is unable to provide this assessment because it has only recently begun its review of the implementation provisions and it would not have been able to provide an in-depth analysis for the Committee.

GAO did indicate that based on the initial assessment, VA and DoD have not finalized a policy nor have they begun implementation of many aspects of the Defense Bill's mandates.

While this is of concern, I feel that it is really premature at this point to criticize the Departments' progress based on incomplete information submitted before the benchmark requirement.

Therefore, my counsel during this hearing will be that the Wounded Warrior provisions must be implemented with a sense of urgency.

Sixteen months have passed since the Washington Post news story revealed some of the instances of inadequate housing of soldiers at the Walter Reed Army Medical Center. While that moment was infamy for some, this Committee has had a longstanding concern that the current DoD and VA disability systems fail to provide a seamless transition, especially for those enduring the military's discharge process.

Over the past 15 years, one commission and a task force report after another has called for measures to streamline the transition process, but such changes have not been implemented.

Therefore, I was pleased that this year's Defense Bill contained these provisions that we had worked on together. That amendment in particular we were able to focus on the use of the uniform separation exam, an evaluation that VA could use for rating decisions.

The electronic DD–214 is something we had talked about for years and I am glad they are finally moving toward that, the real-time access to the veteran's medical history by requiring electronic exchange of critical medical information between DoD and VA. The need for this electronic exchange of medical records was amplified during my many visits. And I am sure, Mr. Chairman, as you too are around, you see that necessity.

While at Landstuhl, I had witnessed patients being transferred from the battlefield with the paper medical files taped to their chests and I was appalled that was being done.

Now, obviously things were being done in transition of air medivac, but, you know, we talk about getting to the electronic medical record. We still have a long way to go.

So, Mr. Chairman, I think what we are going to have to do is perhaps we are going to do this hearing and we are going to have to come back again in maybe September and have another one of these hearings keeping the pressure on, I guess, is what I am going to ask of you. And I think that is what you have done here by moving out here today. But we are going to need to come back and hold them to the timelines on their progress reports would be my counsel to you, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Buyer.

I will say that we are in the 6th year of the second longest war in American history and we are way too late on these things—not too early.

Does anybody want to add any comments before we begin?

Mr. Stearns.

OPENING STATEMENT OF HON. CLIFF STEARNS

Mr. STEARNS. Mr. Chairman, thank you.

As a Member from Florida with my other colleagues, we have a lot of veterans coming back from the war into Florida. It is one of the largest and fastest-growing veterans populations in the country.

And I think, Mr. Chairman, as you pointed out, it is traumatic brain injury, if a veteran suffers from that, that in turn could create a high incidence of post traumatic stress disorder. So obviously Members want to know what is being done.

I understand Title 17 of the "Wounded Warriors Act" specifically requires the Secretary of the VA to develop an individualized plan to help rehabilitate and reintegrate back into our community servicemembers who have received care at the VA for TBI.

The Act also requires the VA to assign a case member for each veteran suffering from TBI while also explicitly stating the family members of the veteran with TBI should be involved in the development of this individualized plan. This is good. I would like to obviously hear how that is progressing.

Just as a side note, Mr. Chairman, if, in fact, a person suffers from traumatic brain injury and this causes post traumatic stress disorder, if we could, through a blood test immediately administered on the field of battle or after the veteran comes back, through a blood test determine if there is this traumatic brain injury, that would indeed give us insight immediately on how to care for these individuals.

There is a company in my congressional district called Banyon Biomarkers that we have helped fund for many years to develop this blood test, and they are on the cusp now of making this into a product that the military could carry into battle and actually test the blood samples of an individual to see if they have traumatic brain injury. And that in turn would give us a head start on post traumatic stress disorder.

And I say that. I am obviously bragging about this company. We have funded it over the last 6, 7 years. And there are real possibilities, Mr. Chairman and my colleagues, that this will be made into

a quantitative case and not into a qualitative case where we are trying to understand the veteran who comes back to fill out forms and things like that.

But we need this urgently to be able to help the veteran even though perhaps he feels there is no problem. But this blood test is on the cusp of being made into a device that can be manufactured.

So I look forward to the hearing. And I think as I pointed out in Title 17, the VA has a heavy responsibility to reintegrate these individuals and to help the family members develop this individual plan. So I look forward to the hearing.

And thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

We will start with the first panel. Lisa Jaycox is a Senior Behavioral Scientist and Terri Tanielian is a Senior Social Research Analyst with the RAND Corporation. They will discuss their recent report called "The Invisible Wounds of War," which I think is an important contribution to our understanding of the issues.

Dr. Jaycox will focus on the key findings on psychological cognitive injuries and Ms. Tanielian will focus on the recommendations for addressing these injuries.

You are welcome to start. Thank you.

STATEMENTS OF LISA H. JAYCOX, PH.D., SENIOR BEHAVIORAL SCIENTIST/CLINICAL PSYCHOLOGIST, AND STUDY CO-DIRECTOR, INVISIBLE WOUNDS OF WAR STUDY TEAM, RAND CORPORATION; AND TERRI L. TANIELIAN, MA, CO-DIRECTOR, CENTER FOR MILITARY HEALTH POLICY RESEARCH, AND STUDY CO-DIRECTOR, INVISIBLE WOUNDS OF WAR STUDY TEAM, RAND CORPORATION

STATEMENT OF LISA H. JAYCOX, PH.D.

Dr. JAYCOX. Thank you, Chairman Filner, Representative Buyer, and distinguished Members of the Committee, thank you for inviting us here today to present on the RAND study, Invisible Wounds of War. It is an honor to be here.

My testimony will present the results of the study which was conducted independently of the DoD and VA and takes a broad perspective on three consequences of war: post traumatic stress disorder or PTSD; depression; and traumatic brain injury or TBI among servicemembers returning from Iraq and Afghanistan.

My colleague, Terri Tanielian, will follow with recommendations for addressing these conditions.

Since October of 2001, approximately 1.6 million U.S. troops have deployed to these theaters at a pace unprecedented in the history of the all volunteer force.

Advances in both medical technology and body armor mean that more servicemembers are surviving their combat experience. However, casualties of a different kind are beginning to emerge, invisible wounds such as mental health and cognitive impairments resulting from deployment experiences.

First, I will discuss our findings relative to PTSD and depression. Our telephone survey representing all previously deployed individuals found substantial rates of mental health problems in the past

30 days with 14 percent screening positive for PTSD and 14 percent for major depression.

Some specific groups previously under-studied including the Reserve components and those who have left military service may be at higher risk of suffering from these conditions, but the single best predictor of PTSD and depression is the number of combat traumas experienced while deployed.

Only about half of those with current PTSD or major depression had sought help for a mental health problem in the past year and only about half of those that sought care received minimally adequate treatment. The number who received quality care would be even smaller.

Many barriers inhibit veterans from getting help for their mental health problems including concerns about treatment leading to negative career repercussions and also concern that treatment might not be effective.

Unless treated, both PTSD and depression have wide-ranging and negative implications that affect work, family, and social functioning including substance abuse, homelessness, and suicide. Thus, early intervention is needed to help stem this cascade of negative consequences.

In dollar terms, the cost associated with PTSD and depression are substantial. We estimated costs incurred within the first 2 years after servicemembers return home to range from $4 to $6 billion.

Our cost model assumes the status quo in which the minority of individuals with PTSD and depression actually get treatment and the minority of that care is acceptable quality of care. If we assume high-quality care goes to every person with PTSD or depression, we see that by increasing treatment costs, the societal costs are reduced by as much as $2 billion in just 2 years.

For active-duty personnel in particular, personal and cultural factors impede the use of services as do structural aspects of services such as wait times and availability of providers.

We identified gaps in organizational tools and incentives that would support the delivery of high-quality mental healthcare to the active-duty population and to retired military who use TRICARE.

The VA provides a promising model for the DoD in quality improvement in mental healthcare. However, it faces challenges in providing access to veterans, many of whom have difficulty securing appointments, particularly in facilities that have been resourced primarily to meet the needs of older veterans.

Improving access to mental healthcare for veterans will require reaching beyond the DoD and VA healthcare systems, but it will be essential to ensure quality care in these systems.

I am now going to turn to our results regarding TBI or traumatic brain injury. In our survey, we found 19 percent reported a probable TBI during deployment, although we do not know the severity of that injury or whether the injury caused functional impairment. Of those reporting probable TBI while deployed, 57 percent had not been evaluated by a physician for brain injury.

In dollar terms, we estimate 1 year cost for mild TBI or concussion to be about $30,000 largely due to productivity losses. In con-

trast, for moderate to severe cases, costs are about ten times higher and are due mostly to mortality costs.

The medical science for treating combat-related TBI is in its infancy. Research is urgently needed to develop effective screening tools as well as to document what treatment and rehabilitation will be most effective.

In terms of the service systems for mild TBI, we found gaps in access to services stemming from poor documentation of blast exposures and failure to identify individuals with probable TBI. Servicemembers with more severe injuries face a different kind of access gap, lack of coordination across the continuum of care.

Thank you for the opportunity to testify today and share our results. Additional research results are available in my written testimony and also available at veterans.rand.org. Thank you.

[The prepared statement of Dr. Jaycox appears on p. 56.]

The CHAIRMAN. Thank you very much.

Ms. Tanielian.

STATEMENT OF TERRI L. TANIELIAN, MA

Ms. TANIELIAN. Chairman Filner, Representative Buyer, and distinguished Members of the Committee. Thank you for inviting me to testify today. It is an honor and pleasure to be here.

My testimony will briefly discuss several recommendations for addressing the psychological and cognitive injuries among servicemembers returning from Afghanistan and Iraq.

The purpose of these recommendations is to close the gaps in access and quality for our Nation's veterans that Dr. Jaycox described.

Our report offers four recommendations that would improve the understanding and treatment of PTSD, depression, and TBI among combat veterans.

First, our report recommends an increase in the number of providers who are trained and certified to deliver proven or what we call evidence-based care. There is a substantial unmet need for treatment of PTSD and depression among military servicemembers following deployment.

Both DoD and the VA have had difficulty in recruiting and retaining appropriately trained mental health professionals to fill existing or new slots. With the possibility of more than 300,000 new cases of mental health conditions among Iraq and Afghanistan vets, a commensurate increase in treatment capacity is needed.

Since there is already an increased need for services, the expansion of trained providers is already several years overdue. With an existing shortage of mental health professionals in the U.S. healthcare system more broadly, this has become a critical pipeline issue.

Such investment could be facilitated by several strategies including adjusting financial reimbursement for providers to offer appropriate compensation and incentives, developing certification processes to document the qualifications of providers, and establishing regional training centers for joint training of DoD, VA, and civilian providers in evidence-based care for PTSD and depression.

Our second recommendation is to change policies that would encourage active-duty personnel and veterans to seek needed care. Many servicemembers are reluctant to seek services for fear of neg-

ative career repercussions. Policies must be changed so that there are no perceived or real adverse career consequences for individuals who seek treatment except when functional impairment compromises fitness for duty.

Such policies will require creating new ways for servicemembers and veterans to obtain treatments that are confidential, off the record, off base, and during off-duty hours. Currently information about being in treatment is available to command staff even though treatment itself is not a sign of dysfunction or poor job performance, providing an option for confidential treatment has the potential to increase total force readiness by encouraging individuals to seek healthcare before problems accrue to a critical level.

Third, to close the gap in quality, our study recommends delivering evidence-based care to servicemembers and veterans wherever and whenever they are served. Treatments for PTSD and depression vary substantially in their effectiveness and while the most effective treatments are being delivered in some sectors of the care system for military personnel and veterans, system-wide implementation remains a problem.

Delivery of evidence-based care to all veterans with PTSD or depression would pay for itself or even save money by improving productivity and reducing medical and mortality costs within only 2 years.

The VA is at the forefront of trying to ensure that evidence-based care is delivered to all of its patients, but it has yet to evaluate its success at these efforts across the entire system nor will the VA serve all veterans.

Transformations are required to achieve the needed improvement in quality of care for our veterans. For example, providers delivering treatments to veterans must be held accountable for the services they are providing.

TRICARE and the VA could require that all patients be treated by therapists who are certified to handle the diagnosed disorders of that patient and use varying payment systems to incentivize the delivery of evidence-based care. Monitoring systems should also be used to ensure quality and coordination of care.

Our final recommendation calls for investing in research to close information gaps and plan effectively for the future. Better understanding is needed of the full range of problems that confront individuals with post-combat PTSD, depression, and TBI. Greater knowledge is also needed to understand who is at risk for developing mental health problems and who is most vulnerable to relapse.

At the same time, policymakers need to be able to accurately measure the costs and benefits of different treatment options so that fiscally responsible investments in care can be made. A coordinated Federal research agenda on these issues within the veterans population is sorely needed.

Such a program would likely require resources in excess of that currently devoted to PTSD and TBI through DoD and the VA and could extend to the National Institutes of Health (NIH), the Substance Abuse and Mental Health Services Administration, the Centers for Disease Control and Prevention, and the Agency for Healthcare Research and Quality.

Addressing PTSD and depression as well as TBI among those deployed to Afghanistan and Iraq should be a national priority, but it is not an easy undertaking. The prevalence of these injuries is relatively high and may grow as these conflicts continue. And the long-term consequences associated with these injuries if left untreated without evidence-based care can be severe.

The systems of care available to address these conditions have been improved significantly, but critical gaps remain. System-level changes across the entire U.S. healthcare system are essential if the Nation is to meet not only its responsibility to recruit, prepare, and sustain a military force but also its responsibility to address service-connected injuries and disabilities.

Thank you again for the opportunity to testify today and to share our research findings and recommendations.

[The prepared statement of Ms. Tanielian appears on p. 61.]

The CHAIRMAN. Thank you both very much.

Mr. Snyder, if you have any questions, you are recognized.

Mr. SNYDER. Is it Tanielian? Am I saying that right? The issue of training, you are very clear multiple times in here talking about evidence-based treatment and that people need to be trained in that.

If I today decided to quit this job and I wanted to become that kind of a trainer, where would I go and how long would it take me?

Ms. TANIELIAN. That is an excellent question. And we recommend actually that regional training centers be developed that would offer this type of training in evidence-based care. Currently, availability of such training is sparse in different locations around the country and we would need additional training centers.

I would also ask Dr. Jaycox who is trained in some of these evidence-based therapies to comment.

Dr. JAYCOX. I think one part of your question is who can be trained. And normally some degree of clinical training be before you get training in evidence-based treatments is required.

But that does not necessarily mean just psychiatrists and psychologists. Social workers, marriage and family therapists, etc., there are many different people with degrees who would be ready to take up this kind of training.

And the DoD is rolling out a number of training programs among and providers within their systems. So there is, you know, a number of different efforts to bring these kinds of treatments into both the DoD settings and the VA.

Mr. SNYDER. Is not one of the problems there, I mean, my impression is we have a lack of general mental health providers in this country anyway already, right? Do you agree with that?

Dr. JAYCOX. Yes.

Mr. SNYDER. And so if what we are talking about is trying to take this pool that we think is inadequate for the country and get some of them to take additional training at these regional training centers and these specific treatment modalities for PTSD and the depression and the kind of thing you are talking about, we are still going to have the same shortage of providers; are we not?

Ms. TANIELIAN. We have a current shortage of providers in the U.S. mental healthcare system. That is why we identified this as a pipeline issue. We do need to think about the pipeline of individ-

uals going into mental health professions as well as those paraprofessionals that Dr. Jaycox described and how they could be trained as well in these particular types of approaches.

We need to think broadly because we need a large investment to get the required expansion as soon as possible.

Mr. SNYDER. One of the issues that comes up sometimes is that there is an interest to meet this need and having probably people with quite limited mental health treatment background, you know, but who may be veterans themselves or have been in combat themselves.

I do not see anywhere in your writing that you are suggesting that we omit step one which is some basic background and education and clinical experience in providing treatment to patients and folks with mental health issues.

Would you elaborate on that?

Ms. TANIELIAN. Yes, I agree that there needs to be some baseline clinical training, but there are also roles for other types of people in the treatment process. We know that support and help with transitions is extremely important for reducing PTSD and depression symptoms.

So, for instance, in the Vet Centers, that role of helping people work out their financial problems, their employment problems, their family problems is important as well.

And in addition, there are some new models that integrate care, for instance in primary care, where the primary care physician can serve as sort of the point of contact that then would help decide, which patients need to go into the more intensive psychotherapy approaches, for instance.

And the primary care physicians can be trained to deliver the medications with psychiatric consult so that individuals would not have to see a psychiatrist directly, but could also work with their primary care physician.

Mr. SNYDER. One of the things that happens, it seems to me, in mental health services is a person goes to see, and you talked about this, I think, Ms. Tanielian, a person goes to see their mental health provider. They spend time with them. Then they come out with their slip that says counseling or just something, and I think it is deliberate, you do not know what happened in the room.

The problem is, it seems, is that part of the issue that makes it difficult to evaluate what has been effective or not effective or if the person is being paid, Federal dollars is providing the kind of what you call evidence-based therapy.

Would you comment on that?

Ms. TANIELIAN. Absolutely. Our healthcare system is designed on a reimbursement system that only asks providers to record the number of minutes that they saw the patients.

Our analyses suggests that we need to break down the black box of what is happening in these sessions and require accountability so it would be more informative for both evaluating the types of care that are being delivered as well as incentivizing the delivery of evidence-based care, to understand what types of therapies or treatments are being delivered in that 30, 45, or 90 minute session.

Mr. SNYDER. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Snyder.

Mr. Stearns.

Mr. STEARNS. Thank you, Mr. Chairman.

Just to put this in perspective, how many, and this is a question each of you can answer separately, how many, if any, of your recommendations were already addressed in the Wounded Warrior provisions of Public Law 110–181? Start with you.

Dr. JAYCOX. You know, our report is complementary to the Wounded Warrior provisions in that we are focusing on depression, PTSD, and——

Mr. STEARNS. No. But that is not the question. The question is, how many of the Wounded Warrior provisions of these recommendations are already being done?

Dr. JAYCOX. Those really focus on the severely wounded individuals so that it is a different system of care that we are looking at, by and large, except for in terms of moderate to severe TBI. So I do not have an exact answer for you.

Mr. STEARNS. Do you?

Ms. TANIELIAN. It is an excellent question. I think that we could look a little bit more closely at the specific provisions in the legislation and provide you with a more detailed response about the exact overlap.

We are suggesting that the issues for raising the level of quality of care that is provided really extend beyond the DoD and the VA and go across the entire U.S. healthcare system in terms of the pipeline issues for providers who are going into these professions as well as the systems that would need to be in place to ensure appropriate quality in terms of the evidence-based care that is being delivered to the veterans.

Mr. STEARNS. So you are also talking about the private sector too?

Ms. TANIELIAN. Absolutely. A number of veterans will be seeking care outside of the DoD and the VA healthcare systems in the private sector as well as the publicly funded healthcare sector.

Mr. STEARNS. Maybe it is difficult for you to answer. But if you took the VA, the DoD, and the private sector and if you could rank them into a professional opinion in terms of the quality of mental healthcare and traumatic brain injury care provided services, is the private sector way ahead of the DoD? I mean, if you took VA and DoD and the private sector, could you give me sort of a ranking here or just a feel for this?

Dr. JAYCOX. I will give you my opinion on that.

Mr. STEARNS. Yes. Just your personal opinion after you have done this.

Dr. JAYCOX. Yes.

Mr. STEARNS. You are the analyst and you are the experts.

Dr. JAYCOX. As we said earlier, the VA is really at the forefront for monitoring quality and rolling out——

Mr. STEARNS. The VA is ahead of the private sector?

Dr. JAYCOX. Yes.

Mr. STEARNS. And ahead of DoD?

Dr. JAYCOX. Yes, in that it is both conscientiously monitoring and trying to enhance quality both for PTSD and depression. The DoD is rolling out a lot of programs, but is not yet monitoring the qual-

ity of those programs. And the civilian sector, I would say, is behind both of them.

Mr. STEARNS. Is that your opinion also that the Veterans Administration is way ahead of the private sector as well as DoD?

Ms. TANIELIAN. Yes. The VA has a number of tools in place that they are using already, as Dr. Jaycox described, to increase the level of evidence-based care that is delivered to its patients as well as to monitor and incentivize the delivery of that type of care.

The DoD also has similar tools that they are now able to roll out. The civilian sector, while there are some models out there, for decades, the veterans healthcare systems as well as the military health systems have led the field, particularly around the treatment of PTSD.

Mr. STEARNS. You probably heard my opening statement in which Banyan Biomarkers, which is affiliated with the University of Florida, which I represent, has done research to identify in the battlefield from a blood test whether there is traumatic brain injury.

Have you ever heard of that or have you been aware of that kind of advancement?

Dr. JAYCOX. I am not aware of that, but we really focused on post-deployment PTSD, TBI and depression, so not during deployment.

Mr. STEARNS. What does RAND define as minimally adequate care for mental health conditions? Do the different policies and procedures among the services and the VA impact the delivery of mental healthcare and TBI care? If so, in what way? And does Public Law 110–181 address any of these issues?

Dr. JAYCOX. We talked about the definition of minimally adequate care. First, we defined it in a way that is similar to the way researchers are doing so in the civilian sector and that is that if people reported having counseling or psychotherapy that they have at least eight sessions of psychotherapy that lasted at least 30 minutes each in the last year.

So really it is just talking about an amount of time in therapy. And for medication that you visited a doctor at least four times and stayed on the medication as long as your doctor wanted you to.

So, again, it is sort of a dose of therapy rather than just talking about the specific type of therapy or the type of medication provided.

Mr. STEARNS. Anything you would like to add?

Ms. TANIELIAN. No, thank you.

Mr. STEARNS. Okay. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Stearns.

We will now hear from the Chairman of our Health Subcommittee, Mr. Michaud.

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

Doctor, you had mentioned, I believe at the beginning of your remarks that societal costs actually could go down by as much as $2 billion if they received treatment earlier.

Is that for the veteran themselves or does that include their families, the cost to society because of the families affected as well?

Dr. JAYCOX. Thank you for letting me elaborate a little bit on that.

The costs in our model included lost productivity at work, so both presenteeism and absenteeism, being able to function less well on the job, lives lost to suicide, and treatment costs, that is direct treatment costs.

We were not able to factor in things that we know exist like difficulty with family members, divorce, substance use because there are not good dollar figures to attach to those and in order to be able to put them as assumptions into the model.

So really the gains with treatment have to do with increased productivity at work and fewer suicides. Productivity is the biggest cost driver for both PTSD and depression.

Mr. MICHAUD. Do those figures include, for example, if someone comes back who has PTSD, which ultimately might lead to alcoholism or drug abuse and incarceration, is the cost of incarceration put onto the county or State?

Is the cost of incarceration incorporated in that as well?

Dr. JAYCOX. No. So that kind of cost is not incorporated, just work productivity, suicide, and treatment costs. And they are very conservative estimates because, as you point out, there are many other costs that we are aware of.

Mr. MICHAUD. Okay. You mentioned that the VA does a better job compared to the DoD as well as in the private sector.

What do you attribute that to? Do you attribute it to the VA does not have to worry about cost reimbursement and they can do a better job?

Ms. TANIELIAN. It is not necessarily that it is about reimbursement, rather it is that there has been an investment in research as well as in training and rolling out evidence-based practice guidelines to train providers in the delivery of evidence-based care as well as the use of tools that they have within the system, such as the electronic medical record that would enable them to kind of monitor care.

Mr. MICHAUD. You had mentioned that there were actually regional training teams, facilities where you can actually train.

Where are those located? And the second part of that question is, if you look at the demographics of our military today, I believe 40 percent are from rural areas, and do you see a disparity between urban versus rural in getting the help that individual military or veterans need?

Ms. TANIELIAN. Sure. We recommend the establishment of regional training centers to train providers in this type of care. It is not that they exist already.

And there is a lot of variation in accessibility of care between urban and rural areas. Those that may be further away from military installations and VA healthcare facilities will have greater difficulty in getting services in those types of settings and will turn to their community-based setting and sector for care.

And that is why civilian providers would also need to be trained in delivering evidence-based therapy as well as be trained in the military culture and being sensitive to the special issues in treating military servicemembers and veterans.

Mr. MICHAUD. And where would you suggest that these facilities be located when you look at the demographics of our veterans?

Dr. JAYCOX. That is a great question. We are hoping to do some further work on that. And I think there is some work underway also to actually map out where servicemembers and veterans are and where the facilities are and figure out the areas of need. But we did not analyze that in this report.

Mr. MICHAUD. And my last question is, when you look at the Department of Defense and you look at the VA system and what is happening out there in the private sector, there definitely is a shortage of healthcare professionals.

Have you looked at, and it would probably be hard to judge, but right now when you look at the war as it continues on, there is definitely a need in DoD for those type of healthcare professionals as well as in the VA system, but as the war winds down, there will probably be less need in DoD but more need actually in the VA system? Have you looked how those two can kind of meld together to work more cooperatively?

Ms. TANIELIAN. That is a critical kind of study that would need to be done. We were not able to examine the data that would be required to look at that and project demand over time and to look at the capacity that would be required in 5, 10 years and where that capacity would be best placed.

We have heard anecdotally that there is a shifting of providers from our community-based mental health sectors to either the DoD or VA now because they are hiring. And so we are taking providers from what is a shortage area already. And so that is why we identify this as a major pipeline issue for the entire U.S. healthcare system.

Mr. MICHAUD. Thank you very much. Appreciate it.

The CHAIRMAN. Thank you.

Mr. Boozman, you are recognized.

Mr. BOOZMAN. Thank you very much.

I was wondering. You talked about evidence-based care as in contrast to what? Will you discuss, you know, some of the things that are going on that you are concerned about versus the evidence-based care?

Dr. JAYCOX. Well, we contrast it with the usual care, which is not necessarily a bad thing, but does not have the higher recovery rates that we find with evidence-based care. And to be frank, we do not know exactly what is going on in usual care. There have been some studies of it, but it is more diffuse supportive type of therapy without using the specific techniques that we know to be effective.

We have a whole section in our report that discusses the evidence-based care for PTSD, depression, and TBI and compares it with—gives a level of evidence for the DoD and VA guidelines for healthcare for those conditions.

And so really when we talk about evidence-based care, we are talking about offering the best that we know is available which offers higher recovery rates, but is not perfect either.

Mr. BOOZMAN. You mentioned, I think, 18½ percent PTSD and depression. How is that in contrast to just the general service, the people that have not deployed or do you have any figures as far as what that represents?

Dr. JAYCOX. We used similar measures to what have been used in other studies, but we do not have good estimates for the non-deployed population.

I can tell you in our sample, everyone had been deployed, but we had a group of people who had not been exposed to any combat exposures while deployed, so no experiences of loss or traumatic events.

And we found very low rates of PTSD and depression there. One percent for PTSD and three percent for depression. So that gives you an idea.

Mr. BOOZMAN. Okay. I guess I think it probably is important to find that out and then, too, just the general population, you know, what kind of depression.

Ms. TANIELIAN. Sure. In the general civilian population, about 7 percent will experience depression in a year and only about 3½ percent will experience PTSD in a year.

Mr. BOOZMAN. The other problem that you mentioned was, you know, people not reporting, you know, the fact that they were having a problem.

Can you talk to us about specific things that you feel like we can do a better job of?

Dr. JAYCOX. Sure. We asked servicemembers what would get in the way of getting treatment and, as we mentioned, three of the top five barriers had to do with concerns about negative repercussions on career, security clearance——

Mr. BOOZMAN. And, yet, I think you also said that the rate of reporting was about the same as the general population.

Dr. JAYCOX. The rate of reporting, that service use was about the same as in the general population?

Mr. BOOZMAN. Yes.

Dr. JAYCOX. Yes. That is true. We do have difficulty getting individuals with mental health problems in the civilian sector into care as well.

Here, though, the types of barriers are very different. In the civilian population, it really has to do more with access and here everybody has access to some type of care. And it is really about concern around negative career repercussions. So that was a striking difference.

Mr. BOOZMAN. Good. Thank you very much, Mr. Chairman. I yield back.

Thank you for your testimony.

The CHAIRMAN. Thank you.

Mr. SNYDER. Mr. Chairman, that report, we do not have that.

The CHAIRMAN. Mr. Snyder would like to look at that book if you would not mind passing it around. And if he does not pay for it, we will get him for it. Thank you.

Mr. Mitchell. Mr. Hare.

Mr. HARE. Thank you, Mr. Chairman.

I just have two questions. Ms. Tanielian, you mentioned in your testimony that slightly more than half of those that are suffering from PTSD and depression are receiving minimally adequate care.

Can you describe what you mean by that and also what are the long-term effects of the inadequate care? What might they be and what are we looking at here?

Ms. TANIELIAN. Sure. Only about half of those who had sought care from a professional in the past year received what we define as minimally adequate care, which really was about the amount of time they spent in either therapy or the number of times that they visited the doctor.

So if they were getting medications, it was four visits to a physician in the past year and taking the medication as long as they were recommended to. If they were in therapy or counseling, it was visiting a therapist for at least eight visits of 30 minutes in duration.

So this is really just a minimum dose of therapy. Without treatment or with under-treatment, we know that there are long-term negative consequences associated with having PTSD, depression, and TBI including impairments in relationship, homelessness, increased risk for suicide, problems with employment, et cetera.

Mr. HARE. So what kind of care? I mean, okay, we know what minimum care here is, minimally. So what would you advocate for that?

Ms. TANIELIAN. We are recommending that veterans and servicemembers, wherever they are treated, wherever, in whichever sector, they be offered the latest evidence-based therapies, treatments that have been demonstrated through research to yield higher recovery rates. So faster recovery as well as more time without symptoms.

Mr. HARE. Okay. And, Dr. Jaycox, just a quick question for you. How could both the VA and the DoD improve the methods for identifying and bringing in soldiers who may be suffering from PTSD, major depression, or TBI to improve their care?

Dr. JAYCOX. That is a really good question. There are a number of screening efforts underway. Unfortunately, you know, there is some concern that servicemembers and veterans do not want a PTSD or depression diagnosis on the record in their personnel file.

And so it is tricky to figure out a way to screen them in a way that will benefit them and get them into care without the concerns about negative career repercussions.

I think the more that the military can do to encourage care, to make it acceptable and seen as a sign of strength to receive mental health treatment post deployment, the more servicemembers would be willing to seek out those services and admit to symptoms when they are screened.

Mr. HARE. The Chairman has advocated for a long time, and I completely agree with him, that we ought to be screening everybody so that person does not have to identify themselves as having a problem and then there is the whether or not it is going to affect whether or not they are going to be able to advance in rank or whether it is going to affect them in their jobs.

So would you concur that what we should be looking at doing is screening everybody that comes back with no exceptions and also then monitoring them for a longer period of time because a lot of times, as I understand it, and I have a Vet Center close to my Congressional district office, a lot of this does not just happen in a matter of weeks or months? It could be down the road. Plus, you know these are things that affect not just the service person but their entire family.

Dr. JAYCOX. There are mandatory screenings post deployment and now 3 to 6 months after return, but those, again, are imperfect in that servicemembers might not be willing to admit to symptoms when screened.

But I agree that long-term follow-up is necessary. Research is necessary to follow individuals over time and track and see how they are doing and particularly around traumatic brain injury where we know so little about the functional impairment, the long-term course, and the types of treatments that are needed, that there really is a strong need to identify and follow individuals over time.

Mr. HARE. How long would you recommend we monitor?

Dr. JAYCOX. I think it needs to be a long-term study. We are still seeing Vietnam veterans who are having new diagnoses of PTSD and they are in their sixties, fifties and sixties. So I think we need to be ready to monitor them for a very long time.

Mr. HARE. Thank you very much.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Mr. Moran.

Mr. MORAN. Mr. Chairman, thank you.

In regard to PTSD, are there studies that demonstrate a cause and effect that certain circumstances that a member of the military encounters are more likely to cause symptoms of PTSD or other mental health issues?

And the reason I ask this question is, can we get to the point in which we know a cause for the symptoms so that we can attempt to eliminate the cause? Are there studies that show number of deployments, length of deployment, or physical or mental issues, characteristics of a particular individual cause a greater propensity to encounter PTSD?

Dr. JAYCOX. We were able to look at that in our study. We have data on the kinds of experiences they had, number of deployments, length of deployments. And we found a number of predictors of heightened risk for PTSD and depression including enlisted versus officers, Marines and Army versus Navy and Air Force. Women and Hispanics are at higher risk in our data. We also have Reserves and those who have left military service as higher risk.

Length of deployment is related, but the single best predictor is the number of combat traumas experienced. So if you control for everything together, really it is that that drives the rates of PTSD and depression.

Combat trauma is a very common experience. We only had about 10 or 15 percent in our sample who have not experienced anything like that while deployed. Particularly in these conflicts, it is quite common to be exposed to an explosion or have a life-threatening situation regardless of whether you have combat-duty military occupational skills or not.

Mr. MORAN. And because of unwillingness to report or lack of statistics, are those studies scientifically based? Is there valid, sufficient data to reach those conclusions?

Dr. JAYCOX. Well, we believe our study is. It has been subject to a fair amount of peer review and is able for the first time to kind of look across the different sectors. Many of the prior studies focus

on one combat unit, for instance, at a particular point in time and ours is a cross-section of a wide variety of individuals who have been deployed.

So that offers something new. And also we were able to promise complete confidentiality to everyone we interviewed, so it is unlinked to any personnel records.

Mr. MORAN. Are these traumas that are the most common denominator, are they things that are experienced by everyone? That is not the right word. Are they experiences that are common in military service such that they could not be eliminated and it is just part of military service, so you could not eliminate that to eliminate PTSD and depression?

Dr. JAYCOX. Yes. The most common are things like having a friend seriously wounded or injured or killed, witnessing an accident or life-threatening event, personally experiencing those types of events. So they are part of military experience.

Mr. MORAN. For events that are more controllable, is there a causal relationship to PTSD and depression?

Dr. JAYCOX. We did not see that.

Mr. MORAN. Okay. And in regard to your review of where we are, structurally how we deliver services, and you may have answered this question with Mr. Michaud's question, is there a differential in services available and quantitatively and qualitatively in rural versus other settings? Are we short-changing rural veterans?

Ms. TANIELIAN. There is wide variability in the accessibility of services across the country in each of these systems. We do know that those that have a harder time getting access to military installations or VA facilities will turn to community-based providers where they could also get care down the street.

And so there may be a more difficult time for veterans in rural areas to find providers that have been trained in the evidence-based approaches by either the DoD or the VA.

Mr. MORAN. My time is 30 seconds from expiring, but this is one of the issues that I want to explore further. I have had several meetings.

In Kansas, we have mental health centers that are really the public sector providing mental health services. And they tell me that they have the willingness and the desire to treat veterans but have no particular relationship with the VA.

And so just structurally, I want to see how we combine the Department of Veterans Affairs and their outpatient clinics, their hospital settings and Vet Centers with the community-based services that are really what we have in rural America.

There is no Vet Center, no VA hospital in the Congressional district I represent. There are community mental health centers and, yet, they would like the opportunity to better avail themselves in cooperating with the VA. And if you have thoughts about that, I would be glad to hear from you aside from this setting.

Thank you very much.

Thank you, Mr. Chairman.

The CHAIRMAN. If I could just clarify what Mr. Moran stated. Were there any controllable things, Doctor, I know you had said no, but you also said earlier that length of deployment and number of tours is controllable, right?

Dr. JAYCOX. Yes. But those are not predictive of PTSD or depression once you control for it. It is the combat traumas that are the largest predictor.

The CHAIRMAN. And, of course, you will join me in the ultimate control, which would be ending the war.

Ms. Herseth Sandlin.

Ms. HERSETH SANDLIN. Thank you, Mr. Chairman.

I would actually like to hear your response to Mr. Moran's question. I represent the entire State of South Dakota and we have vast rural areas. And I recently was in Aberdeen, South Dakota in the northeastern part of the state visiting a Community Based Outpatient Clinic (CBOC) where a local psychiatrist has entered into a contract with the CBOC.

And you both had good things to say about what the VA is doing and I certainly agree, but did you specifically look at the outreach to the rural veterans through the community-based outpatient clinics?

I do agree with Mr. Moran that whether we have CBOCs or medical centers, we also have community mental health centers that are, I think, ready and willing to work with the VA.

Could you specifically talk about any analysis you did with the CBOCs?

Ms. TANIELIAN. We did not do any specific analysis with the CBOCs. However, mental health clinics as well as private providers in our community settings, do provide another avenue for veterans to get care.

And our recommendations would call for ensuring that even those providers be trained in delivering evidence-based care so that wherever our Nation's veterans seek care, they can be afforded the best care available.

Ms. HERSETH SANDLIN. And that is consistent with what I have heard from veterans as well and veterans service organizations, that concern that there is some specific training if indeed we are looking to contract with people outside of the VA system to provide that level of care.

A couple of other areas I would like to follow-up on based on your response to earlier questions. Could you discuss why women are at greater risk for PTSD and if there are any different barriers to women veterans getting access to care than what you found in the maybe five different barriers you had referenced earlier?

Dr. JAYCOX. Yes. Women are more at risk for PTSD and depression nationally. They are more likely to develop those and there are many different theories about why that might be, but it is not specific to the military life.

In terms of specific differences in barriers and such, we have not broken it out that way. Women only comprise about 14 percent of the military force and in our sample, that is the same. So we are not able to really break out the numbers.

We would like to look at that. It is a very important question to look at the specific kinds of traumas they experienced in addition to whether or not they experienced military sexual trauma, for instance. But we have not done that in this study.

Ms. HERSETH SANDLIN. Well, I appreciate your desire to want to look at that closer. Ms. Brown-Waite and I have introduced a bill

specifically working with the Disabled American Veterans and others to address the issues of barriers to access to healthcare across-the-board for women veterans. So we hope to continue to get more information not only in the provisions and our legislation that we hope to advance but also in the work that RAND and others will be doing.

One other question as it relates to the avoidance issues and the stigma that we know continues to exist as it relates to servicemembers and, you know, the civilian public as a whole seeking access to mental healthcare.

One of your recommendations is to "change policies to encourage active-duty personnel and veterans to seek needed care." So the VA has done a terrific job trying to get a grasp of this problem. The DoD is rolling out these programs.

But what specifically? Can you talk a little bit more about your recommendations as to, you know, who carries what level of responsibility to seek the care and do the outreach to veterans, to get them across these avoidance issues not just in the initial access to the care but then, as you mentioned, Doctor, admitting to the symptoms during the treatment?

Ms. TANIELIAN. Sure. We know that stigma is a problem in the general population. But for military servicemembers, active duty in particular, concerns about the impact that getting mental healthcare may have on their career were paramount in terms of the barriers to getting healthcare.

So required disclosures about getting mental health counseling or service, policies that require that you report mental health counseling would be those that could be amended such that there would be no perceived or real adverse career consequences associated with getting mental healthcare.

Ms. HERSETH SANDLIN. Dr. Jaycox, anything to add?

Dr. JAYCOX. I just would add that there is a concern about the large number of people who have separated from the military but have not yet crossed into the VA and that is to that population that the VA is doing outreach efforts, but it is kind of unclear who is responsible for them. They may be seeking care from a variety of different sectors and we need to worry about how to draw them into care more effectively.

Ms. HERSETH SANDLIN. That is a good point. And one of the things that we have been working on with our Subcommittee and the full Committee is sort of that group that separated from service.

You know, they also are now qualified for those in the National Guard and Reserve that separated for education benefits based on their deployment. They may not even know they have those education benefits because we are not able to easily connect with them.

But certainly I think that the State Adjutants General and some of our States have developed good working relationships in which we are trying to share best practices to be able to not lose track of these veterans and allow them to fall through the cracks as we know that they have.

And so, again, we appreciate your testimony and your recommendations.

The CHAIRMAN. Thank you.

I want to assure you and other Members we are going to devote significant chunks of time to the two issues you raised. The first is access for rural veterans and the second is specifically, care for women veterans. We are going to do a series of field hearings and also hearings here in DC. So those are two important areas.

I appreciate your leadership, Ms. Herseth Sandlin.

Mr. Buyer.

Mr. BUYER. Thank you, Mr. Chairman.

What I have in front of me is last year's Defense Bill and the Wounded Warrior provisions that we worked on with the Senate and with the Armed Services Committees of the House and the Senate.

In Section 1618, we have asked that the Secretaries of both of these Departments work together to develop a joint plan. And they are going to get that to us in July.

Now, part of this joint planning between the two Departments, what we wanted to focus in on is prevention, diagnosis, mitigation, treatment, and rehabilitation of and the research on traumatic brain injury, post traumatic stress disorder, and other mental health conditions in members of the Armed Forces including planning for seamless transition of such members from care through the Department of Defense and care through to the VA.

Then we asked for a comprehensive plan. We wanted the assessment of current capabilities, the identification of gaps in current capabilities, and then the identification of the resources.

Then we went with specificity and identified twelve elements that we also were looking for. So we went in with great specificity because we want to be able to be responsive then to what you have referred to as one of the leaders then in mental health and the delivery of these services.

Now, while this is going on, you then have conducted your own piece of research. So part of today's hearing is about implementation not of this, of what you have done, but of this, what we have done.

So what you can be very helpful here to us is by saying, okay, based on your research in this and what we have done in the Defense Bill, are we on the right track? That is my question to you.

Ms. TANIELIAN. I would say that I think we are on the right track. I think the increased attention and the investment in improving the services and the programs that are available in both the DoD and the VA with specific focus on PTSD, TBI, and depression will bring about positive change to improving the care systems for these populations.

Mr. BUYER. So in your review, what we are doing, will this address the gaps in services that you have identified in your study?

Ms. TANIELIAN. It will address the gaps in services within the DoD and the VA. There are gaps that extend beyond these two healthcare systems. There is a pipeline issue for the training of providers that go into these particular professions. It extends well beyond these two agencies. There are also concerns about the quality of care that is provided in the civilian sector and in these community-based settings as well.

And so one of our major conclusions is that these issues extend beyond the DoD and the VA and will require transformation and system-level changes across the entire U.S. healthcare system.

Mr. BUYER. I agree with you. It is one of the reasons we wanted to focus on the case manager because we learned quickly that the case manager was becoming the individual that was in close proximity to the wounded servicemember. Could have been a wife, husband, or it could have been a father. You know, it is someone who is probably outside the medical profession. They are trying to figure out how do they best manage that particular person's health.

And we have, whether it is into the DoD, the polytrauma center, back to DoD, to TRICARE, then upon discharge, VA and whether it was a medical discharge or not a medical discharge and now they are out of the private sector, maybe on contract-based care, whether it was an approved provider.

I mean, you get into all these complexities and so I can understand those challenges in the subacute care system for us to be able to deliver the care that not only does that servicemember believe but also the close loved one also believe.

And so that case manager, Mr. Chairman, you know, becomes that patient advocate and that is extremely important.

So I appreciate that in your testimony.

Earlier you had mentioned about how, and you were absolutely right, whenever you throw out a number, you also invite scrutiny. So all of a sudden, this number, 300,000, since you had interviewed or took a survey of 1,965 servicemembers from 24 communities across the country, it appears that from this that you have concluded that 300,000 of the 1.6 million who served in Iraq and Afghanistan then have symptoms of post traumatic stress disorder or major depression.

The 300,000, is that a possibility or a fact?

Dr. JAYCOX. That is a possibility. That is an estimate based on our numbers. We were able to use state-of-the-art statistical techniques——

Mr. BUYER. All right. Let——

Dr. JAYCOX [continuing]. To weight our sample to the deployed population.

Mr. BUYER. All right. And when you were doing your sampling, obviously you were talking to servicemembers.

Dr. JAYCOX. Yes.

Mr. BUYER. And the servicemembers when you would ask them a question, are you depressed or do you have post traumatic stress disorder or TBI, were these, when they would say I have either of those, is this a self-diagnosis or is this actually my doctor says I have?

Dr. JAYCOX. It is neither of those. We actually assess all the symptoms. So we ask them have you had trouble sleeping in the past 30 days, have you had nightmares, all of those questions that then——

Mr. BUYER. So you are being the doctor over the phone?

Dr. JAYCOX. Well, there are standard surveys that are used that map very well on to a clinical diagnosis. So we used ones with good psychometric properties that map on to a clinician diagnosis with reasonable probability.

Mr. BUYER. Wow. I yield back.

The CHAIRMAN. Mr. Walz.

Mr. WALZ. Thank you, Mr. Chairman.

And thank you both for being here and tackling this tough issue.

I think the Ranking Member brought up a very valid point on this issue of case manager or patient advocates is something that I would really like to see us tackle because I think that getting them into the system and having someone help manage that is critical. And I would applaud Secretary Peake and his staff for addressing that issue.

One of the things we have seen in the State of Minnesota is one of 22 States that has county veterans service officers that are used as the point of contact and something we have asked for is what the State of Minnesota does with National Guard soldiers they have captured all of them—their returning soldiers—because they have that data on 99 percent of them.

And some of the preliminary data seems to show that by capturing them early, getting them in the system early, we see a lower occurrence of PTSD and some of these things which I think is a positive and I applaud them because there are some institutional barriers here, Health Insurance Portability and Accountability Act (HIPAA) laws, those types of things of trying to get there. But I agree that is the way to go.

The question I am going to ask you is a bit subjective, I know, but I am just trying to get at this. You heard it from Representative Herseth Sandlin, Mr. Moran.

I, too, like many of these reps have sprawling districts with very rural areas and the issue in these areas is not being able to go down and choose another provider. There is simply no one that provides mental healthcare at all in the region. Forty percent of these Iraq, Afghanistan veterans fall into that category.

My question to you is, there was a lot of talk last year and in the requirements we put in of using teleconferencing, telepsychology and telemedicine and those types of things of counseling, telecounseling on this. My question to you is that I want to know, evidence-based-wise, is there anything out there that is showing that works? Is it the way to go? Is it a cost-effective as well as an outcome-based, effective way to do this?

Dr. JAYCOX. There are a number models like that that are under study, but we do not have the answer yet. But there are things funded by NIH, for instance, that are really trying to bring these kinds of services to people in rural settings using Telehealth models.

And so we should know that in the coming years, but there is not good evidence yet.

Mr. WALZ. Your advice would be just we need to just wait and see as that comes out? And, I mean, I am wondering, is there anything out there, any other studies, and any other way from the civilian sector that this type of, you know, teletherapy is working?

Dr. JAYCOX. I think that these kinds of cognitive behavioral treatments that are the evidence-based treatments for PTSD and depression lend themselves well to internet-based and therapist-supported telephone services. So I think there are models that could be begun to roll out, although the evidence is not fully in.

Mr. WALZ. Very good. Thank you.

And I yield back, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Walz.

Mr. Space, any questions?

Mr. SPACE. I yield back my time, Mr. Chairman.

The CHAIRMAN. Mr. Hall.

Mr. HALL. Thank you, Mr. Chairman.

And thank you to our witnesses. I am sorry I missed your opening statements, but I have been perusing them during other questions.

Based on what you said about stressors, Ms. Tanielian, for VA compensation purposes, should the VA use a broader definition of engaged in combat with the enemy that goes beyond infantry activity or direct participation in an attack?

I am thinking about the incoming rounds in the green zone where I slept last October, where people never know when they hear a shell coming down or a round coming down if it is going to hit them or land right next door or, for instance, somebody traveling in a convoy and witnessing the vehicle in front of them being hit or civilians being hit. We have heard stories of nightmares and depression and so on from people like this who have not themselves been engaged in what is conventionally called combat.

Ms. TANIELIAN. Yes. The nature of exposures on the battlefield has really changed quite dramatically with these particular conflicts because the risk is more disperse. And so we are seeing individuals who are not in typical infantry roles or military combat roles that are being exposed to traumatic events while they are deployed.

And so our data did show that the types of exposures that are predicting PTSD are relatively common in those who have been deployed.

Mr. HALL. That is good to hear because we have a bill that this full Committee reported favorably out to the House that would, among other things, do that.

I notice, Dr. Jaycox, in your testimony that you estimate the PTSD related and depression related costs could range from $4 to $6.2 billion over 2 years in 2007 dollars. We do not know yet what the Congressional Budget Office estimate will be on this "Claims Modernization Act" which we passed out of Committee, but assuming that it does pass and that the numbers are anything like what we hear, they are a fraction of what it would cost to treat PTSD and to give a presumption of PTSD to those who served in Iraq and Afghanistan or similar conflicts in the future, is a small fraction of what the cost to society is from lost productivity and other causes that you mention here.

I am not asking you for an answer to that. I am just interested that you are putting a number on untreated PTSD that runs well into the billions of dollars.

Regarding women's health and mental health, what I have heard and not just from the services but from the service academies is that women's experience in combat is not just the same type of trauma that men have but also the problems of sexual harassment and the change from an all male or mostly male force to—it is only 17 percent now, but it is still the largest percentage of women, I

think, serving ever in our country's history in our Armed Forces, and that many of them when they come home cannot or do not want to take part in a discussion group or an encounter session with a bunch of guys who are veterans because their experience is so different.

Is that something you have encountered?

Dr. JAYCOX. Unfortunately, we did not look at women separately in this study and we did not ask different questions of the women than the men. So we do not have good data on that to offer.

Ms. TANIELIAN. I would say it is an absolutely critical issue to try and understand the experiences of women. To do that would require a different study than we did. You would need to kind of over-sample and look at much larger groups of women.

Our study was designed to look at the entire representative population of the deployed force. And as Dr. Jaycox said, it is only about 12 to 14 percent women.

Mr. HALL. Okay. Thank you.

And the concept of telecounseling and teletherapy based on what limited knowledge I have of counseling and therapy in general, my guess is that it would probably work to the extent that it works for the milder cases of depression and PTSD, but that for many veterans—a lot of veterans that I have heard testifying before the Committees or Subcommittees who were veterans in our district that I have spoken to, they not only want to talk to a human being, they want to talk to a veteran, you know, who they feel understands them and having a voice on the other end of the phone is helpful probably in some instances.

Having somebody under the computer screen, I think, is probably less helpful unless it is dispensing medication or something like that, which in some cases, may be appropriate as a temporary measure at least.

But does that sound accurate?

Dr. JAYCOX. Yes. I agree. Even with these Telehealth models, there needs to be psychiatric backup locally so that for emergencies and all those kinds of things. And it may serve a certain purpose, but it is not going to solve everything.

Mr. HALL. Thank you very much.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Mr. Rodriguez.

Mr. RODRIGUEZ. I apologize. I am on the Homeland Security Committee.

Let me just do one brief question and then we can go to the next panel. Your data shows that you are indicating roughly of the 800,000 that have gone to Iraq and Afghanistan that 300,000 might suffer from post traumatic stress disorder. That is a significant number from what we have been told—I do not recall the figure. I think the VA might have had 100,000 maybe potential. So that is about a 300 percent increase.

Do you have any comments?

Dr. JAYCOX. Well, that is based on a survey that we did with representing the whole deployed force, so it is a cross-section of everyone. That data has not yet been available. And it is a cross-section,

so it is how many people are currently suffering and an estimate then based on the whole deployed force.

We hear some people think that it is an underestimate as well. The numbers come in around the same as many of the DoD studies, so our rate of 18½ percent sort of corroborates the DoD studies and is not vastly different.

Mr. RODRIGUEZ. Come again. You said it is not vastly different in terms of—now, do you know the approach that they are utilizing to make that determination versus yours?

Dr. JAYCOX. Sir, the DoD has conducted a number of studies on specific groups of individuals at a particular point in time post deployment. So, for instance, a brigade or a combat unit either 1 month or 3 months after they have gotten back. And they have also found rates in the high teens similar to ours.

Mr. RODRIGUEZ. Okay. Thank you very much.

Thank you, sir.

The CHAIRMAN. I thank you both. Your report has had wide visibility and is quoted. Your expertise to these questions is much appreciated and gives added weight to your study.

Let me just ask a couple questions along the lines that some of the other Members have asked. I personally think these are low estimates based on my own studies. But if you take even the 300,000, and I assume the TBI, there is an overlap with the PTSD, I mean, that again is ten times the official casualty statistics from the Pentagon.

Shouldn't these 300,000 be included in number?

Dr. JAYCOX. Well, they are an injury condition resulting from combat deployment and so it is a different kind of casualty. But, yes, they are very important numbers.

The CHAIRMAN. Again, a 300,000 casualty figure versus 30,000 is very, very different and I think we in America should understand what has happened. That is a significant number of casualties and again, I think it is on the low side.

You told us about the scientific sampling and you had roughly 2,000 or just slightly less than 2,000 telephone interviews, right? Is that correct?

Dr. JAYCOX. Yes, that is correct. Let me point out one other thing which is that this is a cross-section at a particular point in time. So this is the number of people who we interviewed who said I am currently suffering from PTSD or depression by virtue of the symptoms they endorsed.

There are more people who may have been suffering earlier when they got back from deployment and who may develop these disorders later.

The CHAIRMAN. Right. But, just as a brainstorming idea, if one of the elements of depression was refusal to answer the phone, the numbers could be vastly under-reported. I can see something like that occurring.

Also, the stigma and the screenings that you referred to could also apply to the telephone interviews. That is, people are smart enough to know that if they say this, it shows that they are weak.

So, even in a so-called confidential setting, which I doubt anybody would really believe in a telephone conversation—I certainly

would not—they may also be under-reporting their symptoms. It is part of the whole problem that you referred to.

So, I think for a lot of reasons it is still on the low side, even though it is ten times higher than the military would like to admit.

Another Member pointed out that I had been trying to talk about mandatory evaluations, I use that word differently than screenings. I know, you said there are mandatory screenings, however, I am not sure that is true in terms of the Guard and Reserve units.

Those screenings, as I understand them, and tell me if you have a different understanding, are usually self-administered questionnaires. There is no qualified provider there actually observing the soldier or exploring other things. Is that correct?

Ms. TANIELIAN. Correct. We learned a lot about a lot of variability in the way that those screenings are being implemented across the services.

The CHAIRMAN. I think we have to say that there are no mandatory evaluations. When I mean evaluation, I mean spending an hour with a qualified mental health professional who could—we had one Member refer to blood tests, administer brain scans, and conduct interviews.

I think the best approach that we can do and the simplest thing is that while on active duty we can provide a mandatory evaluation, not screen, for all of our soldiers because we are letting them out with PTSD and brain injury which, as we all know, causes enormous problems for themselves, their families, and their communities.

And, you know, the VA always says, "Well, we screen everybody who comes in." Well, first of all, not everybody comes in. You know, it is probably fewer than 20 percent. The screening, and the VA should be able to answer this on the next panel, is a couple of questions from a clerk.

A psychiatrist told me there are 15 predictors or factors in PTSD or suicide risk. If you are asking two questions, as I believe the VA does, you are not getting at hardly any of the risk factors.

I think we have a long way to go. Your report has helped us because it has shown that the need is so great. I agree that while on active duty, every soldier should be evaluated and provided follow-ups, as you point out. I mean, the very title of your report, the Hidden—is it Hidden Wounds?

Ms. TANIELIAN. Invisible.

The CHAIRMAN. The Invisible Wounds. Clearly they are both invisible because of denial and invisible because of stigma. But it is also invisible because it might not have manifested itself yet.

So we have to look at people 3 months, a year, and, as you said, maybe 30 years later. We have to keep doing that.

But this problem is a matter of life and death for so many individuals. You said suicide several times in your answers. We are talking about significant numbers and we have to get these evaluations. Your work has helped us toward that and I appreciate it.

You have a chance for any last minute comments or words. Again, your expertise is well-evident and we appreciate it so much.

Dr. JAYCOX. Thank you.

Ms. TANIELIAN. Thank you.

The CHAIRMAN. I thank the first panel for testifying.

We will call the second panel. Both the Department of Defense and the Department of Veterans Affairs are here with us today. We thank you. We thank both Departments.

As the Ranking Member said, we are a little bit ahead of your official reporting period. But, given all the publicity on suicides, homelessness, and other issues, we thought we needed, as a service to our veterans, and our Nation to know more about what is going on now.

Representing the Department of Defense is Michael Dominguez who is the Principal Deputy Under Secretary of Defense for Personnel and Readiness. Representing VA is Admiral Patrick Dunne, the Acting Under Secretary for Benefits and the Assistant Secretary for Policy and Planning.

Admiral Dunne, if you would proceed and introduce those who have accompanied you today?

STATEMENTS OF HON. PATRICK W. DUNNE, RADM, USN (RET.), ACTING UNDER SECRETARY FOR BENEFITS, AND ASSISTANT SECRETARY FOR POLICY AND PLANNING, VETERANS BENEFITS ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY MADHULIKA AGARWAL, M.D., CHIEF PATIENT CARE SERVICES OFFICER, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND PAUL A. TIBBITS, M.D., DEPUTY CHIEF INFORMATION OFFICER, OFFICE OF ENTERPRISE DEVELOPMENT, OFFICE OF INFORMATION AND TECHNOLOGY, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND HON. MICHAEL L. DOMINGUEZ, PRINCIPAL DEPUTY UNDER SECRETARY OF DEFENSE FOR PERSONNEL AND READINESS, U.S. DEPARTMENT OF DEFENSE

STATEMENT OF HON. PATRICK W. DUNNE, RADM, USN (RET.)

Admiral DUNNE. Thank you, Mr. Chairman. Good morning, Members of the Committee. Thank you for the opportunity to update the Committee today on VA's progress in implementing the Wounded Warrior provisions in the fiscal year 2008 National Defense Authorization Act.

I would like to thank the Committee for its work in passing this important legislation and I am pleased to report VA and DoD are making demonstrable progress.

I am accompanied this morning by Dr. Madhulika Agarwal, Chief Patient Care Services Officer for the Veterans Health Administration, and Dr. Paul Tibbits, Deputy Chief Information Officer, Office of Enterprise Development.

In January, VA awarded a contract for two studies on disability benefits. The first study will examine the nature and feasibility of making long-term transition payments to veterans undergoing rehabilitation. The second study concerns appropriate compensation for loss in earnings capacity and information on potential quality of life payments.

The reports are due by August and will inform our efforts regarding disability benefits, policies, and procedures.

VA is working on two handbooks, one for our Federal Recovery Coordinators and another for transition assistance and case management of OEF and OIF veterans.

The Federal Recovery Coordinator handbook will guide the FRCs in the delivery of all needed programs and services to recovering servicemembers and veterans. The target date for completion is this summer.

VA completed a separate handbook on the transition assistance and case management of OEF and OIF veterans in May of 2007. And we will continue to review and update this handbook as necessary.

A charter group comprised of Specialty Care Managers to include OEF/OIF teams. Spinal cord, blind rehabilitation, mental health, trauma, and others will be making recommendations in July for a system-wide approach to care management with emphasis on the coordination between programs. This charter group will also assist in the development of VA policy for care management.

We are currently piloting a single joint VA/DoD medical examination process for servicemembers from Walter Reed Army Medical Center, National Naval Medical Center at Bethesda, and Malcolm Grow Medical Center enrolled in the disability evaluation system. The Senior Oversight Committee will be briefed in July regarding the expansion of this proposal.

Last August, the Deputy Secretaries of Defense and Veterans Affairs signed an Memorandum of Understanding establishing the Federal Recovery Coordination Program.

In January, the newly identified FRCs completed a comprehensive VA and DoD training program. FRCs are already developing individual recovery plans for severely injured servicemembers and veterans.

As of June 1st, this program has enrolled and is currently serving 80 servicemembers and veterans.

The DoD Center of Excellence for TBI and Psychological Health will be supported by VA with the Deputy and two subject matter experts, one in TBI and one in PTSD.

VA and DoD continue to collaborate on a number of projects related to mental health and TBI. Some examples include developing revisions to medical coding for TBI for submission to revision nine of the international classification of diseases (ICD), developing clinical practice guidelines for TBI, assigning VA polytrauma rehabilitation nurse liaisons at Water Reed and Bethesda, establishing a 5-year assisted living pilot project for veterans with TBI for implementation between now and June 2013.

The Veterans Health Administration's Office of Research and Development has a strong portfolio of neurotrauma research, which included $43 million of support in fiscal year 2007.

VA also maintains a continuing relationship with DoD's research programs and both Departments work closely on projects funded through DoD's Congressionally directed medical research program.

VA and DoD are working together to address eye injuries. Beginning in November 2007, VA and DoD ophthalmologists and optometrists began meeting to discuss approaches for improving care and coordination. They initiated a consensus validation process, which

will identify and disseminate the most effective strategies for treatment and services.

In May, VA and DoD work group members began reviewing draft documents on system requirements and concepts of operations for military eye or vision injury registry.

An OEF/OIF veteran seen at a VA medical facility is automatically screened for TBI. Veterans for whom the screen is positive are referred for a full in-depth evaluation, which includes checks for visual impairment.

For veterans and active-duty personnel with visual impairment, VA provides comprehensive blind rehabilitation services that have demonstrated significantly greater success in increasing independent functioning than any other blind rehabilitation program anywhere.

The law also requires development of a VA/DoD interagency program office to act as the single point of accountability for rapid development of fully interoperable personal healthcare information between VA and DoD.

Last month, the Departments formed this office and appointed an acting Director from DoD and an acting Deputy Director from VA.

On April 29th, VA and DoD delivered a joint implementation plan to Congress regarding interoperability of electronic health records. This plan also expands our vision for sharing essential viewable data by identifying improvements VA and DoD could make to meet the goal of interoperability by September of 2009.

Mr. Chairman, this concludes my statement, and I would be pleased to answer questions.

[The prepared statement of Admiral Dunne appears on p. 68.]

The CHAIRMAN. Thank you.

Mr. Dominguez.

STATEMENT OF HON. MICHAEL L. DOMINGUEZ

Mr. DOMINGUEZ. Thank you very much.

The first thing I want to do is apologize to the Committee for the lateness of my prepared testimony and to the staff. I recognize that poses a special burden on them.

And I would like to make four major points. The first is I want to inform the Congress that we in the DoD have devoted a huge portion of energy and attention to fixing the continuum of care for our wounded, ill, and injured. And we, in DoD, are deeply grateful for our partnership with the Department of Veterans Affairs in this endeavor over the last 15 months.

Second, I want to acknowledge that while we have accomplished much, much remains to be accomplished. We will continue to dedicate ourselves to the mission of creating a world-class continuum of care and that it is seamless between the Department of Defense and the Department of Veterans Affairs.

Third, I would like to share my observation that over the last 15 months, our organizations have deeply internalized important lessons. We know, and this knowledge extends deeply into the career leadership of our organizations, both military and civilian, we know the importance of this mission and we know how important it is that what we do in DoD is to the VA's successful accomplishment

of their mission. And further we have learned in DoD to rely on the VA's expertise to help us with the challenges we face.

The fourth point I would like to make is that I am confident, therefore, that we will sustain our momentum, our energy, and our leadership focus through the end of this year and that momentum and that energy and that focus will also continue through the transition to the next Administration.

Now, lastly, sir, I would like to correct what I think may be an important misunderstanding from the prior testimony, that the RAND study did not and cannot definitively say that there are 300,000 cases of clinically diagnosed PTSD. The fact that out of 1.6 million——

The CHAIRMAN. They never said that.

Mr. DOMINGUEZ. Sir, out of 1.6 million——

The CHAIRMAN. They never said there were 300,000 clinically diagnosed. They said based on their data, it was an extrapolation to a possible——

Mr. DOMINGUEZ. Yes. Well, they are certainly consistent with our data. Out of the 1.6 million members who have deployed into the combat theater, 300,000 people who experience some kind of mental health stress is very consistent with our data. And those people do need to be discovered. They need to get help.

Many of them will with very little counseling and assistance resolve those combat stress issues themselves. A few, a few will, in fact, manifest the clinical diagnosis of PTSD and they will need much more sustained intervention by medical healthcare professionals.

The CHAIRMAN. How many is a few?

Mr. DOMINGUEZ. Sir?

The CHAIRMAN. How many is a few?

Mr. DOMINGUEZ. Well, this is part of the research efforts that we are now undergoing. But in the data that we have garnered so far, which I have to say are incomplete and not definitive, it is less than 1 percent will actually have clinical PTSD that will need treatment over the——

The CHAIRMAN. You believe that? You believe what you just said, that there are fewer than 1 percent of these deployed soldiers who will have PTSD as a clinical diagnosis?

Mr. DOMINGUEZ. I mean, so far, this is the numbers that we are seeing that——

The CHAIRMAN. And that shows why you do not do anything, because you think there are only a few?

Mr. DOMINGUEZ. No. Well, sir, no, not at all. I mean, I said the 300,000 need treatment and the 300,000 need care. The 300,000 need to access mental health professionals to guide them through treatment.

But if you look a year after their deployment in our system—now, there are a lot of leakers in our system. We do not capture all the data yet from the VA. We do not capture all the Guard and Reserve members who do not come to our system. In our system, it is less than 1 percent, but that is not definitive. It is not authoritative.

That is why, with my gratitude to the Congress for the appropriations and the supplemental last year, we are doing this re-

search to really understand this problem with much greater detail, sir.

[The prepared statement of Hon. Dominguez appears on p. 74.]

The CHAIRMAN. I am going to call on Mr. Boozman for some questions. I know you are all trained in the process of Congressional testimony and you have to be objective and nonpolitical. But I think there has been a contest to see who can suck the humanity out of this issue better in one or the other bureaucracy.

We are talking about our children. We are talking about life and death. We are talking about suicides. We are talking about homelessness. We are talking about a lifetime of dealing with brain injuries. And you all sit there without anything to say. It is absolutely unacceptable. We are going to do this and this and this, get angry, you know. You read a few sentences that do not say anything. You tell me there is 1 percent.

I was going to give the award to the one who was most bureaucratic to the Admiral, but, Mr. Dominguez, with your notion that there are a few people who are deployed who will have a diagnosis of PTSD when your doctors in the Department of Defense have been told to purposely misdiagnose PTSD as personality disorder so we do not have to deal with them takes the prize.

And the VA is sending e-mails to say do not diagnose PTSD. It is too expensive for us. Give them a diagnosis of adjustment disorder. And you are sitting here telling me that everything is fine. There are only a few.

Mr. Boozman.

Mr. BOOZMAN. Thank you, Mr. Chairman.

One of the things that I have been concerned about and working on is the eye registry and the Center of Excellence. And I guess I am a little concerned. I know we have made some headway, but I just want to make sure where we are at with that and kind of what is going on.

I know that right now there is a working group with optometry and ophthalmology regarding the computer programming for the eye registry. I guess what I would like to know is when that is going to be online, when we are going to do some testing.

Have we got some dates? Have we got something a little bit more concrete?

Mr. DOMINGUEZ. Sir, I will start.

Mr. BOOZMAN. I guess what I would like to know is when are we going to test it and when are we going to implement it?

Mr. DOMINGUEZ. I cannot specifically answer the question. I think maybe my colleagues could.

I do want to report to you that the Assistant Secretary for Health Affairs, Dr. Caselles, met yesterday with the Surgeon Generals and with, I believe, the VA colleagues and they have agreed on the concept of operations for how the Center of Excellence will work. They have committed to the first steps of getting that registry in place.

They have worked out how they are going to tap into and bond with the excellent technical capabilities in the VA and their centers. So the concept of ops of this thing has been worked out, has been approved, and we are on the way to moving it forward.

I would like to yield if anyone has any dates.

Admiral DUNNE. Sir, we will get you a timeline for the IT portion of building the registry.

[The DoD provided the following information:]

In September 2007, the Vision Center of Excellence (VCoE) concept was developed and two workgroups were formed—one dealing with the stand up of the VCoE and the other dealing with the Department of Defense (DoD)/Department of Veterans Affairs (VA) Eye Injury Registry.

In June 2008, the Assistant Secretary of Defense for Health Affairs determined that the VCoE will be a distributed center with the headquarters in the National Capital Region. The VCoE Director will report to the Director, TRICARE Management Activity.

The DoD/VA Eye Injury Registry workgroup determined that the registry should be housed on separate, stand-alone servers and managed at VCoE headquarters and that the registry's primary architecture should be the same as the existing Joint Theater Trauma Registry and in compliance with the Bi-directional Health Information Exchange, AHLTA, and Veterans Health Information Systems and Technology Architecture.

In November 2008, Colonel (Dr.) Donald Gagliano was named as the Director and Dr. Claude Cowan (VA) was named as the Deputy Director of the VCoE. Both are in the process of leaving their current jobs. Once in place at the VCoE, they will work on development of the concept of operations (CONOPS). The CONOPS and related functional and technical requirements will be fully coordinated with DoD and VA to ensure compliance. DoD and VA will work collaboratively to obtain approval and funding, develop project milestones, and support design, development, and implementation efforts.

Mr. BOOZMAN. Good. Thank you very much.

The Palo Alto, the VA Medical Center there, the vision screening program for TBI seems to be really, you know, doing a great job and things. It seems like it would be a key priority, you know, to replicate that in a sense.

Is VHA going to ensure that occurs? Is that spreading throughout the system?

Dr. AGARWAL. Sir, thank you for that question.

The VA is very interested in doing the comprehensive TBI specific evaluation for those who have had severe traumatic brain injury. And that is exactly what people at Palo Alto have done.

We are in the midst of writing a directive because we would like to ensure that at all our Level 1 polytrauma center sites, this specific evaluation, which is TBI related, happens for all the servicemembers and the veterans who are currently in our system or who have been through our polytrauma centers in the past.

Mr. BOOZMAN. Okay. The continuing education of DoD and VA medical staff on screening for vision complications from TBI should be a priority, I think, for the TBI Centers of Excellence.

Optometry and ophthalmology, you know, being involved seems to be key. And I guess I would like to know, you know, kind of what we are doing in that area. And, you know, again, are we getting it done?

Dr. AGARWAL. Sir, that is a work in progress at this moment in time. And within a short period, we will be giving you full updated report on that.

Mr. BOOZMAN. Good. Well, again, like I say, I am very concerned. We had testimony not too long ago and the Colonel said, you know, we need a little less talk and a lot more action regarding this. And we seem to be moving forward, so I would like a timeline again on what is going on in regard to these things.

You know, we can disagree about the number of, you know, reported this and that, but I think we can all agree that we do have a significant number of eye injuries, some of which we do not really understand, you know, the mechanism yet. And, again, those things have to be addressed.

So I would say, too, that, like I say, while we disagree with some of, you know, the numbers and the this and that, I know that you all are working hard. I know that you are doing the best. Certainly we are not doing near as good as we need to do in many of these issues, but I know that you have worked hard and that we are doing better than we ever have before.

But, again, like I say, I hope you follow-up in a very timely way on the request so that we can move that issue forward. Thank you very much.

The CHAIRMAN. Thank you, Mr. Boozman.

Mr. Walz.

Mr. WALZ. Well, thank you, Mr. Chairman.

I am going to follow up on Mr. Boozman's question because I think this is critical. I think it is critical for the reason we are here on the wounded warrior side of it and I think it is critical with the disconnect on the seamless transition between VA and DoD. Mr. Boozman was very kind on this, but he asked some very specific questions and I appreciate the offer to get the timeline on this.

But make no mistake about it. All of us are here with the same commitment to our warriors and our veterans, which is uncompromised. That is an absolute given.

This issue on TBI and the peripheral damage, vision damage that starts to happen because of this is absolutely critical. So this Center for Eye Care Excellence on these injuries is a big part of dealing with that. And this is mandated by what we came out with. And, granted, as was stated earlier, we are just a little bit ahead on this.

But I would have to say I have been incredibly pleased with VA, detailed cost estimates all the way down the line, things that have been given to us. And, in fact, my office, myself have written Secretary Peake urging him to sign that in.

DoD, on the other hand, it is vague. It is not here. I have not heard anything to tell me that it is coming other than some vague reassurances on this. And it gets back to the heart of the problem again, where is the seamless transition? Where is seeing the warrior and the veteran as one inseparable individual, that their quality of care from that originating station of when they raise their hand to when we honor them with a burial at one of our cemeteries, where is that there?

And on this issue alone, it is mandated. It has been there. I have seen what I consider to be very positive movement on the VA side. And, quite honestly, and this is for you, Mr. Dominguez, I have not seen it on the DoD side to the same level.

And I would like you to convince me or tell me why what I am seeing here is a picture of disconnect that does not reflect many of the problems we have had in the past on disconnect and why should I, as Mr. Boozman asked, how do I know this is actually going to come forward?

Mr. DOMINGUEZ. Sir, it will come forward because it is mandated in the law and we are going to prepare a report, deliver that report. As I mentioned earlier, Dr. Caselles has met with the Surgeons General and they have agreed on the concept of operations, how this thing is going to work, where it ties into, you know, how information will move, who does what.

Those concepts of operation are critical to costing the detailed specifics of, okay, how do we put it in place. Now that we understand what it is going to look like, how it is going to work, where it is going to be, how do we build all that stuff.

So that work, you know, is now underway in partnership with the VA because, as I said, over the last 15 months, we have learned that we have to be together on these things absolutely.

Mr. WALZ. And this will look different than if I went back and found 18 years ago the seamless transition on electronic medical records where you were working together and 18 years later, we are asking the same questions.

My concern is you are telling me that it takes more and you have to have the plan first before you can get the cost estimates. VA provided some pretty detailed cost estimates at this point, which is helpful in the implementation. So I guess we will wait and see.

My optimism is, and I assure you, Mr. Dominguez, I know your commitment to these veterans and their eye care is unwavering, and so that is never the question. What we are questioning is how we actually deliver this on the large scale and I think it is our responsibility as the overseers of this to make sure that we are continuing to ask and push those questions. It is never a question of motive. It is always a question of how we get it in and especially this seamless transition.

But I am pleased. There is movement forward. I am optimistic on this one and I think it is going to be a big first step in helping that seamless transition part get there.

My last question to you on this, and this goes back, Mr. Dominguez, as the question in the interchange, I guess, with the Chairman on this, is I just want to be clear on this, do you have problems with the methodology in the RAND study?

Mr. DOMINGUEZ. No. Well, they found the same thing that we are experiencing. It is just the conclusions.

Mr. WALZ. The extrapolation of the finding?

Mr. DOMINGUEZ. No. Three hundred thousand people out there with combat stress symptoms that need attention is consistent with our findings internally. My objection was that you cannot conclude that those are clinical PTSD cases that a physician would say that is PTSD.

Mr. WALZ. All right. Very good. Thank you. I just wanted to be clear.

I yield back.

The CHAIRMAN. Thank you, Mr. Walz.

Mr. Rodriguez.

Mr. RODRIGUEZ. Thank you very much.

Let me first of all start by qualifying my statements and saying that I was extremely pleased to see Secretary Peake get appointed because he had been with the Department of Defense prior. And I

was hoping and I am still hoping that will result in some efforts on both parts.

I came to Congress in 1997. We talked about this issue then and, you know, we are talking about it 12 years later. They had talked about it prior to me arriving here. For the longest time, we have been talking. It is not a new issue. And I do not want to make it personal because the people that are here before me are not necessarily the ones responsible. It is a system the DoD and VA that need to get together.

It is not only in terms of bringing down the cost when you work cooperatively, but also from a humane perspective in terms of what needs to happen for those soldiers. And the sooner we recognize that this is going to help our soldiers and that is the right thing to do, we are going to do it.

And I hear the words we have to prepare the report, the importance of the mission. My God, we have been waiting for this for some time. It is not something that all of a sudden came about. And we have been talking about making every effort to start coming together and bring forth an effort to sincerely respond.

When a soldier serves our country, that folder ought to follow him to the VA as quickly as possible so that we can be able to prepare the best type of services for him. And it is just as simple as that.

And, again, I have been here. This is going to be my 12th year. And it has been like pulling teeth. And, once again, I do not want you to take this personally because you personally as individuals are not necessarily the ones responsible for this, but the system is, so that we have to show some sense of responsibility. As the Chairman talks about these are individuals that are hurting. And we have to start from scratch when they come to the VA and start the process all over again when in some of those cases, that is not needed. And we could be saving resources not to mention what it means in terms of the approach, the humane approach in terms of treating some of these individuals.

Now, post traumatic stress disorder, in this area, we have to be able to pick it up as quickly as possible. I know we are doing some research now and we had not provided the resources there. And we also have a responsibility there that we had not been providing those resources in order to make that happen.

And I agree and I hope that the result is that as soon as we engage them and provide that treatment that hopefully it will not be a long duration that they will be suffering from that. And hopefully within 6 months or a year, they will be okay. And I am hoping that will be the diagnosis that will come about.

But the sooner we engage them, because right now my understanding was that it was taking almost over a year before we get to pick them up and so the sooner we pick them up, the better. And so it should not take a year in order for that to happen.

So I do at least, Mr. Chairman, I want to thank you because I do not recall during the time that I have been in this Committee that we have been able to even get a DoD person to come before us, perhaps a very few times.

So I do want to thank you for being here. That is a big plus, the fact that both of you are here. And we had not been able to even

accomplish that with the previous Administration. And so, the fact that we got you both here is a big plus.

The key now is to move forward and try to come up with some responses to how are we going to make it a seamless transition. How do we get that folder when that soldier leaves the DoD and allow that folder to follow him to the VA?

You mentioned one other area that now concerns me, the National Guard and Reservists, 40 percent. How do we, and I will throw this out, how do we go after that 40 percent that are out there, State Guard and all the other National Guard, to be able to do the same thing?

Admiral DUNNE. Sir, Secretary Peake is equally concerned about the rural healthcare in all facets, not just PTSD. And, in fact, we do have an Advisory Committee, which is in place now to take a look and give him specific recommendations and advice in addition to his own staff working on it so that we can improve our capabilities.

But things like the telemedicine, which we talked about earlier, those are key things that we are taking advantage of now and will continue to take advantage of any innovations that become available so that we can take care of veterans.

Mr. RODRIGUEZ. And I do want to thank you because I have a lot of rural areas in my district. But let me go to that question. How do we zero in on the Reservists that are—if 40 percent of the Reservists are in Iraq and Afghanistan in harm's way, how do we reach out to them and who has their files?

Admiral DUNNE. Well, we also have worked together with the National Guard and Reserve to create advocates in each of the Guard units who in each State work together with VA very closely to make sure that we are aware of events where we could conduct outreach and get information out to the members of the Guard so that they know where we are and how to get in touch with us and come get care or compensation as appropriate.

We are in the process of developing a similar memorandum of understanding with the Reserve throughout the country and we will continue to provide those same services to the members of the Reserve.

Dr. TIBBITS. Sir.

Mr. RODRIGUEZ. Yes, sir. Go ahead.

Dr. TIBBITS. Just to think out loud for a moment on that issue, the Guard and Reserve, as you heard, also could imply from the RAND comments is a broadly distributed problem. Part of the issue with respect to the folder that you brought up, I wanted to speak to a little bit.

The electronic exchange of clinical information is problematic and a challenge and, of course, we have a lot of stuff we could say about that later if you wish to get into it. But when you add the distributed nature of the Guard and Reserve, it makes that further complex and it makes it complex for a variety of reasons.

One, we are talking about a substantial amount of healthcare delivery that takes place in the private sector, where the penetration of information technology is very low. So in order for there to be an electronic exchange when that Guard and Reservist goes back

home and may be seeking care from neither of our institutions is itself a whole other set of challenges.

Mr. RODRIGUEZ. Anybody looking at that right now?

Dr. TIBBITS. Well, our Secretary has asked us to begin to make some serious, let us say, end roads into that. There are several levels and I will yield back in a minute here. There are several levels.

One is with the Guard and Reserve itself and the equipment they have.

Number two, what it is both Departments do for purchased care when we purchase healthcare from the private sector not delivered inside of our institutions.

And, thirdly, is the relationship that we need to develop or are developing with the National Health Information Network Initiative of the U.S. Department of Health and Human Services to facilitate the connection between us and all those private sector doctors who ultimately are going to be linking themselves electronically to that National Health Information Network.

So it is a layered problem. There is a lot to think about there. And, yes, our Secretary is very interested in having us now weigh into that specifically.

Mr. RODRIGUEZ. Mr. Chairman, I know I went after my time, but can I get Mr. Dominguez to respond? I think he also wanted to respond. Is that okay, Mr. Chairman?

Mr. DOMINGUEZ. Sir, if that is okay, the first is that the Authorization Act did require us to address in every report that we send to the Congress and every aspect of this continuum of care the unique challenges associated with providing that care and support to the members of the Guard and Reserve. So we intend to do that.

There was a similar provision on gender issues, by the way, which we intend to do that.

The next thing is that in the Authorization Act, NDAA 2008, it established the Yellow Ribbon Reintegration Program. We take a couple of experiments we were running with States in terms of trying to support Guard and Reserve members coming back and extended that to all 54 States and territories.

Secretary Hall, the Assistant Secretary for Reserve Affairs, is now putting that program together to reach out to Guard and Reserve team people who are coming back with a full spectrum of care which will include some healthcare and mental health counselors and those kind of people that either we will provide or—and we have also actually seen our TRICARE network providers step up and in particular deal with the rural challenges by getting deployed teams of healthcare providers and particularly mental health people out to these events where we are either, you know, shipping people out or bringing them back.

So there is a lot going on, a lot to be done, a lot going on.

The CHAIRMAN. Mr. Dominguez, you said earlier that you do not have any problem with the 300,000 figure of people who showed some symptoms of mental illness.

Would you consider those casualties of war?

Mr. DOMINGUEZ. I do not know that I would call them casualties of war. I mean, they are people exhibiting——

The CHAIRMAN. If someone has a broken arm, it is a casualty, right? If somebody gets a broken arm while in battle, is that a casualty?

Mr. DOMINGUEZ. Uh-huh.

The CHAIRMAN. So if somebody has depression or brain injury, is that a casualty?

Mr. DOMINGUEZ. Well, brain injury is, I think, a different——

The CHAIRMAN. Okay. Well, the RAND report gave a 320,000 estimate. Do you accept that figure?

Mr. DOMINGUEZ. What I——

The CHAIRMAN. You made fun of the 300,000. How about 320,000 who have brain injury?

Mr. DOMINGUEZ. Well, again, I think you do not have 320,000 brain injuries. You have 320,000 people who have been in or around a concussive event. Again, it is a spectrum of experience and then a spectrum of need that manifests itself there. So, no, there are not 320,000 people out there——

The CHAIRMAN. Probably just a few, right?

Mr. DOMINGUEZ [continuing]. Who have brain injuries.

The CHAIRMAN. Probably just a few? I am just using your words.

Mr. DOMINGUEZ. At the very severe end of the——

The CHAIRMAN. You know, here is the problem that I have with your testimony and then I will shift over to the VA. You are a leader in the Department of Defense and people hear your words and you create a tone. You are the leader, or you are one of the leaders and the leadership creates a tone. Your tone is that it is only a few. We get them back into battle because they are not casualties. They have some symptoms.

That leads to a lot of things. It leads to people not willing, first of all, to admit anything and commanders saying "Do not admit to anything because your promotion will be held up." It leads to, as I understand some of the reports, at least 20,000 people who had a PTSD diagnosis were rediagnosed, or deliberately diagnosed, with personality disorders.

And now, not only does that beg the question of why we let these people in with personality disorders, but it means that the VA does not have to treat them because it was a pre-existing condition. That is what your type of testimony leads to. It leads to people saying we are not going to even take this seriously.

Mr. DOMINGUEZ. Sir, I apologize if I conveyed that tone. I want to emphasize that all of these people who experience combat stress need help. They need to get to people, therapists, counselors, and staff who can help them process that stress. What they have been through——

The CHAIRMAN. Are they doing it?

Mr. DOMINGUEZ [continuing]. Is not normal.

The CHAIRMAN. Are they getting that help?

Mr. DOMINGUEZ. We are trying our best, sir.

Now, one of the things I do want to point out is the line leadership of the Department. Secretary Gates himself attacked this problem of question 21 on the security clearance form. And this year, we made some major revisions of that in terms of what people need to be able to answer again to deal with that stigma.

The CHAIRMAN. It is an important step forward. I agree.

Mr. DOMINGUEZ. Now, the line leadership, if you look at, for example, the Army, Secretary Garren and General Casey, the Chief of Staff, ensured that every soldier in the Army, including every leader in the Army, was trained about combat stress, the symptoms of combat stress, the importance of watching your peers, your buddies.

The CHAIRMAN. There is no question you are doing all these good things.

Mr. DOMINGUEZ. The leaders are——

The CHAIRMAN. But there are thousands and thousands of young men and women who are not getting help. They are not allowed to admit they have a problem. When they get home, they do not get the help they need or they deny that they need the help.

So, yes, you are doing all these things, but you have all this evidence that we are not doing enough or anywhere close to enough. The signals are being sent that we do not have to take it that seriously because——

Mr. DOMINGUEZ. Sir, we are taking it very seriously and these things——

The CHAIRMAN. When you say there are only a few who have PTSD, that is demonstrably false, demonstrably. You need to come to my district. Come home with me tomorrow. I have Camp Pendleton right near my district. We have the biggest Navy base in the world. I will show you more than a few with PTSD—both active duty and veterans. I see them every day and they do not know what to do.

Some of them commit suicide. You have the highest rates of suicide since the Vietnam War in the Army, right, of our combat troops? Does that say it is just a problem, a few? A third of those who have been diagnosed with PTSD, that is who actually got the diagnosis, have committed felonies when they come home. Is that a big problem?

Two hundred homicides among those felonies of family members. That is real, it is significant and it needs to be taken seriously by everybody from you on up to the President. And, I do not see anybody saying it. They just keep denying these figures. They say they are vastly overblown. It is only a few, so we do not have to take care of them.

Mr. DOMINGUEZ. We are taking seriously the issue of combat stress, of finding people who need help and getting them help.

The CHAIRMAN. How do you account for 200 homicides of guys coming right out of Iraq who have killed 200 people, most of them in their own family? How do you explain that? Because we are not doing our job. How do you explain the suicides? We are not doing the job. And if you do not——

Mr. DOMINGUEZ. Suicide——

The CHAIRMAN [continuing]. See that every suicide or every homicide is a criminal act that we committed, then you are not going to ever solve the problem. We have not taken care of our children. The evidence is there. You just do not want to admit it or look at it.

Mr. DOMINGUEZ. What I am saying, sir, is that we are mounting an aggressive effort. It is continuing to deal with this combat stress.

The CHAIRMAN. I notice you did not respond to my——

Mr. DOMINGUEZ. We have every possible way we can do it.

The CHAIRMAN. You did not respond to my statement about personality disorders. We have had, at this table, people who were diagnosed with personality disorders, who had demonstrated PTSD and they were not getting the help they needed.

Mr. DOMINGUEZ. Sir, I have today, just today, sent to you the report that was required by the Congress on the personality disorder discharges and the percent of that 20,000 or so over the last several years and——

The CHAIRMAN. So, you will say it is only a few. I have not read the report, but I am positive it is going to say there are only a few.

Mr. DOMINGUEZ. For those who have been at discharge, the majority who have been in less than 2 years, the majority were not deployed into combat. However, this discussion of and your focus on that did cause us to tighten our policy.

So the use of that discharge now requires certification by a psychiatrist that PTSD is not present. And if the person being discharged with this discharge has been to combat, that Surgeon General of the Service must sign off on it.

[The report entitled, "Administrative Separations Based on Personality Disorder," as required by section 597 of the National Defense Authorization Act for Fiscal Year 2008, appears on p. 83.]

The CHAIRMAN. Okay. Well, I will read the report, but I can guess what is in it.

I can tell you that doctors have come to me, I wish they would testify in public and I am trying to get them to do that, that they have been ordered to misdiagnose PTSD as personality disorder. I wish I could do this in public and I will try to do that. It is a real concern.

As for the VA, you know about this e-mail that went out and became public. The head of the post-combat trauma unit at a VA hospital writes to all of her team. "Given that we are having more and more compensation seeking veterans, I would like to suggest that you refrain from giving a diagnosis of PTSD straight out. Consider a diagnosis of adjustment disorder. Additionally, we really do not have time to do the extensive testing that should be done to determine PTSD."

Also, there have been some incidents where the veteran has his compensation and pension exam and is not given a diagnosis of PTSD. Then the veteran comes here and we give the diagnosis of PTSD and the veteran appeals his case based on our assessment. Now we have a problem. We are going to have to compensate them.

How does that happen? I think it happens because of the kind of testimony you give today, that the leadership is giving the signals that we are spending too much money, we do not take it seriously. We only have a few, so some middle-level administrator has the nerve to send that kind of message out to her people. How does that happen?

Admiral Dunne, they are your people.

Admiral DUNNE. Sir, that e-mail was poorly worded and Dr. Kussman——

The CHAIRMAN. That is just like your head of mental health who poorly worded his "shh, do not talk about suicide statistics" email.

Everybody seems to be poorly wording stuff. You should give them a course in not doing that. But, I mean, it is not poorly worded. It is very well worded. It says cut out the diagnosis of PTSD.

Where is she getting that kind of instruction? Where is she getting that kind of sense? Where is she getting the right to say that? Is that coming from you at the top?

Admiral DUNNE. It did not come from me, sir.

The CHAIRMAN. Well, did it come from anybody?

Admiral DUNNE. It did not come from anybody in the leadership of VA, sir.

The CHAIRMAN. It came from somewhere. Nobody sends out a memo like that. It is based on the signals that you guys are giving at hearings like this. That is where it comes from.

Now, can you explain to me? Everybody who comes to testify here says anybody who comes in the VA from OEF or OIF gets a mandatory screening for PTSD and TBI. First, you are saying only those who come in, right? You are not going out and finding people. Second, what happens in that screening, exactly?

Dr. AGARWAL. Sir, let me address two things. The first question is what are we doing about those who are not coming to us for care. Secretary Peake has an initiative of a call center which got started a few weeks ago where we are reaching out to all the servicemembers or veterans who have been discharged with——

The CHAIRMAN. They have to call into the call center.

Dr. AGARWAL. No. They are making the outreach call.

The CHAIRMAN. And what are they saying in that outreach? What is the script?

Dr. AGARWAL. And they are actually offering them services that VA offers including the sites. And if any of them need an appointment or assistance——

The CHAIRMAN. Okay, that is great. I will tell you, by the way, because I have seen your suicide brochures that the very people you need to reach are those who do not want to talk to the government, they do not want to talk to bureaucrats. They want something else. But you are telling them to come see the government. We are here to help you.

Dr. AGARWAL. It is being done by a contracted service. But the second point more specifically——

The CHAIRMAN. I would like to see the script for what they are saying.

Dr. AGARWAL. We can have it.

The CHAIRMAN. Thank you.

Dr. AGARWAL. Sure.

The CHAIRMAN. Okay. What happens when they come in and they get their screening?

Dr. AGARWAL. Actually, OEF/OIF veterans, there is a clinical reminder in the computerized record system which is based on Boolean logic. So anyone who has been discharged from the service since 2001, there are a series of reminders that they have to undergo and which the clinicians, especially the primary care physicians in our clinics, both in the community-based outpatient clinics as well as the medical centers, have been trained to complete which includes a series of questions related to PTSD——

The CHAIRMAN. The Secretary said when he was here and you said today that everybody who comes in gets a mandatory screening for PTSD.

Dr. AGARWAL. Yes, sir.

The CHAIRMAN. Tell me what that screening is. What exactly is that? Is that an appointment for an hour with a psychiatrist? Is that a questionnaire given out by a clerk? What is it?

Dr. AGARWAL. Let me explain that, sir. It is actually a series of questions which are asked by the clinician. So a clinician who is seeing——

The CHAIRMAN. How many questions are in that series?

Dr. AGARWAL. Sir, it has been a while since I have given it myself. I am a practicing clinician.

The CHAIRMAN. It is two. I have seen the questionnaire. I have talked to the guys who have gone through the questionnaire. There are two questions that are asked, one that says have you ever been subject to a blast. I forget the other one but I believe it asks if you have nightmares. There are two questions. Am I wrong?

Dr. AGARWAL. Sir, I would need to get you the questionnaire.

The CHAIRMAN. Well, you know, I want to know the exact screening. What happens? Who does it? What are the questions asked and for what time period?

I am told by dozens and dozens of soldiers that there are only two questions. It is done by an intake clerk. And, if they do not want to admit that they have it, they know what to say—no on both—and then there is no follow-up on it. They just say no and that is it.

Dr. AGARWAL. No, sir. It is actually a more detailed questionnaire than two questions. And the clinical questions are not asked by clerks. They are asked by a clinician.

The CHAIRMAN. Well, you will have to show me because everybody I talk to tells me what they said to these questions.

Dr. AGARWAL. Sir, I will get you the screen.

[The VA subsequently provided a Call Back Scripts, which appear on p. 120.]

The CHAIRMAN. And, again, the Army and the Marines give mandatory evaluations for PTSD and brain injury when they leave combat areas or leave the service?

Mr. DOMINGUEZ. Sir, we do these screening surveys, questionnaires to cue people to get them brought in for face-to-face talks with a clinical provider.

The CHAIRMAN. If they say yes to any of the questions?

Mr. DOMINGUEZ. That is correct. And then——

The CHAIRMAN. So, I mean, if a Marine knows that his promotion is threatened or he is not going to get a job in law enforcement when he leaves, most of your Marines are smart enough to answer "no" to those questions. If somebody checks yes, and I can give you the names and dates. Their commander says you better look at this again because if that stays yes, you are going to have to stay here a few more days for some further evaluation. That Marine wants to go home. He does not want to be saddled as weak. Everything is set up to make sure that they fear admitting——

Mr. DOMINGUEZ. Well, which is why we are changing a lot of things in the Department. First, many places, not all yet, but many

places the counselors and the psychologists, psychiatrists are actually in the health clinic, so you do not have to go some place else, you know, so you can mask that you are getting mental health treatment.

Second is this training that is going on in the leadership about combat stress, taking care of your buddy, be observant, help your buddy. And then communicate that part of the warrior ethos is, you know, being strong, to get strong enough to get help, taking the stigma out of it by, you know, attacking that question 21 that Secretary Gates——

The CHAIRMAN. Tell Secretary Gates, as I have told several of your Surgeon Generals, the best thing he can do is to take a Colonel who has had PTSD and publicly talk about his PTSD, treatment, and his healing and promote him to General. That would send a signal.

I asked the Army Surgeon General how many Generals have had PTSD. He said many. I said name one and he said he cannot do that.

Mr. DOMINGUEZ. Right.

The CHAIRMAN. That is what you need to do.

Mr. DOMINGUEZ. Sir, we are trying a lot of different things. I want to point out there is a brigade commander at Fort Lewis who has taken his entire brigade through mental health counseling as they redeploy starting with him. Okay? So there are things like that are going on——

The CHAIRMAN. That is good.

Mr. DOMINGUEZ [continuing]. Today in the Army to try, and the Department of Defense, try and understand how to do this better and how to make sure that people who do need care, because combat stress is real and combat is not a normal and natural thing, and people need help dealing with it, so we are trying to understand how to make that happen more effectively.

Mr. BUYER. Will the gentleman yield?

The CHAIRMAN. I will yield to you your time in a second. I just want one final thing.

I think you need to do that a lot faster and a lot more comprehensively and get mad that it is not being done.

Mr. Buyer, I would yield to you.

Mr. BUYER. It was just to the point that you were making. If you remember when you held the hearing on personality disorders and your concern on PTSD and I had proposed that we had a brigade that was going. And it is the 76th brigade out of Indiana and this is their third deployment.

And so what has happened, and just to tell you about this, is we have had extraordinary cooperation from VA and DoD with regard to this National Guard brigade. And we were going to try to do something outside the box that we had never done before. And it is about baselining.

And so the VA normally is the receiver of the consequences of war and then manages that health aspect along with other things. This is where the VA, upon our request and your request, Mr. Chairman, they actually involved themselves in deployment. And DoD invited them in to do that.

So the VA came. It was part of the counseling they gave not only to soldiers but also to family members and the spouses. It was done not only at Camp Atterbury but then you went down to Fort Stewart before they went over. The VA did that. That is operating outside the lines and the jurisdiction of the VA.

Now, why was that pretty important? Because I think that was the VA being responsive to the concern that not only you have had over time but what you just brought up and that is when Secretary Dominguez talked about the job at DoD is to build warriors. And they build warriors. They build a warrior ethos. They instill them with values and the ideals to defend liberty and this country. And we want them strong, but we also recognize that there are times that it can be very challenging for them.

And when they come back, you are absolutely right, Mr. Chairman, they are eager to get back to their families. They are eager to get back to their lives. And that is why the VA being responsive to DoD opening the door to be there, it is telling the first line of diagnosis. It is really the husband or wife that was left at home. They are watching the transition of their loved one in how they talk on the telephone, in their writings, what are they saying on e-mail.

And then when they come home, are there sleepless nights? How are they reacting to the children? What do they see that is different? And they are the ones now that they are building a relationship with the VA that has been established during the family support centers. I think this is a good thing that is going on.

It addresses the point that you were making. So I wanted to give you sort of an update on what is going on. I will yield back.

The CHAIRMAN. Thank you.

I would invite both Secretaries to meet with some of the people that are giving us this other kind of sense of what is going on and put a human face on all this stuff.

I yield to Mr. Buyer for his questions.

Mr. BUYER. Thank you, Mr. Chairman.

I am going to get back to sort of the purpose of our hearing and that is the implementation of the Wounded Warrior provisions.

Now, I have the Defense Authorization Act. And the reason all of this is in the Defense Authorization Act is that the Chairman waived jurisdiction of this Committee and we gave it then to the House Armed Services Committee in cooperation though. When the Chairman did that, he worked with Chairman Ike Skelton. So the House then adopted the recommendations of this Committee and so that is why I am referring now to this.

Now, one of the things we did is that we put in specific benchmarks and reports. And we have done this because of oversight on implementation. So we are putting you under the gun.

So in my opening critique here of the Chairman, my first reaction was, Mr. Chairman, a lot of these reports are not coming due until July and GAO in particular. But you know what? There are some reports and things that you were supposed to have done that I do not know if you have done or not.

So let me ask you about these. Section 1616 was the establishment of a Wounded Warrior resource center and among other things, the center was to provide a multi-method of access includ-

ing at a minimum one Internet Web site and a toll-free phone number. I believe this was supposed to have been done within 90 days.

Has this been done?

Mr. DOMINGUEZ. No, sir. We are late on that.

Mr. BUYER. Why?

Mr. DOMINGUEZ. It is harder than it sounds. We have——

Mr. BUYER. A toll-free number is harder than it sounds?

Mr. DOMINGUEZ. Well, the important thing is ensuring that, and we have made the decision Military OneSource will be the number, but ensuring that the capacity to answer all the questions that are going to be there so that you can, when somebody calls, you can make sure that they get the assistance that they need. We are building that structure. And I want to say that we are doing that in partnership again with the military services who do also have their 800 numbers out there and working.

Mr. BUYER. When can we anticipate that you are in compliance with section 1616 of the "Wounded Warrior Act"?

Mr. DOMINGUEZ. Sir, I will get you that for the record.

Mr. BUYER. Oh, no. No. No. Sorry, Mr. Secretary. You are already behind.

Mr. DOMINGUEZ. Yes, sir, we are behind.

Mr. BUYER. So give us your expectation. You are the leader.

Mr. DOMINGUEZ. Sir, I think it is best for me to provide that to you for the record so that we can be accurate in our communications to you about when that whole capability will be available.

Mr. BUYER. No. No. You have the opportunity to provide the leadership. We have given you what we have wanted. You have had a lot of time. So please provide here to the Committee an expectation of when this will be implemented. You have already busted through our expectation as to when we thought it could be done.

So what are we talking about? Within 15 days or within 30 days, within 60 days, within 90 days? I mean, you are now not in compliance with the law. I would feel uncomfortable if I was a Secretary and I was not compliant with the law.

Mr. DOMINGUEZ. Yes, sir. We are late in standing up that capability. It is of concern to me. And I have people working it assiduously.

Mr. BUYER. So what is the expectation? What is your expectation?

Mr. DOMINGUEZ. I cannot provide you that right now, sir.

Mr. BUYER. Within a year? Within the year?

Mr. DOMINGUEZ. Oh, yes, sir, absolutely.

Mr. BUYER. Within 6 months?

Mr. DOMINGUEZ. I would say so, yes, sir.

Mr. BUYER. There we go, within 6 months.

All right. Let us talk about the other provision. Section 1664 was the report on traumatic brain injury classifications. Not later than 90 days after the date of the enactment of the "Wounded Warrior Act," the Secretary of Defense and the Secretary of Veterans Affairs shall jointly submit to the Committee on Armed Services and the House of Representatives a report describing the changes undertaken within the Department of Defense and the Department of Veterans Affairs to ensure that traumatic brain injury victims receive a medical designation that is concomitant with their injury

rather than medical designation that assigns a generic classification.

Now, to the DoD and the VA, do you have the report?

Mr. DOMINGUEZ. No, sir. I think we are probably late on that one too. Now, I know that we are working this issue of the—do you have some better information?

Dr. AGARWAL. Provide some information, sir. Yes, there is a VA/DoD group that has been currently working on the coding proposal. This proposal is going to be submitted to the National Center of Health Statistics. And following that period, there is a comment period before it is accepted by the ICD–9 classification.

Mr. BUYER. All right. One of the challenges that the Chairman and I and other Members of the Committee have had is working with the medical communities with regard to designations because we have been sort of uncomfortable with this mild traumatic brain injury and coming up with the right terminology because it is like what is the difference between a concussion and a mild TBI. And we are moving into this mental health and exploring this in greater detail.

So we wanted to make sure when we put this together that with regard to the VA and DoD, if we are going to be seamless, that we wanted to make sure that everyone is using the right terminology and everything is coded in cooperation because if the VA, in fact, is the leader as RAND testified, that we wanted to make sure that as we then work in concert through TRICARE and with other providers that everybody begins to take off of our lead in designations and in coding.

This is pretty important. Do you agree? All right. Admiral.

Admiral DUNNE. I agree.

Mr. BUYER. Can you tell me where you are and why you have not met this deadline?

Admiral DUNNE. The revision will be submitted to the Committee by September of this year. The expectation is it takes about a year for that to go through the peer review and get actually assigned to that. VA does not, nor does DoD, control that international organization.

Mr. BUYER. So the 90 day after enactment was really sort of an unrealistic deadline? I mean, we want it to be done accurately, the Chairman and I do, because we recognize this is pretty doggone important. You are leading a country with regard to best coding and designation and terminology, nomenclature. So 90 days was unrealistic?

Dr. AGARWAL. Sir, I could not answer you because I am not a subject matter expert. But what I do know that it does have to go, the proposal is pretty ready, but it has to go through external agencies like the National Center of Health Statistics before it can be submitted for the actual coding.

The ICD–9 code currently, as you know, does not have a code for mild TBI, so there is a process that it has to go through and it is fairly in final processes of being submitted.

Mr. BUYER. So you anticipate the compliance then with section 1664 by September?

Dr. AGARWAL. It will be submitted to the ICD–9 Committee by September.

Mr. BUYER. All right. Let me ask this. We have other reports. You have all kinds of requirements here on reporting. Are you going to meet any of them? What I would like to know is why do you not just go ahead and tell us now. I mean, you have an incredible upcoming list of deadlines.

Admiral DUNNE. Yes, sir. We have——

Mr. BUYER. And we are not beating the heck out of you here. Are these realistic deadlines that we set for you or which ones are you going to be able to accomplish and not accomplish?

Admiral DUNNE. Sir, Mike and I Chair a DoD/VA Committee which is tracking these. We have a spreadsheet that we have created that breaks those down based on the reports. We would be happy to provide you a copy of the spreadsheet. It gives you an indication of our progress on each of those requirements.

[The DoD subsequently provided a table showing the *Status of Congressionally Mandated Requirements,* which appears on p. 129.]

Mr. BUYER. All right. To the two Secretaries, being transparent with us a good thing, right? Letting us know what you can achieve, what is realistic.

And, you know, Secretary Dominguez, I did not mean to be too hard on you, but I am going to be hard on you because, you know, I think you need for us to do that. You are dealing with some pretty strong bureaucracies over there and we set these timelines for a reason, to set that backdrop so difficult decisions are not procrastinated.

I do not question your heart. Neither of you. No one on this panel. That is why I am asking are the deadlines that we set, are they realistic to accomplish what the Committee has asked you to do?

Mr. DOMINGUEZ. Sir, we have an already scheduled session. We are going to go through these reports when they are due. And so I think I will be able to have a better sense of that for you later this month.

I do want to express some disappointment that I thought we were tracking every one of those and had sent you interim reports on the deadlines that were specified that told you what we were doing and that we were going to be late in those cases where we have.

If we missed some of those and it appears we did, I will go back and make sure that we tighten up that effort. I apologize for that.

Mr. BUYER. I am going to now switch gears about the disability evaluation systems, the pilot. I think the Chairman and I both were pleased that the VA and DoD got an early start. You began the joint pilot program on the disability evaluation system last November.

Combining the examinations and evaluations into one process and having a single rating system for the use by both Departments is undoubtedly, it is a cumbersome task, but it is something that should have been accomplished long ago. It would have saved wounded warriors a lot of frustration and worry that they should not have to endure after sacrificing so much already.

I see this pilot as a great opportunity for both Departments to start from scratch and to put in place a streamlined and efficient

system that avoids many of the complications that mire the current system.

As you know, I am a longstanding advocate for increased use of information technology and the electronic medical records.

Here are my questions. Is the pilot program establishing electronic file systems for its claims?

Admiral DUNNE. Sir, it is through organization of the interoperable health records that we are getting. However, there is nothing unique to the pilot for IT support. It will benefit from the interagency program office, which we stood up for health records for everyone.

Dr. TIBBITS. Right. Yes, sir. And I will just add to that, of course, is an accurate statement of affairs today. As that pilot moves forward and we and DoD get smarter on how we want to conduct it, we well could come to realize that some additional requirements are necessary. Those will be formulated and more IT solutions will be brought to bear. But right now the answer is nothing unique to that. But we intend to learn from it.

Mr. BUYER. It is an interest of the Chairman and myself. You know, we look out there in the private sector on how well they do the electronic claims processing and we do not do it as well. And so it is of interest to us, I want you to know.

What successes and problems has the pilot revealed thus far?

Mr. DOMINGUEZ. Sir, I will just start with a little. The success with right now a very limited sample size of one is, in fact, we did compress the time from entry into the disability system to the time when you have a notice in your hands of here are the benefits you will get from the Department of Veterans Affairs. We compressed that quite significantly. It was about 160 days where normally it is in excess of 500.

That 160 days actually involves about 70 or so days of convenience time to the member so that there is actually, you know, about 90 days of administrative processing time for us in our two Departments. So we have compressed the time.

The second is there is a lot more customer care, a lot more customer care. So it is a higher touch, higher trained people around this system to make it work and to make sure that the people going through it understand what is going on. So we anticipate higher satisfaction which we are now surveying with that.

Mr. BUYER. Those are positive. Any problems we see so far, challenges?

Admiral DUNNE. Sir, there are lots of challenges in conducting a process like that where we are working between not only just VA and DoD but between each of the services because they all do it slightly differently in accordance with their instructions.

So we have had problems similar to getting the right type of computer on a coordinator's desk, getting the right amount of bandwidth to that person's computer so that they could provide the service that was needed.

In some cases, we would have someone assigned an appointment and we might find that their commanding officer, for good reasons, had sent them on leave to be with their family and they were not available. We had to reschedule the appointment.

So there are a lot of those sort of interaction type things.

Mr. BUYER. Yeah. Those are anecdotal. You do not have show-stopper challenges, right?

Admiral DUNNE. No, sir.

Mr. BUYER. This can be done? It can be accomplished?

Admiral DUNNE. Yes, I am confident that it can be accomplished, sir. And as we look toward the expansion, we are going to look at more challenges of having capabilities close at hand.

Mr. BUYER. So to date, Admiral, are you aware of how many claims have been processed through the pilot up to today?

Admiral DUNNE. There is one individual who has been completely through the process and been discharged through that process, sir. There are approximately 400 individual servicemembers who have been enrolled in this pilot program and they are in various stages.

Mr. BUYER. When did you open the door for the pilot?

Admiral DUNNE. November 26th, sir.

Mr. BUYER. And you have only processed one person through since November under the pilot?

Admiral DUNNE. One person has been discharged as a result of that, sir.

Mr. BUYER. How many are in the pilot right now?

Admiral DUNNE. The last number I saw, which may be as much as a week old, was 387.

Mr. BUYER. Okay. And so, Secretary Dominguez, when you said you compressed this, your expectation and anticipation is that this is going to be done and processed within 160 days——

Mr. DOMINGUEZ. Well, the——

Mr. BUYER [continuing]. When someone comes in?

Mr. DOMINGUEZ. Yeah. The achievement that we had with this one individual, again, if you count the convenience time to them, allowing them to take leave and those kind of things, which runs on our clock. But, yeah. The goal we set was to cut this time in half from the time you enter the disability system to the time you have the VA benefits. So 180 was kind of where we were hoping——

Mr. BUYER. Can you give the Committee some kind of a sense? Maybe this is too premature to ask these questions about an ongoing pilot, but the Chairman and I are both eager to learn. What is the rate of satisfaction among people who are involved in the program? That is my last question.

Mr. DOMINGUEZ. Yeah. We are surveying now, so we do not have anything definitive other than, you know, the anecdotes and the fact that we are not getting complaints. And many people are not appealing, you know, their ratings. But, again, it is so early and such preliminary numbers, it is hard to tell. I mean, we were very concerned that this be a process that our people view as more user friendly and more open and concerned to them as opposed to for the convenience of the government.

Mr. BUYER. All right. I do have the last, last thing. So when can you give the testimony to the Committee, not only ours, but the Armed Services Committee of the House and the Senate, definitive that this type of pilot, your findings? A year?

Admiral DUNNE. Sir, we instituted the pilot for a 1-year period of time and expected to gather data over that period of time. So I

would say after November 26, 2008. We would need time to evaluate the numbers and we would be happy to provide a report.

The CHAIRMAN. Thank you, Mr. Buyer.

I do not think either Mr. Buyer or I disguised our frustration very well with what is going on. You talk about timelines and evaluations and a year to report the status to this Committee.

If your child received a brain injury or concussion in Iraq, would you want to wait this amount of time before we make sure whether he has a brain injury or the treatment for it? Think of that because I have said it several times. These are our children. We are not taking care of them properly.

And you sit here and talk about 1-year timelines. In that year, you are going to have thousands and thousands of our bravest young men and women who are injured, who do not get the proper help and may commit suicide. They may commit a felony. They may kill a family member. We know that is happening. Get mad and do something about it.

This hearing is adjourned.

[Whereupon, at 12:46 p.m., the Committee was adjourned.]

APPENDIX

Prepared Statement of Hon. Bob Filner,
Chairman, Full Committee on Veterans' Affairs

I would like to thank the Members of the Committee, our witnesses, and all those in the audience for being here today.

Over 33,000 servicemembers have been wounded in Operations Enduring Freedom and Iraqi Freedom. Due to improved battlefield medicine, those who might have died in past conflicts are now surviving, many with multiple serious injuries such as amputations, traumatic brain injury (TBI), and post traumatic stress disorder (PTSD).

In February 2007, a series of Washington Post articles about conditions at Walter Reed Army Medical Center highlighted the challenges our veterans face.

The Wounded Warrior provisions of the 2008 National Defense Authorization Act were intended to address these issues. Many of them require the Department of Veterans Affairs (VA) and the Department of Defense (DoD) to collaborate to improve the care, management and transition of recovering servicemembers.

The hearing today will explore the progress the two Departments have made in implementing the Wounded Warrior provisions.

To improve care management in the Army, 32 Warrior Transition Units were established. Injured Soldiers are now assigned a primary care manager, nurse case manager and a squad leader to guide them through their recovery.

The rapid creation of WTUs are a success, however according to GAO several challenges remain, including hiring medical staff in a competitive market, replacing temporarily borrowed personnel with permanent staff, and getting eligible servicemembers into the units.

In December 2007, the VA, in coordination with DoD and the Department of Health and Human Services, established the joint Federal Recovery Coordinator Program to coordinate clinical and non-clinical care for severely injured and ill servicemembers. As of May 7, 2008, there were only six field staff members working with 85 patients at three sites. I look forward to hearing how effective this program has been and how it will be expanded to benefit more veterans.

As our injured veterans transition from the military health system to the VA system, they face the difficulty of navigating through two different and cumbersome disability evaluation systems. The current system is a source of stress and frustration for many veterans.

Last November, DoD and VA jointly initiated a 1-year pilot program to evaluate a streamlined evaluation system. I hope the departments will be able to expand this program in the coming months.

Post-Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI) are considered by many to be the signature injury of the war. According to a RAND Corporation report released on April 17, 2008, nearly 300,000 veterans of OEF and OIF are suffering from PTSD or major depression and nearly 20 percent of the 1.64 million veterans of Iraq and Afghanistan reported a probable traumatic brain injury (TBI) during deployment.

Unfortunately, these veterans are not getting the care they deserve. Only 43 percent of those reporting a probable TBI have been evaluated by a physician for brain injury and only half of those who meet the criteria for PTSD or major depression sought help from a physician or mental health provider. This is not acceptable and we must do better.

In November 2007, the DoD established the Center of Excellence for Psychological Health and Traumatic Brain Injury. I look forward to hearing how the VA and DoD are working together to conduct research and develop best practices.

An essential component toward improving continuity of care for veterans is the development of an interoperable electronic health record. This will allow for the seamless transfer of medical information between departments.

Over the past year and a half, both Departments have made significant progress toward improving care management and transition of recovering servicemembers. However, much work remains to be done. I look forward to hearing what progress has been made, what obstacles remain and how this Committee can help the two Departments move ahead.

We look forward to an informative hearing, and a frank exchange. We wish to thank Terri Tanielian and Lisa Jaycox on our first panel for coming before us today to provide us with the background we need to begin this discussion, and we thank Mr. Dominguez and Admiral Dunne for joining us to give us updates from DoD and the VA.

No matter where we stand on the war in Iraq, we all stand together in our desire to make sure that our returning servicemembers get the seamless healthcare they need, and the benefits they have earned.

Prepared Statement of Hon. Stephanie Herseth Sandlin

Thank you Chairman Filner and Ranking Member Buyer for holding today's hearing on implementing the wounded warrior provisions of the National Defense Authorization Act for Fiscal Year 2008.

Like all Americans, I was outraged by the deplorable conditions reported at Walter Reed Army Medical Center's outpatient facilities. I am hopeful that the wounded warrior provisions implemented by last year's Defense Authorization Act and the public outcry generated from the shoddy treatment of our servicemen and women will focus enough attention on these problems to lead to the implementation of meaningful changes.

For far too long, Congress did not live up to its constitutional duty of asking the tough questions to ensure that government programs and services are run efficiently, transparently, and free of corruption and incompetence.

Today's hearing will provide us a valuable opportunity to examine what progress has been made in implementing the wounded warrior provisions and to explore barriers to implementation. I look forward to working with fellow Members of the Committee to ensure the VA and DoD are improving care for our wounded servicemembers.

Again, I want to thank everyone for taking the time to be here and discuss these important matters.

Prepared Statement of Hon. Harry E. Mitchell

Thank you, Mr. Chairman.

Thank you also for holding this hearing, today.

Caring for the veterans of the wars in Iraq and Afghanistan has been a top priority for this Committee and this Congress.

In the past 16 months, I have heard from veterans across the Nation that excessive bureaucracy and substandard living arrangements are complicating their war injuries.

Last year, an outraged Nation learned about the terrible conditions many of our wounded warriors had to endure as they recovered from their battlefield injuries at the Walter Reed Army Medical Center. We have all heard the sad stories of moldy walls and rat droppings at Building 18.

Even worse, we learned that these dilapidated conditions extended beyond Walter Reed, to other military facilities . . . and even veterans' facilities, where troops turned veterans faced a long, complicated and confusing process to get the benefits and care they have earned.

Conditions like these, and miles of bureaucratic red tape, rob our troops and veterans of what they deserve the most: dignity; respect; honor.

Following The Washington Post report, I partnered with Rep. Rahm Emanuel and Sens. Barack Obama and Claire McCaskill to introduce H.R. 1268, the Dignity for Wounded Warriors Act, to address the most serious problems facing our servicemembers and veterans.

I was happy to see many pieces of that legislation included in the 2008 National Defense Authorization Act, which was signed into law this January.

This is a good start, but I believe we can, and will, do better.

Our Nation's veterans served honorably to protect us and our country. The least we can do is fight for them when they come home.

I yield back the balance of my time.

Prepared Statement of Hon. Steve Scalise

Mr. Chairman, I want to thank you and Ranking Member Buyer for holding this important hearing on implementing the wounded warrior provisions of the National Defense Authorization Act for Fiscal Year 2008. It is important that we examine the progress of the Departments of Veterans Affairs and Defense in carrying out these provisions so we can improve the care, management, and transition of recovering servicemembers.

Throughout American history, the men and women of our armed forces have answered their nation's call to battle. These men and women have bravely sacrificed for our country and defended our freedom while risking their lives and livelihoods. Unfortunately, for veterans wounded while fighting for our country, the conflict does not end when they leave the battlefield. Many of our servicemembers return home with life-changing injuries and disabilities.

Currently, there are more than two million veterans with service connected injuries or illnesses. Thousands of these veterans have returned from Operation Enduring Freedom and Operation Iraqi Freedom, many with psychological distress from the horrors of war and severe injuries from IED attacks and other hazards.

Modern medical science has allowed many of these veterans to survive injuries that would have proven fatal in previous wars. But there is still much work that needs to be done to adequately treat our wounded warriors. Military and VA hospitals are filling with veterans suffering from traumatic brain injuries and post-traumatic stress disorder.

We must ensure that our wounded warriors receive the best care available to treat their injuries when they return home. We made a promise to these soldiers that they would be cared for when they return home, and that promise must be fulfilled.

Our servicemembers deserve the best available medical, mental health, and dental care services when they return home. And we must ensure that our soldiers have a seamless transition from military service to veteran status, so they will continue to get the best treatment possible.

In my own district, wounded warriors may have experienced additional problems receiving proper care because of the closure of the Southeast Louisiana VA Hospital due to damage caused by Hurricane Katrina. Because of this closure, approximately 221,000 veterans in a twenty-three parish area in southeast Louisiana are having to travel up to four hours to go to other VA hospitals just to receive basic care.

With the help of this Committee, and the leadership of Chairman Filner and Ranking Member Buyer, the House passed the VA Medical Facility Authorization and Lease Act, which brought the full authorization for our replacement hospital to $625 million, which has already been appropriated. I'd like to take this opportunity to thank the Committee for their commitment to Louisiana veterans who are still recovering from the 2005 storms.

Unfortunately, our hospital is not likely to be rebuilt before 2013. It is my commitment to the veterans in Louisiana that I will work to change policy so they are able to receive quality healthcare in their own communities by the doctors of their choice until the new VA hospital opens.

I look forward to working with the Committee to ensure that our wounded warriors throughout the country have access to the care that they deserve.

Prepared Statement of Lisa H. Jaycox, Ph.D.,
Senior Behavioral Scientist/Clinical Psychologist, and Study Co-Director,
Invisible Wounds of War Study Team, RAND Corporation

Invisible Wounds of War: Summary of Key Findings on Psychological and Cognitive Injuries

Chairman Filner, Representative Buyer, and distinguished Members of the Committee, thank you for inviting us to testify today to present the findings from our study of the Invisible Wounds of War. It is an honor and pleasure to be here.

My testimony will briefly discuss the prevalence of post traumatic stress disorder and depression, as well as the incidence of traumatic brain injury among servicemembers returning from Operations Enduring Freedom and Iraqi Freedom; the costs to society associated with these conditions and of providing care to those afflicted with these conditions, and the gaps in the care systems designed to treat these conditions among our Nation's servicemembers and veterans. These findings form the basis of several recommendations which will be presented in the testimony of my colleague, Terri Tanielian. Together, Ms. Tanielian and I co-directed more than 30 researchers at RAND in the completion of this study and our testimony is drawn from the same body of work.

Background

Since October 2001, approximately 1.64 million U.S. troops have deployed as part of Operation Enduring Freedom (OEF; Afghanistan) and Operation Iraqi Freedom (OIF; Iraq). The pace of the deployments in these current conflicts is unprecedented in the history of the all-volunteer force (Belasco, 2007; Bruner, 2006). Not only is a higher proportion of the armed forces being deployed, but deployments have been longer, redeployment to combat has been common, and breaks between deployments have been infrequent (Hosek, Kavanagh, and Miller, 2006). At the same time, episodes of intense combat notwithstanding, these operations have employed smaller forces and have produced casualty rates of killed or wounded that are historically lower than in earlier prolonged wars, such as Vietnam and Korea. Advances in both medical technology and body armor mean that more servicemembers are surviving experiences that would have led to death in prior wars (Regan, 2004; Warden, 2006). However, casualties of a different kind are beginning to emerge—invisible wounds, such as mental health conditions and cognitive impairments resulting from deployment experiences.

As with safeguarding physical health, safeguarding mental health is an integral component of the United States' national responsibilities to recruit, prepare, and sustain a military force and to address Service-connected injuries and disabilities. But safeguarding mental health is also critical for compensating and honoring those who have served our Nation.

Public concern over the handling of such injuries is running high. The Department of Defense (DoD), the Department of Veterans Affairs (VA), Congress, and the President have moved to study the issues related to how such injuries are handled, quantify the problems, and formulate policy solutions. And they have acted swiftly to begin implementing the hundreds of recommendations that have emerged from various task forces and commissions. Policy changes and funding shifts are already occurring for military and veterans' healthcare in general and for mental healthcare in particular. However, despite widespread policy interest and a firm commitment from DoD and the VA to address these injuries, fundamental gaps remain in our knowledge about the mental health and cognitive needs of U.S. servicemembers returning from Afghanistan and Iraq, the adequacy of the care systems available to meet those needs, the experience of veterans and servicemembers who are in need of services, and factors related to whether and how injured servicemembers and veterans seek care.

To begin closing these gaps, RAND undertook this unprecedented, comprehensive study. We focused on three major conditions—post-traumatic stress disorder (PTSD), major depressive disorder and depressive symptoms, and traumatic brain injury (TBI)—because these are the conditions being assessed most extensively in servicemembers returning from combat. In addition, there are obvious mechanisms that might link each of these conditions to specific experiences in war—i.e., depression can be a reaction to loss; PTSD, a reaction to trauma; and TBI, a consequence of blast exposure or other head injury. Unfortunately, these conditions are often invisible to the eye. Unlike the physical wounds of war that maim or disfigure, these conditions remain invisible to other servicemembers, to family members, and to society in general. All three conditions affect mood, thoughts, and behavior; yet these wounds often go unrecognized and unacknowledged. The effects of traumatic brain

injury are still poorly understood, leaving a large gap in knowledge related to how extensive the problem is or how to handle it.

The study was guided by a series of overarching questions:

Prevalence: What is the scope of mental health and cognitive conditions that troops face when returning from deployment to Afghanistan and Iraq?

Costs: What are the costs of these conditions, including treatment costs and costs stemming from lost productivity and other consequences? What are the costs and potential savings associated with different levels of medical care—including proven, evidence-based care; usual care; and no care?

The care system: What are the existing programs and services to meet the health related needs of servicemembers and veterans with post traumatic stress disorder, major depression, or traumatic brain injury? What are the gaps in the programs and services? What steps can be taken to close the gaps?

Key Findings

Our study was the first of its kind to independently assess and address these issues from a societal perspective. Below we summarize the key findings of our research. We consider each of the questions in turn. Please note that in the findings discussed below, we use the term servicemembers returning from OIF or OEF, this includes servicemembers in the Active and Reserve component, as well as those that may have since separated from the military. We use the term veteran to refer to any servicemember who served in major combat operations.

What is the scope of mental health and cognitive issues faced by OEF/OIF troops returning from deployment?

Most of the 1.64 million military servicemembers who have deployed in support of OIF or OEF will return home from war without problems and readjust successfully, but many have already returned or will return with significant mental health conditions. Among OEF/OIF veterans, rates of PTSD, major depression, and probable TBI are relatively high, particularly when compared with the general U.S. civilian population. A telephone study of 1,965 previously deployed individuals sampled from 24 geographic areas found substantial rates of mental health problems in the past 30 days, with 14 percent screening positive for PTSD and 14 percent for major depression. Major depression is often not considered a combat-related injury; however, our analyses suggest that it should be considered one of the post-deployment mental health consequences. In addition, 19 percent, reported a probable TBI during deployment. Although a substantial proportion of respondents had reported experiencing a TBI while they were deployed, it is not possible to know from the survey the severity of the injury or whether the injury caused functional impairment.

Assuming that the prevalence found in this study is representative of the 1.64 million servicemembers who had been deployed for OEF/OIF as of October 2007, we estimate that approximately 300,000 individuals currently suffer from PTSD or major depression and that 320,000 individuals experienced a probable TBI during deployment.

About one-third of those previously deployed have at least one of these three conditions, and about 5 percent report symptoms of all three. Some specific groups, previously understudied—including the Reserve Components and those who have left military service—may be at higher risk of suffering from these conditions.

Seeking and Receiving Treatment. Of those reporting a probable TBI while deployed, 57 percent had not been evaluated by a physician for brain injury. Without such clinical evaluation, it is unclear the extent of treatment need among those that reported a probable TBI. If TBI is diagnosed, treatment would depend in large part on the associated impairments. Military servicemembers with probable PTSD or major depression seek care at about the same rate as the civilian population, and, just as in the civilian population, many of the afflicted individuals were not receiving treatment. About half (53 percent) of those who met the criteria for current PTSD or major depression had sought help from a physician or mental health provider for a mental health problem in the past year.

Getting Quality Care. Even when individuals receive care for their mental health condition, too few receive acceptable quality of care. Of those who have a mental disorder and also sought medical care for that problem, just over half received a minimally adequate treatment. The number who received *quality* care (i.e., a treatment that has been demonstrated to be effective) would be expected to be even smaller. Focused efforts are needed to significantly improve both accessibility to care and quality of care for these groups. The prevalence of PTSD and major de-

pression will likely remain high unless greater efforts are made to enhance systems of care for these individuals.

Survey respondents identified many barriers that inhibit getting treatment for their mental health problems. In general, respondents were concerned that treatment would not be kept confidential and would constrain future job assignments and military-career advancement. About 45 percent were concerned that drug therapies for mental health problems may have unpleasant side effects, and about one-quarter thought that even good mental healthcare was not very effective. These barriers suggest the need for increased access to confidential, evidence-based psychotherapy, to maintain high levels of readiness and functioning among previously deployed servicemembers and veterans.

What are the costs of these mental health and cognitive conditions to the individual and to society?

Unless treated, each of these conditions (PTSD, depression, and diagnosed TBI) has wide-ranging and negative implications for those afflicted. We considered a wide array of consequences that affect work, family, and social functioning, and we considered co-occurring problems, such as substance abuse, homelessness, and suicide. The presence of any one of these conditions can impair future health, work productivity, and family and social relationships. Individuals afflicted with any of these conditions are more likely to have other psychiatric diagnoses (e.g., substance use) and are at increased risk for attempting suicide. They have higher rates of unhealthy behaviors (e.g., smoking, overeating, unsafe sex) and higher rates of physical health problems and mortality. Individuals with any of these conditions also tend to miss more days of work or report being less productive. There is also a possible connection between having one of these conditions and being homeless. Suffering from these conditions can also impair relationships, disrupt marriages, aggravate the difficulties of parenting, and cause problems in children that may extend the consequences of combat experiences across generations.

Associated Costs. In dollar terms, the costs associated with PTSD, depression, and diagnosed TBI stemming from the conflicts in Afghanistan and Iraq are substantial. We estimated costs using two separate methodologies. For PTSD and major depression, we used a microsimulation model to project *two-year costs*—costs incurred within the first two years after servicemembers return home. Because there were insufficient data to simulate two-year-cost projections for TBI, we estimated one-year costs for TBI using a standard, cost-of-illness approach. On a per-case basis, two-year costs associated with PTSD are approximately $5,904 to $10,298, depending on whether we include the cost of lives lost to suicide. Two-year costs associated with major depression are approximately $15,461 to $25,757, and costs associated with co-morbid PTSD and major depression are approximately $12,427 to $16,884. One-year costs for servicemembers who have accessed the healthcare system and received a diagnosis of traumatic brain injury are even higher, ranging from $25,572 to $30,730 in 2005 for mild cases ($27,259 to $32,759 in 2007 dollars), and from $252,251 to $383,221 for moderate or severe cases ($268,902 to $408,519 in 2007 dollars). However, our cost figures omit current as well as potential later costs stemming from substance abuse, domestic violence, homelessness, family strain, and several other factors, thus understating the true costs associated with deployment-related cognitive and mental health conditions. Translating these cost estimates into a total-dollar figure is confounded by uncertainty about the total number of cases in a given year, by the little information that is available about the severity of these cases, and by the extent to which the three conditions co-occur. Given these caveats, we used our microsimulation model to predict two-year costs for the approximately 1.6 million troops who have deployed since 2001.

We estimate that PTSD-related and major depression-related costs could range from $4.0 to $6.2 billion over two years (in 2007 dollars). Applying the costs per case for TBI to the total number of diagnosed TBI cases identified as of June 2007 (2,726), our analyses estimates that total costs incurred within the first year after diagnosis could range from $591 million to $910 million (in 2007 dollars). These figures are for diagnosed TBI cases that led to contact with the healthcare system; they do not include costs for individuals with probable TBI who have not sought treatment or who have not been formally diagnosed. To the extent that additional troops deploy and more TBI cases occur in the coming months and years, total costs will rise. Because these calculations include costs for servicemembers who returned from deployment starting as early as 2001, many of these costs (for PTSD, depression, and TBI) have already been incurred. However, if servicemembers continue to be deployed in the future, rates of detection of TBI among servicemembers increase, or there are costs associated with chronic or recurring cases that linger beyond two

years, the total expected costs associated with these conditions will increase beyond the range.

Lost Productivity. Our findings also indicate that lost productivity is a key cost driver for major depression and PTSD. Approximately 55 to 95 percent of total costs can be attributed to reduced productivity; for mild TBI, productivity losses may account for 47 to 57 percent of total costs. Because severe TBI can lead to death, mortality is the largest component of costs for moderate to severe TBI, accounting for 70 to 80 percent of total costs.

Providing Evidence-Based Treatment for PTSD and Depression. Certain treatments have been shown to be effective for both PTSD and major depression, but these *evidence-based treatments* are not yet available in all treatment settings. We estimate that evidence-based treatment for PTSD and major depression would pay for itself within two years, even without considering costs related to substance abuse, homelessness, family strain, and other indirect consequences of mental health conditions. Evidence-based care for PTSD and major depression could save as much as $1.7 billion, or $1,063 per returning veteran; the savings come from increases in productivity, as well as from reductions in the expected number of suicides. Given these numbers, investments in evidence-based treatment would make sense from DoD's perspective, not only because of higher remission and recovery rates but also because such treatment would increase the productivity of servicemembers. The benefits to DoD in retention and increased productivity would outweigh the higher costs of providing evidence-based care. These benefits would likely be even stronger (higher) had we been able to capture the full spectrum of costs associated with mental health conditions. However, a caveat is that we did not consider additional implementation and outreach costs (over and above the day-to-day costs of care) that might be incurred if DoD and the VA attempted to expand evidence-based treatment beyond current capacity.

Cost studies that do not account for reduced productivity may significantly understate the true costs of the conflicts in Afghanistan and Iraq. Currently, information is limited on how mental health conditions affect career outcomes within DoD. Given the strong association between mental health status and productivity found in civilian studies, research that explores how the mental health status of active duty personnel affects career outcomes would be valuable. Ideally, studies would consider how mental health conditions influence job performance, promotion within DoD, and transitions from DoD into the civilian labor force (as well as productivity after transition).

What are the existing programs and services to meet the health-related needs of servicemembers with PTSD or major depression? What are the gaps in the programs and services? What steps can be taken to close the gaps?

To achieve the cost savings outlined above, servicemembers suffering from PTSD and major depression must be identified as early as possible and be provided with evidence-based treatment. The capacity of DoD and the VA to provide mental health services has been increased substantially, but significant gaps in access and quality remain.

A Gap Between Need and Use. For the active duty population in particular, there is a large gap between the need for mental health services and the use of such services—a pattern that appears to stem from institutional and cultural factors barriers as well as from structural aspects of services (wait times, availability of providers). Institutional and cultural barriers to mental healthcare are substantial—and not easily surmounted. Military servicemembers expressed concerns that use of mental health services will negatively affect employment and constrain military career prospects, thus deterring many of those who need or want help from seeking it. Institutional barriers must be addressed to increase help-seeking and utilization of mental health services. In particular, the requirement that service usage be reported may be impeding such utilization. In itself, addressing the personal attitudes of servicemembers about the use of mental health services, although important, is not likely to be sufficient if the institutional barriers remain in place.

Quality-of-Care Gaps. We also identified gaps in organizational tools and incentives that would support the delivery of high-quality mental healthcare to the active duty population, and to retired military who use TRICARE, DoD's health insurance plan. In the absence of such organizational supports, it is not possible to provide oversight to ensure *high quality of care,* which includes ensuring both that the treatment provided is evidence-based and that it is patient-centered, efficient, equi-

table, and timely. DoD has initiated training in evidence-based practices for providers, but these efforts have not yet been integrated into a larger system redesign that values and provides incentives for quality of care. The newly created Defense Center of Excellence for Psychological Health and Traumatic Brain Injury, housed within DoD, represents a historic opportunity to prioritize a system-level focus on monitoring and improving quality of care; however, continued funding and appropriate regulatory authority will be important to sustain this focus over time. The VA provides a promising model of quality improvement in mental healthcare for DoD. Significant improvements in the quality of care the VA provides for depression have been documented, and efforts to evaluate the quality of care provided within the VA for PTSD remain under way. However, it too faces challenges in providing access to OEF/OIF veterans, many of whom have difficulty securing appointments, particularly in facilities that have been resourced primarily to meet the demands of older veterans. Better projections of the amount and type of demand among the newer veterans are needed to ensure that the VA has the appropriate resources to meet the potential demand. At the same time, OEF/OIF veterans report feeling uncomfortable or out of place in VA facilities (some of which are dated and most of which treat patients who are older and chronically ill), indicating a need for some facility upgrades and newer approaches to outreach.

Going Beyond DoD and the VA. Improving access to mental health services for OEF/OIF veterans will require reaching beyond DoD and VA healthcare systems. Given the diversity and the geographic dispersal of the OEF/OIF veteran population, other options for providing health services, including Vet Centers, nonmedical centers that offer supportive counseling and other services to veterans, and other community-based providers, must be considered. Vet Centers already play a critical role and are uniquely designed to meet the needs of veterans. Further expansion of Vet Centers could broaden access, particularly for veterans in underserved areas. Networks of community-based mental health specialists (available through private, employer-based insurance, including TRICARE) may also provide an important opportunity to build capacity. However, taking advantage of this opportunity will require critical examination of the TRICARE reimbursement rates, which may limit network participation.

Although Vet Centers and other community-based providers offer the potential for expanded access to mental health services, ways to monitor performance and quality among these providers will be essential to ensuring quality care. Although ongoing training for providers is being made broadly available, it is not supported with a level of supervision that will result in high-quality care. Systems for supporting delivery of high-quality care (information systems, performance feedback) are currently lacking in these sectors. Commercial managed healthcare organizations have some existing approaches and tools to monitor quality that may be of value and utility, but many of the grassroots efforts currently emerging to serve OEF/OIF veterans do not.

What are the existing programs and services to meet the health-related needs of those with Traumatic Brain Injuries? What are the gaps in care? What steps can be taken to close those gaps?

The medical science for treating combat-related traumatic brain injury is in its infancy. Research is urgently needed to develop effective screening tools that are both valid and sensitive, as well as to document what treatment and rehabilitation will be most effective. For mild TBI (or concussion), a head injury that may or may not result in symptoms and long term neurocognitive deficits, we found gaps in access to services stemming from poor documentation of blast exposures and failure to identify individuals with probable TBI. These gaps not only hamper provision of acute care but may also place individuals at risk of additional blast exposures. Servicemembers with more severe injuries face a different kind of access gap: lack of coordination across a continuum of care. Because of the complex nature of healthcare associated with severe combat injuries, including moderate and severe TBI, an individual's need for treatment, as well as for supportive and rehabilitative services, will change over time and involve multiple transitions across systems. Task forces, commissions, and review groups have already identified multiple challenges arising from these complexities; these challenges remain the focus of improvement activities in both DoD and the VA.

Summary

Our study revealed a high prevalence (18½ percent) of current PTSD and depression among servicemembers who had returned from OEF or OIF, as well as significant gaps in access to and the quality of care provided to this population. Too few

of those with PTSD and depression were getting help, and among those that were getting help too few were getting even minimally adequate care. If left untreated or under-treated, these conditions can have negative, cascading consequences and result in a high economic toll. Investing in evidence-based care for all of those in need can reduce the costs to society in just two years.

With respect to TBI, we found that approximately 19 percent report having experienced a probable TBI during deployment but that 57 percent of them had not been evaluated by a physician for a head injury. While the majority of these cases were likely to be mild, similar to a concussion, the extent of impairment in this group remains unknown. At the same time, the science of treating combat-related traumatic brain injury remains in its infancy leaving many unknowns for planning and delivering high quality care to those suffering from long-term impairments associated with TBI.

Thank you again for the opportunity to testify today and to share the results of our research. Additional information about our study findings and recommendations can be found at http://veterans.rand.org.

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The summary of "Invisible Wounds of War—Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery" can be found at http://www.rand.org/pubs/monographs/2008/RAND_MG720.sum.pdf

The full report of "Invisible Wounds of War—Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery" can be found at http://www.rand.org/pubs/monographs/2008/RAND_MG720.pdf

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Prepared Statement of Terri L. Tanielian, MA, Co-Director, Center for Military Health Policy Research, and Study Co-Director, Invisible Wounds of War Study Team, RAND Corporation

Invisible Wounds of War: Recommendations for Addressing Psychological and Cognitive Injuries

Chairman Filner, Representative Buyer, and distinguished Members of the Committee, thank you for inviting me to testify today to discuss the findings and rec-

ommendations from our study of the Invisible Wounds of War. It is an honor and pleasure to be here.

My testimony will briefly discuss several recommendations for addressing the psychological and cognitive injuries among servicemembers returning from deployments to Operations Enduring Freedom and Iraqi Freedom. Dr. Jaycox shared with you our findings about the prevalence of post traumatic stress disorder and depression, as well as the incidence of traumatic brain injury among servicemembers returning from Operations Enduring Freedom and Iraqi Freedom; the costs to society associated with these conditions and of providing care to those afflicted with these conditions, and the gaps in the care systems designed to treat these conditions among our Nation's servicemembers and veterans. Together, Dr. Jaycox and I co-directed more than 30 researchers at RAND in the completion of this study and our testimony is drawn from the same body of work. The purpose of these recommendations is to close the gaps in access and quality for our Nation's veterans that Dr. Jaycox briefly described in her testimony.

Background

Throughout its history, the United States has striven to recruit, prepare, and sustain an armed force with the capacity and capability to defend the Nation. The Department of Defense (DoD), through the Secretary of Defense and the Services, bears the responsibility for ensuring that the force is ready and deployable to conduct and support military operations. The Nation has committed not only to compensating military servicemembers for their duty but also to addressing and providing compensation, benefits, and medical care for any Service-connected injuries and disabilities. For those who suffer injuries but remain on active duty, benefits and medical care are typically provided through DoD, which remains their employer. Veterans who have left the military may be eligible for healthcare and other benefits (disability, vocational training), as well as memorial and burial services, through the Department of Veterans Affairs (VA).

Safeguarding mental health is an integral part of the national responsibility to recruit, prepare, and sustain a military force and to address Service-connected injuries and disabilities. Safeguarding mental health is also critical for compensating and honoring those who have served the nation. The Departments of Defense and Veterans Affairs are primarily responsible for these critical tasks; however, other Federal agencies (e.g., the Department of Labor) and states also play important roles in ensuring that the military population is not only ready as a national asset but also valued as a national priority. Our research focused mainly on services available through DoD and the VA; however, where applicable, we also examined state programs and other resources.

Addressing the Invisible Wounds of War

With the United States still involved in military operations in Afghanistan and Iraq, psychological and cognitive injuries among those deployed in support of Operations Enduring Freedom (OEF) and Iraqi Freedom (OIF) are of growing concern. Most servicemembers return home from deployment without problems and successfully readjust to ongoing military employment or work in civilian settings. But others return with mental health conditions, such as post traumatic stress disorder (PTSD) or major depression, and some have suffered a traumatic brain injury (TBI), such as a concussion, leaving a portion of sufferers with cognitive impairments. Our analyses found that approximately 18½ percent of U.S. servicemembers who have returned from Afghanistan and Iraq currently have post traumatic stress disorder or depression; and 19 percent report experiencing a probable traumatic brain injury while they were deployed. Based on the existing literature, our study found that these conditions can have negative, cascading consequences if left untreated. In addition, the economic costs to society associated with PTSD and depression among veterans are high, totaling an estimated $6.2 billion over two years following deployment. Our research demonstrated that delivering evidence based treatment to all of combat veterans afflicted with PTSD and depression would significantly reduce these costs to society.

Despite widespread policy interest and a firm commitment from the Departments of Defense and Veterans Affairs to address these injuries, fundamental gaps remain in the understanding of these conditions and the adequacy of the care systems to meet the mental health and cognitive needs of U.S. servicemembers returning from Afghanistan and Iraq. RAND undertook this comprehensive study to examine these conditions and make their consequences visible. Our study focused on three major conditions—post traumatic stress disorder, major depression, and traumatic brain injury—because there are obvious mechanisms that link each of these conditions to specific experiences in war. All three conditions affect mood, thoughts, and behavior,

yet these conditions often go unrecognized or unacknowledged. In addition, the effects of traumatic brain injury are still poorly understood, leaving a substantial gap in knowledge about the extent of the problem and its effective treatment.

Closing the Gaps

Concern about the invisible wounds of war is increasing, and many efforts to identify and treat those wounds are already under way. Our data show that these mental health and cognitive conditions are widespread; in a cohort of otherwise-healthy, young individuals they represent the primary type of morbidity or illness for this population in the coming years. Unfortunately, only about half of those who need treatment for a mental health condition sought it in the past year. Servicemembers and veterans report several barriers to seeking care, including concerns about negative career repercussions if they seek help for a mental health problem.

What is most worrisome is that these problems are not yet fully understood, particularly TBI, and systems of care are not yet fully available to assist recovery for any of the three conditions. OEF and OIF veterans, depending on their current status, may be eligible to seek care through the Department of Defense or the Department of Veterans Affairs. Many may also seek care in the private sector. Our analyses found that while effective treatments for these conditions exist, they were not being implemented in all sectors that provide healthcare to OEF and OIF veterans. In addition, our survey found that only slightly more than half of those with PTSD and depression who receive treatment get what is defined as minimally adequate care. Our review of the systems of care also found that the use of performance and quality monitoring techniques was lacking in several of the sectors that serve OEF and OIF veterans. Our analyses also concluded that improving access to high quality care can be cost-effective and improve recovery rates. Improving access to high quality care for these veterans, however, will require closing the gaps in access and quality that our study identified.

Looking across the dimensions of our analysis and findings, our report offers four specific recommendations that would improve the understanding and treatment of PTSD, major depression, and TBI among military servicemembers and veterans. Below, I briefly describe each recommendation and then discuss some of the issues that would need to be addressed for its successful implementation. To the greatest extent possible efforts to address these recommendations should be standardized to the greatest extent possible *within DoD* (across Service branches, with appropriate guidance from the Assistant Secretary of Defense for Health Affairs), *within the VA* (across healthcare facilities and Vet Centers), and *across these systems* and extended *into the community-based civilian sector.* These policies and programs must be consistent within and across these sectors in order to have the intended effect on care seeking and improvements in quality of care for our Nation's veterans.

1. **Increase the cadre of providers who are trained and certified to deliver proven (evidence-based) care, so that capacity is adequate for current and future needs.**

There is substantial unmet need for treatment of PTSD and major depression among military servicemembers following deployment. Both DoD and the VA have had difficulty in recruiting and retaining appropriately trained mental health professionals to fill existing *or* new slots. With the possibility of more than 300,000 new cases of mental health conditions among OEF/OIF veterans, a commensurate increase in treatment capacity is needed. Increased numbers of trained and certified professionals are needed to provide high-quality care (evidence-based, safe, patient-centered, efficient, equitable, and timely care) in all sectors, both military and civilian, serving previously deployed personnel. Although the precise increase of newly trained providers is not yet known, it is likely to number in the thousands. These would include providers not just in specialty mental health settings but also embedded in settings such as primary care, where servicemembers are already served. Stakeholders consistently referred to challenges in hiring and retaining trained mental health providers. Determining the exact number of providers will require further analyses of demand projections over time, taking into account the expected length of evidence-based treatment and desired utilization rates. Additional training in evidence-based approaches for trauma will also be required for tens of thousands of existing providers. Moreover, since there is already an increased need for services, the required expansion in trained providers is already several years overdue.

This large-scale training effort necessitates substantial investment immediately. Such investment could be facilitated by several strategies, including the following:

- Adjustment of financial reimbursement for providers to offer appropriate compensation and incentives to attract and retain highly qualified professionals and ensure motivation for delivering quality care.

- Development of a certification process to document the qualifications of providers. To ensure that providers have the skills to implement high-quality therapies, substantial change from the status quo is required. Rather than relying on a system in which any licensed counselor is assumed to have all necessary skills regardless of training, certification should confirm that a provider is trained to use specific evidence-based treatments for specific conditions. Providers would also be required to demonstrate requisite knowledge of unique military culture, military employment, and issues relevant to veterans (gained through their prior training and through the new training/certification our report recommends).
- Expansion of existing training programs for psychiatrists, psychologists, social workers, marriage and family therapists, and other counselors. Programs should include training in specific therapies related to trauma and to military culture.
- Establishment of regional training centers for joint training of DoD, VA, and civilian providers in evidence-based care for PTSD and major depression. The centers should be federally funded. This training could occur in coordination with or through the Department of Health and Human Services. Training should be standardized across training centers to ensure both consistency and increase fidelity in treatment delivery.
- Linkage of certification to training to ensure that providers not only receive required training but also are supervised and monitored to verify that quality standards are met and maintained over time.
- Retraining or expansion of existing providers within DoD and the VA (e.g., military community-service program counselors) to include delivery or support of evidence-based care.
- Evaluation of training efforts as they are rolled out, so that there is an understanding about how much training is needed and of what type, thereby ensuring delivery of effective care.

2. Change policies to encourage active duty personnel and veterans to seek needed care.

Creating an adequate supply of well-trained professionals to provide care is but one facet of ensuring access to care. Strategies must also increase demand for necessary services. Many servicemembers are reluctant to seek services for fear of negative career repercussions. Policies must be changed so that there are no perceived or real adverse career consequences for individuals who seek treatment, except when functional impairment (e.g., poor job performance or being a hazard to oneself or others) compromises fitness for duty. Primarily, such policies will require creating new ways for servicemembers and veterans to obtain treatments that are confidential, to operate in parallel with existing mechanisms for receiving treatment (e.g., command referral, unit-embedded support, or self-referral). We are not suggesting that the confidentiality of treatment should be absolute; both military and civilian treatment providers already have a legal obligation to report to authorities/commanders any patients that represent a threat to themselves or others. However, information about being in treatment is currently available to command staff, even though treatment itself is not a sign of dysfunction or poor job performance and may not have any relationship to deployment eligibility. Providing an option for confidential treatment has the potential to increase total-force readiness by encouraging individuals to seek needed healthcare before problems accrue to a critical level. In this way, mental health treatment would be appropriately used by the military as a tool to avoid or mitigate functional impairment, rather than as evidence of functional impairment. Our analyses suggest that this option would ultimately lead to better force readiness and retention, and thus be a beneficial change for both the organization and the individual. This recommendation would require resolving many practical challenges, but it is vital for addressing the mental health problems of servicemembers who, out of concern for their military careers, are not seeking care. Specific strategies for facilitating care seeking include the following:

- Developing strategies for early identification of problems that can be confidential, so that problems are recognized and care sought early before the problems lead to impairments in daily life, including job function or eligibility for deployment.
- Developing ways for servicemembers to seek mental healthcare voluntarily and off-the-record, including ways to allow servicemembers to seek this care off-base if they prefer and ways to pay for confidential mental healthcare (that is not necessarily tied to an insurance claim from the individual servicemember). Thus, the care would be offered to military personnel without mandating disclo-

sure, unless the servicemember chooses to disclose use of mental healthcare or there is a command-initiated referral to mental healthcare.
- Separating the system for determining deployment eligibility from the mental healthcare system. This may require the development of new ways to determine fitness for duty and eligibility for deployment that do not include information about mental health service use.
- Making the system transparent to servicemembers so that they understand how information about mental health services is and is not used. This may help mitigate servicemembers' concerns about detriments to their careers.

3. Deliver proven, evidence-based care to servicemembers and veterans whenever and wherever services are provided.

Our extensive review of the scientific literature documented that treatments for PTSD and major depression vary substantially in their effectiveness. In addition, the recent report from the Institute of Medicine shows reasonable evidence for treatments for PTSD among military servicemembers and veterans (Institute of Medicine, 2007). Our evaluation shows that the most effective treatments are being delivered in some sectors of the care system for military personnel and veterans, but that gaps remain in system-wide implementation. Delivery of evidence-based care to all veterans with PTSD or major depression would pay for itself, or even save money, by improving productivity and reducing medical and mortality costs within only two years. Providing evidence-based care is not only the humane course of action but also a cost-effective way to retain a ready and healthy military force for the future. Providing one model, the VA is at the forefront of trying to ensure that evidence-based care is delivered to its patient population, but the VA has not yet fully evaluated the success of its efforts across the entire system. Our analysis suggests requiring all providers who treat military personnel to use treatment approaches empirically demonstrated to be effective. This requirement would include uniformed providers in theater and embedded in active duty units; primary and specialty care providers within military and VA healthcare facilities and Vet Centers; and civilian providers. Evidence-based approaches to resilience-building and other programs need to be enforced among informal providers, including promising prevention efforts pre-deployment, noncommissioned officer support models in theater, and the work of chaplains and family support providers. Such programs could bolster resilience before mental health conditions develop, or help to mitigate the long-term consequences of mental health conditions. The goal of this requirement is not to stifle innovation or prevent tailoring of treatments to meet individual needs, but to ensure that individuals who have been diagnosed with PTSD or major depression are provided the most effective evidence based treatment available. Some key transformations may be required to achieve this needed improvement in the quality of care:

- The "black box" of psychotherapy delivered to veterans must be made more transparent, making providers accountable for the services they are providing. Doing so might require that TRICARE and the VA implement billing codes to indicate the specific type of therapy delivered, documentation requirements (i.e., structured medical note-taking that needs to accompany billing), and the like.
- TRICARE and the VA should require that all patients be treated by therapists who are certified to handle the diagnosed disorders of that patient.
- Veterans should be empowered to seek appropriate care by being informed about what types of therapies to expect, the benefits of such therapies, and how to evaluate for themselves whether they are receiving quality care.
- A monitoring system could be used to ensure sustained quality and coordination of care and quality improvement. Transparency, accountability, and training/certification, as described above, would facilitate ongoing monitoring of effectiveness that could inform policymaking and form the basis for focused quality improvement initiatives (e.g., through performance measurement and evaluation). Additionally, linking performance measurements to reimbursement and incentives for providers may also promote delivery of quality care.

4. Invest in research to close information gaps and plan effectively.

In many respects, this study raised more research questions than it provided answers. Better understanding is needed of the full range of problems (emotional, economic, social, health, and other quality-of-life deficits) that confront individuals with post-combat PTSD, major depression, and TBI. This knowledge is required both to enable the healthcare system to respond effectively and to calibrate how disability benefits are ultimately determined. Greater knowledge is needed to understand who is at risk for developing mental health problems and who is most vulnerable to re-

lapse, and how to target treatments for these individuals. Policymakers need to be able to accurately measure the costs and benefits of different treatment options so that fiscally responsible investments in care can be made. Better documentation how these mental health and cognitive conditions affect families of servicemembers and veterans is needed so that appropriate support services can be provided. Sustained research is also needed into the effectiveness of treatments, particularly treatments that can improve the functioning of individuals who do not improve from the current evidence-based therapies. Finally, more research is needed that evaluates the effects of policy changes implemented to address the injuries of OEF/OIF veterans, including how such changes affect the health and well-being of the veterans, the costs to society, and the state of military readiness and effectiveness. Addressing these vital questions will require a substantial, coordinated, and strategic research effort. Several types of studies are needed to address these information gaps. A coordinated Federal research agenda on these issues within the veterans' population is needed. Further, to adequately address knowledge gaps will require funding mechanisms that encourage longer term research that examines a broader set of issues than can be financed within the mandated priorities of an existing funder or agency. Such a research program would likely require funding in excess of that currently devoted to PTSD and TBI research through DoD and the VA, and would extend to the National Institutes of Health, the Substance Abuse and Mental Health Services Administration, the Centers for Disease Control and Prevention, and the Agency for Healthcare Research and Quality. These agencies have limited research activities relevant to military and veteran populations, but these populations have not always been prioritized within their programs.

Initial strategies for implementing this national research agenda include the following:

- Launch a large, longitudinal study on the natural course of these mental health and cognitive conditions among OEF/OIF veterans, including predictors of relapse and recovery. Ideally, such a study would gather data pre-deployment, during deployment, and at multiple time points post-deployment. The study should be designed so that its findings can be generalized to all deployed servicemembers while still facilitating identification of those at highest risk, and it should focus on the causal associations between deployment and mental health conditions. A longitudinal approach would also make it possible to evaluate how use of healthcare services affects symptoms, functioning, and outcomes over time; how TBI and mental health conditions affect physical health, economic productivity, and social functioning; and how these problems affect the spouses and children of servicemembers and veterans. These data would greatly inform how services are arrayed to meet evolving needs within this population of veterans. They would also afford a better understanding of the costs of these conditions and the benefits of treatment so that the Nation can make fiscally responsible investments in treatment and prevention programs. Some ongoing studies are examining these issues (Smith et al., 2008; Vasterling et al., 2006); however, they are primarily designed for different purposes and thus can provide only partial answers.
- Continue to aggressively support research to identify the most effective treatments and approaches, especially for TBI care and rehabilitation. Although many studies are already under way or under review (as a result of the recent congressional mandate for more research on PTSD and TBI), an analysis that identifies priority-research needs within each area could add value to the current programs by informing the overall research agenda and creating new program opportunities in areas in which research may be lacking or needed. More research is also needed to evaluate innovative treatment methods, since not all individuals benefit from the currently available treatments.
- Evaluate new initiatives, policies, and programs. Many new initiatives and programs designed to address psychological and cognitive injuries have been put into place, ranging from screening programs and resiliency training, to use of care managers and recovery coordinators, to implementation of new therapies. Each of these initiatives and programs should be carefully evaluated to ensure that it is effective and is improving over time. Only programs that demonstrate effectiveness should be maintained and disseminated.

Treating the Invisible Wounds of War

Addressing PTSD, depression, and TBI among those who deployed to Afghanistan and Iraq should be a national priority. But it is not an easy undertaking. The prevalence of these injuries is relatively high and may grow as the conflicts continue. And long-term negative consequences are associated with these injuries if they are not

treated with evidence-based, patient-centered, efficient, equitable, and timely care. The systems of care available to address these injuries have been improved significantly, but critical gaps remain.

The Nation must ensure that quality care is available and provided to its military veterans now and in the future. As a group, the veterans returning from Afghanistan and Iraq are predominantly young, healthy, and productive members of society. However, about a third are currently affected by PTSD or depression, or report exposure to a possible TBI while deployed. Whether the TBIs will translate into any lasting impairments is unknown. In the absence of knowing, these injuries cause great concern for servicemembers and their families. These veterans need our attention now, to ensure a successful adjustment post-deployment and a full recovery.

Meeting the goal of providing quality care for these servicemembers will require system-level changes, which means expanding our focus to consider issues not just within DoD and the VA, from which the majority of veterans will receive benefits, but across the overall U.S. healthcare system, where veterans may seek care through other, employer-sponsored health plans and in the public sector (e.g., Medicaid). System-level changes are essential if the Nation is to meet not only its responsibility to recruit, prepare, and sustain a military force but also its responsibility to address Service-connected injuries and disabilities.

Thank you again for the opportunity to testify today and to share the results of our research. Additional information about our study findings and recommendations can be found at http://veterans.rand.org.

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The summary of "Invisible Wounds of War—Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery" can be found at http://www.rand.org/pubs/monographs/2008/RAND_MG720.sum.pdf

The full report of "Invisible Wounds of War—Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery" can be found at http://www.rand.org/pubs/monographs/2008/RAND_MG720.pdf

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Prepared Statement of Hon. Patrick W. Dunne, RADM, USN (Ret.), Acting Under Secretary for Benefits, and Assistant Secretary for Policy and Planning, Veterans Benefits Administration, U.S. Department of Veterans Affairs

Good morning Chairman Filner, Ranking Member Buyer, and Members of the Committee. Thank you for inviting me here to update the Committee on the Department of Veterans Affairs' (VA) progress in implementing the wounded warrior provisions in the National Defense Authorization Act of Fiscal Year 2008. I also would like to thank the Committee for its work in passing this important legislation, and I am pleased to report VA and the Department of Defense (DoD) are making demonstrable progress in implementing the provisions of the Wounded Warrior Act, title XVI of Public Law 110–181, which addresses those matters that require VA and DoD cooperation to improve the care, management and transition of recovering servicemembers. I will describe VA and joint VA/DoD efforts with respect to eight specific sections of the law in which this Committee has particular interest. I am accompanied today by Dr. Madhulika Agarwal, Chief Patient Care Services Officer for the Veterans Health Administration (VHA), and Dr. Paul Tibbits, Deputy Chief Information Officer, Office of Enterprise Development.

Section 1611. Comprehensive policy on improvement to care, management, and transition of recovering servicemembers

Section 1611 requires VA and DoD to:

- Jointly develop and implement a comprehensive policy on improvements to the care, management, and transition of recovering servicemembers.
- Jointly and separately conduct a review of all policies and procedures of VA and DoD that apply to, or shall be covered by, the comprehensive policy described above.

In January 2008, VA awarded a contract for two studies on disability benefits. The first study will examine the nature and feasibility of making "long-term transition payments" to veterans undergoing rehabilitation. The second study concerns appropriate compensation for loss in earnings capacity and information on potential quality of life payments. The report on both study findings is due to VA by August 2008 and will inform VA efforts regarding disability benefits' policies and procedures.

As part of our comprehensive policy, VA is working on two handbooks: one for our Federal Recovery Coordinators, and another for Transition Assistance and Case Management of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) Veterans.

VA, in collaboration with DoD, is developing a Federal Recovery Coordinator (FRC) handbook, which will significantly improve care for veterans and servicemembers. The FRC Handbook describes primary approaches and available resources to Federal Recovery Coordinators (FRCs) and other care managers. This handbook will guide the FRCs in the delivery of all needed programs and services to recovering servicemembers and veterans. In an effort to comply with section 1611 and to maintain the handbook's value, VHA's Care Management and Social Work Service will be responsible for the final review of the FRC Handbook. The target date for completion of this handbook is summer 2008.

VA completed a separate handbook on the Transition Assistance and Case Management of OEF/OIF Veterans on May 31, 2007. VA will continue to review and update the Handbook as necessary.

Another effort currently underway is a charter group comprised of specialty care managers across VA including OEF/OIF teams, spinal cord, blind rehabilitation, mental health, polytrauma and others. This group will be making recommendations for a systemwide approach to care management with emphasis on the coordination between programs. This charter group is expected to submit its report to VA leadership in July 2008. In addition, this charter group will assist in the development of VHA policy for care management.

Section 1612. Medical evaluations and physical disability evaluations of recovering servicemembers

Section 1612 requires:

- The Secretary of Defense shall, no later than July 1, 2008, develop a policy on improvements to the processes, procedures, and standards for the conduct by the military departments of medical evaluations of recovering servicemembers.
- The Secretary of Defense and the Secretary of Veterans Affairs shall, no later than July 1, 2008, develop a policy on improvements to the processes, procedures, and standards for the conduct of physical disability evaluations of recovering servicemembers by the military departments and by the Department of Veterans Affairs.
- The Secretary of Defense and the Secretary of Veterans Affairs shall jointly submit to the appropriate Committees of Congress a report on the feasibility and advisability of consolidating the disability evaluation systems of the military departments and the disability evaluation system of the Department of Veterans Affairs into a single disability evaluation system.

VA and DoD are improving the medical and disability evaluation processes. This was a key recommendation by the President's Commission on Care for America's Returning Wounded Warriors, chaired by former Senator Dole and former Secretary Shalala. We are currently piloting a joint VA/DoD medical examination process for servicemembers from Walter Reed Army Medical Center, National Naval Medical Center at Bethesda, and Malcolm Grow Medical Center. This pilot combines the examination processes into one examination and the evaluation processes into one rating decision for use by both VA and DoD and is currently in operation at the Washington, D.C. VA Medical Center. Military Departments make the Fitness for Duty determination using the above information.

Section 1614. Transition of recovering servicemembers from care and treatment through the Department of Defense for the care, treatment, and rehabilitation through VA

Section 1614 requires VA and DoD to jointly develop and implement processes, procedures, and standards for the transition of recovering servicemembers from DoD to VA.

On August 31, 2007, the Deputy Secretaries of Defense and Veterans Affairs signed a Memorandum of Understanding establishing the Federal Recovery Coordination Program (FRCP) as a joint VA/DoD Program. This program was implemented in January 2008. VA and DoD continue to jointly review and develop this program through recurring meetings and initiatives.

On January 7, 2008, the newly identified FRCs completed a comprehensive VA and DoD training program, which included specialized training on the newly developed Federal Individualized Recovery Plan (FIRP). FRCs are already developing FIRPs for severely injured servicemembers and veterans. As of June 1, 2008, this program has enrolled and is currently serving 80 servicemembers and veterans. Presently, an ongoing, iterative approach to enhance the FIRP is underway to ensure those needs identified by recovering servicemembers and veterans are included as the program matures. Over time, the FRCP will take increasing advantage of on-site mentoring and online delivery of training resources to ensure our Coordinators are employing best practices and are responsive to the needs of America's brave wounded warriors.

Sections 1618, 1621, and 1622 of the 2008 National Defense Authorization Act (NDAA) assign DoD primary responsibility for establishing traumatic brain injury (TBI) and post traumatic stress disorder (PTSD) Centers of Excellence and for establishing a comprehensive plan to deal with TBI and mental health conditions. VA is collaborating with DoD to support these efforts.

Section 1618. Comprehensive plan on prevention, diagnosis, mitigation, treatment, and rehabilitation of, and research on, traumatic brain injury, post traumatic stress disorder, and other mental health conditions in members of the Armed Forces

Section 1618 requires joint planning between VA, DoD, and the military departments regarding the prevention, diagnosis, mitigation, treatment, research, and rehabilitation of TBI, PTSD, and other mental health conditions in members of the Armed Forces. This planning will cover the continuum of care from DoD to VA for those in need of this care.

Section 1618 also specifically requires the Secretary of Defense, with VA consultation, to provide to the Congressional defense Committees a comprehensive plan for DoD programs and activities to prevent, diagnose, mitigate, treat, research, and otherwise respond to TBI, PTSD, and other mental health conditions in members of the Armed Forces. This plan should assess current DoD capabilities, identify gaps in current capabilities, and identify the resources required to address those gaps.

Section 1621. Center of excellence in the prevention, diagnosis, mitigation, treatment, and rehabilitation of traumatic brain injury

Section 1621 requires the Secretary of Defense to establish, within the Department of Defense, a center of excellence in the prevention, diagnosis, mitigation, treatment, and rehabilitation of traumatic brain injury, including mild, moderate and severe TBI. The Secretary of Defense is to maximize collaborative efforts with various private and public entities, including VA, to carry out the responsibilities enumerated in section 1621.

Section 1622. Center of excellence in prevention, diagnosis, mitigation, treatment, and rehabilitation of post traumatic stress disorder and other mental health conditions

Section 1622 requires the Secretary of Defense to establish, within the Department of Defense, a center of excellence in the prevention, diagnosis, mitigation, treatment, and rehabilitation of post traumatic stress disorder, including mild, moderate and severe PTSD. The Secretary of Defense is to maximize collaborative efforts with various private and public entities, including VA, to carry out the responsibilities enumerated in section 1622.

VA and DoD Collaborations on TBI and PTSD

In response to sections, 1618, 1621 and 1622, VA provides expertise and experience to the DoD Center of Excellence for TBI and Psychological Health. VA's contribution will include providing a Deputy and two subject matter experts, one in TBI and one in PTSD. VA's Acting Deputy Director for the Center of Excellence (COE) is already in place.

VA and DoD continue to collaborate on a number of projects related to mental health and TBI. Some examples include:

- VA and DoD are developing revisions to medical coding for TBI for submission to the International Classification of Diseases (ICD) revision 9. These will be submitted in September 2008 and should become effective October 1, 2009.
- VA and DoD are developing clinical practice guidelines for TBI for use by both Departments, to be completed by September 2008.
- VA assigned Polytrauma Rehabilitation Nurse Liaisons at Walter Reed Army Medical Center and the National Naval Medical Center at Bethesda.
- VA establishing a 5-year Assisted Living Pilot project for veterans with TBI for implementation between April 2008 and June 2013.
- Since 2004, VA and DoD have operated a Mental Health Work Group to improve collaboration and clinical coordination between the two Departments. This Group identifies issues and develops policies for improving care for veterans with mental disorders, including support for disseminating evidence-based Cognitive Processing Therapy and Prolonged Exposure Therapy for PTSD and collaborating on PTSD research.
- VA, DoD, and the National Institute of Mental Health began meeting in January 2008 to improve research methodology regarding effective treatments for PTSD. On January 22 and 23, 2008, VA, DoD, and the Department of Health and Human Services convened a group of scientific experts and research administrators to develop methodological guidance for conducting treatment studies for patients with PTSD. This is particularly significant because this will allow our researchers to have identified objectives and measures for any study on PTSD, which will enable them to make comparisons between studies, meaningfully analyze results, and advance our understanding of the field. This group will publish and distribute a report this summer. VA is aggressively pursuing numerous activities to improve treatment for PTSD, including:
  - Interagency coordination with the National Institute of Mental Health, National Institute of Drug Abuse, National Institute on Alcohol Abuse and Alcoholism, and DoD, including the Congressionally Directed Medical Research Program, Defense Centers of Excellence, and the Office of the Assistant Secretary of Defense for Health.
  - Ensuring research priorities are identified and addressed by working with the Federal research funding agencies.
- Recently, a joint VA/National Institutes of Health solicitation for proposals was issued entitled, "Network(s) for Developing PTSD Risk Assessment Tools." Discussions continue about other ways to collaborate to answer important treatment questions. Proposals are due August 2008, and the review will be complete in Fiscal Year 2009. VA and the National Institutes of Health may each fund up to three projects.
- VA is disseminating evidence-based psychotherapies for PTSD, including Cognitive Processing Therapy and Prolonged Exposure Therapy, throughout the VA

system and to DoD clinicians. As of May 28, 2008, 1,168 VA Mental Health providers have been trained in Cognitive Processing Therapy: 839 of these were trained as part of the national rollout, while the others were trained through locally arranged and funded training. In addition, 607 DoD clinicians separately participated in a 2-day training seminar on Cognitive Processing Therapy similar in format to VA's training.

- VA continues to work with identified DoD PTSD experts in an effort to continually improve clinical care and enhance research programs on PTSD. VA will fully collaborate with DoD's Center of Excellence for TBI and Psychological Health on research and educational programs including, but not limited to, projects involving VA's National Center for PTSD.

The Veterans Health Administration's Office of Research and Development has a strong portfolio of neurotrauma research, which included $43 million of support in Fiscal Year 2007. This Office sponsored a State of the Art Conference from April 30 to May 2, 2008, titled, "Research to Improve the Lives of Veterans: Approaches to traumatic brain injury: Screening, Treatment, Management, and Rehabilitation." Representatives from DoD, the National Institutes of Health, the Defense and Veterans Brain Injury Center, and VA attended. VA also maintains a continuing relationship with DoD's research programs, and both Departments work closely on projects funded through DoD's Congressionally Directed Medical Research Program.

Section 1623. Center of Excellence in Prevention, Diagnosis, Mitigation, Treatment, and Rehabilitation of Military Eye Injuries

Section 1623 directs DoD to establish a Center of Excellence in the prevention, diagnosis, treatment, and rehabilitation of eye injuries, and requires VA to collaborate to the maximum extent practicable with the activities of the Center. It further requires a comprehensive plan and strategy for a registry and establishes several conditions the registry must achieve. Finally, section 1623 requires VA and DoD to jointly provide for a cooperative program on traumatic brain injury post traumatic visual syndrome, including vision screening, diagnosis, rehabilitative management, and vision research, including research on prevention and visual dysfunction related to traumatic brain injury.

VA and DoD began working together to address eye injuries before the passage of the NDAA. In November 2007, VA's Director of Ophthalmology began meeting with DoD ophthalmologists and optometrists to discuss approaches for improving care and coordination. In December 2007, VA and DoD participated in a conference on the visual consequences of TBI, which was well attended by representatives from VA Polytrauma Rehabilitation Centers and blind rehabilitation specialists, as well as optometrists and ophthalmologists from both Departments. This conference provided an opportunity to initiate a consensus validation process, which will identify and disseminate the most effective strategies for treatment and services when they are known and to determine where additional research is needed. VA has also assembled teams of specialists, to develop questions for determining evidence-based treatments; we anticipate this process will be complete in the summer.

In February 2008, VA's Directors of Ophthalmology and Optometry met with their DoD counterparts to begin preparing a presentation on the concept of the Center of Excellence; VA and DoD appreciate the importance of the Center and have even agreed to call it a joint Center of Excellence. The following month, VA and DoD began developing an interoperative plan that will help establish the registry and allow a bidirectional flow of information. Throughout the month of April, VA and DoD continued discussing both the Center of Excellence and the registry. In May, VA and DoD workgroup members began reviewing draft documents on Systems Requirements and Concept of Operations for a Military Eye/Vision Injury Registry.

From April 30 to May 2, 2008, VA's Office of Research and Development held a State of the Art meeting in Arlington, Virginia examining the latest advances and research on diagnosis and management of traumatic brain injury and put forth an agenda for research to explore currently unanswered questions. One session of this meeting was devoted to sensory changes (i.e., hearing and vision) and the results of this meeting will soon be published to guide future research.

Any OEF/OIF veteran seen at a VA medical facility is automatically screened for TBI. Veterans for whom the screen is positive are referred for a full, in-depth evaluation. The evaluation process includes a standardized evaluation template of common problems following brain injury. This template includes checks for visual impairment. Our visual treatment specialists conduct full visual examinations including, but not limited to, acuity, full visual field testing, pressures within the eye, and imaging of both the retina and the cornea to assess damage to these structures. In all, this screening process includes a 22-item checklist, including an evaluation for visual impairment and presence of visual symptoms. VHA is currently drafting pol-

icy to initiate eye examinations for active duty servicemembers and veterans who are currently receiving care or who previously received care at a VA Polytrauma Rehabilitation Center.

For veterans and active duty personnel with visual impairment, VA provides comprehensive Vision Rehabilitation services. Currently, 164 Visual Impairment Service Team (VIST) Coordinators provide lifetime case management for all legally blind veterans, and all OEF/OIF patients with visual impairments. Additionally, 38 Blind Rehabilitation Outpatient Specialists (BROS) provide blind rehabilitation training to patients who are unable to travel to a blind center. These Polytrauma Blind Rehabilitation Specialists have certification in two areas, low vision rehabilitation and orientation and mobility training. They work in close collaboration with our neuro-ophthalmologists and low vision optometrists who evaluate, diagnose, and recommend treatment for our patients with visual impairments. Each Polytrauma Rehabilitation Center and Polytrauma Network Site has dedicated funding for a BROS on the Polytrauma team.

Blind Rehabilitation Service involvement often begins while the injured servicemember is still a patient at a military treatment facility. The patient is transferred to a VA Blind Rehabilitation Center as soon as it is medically needed and at the patient's request. There is no waiting time for OEF/OIF veterans for this service.

Section 1635. Fully interoperable electronic personal health information for the Department of Defense and Department of Veterans Affairs

Section 1635 requires VA and DoD to jointly develop and implement electronic health record capabilities that allow for full interoperability of personal healthcare information by September 2009. Section 1635 also requires development of a VA/DoD Inter-Agency Program Office to act as a single point of accountability. This office will oversee the rapid development of capabilities that will allow for full interoperability of personal healthcare information between VA and DoD. The office will then implement those developed capabilities while continuing to accelerate information exchanges.

Fully Interoperable Electronic Personal Health Information

VA and DoD have been, and will continue to be, extremely committed to achieving the goal of health information interoperability. To that end, on April 17, the Departments formed the Interagency Program Office (IPO) and appointed an Acting Director from DoD and an Acting Deputy Director from VA. Shortly thereafter, on April 29, VA and DoD delivered a joint National Defense Authorization Act (NDAA) Implementation Plan to Congress regarding interoperability of electronic health records. The Implementation Plan includes a detailed schedule for developing electronic health record (EHR) requirements, acquisition and testing activities, and implementation milestones for the interoperable EHR. The Implementation Plan also documents the intended course of action for the IPO, and builds upon the already significant success achieved by the Departments toward sharing health information used in the care and treatment of all VA and DoD shared patients. The Implementation Plan also expands our vision for sharing essential viewable data—as depicted in Exhibit 1 and Exhibit 2—by identifying improvements VA and DoD could make to meet the goal of interoperability by September 2009, as well as further improvements to our EHR capabilities in years beyond.

Status of the Interagency Program Office

VA understands the imperative to form a joint IPO and is working closely with our DoD partners to ensure our commitments are fulfilled. Based on our Implementation Plan, the IPO is now implementing other activities and milestones identified in the Implementation Plan, including efforts to secure permanent shared facilities and infrastructure for the IPO. We believe our Implementation Plan is both aggressive and achievable. By October 2008, we anticipate we will complete much of the initial staffing and facilities activities, including appointing a permanent Director and Deputy. While we do not have a permanent IPO facility and staff yet, we continue to make progress toward our goals. As of last week, the IPO facilities and space requirements are being finalized in the format required by the DoD Facilities personnel. In addition, the IPO budget submission is being finalized for inclusion in the Wounded Warrior Program Object Memorandum, which covers FY 2010 to FY 2015.

IPO and Joint Activities Governance

The mission of the IPO will evolve over time. Initially, the IPO will provide a forum for high level coordination and guidance to ensure the Departments achieve full interoperability of the electronic health record data. Moving forward, the IPO will work in parallel with and build upon the successes already achieved by the VA/

DoD Joint Executive Council (JEC) and the Senior Oversight Committee (SOC). This will ensure necessary IPO activities are captured and incorporated into the JEC's Joint Strategic Plan as measurable objectives. Operationally, the IPO will report to, and receive guidance from, the JEC and its cochairs.

Strategy to Achieve an Interoperable Electronic Health Record

VA and DoD are already sharing some viewable health information one-way and some bidirectionally. Some selected data elements can be used as computable data. For example, the Departments now share computable allergy and pharmacy information that checks for drug or allergy interactions using data from each other's systems.

We continue to take steps to expand our bidirectional sharing of viewable data. For example, VA and DoD are already sharing pharmacy, radiology, laboratory, progress notes, problems and procedures, theater data and limited inpatient data in bidirectional viewable format. This month, we will begin to share vital sign information, such as heart rate, temperature and blood pressure readings, to our existing capabilities. We will add history data and questionnaires by September 2008. Additionally, throughout 2008, we are expanding a successful bidirectional image sharing pilot beyond the William Beaumont Army Medical Center and El Paso VA Healthcare System, our initial test sites, and we will continue to expand our image sharing program in 2009. These steps will address the Dole-Shalala Commission's Recommendation to ensure that all essential health information is viewable and sharable by October 2008.

VA and DoD have formed a VA/DoD Joint Clinical Information Board. This Board is essential to our overall acquisition strategy for a fully interoperable EHR and is composed of clinical experts and physicians tasked with prioritizing the data needs of an interoperable EHR. The Board's work includes defining what information must be shared and determining how that information will be shared. The Board will serve as a bridge between our current capabilities in viewable format and our future needs for full interoperability.

The Joint Clinical Information Board has already defined and validated EHR requirements, which should be approved by the end of the month. Following this, and contingent upon funding, the Departments will proceed with acquisition, development, testing, and implementation of interoperable EHR capabilities. VA is confident we will achieve full interoperable electronic health record capability with DoD by September 2009.

Beyond the 2009 Target for Interoperability

VA recognizes "interoperability" does not have a discrete end point, since technologies and standards continue to evolve. VA and DoD remain leading stakeholders in the effort led by Office of the National Coordinator for Health Information Technology and the Department of Health and Human Services. VA and DoD will advance the identification and implementation of standards and will achieve a national framework for sharing health information with other key health providers.

This concludes my prepared statement. I would be pleased to answer any questions you or any of the Members of the Committee may have.

Exhibit 1—Health Data Sharing

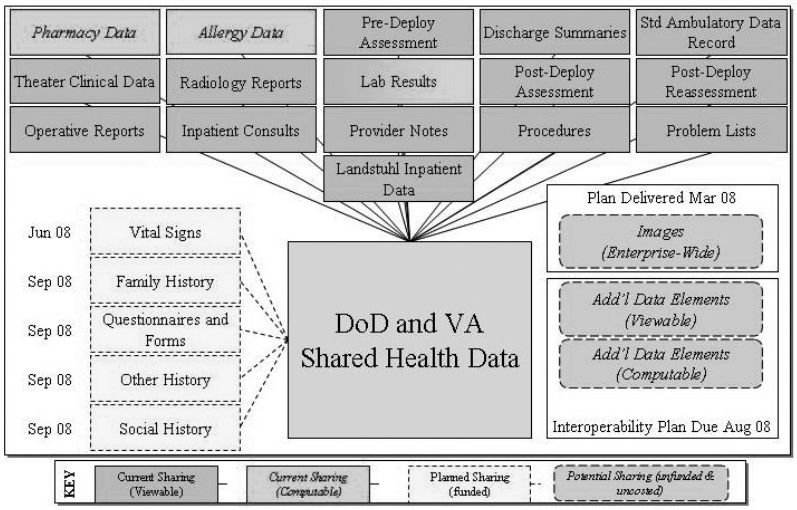
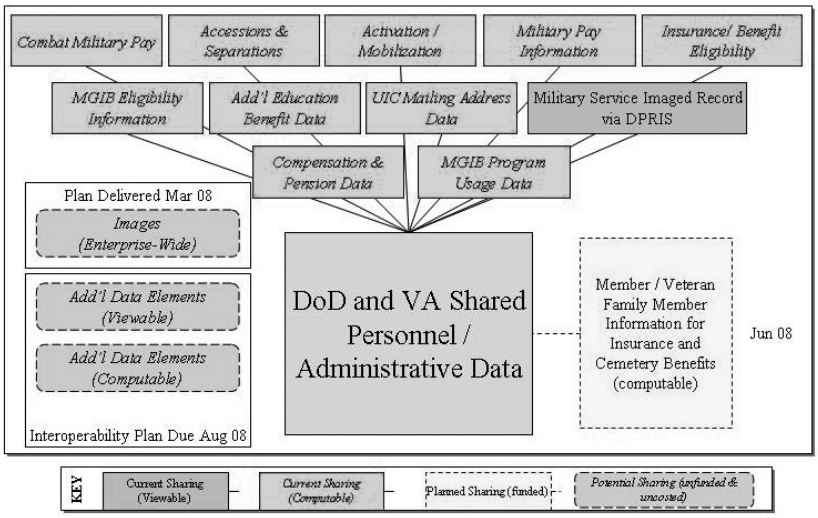


Exhibit 2—Personnel/Administrative Data Sharing



Prepared Statement of Hon. Michael L. Dominguez,
Principal Deputy Under Secretary of Defense for Personnel and Readiness,
U.S. Department of Defense

Chairman Filner, Congressman Buyer, Members of the House Committee on Veterans' Affairs, we appreciate your support of our military and welcome the opportunity to appear here today to discuss improvements implemented and planned for the care, management, and transition of wounded, ill, and injured Servicemembers.

We are pleased to report that while much work remains to be completed, meaningful progress has been made.

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

Many of the specific initiatives we have implemented are described in the remainder of this testimony. These initiatives fit within a context of four fundamental changes we have made over the last year. First, DoD and VA are collaborating on more issues to deliver a world class continuum of care for our wounded, ill and injured. Second, we've completely overhauled our approach to command and control of recovering Servicemembers and now provide for people in long-term outpatient status, the same military leadership structure found in our maneuver units. Third, we have revamped our approach to care and case management and we have fully embraced "customer"-centered processes. Finally, we recognize psychological fitness is as important to the warrior's mission as is physical fitness, and we can both prepare warriors for the stress of combat and help them regain their psychological fitness after enduring the combat experience. The initiatives I will describe to you will help us make permanent these big changes in direction.

The critical clarification and simplification in the fundamental responsibilities of the DoD and VA, however, remain one of the most significant recommendations from the many task forces and commissions yet to be implemented. This shift in the fundamental responsibilities would take the DoD out of the disability rating business. Creating this clear line between the responsibilities of the two Departments, as specifically recommended by the Dole/Shalala Commission, would allow DoD to focus on the fit or unfit determination and streamline the transition from Servicemember to veteran.

Senior Oversight Committee

The driving principle guiding SOC efforts is the establishment of a world-class *continuum of care* that is efficient and effective in meeting the needs of our wounded, ill, and injured Servicemembers, veterans, and their families. The body is composed of senior DoD and VA representatives and cochaired by the Deputy Secretary of Defense and Deputy Secretary of Veterans Affairs. The SOC brings together, on a regular basis, the most senior decisionmakers to ensure wholly informed, timely action.

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

Major Initiatives and Improvements

The two Departments are in the process of implementing recommendations of five major studies, as well as implementing the Wounded Warrior and Veterans titles of the National Defense Authorization Act (NDAA) for Fiscal Year 2008. We continue to implement recommended changes through the use of policy and existing authorities. Described below are some of the major SOC initiatives now underway.

Disability Evaluation System

The fundamental goal is to improve the continuum of care from the point-of-injury to reintegration. To that end, in November of last year, a Disability Evaluation System (DES) Pilot test was implemented for disability cases originating at the three major military medical treatment facilities (MTFs) in the National Capital Region (Walter Reed Army Medical Center, National Naval Medical Center Bethesda, and Malcolm Grow Medical Center). The pilot is a Servicemember-centric initiative designed to eliminate the often-confusing elements of the two current disability processes of our Departments. Key features include both a single medical examination and single disability rating for use by both Departments. A primary goal is to reduce by half the time required to transition a member to veteran status and receipt of VA benefits and compensation. Its specific objectives are to improve timeliness, effectiveness, transparency, and resource utilization by integrating DoD and VA processes, eliminating duplication, and improving case management practices. To

ensure a continuum of care for our wounded, ill, or injured from the care, benefits, and services of DoD to VA's system, the pilot is testing enhanced case management methods and identifying opportunities to improve the flow of information and identification of additional resources to the Servicemember and family.

Psychological Health and TBI

Improvements have been made in addressing issues concerning Psychological Health (PH) and traumatic brain injury (TBI). The focus of these efforts has been to create and ensure a comprehensive, effective, and individually focused program dedicated to prevention, protection, identification, diagnosis, treatment, recovery, and rehabilitation for our Servicemembers and to support their families who deal with these challenging health conditions.

To facilitate the evaluation and management of TBI cases, DoD is about to expand a program to collect baseline neurocognitive information on all Active and Reserve personnel before their deployment to combat theaters. The Army has incorporated neurocognitive assessments as part of its Soldier Readiness Processing in select locations. Select Air Force units are assessed in Kuwait before going into Iraq.

To ensure all Servicemembers are appropriately screened for PTSD, questions have been added to the Post-Deployment Health Assessment and the Post-Deployment Health Reassessments. That same information is shared with VA clinicians for patients who seek care with the VA as part of an effort to facilitate the continuity of care for the veteran or Servicemember.

To ensure appropriate staffing levels for PH, a comprehensive staffing plan for PH services has been developed based on a risk-adjusted, population-based model and the Services have received resources to staff that model. In addition, DoD has partnered with the Department of Health and Human Services (HHS) to provide uniformed Public Health Service (PHS) officers in medical treatment facilities (MTFs) to increase available mental health providers for DoD. The two Departments recently signed a Memorandum of Agreement and have begun hiring PHS officers. DoD program expansions, documented in an updated report to Congress submitted in February 2007, include:

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

In November 2007, the Department of Defense Center of Excellence (DCoE) for Psychological Health and traumatic brain injury was established as a national Center of Excellence for PH and TBI. It includes VA and HHS liaisons, as well as an external advisory panel organized under the Defense Health Board, to provide the best advisors across the country to the military health system. The center facilitates coordination and collaboration for PH and TBI related services among the Military Services and VA, promoting and informing best practice development, research, education, and training. The DCoE is designed to lead clinical efforts toward developing excellence in practice standards, training, outreach, and direct care for our military community with PH and TBI concerns. It also serves as a nexus for research planning and monitoring the research in this important area of knowledge. Functionally, the DCoE is engaged in several focus areas, including:

- Mounting a pro-resiliency campaign (Army's Mental Health Advisory Team V survey shows that stigma and fears of seeking help are being reduced, but more to do);
- Establishing effective outreach and educational initiatives;
- Promulgating a Telehealth network for care, monitoring, support, and follow-up;
- Coordinating an overarching program of research including all DoD assets, academia and industry, focusing on near-term advances in protection, prevention, diagnosis, and treatment;
- Providing training programs aimed at providers, line leaders, families, and community leaders; and

- Designing and planning for the National Intrepid Center of Excellence (anticipated completion in fall 2009), a building that will be located on the Bethesda campus adjacent to the new Walter Reed National Military Medical Center.

The FY 2007 Supplemental Appropriation provided DoD $900 million in additional funds to make improvements to our PH and TBI systems of care and research. These funds are important to support, expand, improve, and transform our system and are being used to leverage change through optimal planning and execution. The funds have been allocated and distributed in three phases to the Services for execution based on an overall strategic plan created by representatives from DoD and the Services with VA input.

The Department is in close collaboration with VA to plan for and establish a center of excellence that would build and operate the Military Eye Injury Registry. Planning for the registry is underway by working groups comprised of military and VA subject matter experts. These specialty leaders recognize the value and contribution such a registry will make toward improved care and rehabilitation of their patients. Our initial plan will co-locate the Eye Center of Excellence with the Defense Center of Excellence for TBI/PTSD at Bethesda with treatment facilities at Brooke Army Medical Center, Madigan, Balboa and Bethesda.

Care Management

To improve the continuity of care management and transitions across our two Departments, new programs and processes are being put into place like the Federal Recovery Coordination Program, which will identify and integrate care and services for the severely wounded, ill, and injured Servicemembers, veterans, and their families through the phases of recovery, rehabilitation, and reintegration.

This Dole/Shalala recommended program will be linked to additional efforts in response to the National Defense Authorization Act 2008 regarding recovering Servicemembers. Progress is being made toward an integrated continuity of quality care and service delivery through inter-Service, interagency, intergovernmental, public, and private collaboration. Our joint DoD and VA efforts include important reforms such as uniform training for medical and non-medical care/case managers and recovery coordinators, and a single tracking system and a comprehensive recovery plan for the seriously and severely injured or ill.

The joint Program, coordinated by VA, trains and assigns Federal Recovery Coordinators (FRCs) to work closely with medical and non-medical care/case managers in the care, management, and transition of severely ill, and injured Servicemembers, veterans, and their families. The Program will develop and implement two significant web-based tools: including a Servicemember/veteran/family focused Federal Individualized Recovery Plan (FIRP) to identify goals and needs across time and a national Resource Directory for use by all care providers and the general public to identify and deliver the full range of medical and non-medical services and resources identified in the plan.

The Departments have:

- Hired, trained, and placed eight FRCs at three of our busiest medical treatment facilities as recommended by the Dole/Shalala Commission. Currently, there are four FRCs located at Walter Reed Army Medical Center, National Naval Medical Center in Bethesda, and Brooke Army Medical Center. As of July 1, there will be an additional FRC at Brooke Army Medical Center and National Naval Medical Center, and one FRC at Naval Medical Center Balboa.
- Developed a prototype of the Federal Individual Recovery Plan (FIRP) as recommended by the Dole/Shalala Commission; and
- Produced educational/informational materials for FRCs, Multi-Disciplinary Teams, and Servicemembers, veterans, families, and caregivers.

We have also:

- Developed a prototype of the National Resource Directory in partnership with Federal, State, and local governments and the private/voluntary sector, with public launch this summer;
- Produced a Family Handbook in partnership with relevant DoD/VA offices; and
- Identified a process to review workloads for Medical Case/Care Managers, Non-medical Care Managers, and Recovery Coordinators.

Data Sharing Between Defense and Veterans Affairs

Steps have been taken to improve the sharing of medical information between our Departments to develop a seamless health information system. Our long-term goal is to ensure appropriate beneficiary and medical information is visible, accessible, and understandable through secure and interoperable information technology. The

SOC has approved initiatives to ensure health and administrative data are made available and are viewable by both agencies. DoD and VA are securely sharing more electronic health information than at any time in the past. In addition to the outpatient prescription data, outpatient and inpatient laboratory and radiology reports, allergy information, access to provider/clinical notes, problem lists, and theater health data have recently been added. In December 2007, DoD began making inpatient discharge summary data from Landstuhl Regional Medical Center immediately available to VA facilities. The plan for information technology support of a FIRP for use by Federal Recovery Coordinators was approved in November 2007. A single Web portal to support the needs of wounded, ill, or injured Servicemembers, commonly referred to as the eBenefits Web Portal, is planned based on VA's successful My Health*e*Vet website. The Veterans Tracking Application (VTA) is a data management tool utilized by both Veterans Benefits Administration and Veterans Health Administration staff to track very severely injured veterans, and assist in case management and prioritizing care for all Operation Enduring Freedom and Operation Iraqi Freedom veterans.

Medical Facilities Inspection Standards

Progress has been made to ensure our wounded warriors are properly housed in appropriate facilities. Using the comprehensive Inspection Standards, all 475 military MTFs were inspected and found to be in compliance although deferred maintenance and upgrades were cited. The Services are inspecting MTFs on a semi-annual basis to ensure continued compliance, identify maintenance requirements, and sustain a world-class environment for medical care. In the event a deficiency is identified, the commander of the facility will take immediate action to mitigate the condition. The commander will submit to the Secretary of the Military Department a detailed plan to correct the deficiency, and the commander will periodically re-inspect the facility until the deficiency is corrected. All housing units for our wounded warriors have also been inspected and determined to meet applicable quality standards. The Services recognize that existing temporary medical hold housing is an interim solution and have submitted FY 2008 military construction budgets to start building appropriate housing complexes adjacent to MTFs. They will also implement periodic and comprehensive follow-up programs using surveys, interviews, focus groups, and town-hall meetings to learn how to improve housing and related amenities and services.

Transition Issues/Pay and Benefits

Servicemembers transitioning from military to civilian life can benefit from collaborative efforts between DoD and the Department of Labor (DoL). The DoD Pre-Separation Guide, which informs Servicemembers and their families of available transition assistance services and benefits, is now available at http://www.TurboTAP.org and was developed in collaboration with DoL. Additionally, DoD and DoL are working to assure needed employment services are provided to Servicemembers. DoL has been an active participant in many of the SOC activities.

DoD and VA have shared information concerning the traumatic injury protection benefit under Servicemembers' Group Life Insurance (TSGLI) and implemented plans replicating best practices. The Army is now placing subject-matter experts at MTFs to provide direct support of the TSGLI application process and improve processing time and TSGLI payment rates. Upon receipt of a completed claim form, the claim is adjudicated by the Services and paid within 3 weeks. VA's insurance provider's payment time, upon receipt of a certified claim from the branch of Service, averages between 2 and 4 days.

DoD has been successful using Congressional authority from the NDAA allowing continuation of deployment related pays for those recovering in the hospital after injury or illness in the combat zone. This ensures no reduction in deployment pays while the Servicemember is recovering.

Wounded Warrior Resource Center

In accordance with the FY 2008 NDAA, we are establishing a Wounded Warrior Resource Center to provide wounded warriors, their families, and their primary caregivers with a single point of contact for assistance through a 24-hour/7 day a week, 1–800 number.

The Wounded Warrior Resource Center will operate under the universally known Military OneSource call center and take hotline calls, track all calls and responses, refer the issue for remediation and follow up with the caller. To ensure the calls are handled appropriately, we are developing a comprehensive contact list for health issues, facility concerns and benefit information. We have established a working group with the Services to integrate the comprehensive programs and services provided by the individual Services and FRCs.

Conclusion

The SOC and its OIPT continue to work diligently to resolve the many outstanding issues while aggressively implementing Dole/Shalala, the NDAA, and the various aforementioned task forces and commissions. These efforts will expand in the future to include the recommendations of the DoD Inspector General's Report on DoD/VA Interagency Care Transition, which is due shortly.

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

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

- Increased VA and DoD collaboration on more projects related to improved care coordination for returning veterans and Servicemembers.
- Identified new approaches to support outpatients (e.g., Warrior Transition Units and Americans with Disabilities Act compliant barracks).
- Developed new approaches to address PH and TBI.Revolutionized customer care.

We envision five major changes that need to be addressed:

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

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

Chairman Filner, Congressman Buyer, and Members of the Committee, thank you again for your generous support of our wounded, ill, and injured Servicemembers, veterans, and their families. I look forward to your questions.

Statement of Kerry Baker,
Associate National Legislative Director, Disabled American Veterans

Mr. Chairman and Members of the Committee:

On behalf of the 1.3 million members of the Disabled American Veterans (DAV), I am honored to present this testimony to the Committee to address the implementation of the wounded warrior provisions of the National Defense Authorization Act of 2008 (NDAA). In accordance with our congressional charter, the DAV's mission is to "advance the interests, and work for the betterment, of all wounded, injured, and disabled American veterans."

The Department of Defense (DoD) Knowingly Violated the Law and Ignored the Intent of Congress When it Implemented section 1646 of the NDAA.

The NDAA made several positive changes as part of an enhanced wounded warrior benefits plan—changes that in many respects, were nothing short of groundbreaking. The DAV applauds Congress for achieving these milestones on behalf of all service men and women injured in the line of duty.

One of those changes was improvements in disability severance pay from the military, which previously was based on a maximum of 12 years of military service, and is now based on a maximum 19 years of military service. This change alone will make a remarkable difference in the lives of career service men and women who received disability separations from service prior to reaching full retirement tenure.

The above change would be pointless if an applicable servicemember was forced to pay back that severance pay from any future VA compensation, which has always been required until passage of the NDAA. Disability severance pay is based on past achievements in a servicemember's career, *i.e.,* rank and number of service years completed. Alternatively, VA disability compensation is paid based on *future* loss of earnings potential. It is obvious the two are designated for different purposes. As a consequence, a servicemember should not be forced to return his or her severance pay to the DoD via his or her VA disability compensation.

Congress understood this, and in addition to increasing the amount of severance pay, section 1646 of the NDAA ("enhancement of disability severance pay for members of the armed forces") (emphasis omitted) eliminated the offset of VA disability compensation by the amount of any severance pay received by certain servicemembers, but not all. The pertinent language in sec. 1646 reads:

> No deduction may be made . . . in the case of disability severance pay received by a member for a disability incurred in line of duty in a combat zone or incurred during performance of duty in combat-related operations as designated by the Secretary of Defense.

National Defense Authorization Act of 2008, Pub. L. No. 110–181, § 1646(b), 122 Stat 3 (codified at 10 U.S.C. § 1212).

A veteran must satisfy one of two criteria in order to be exempt from the offset of disability compensation. The first criterion—"in line of duty in a combat zone"—is self-explanatory and not in dispute. The latter criterion requires a deeper understanding of the term "combat-related."

The logical explanation is that "combat-related" disabilities are incurred as a result of "combat-related" operations. The term "combat-related disability" is defined by the NDAA in, *inter alia,* section 1632 as "having the meaning given that term in 10 U.S.C.A. § 1413a" ("Combat-related special compensation"). *Id.* at sec. 1632. Section 1413a defines the phrase as follows:

> *Combat-related disability.*—In this section, the term "combat-related disability" means a disability that is compensable under the laws administered by the Secretary of Veterans Affairs and that—
>
> (1) is attributable to an injury for which the member was awarded the Purple Heart; or
>
> (2) was incurred (as determined under criteria prescribed by the Secretary of Defense)—
>
> (A) as a direct result of armed conflict;
>
> (B) while engaged in hazardous service;
>
> (C) in the performance of duty under conditions simulating war; or
>
> (D) through an instrumentality of war.
>
> 10 U.S.C.A. 1413a(e) (West 2002 & Supp 2007).

The Department of Defense (DoD) has defined the foregoing terms in DoD Instruction (DoDI) 1332.38, as follows:

> E3.P5.2.2. *Combat-related.* This standard covers those injuries and diseases attributable to the special dangers associated with armed conflict or the preparation or training for armed conflict. A physical disability shall be considered combat-related if it makes the member unfit or contributes to unfitness and was incurred under any of the circumstances listed in paragraphs E3.P5.2.2.1. through E3.P5.2.2.4., below.
>
> E3.P5.2.2.1. As a direct result of *armed conflict.* The criteria are the same as in paragraph E3.P5.1.2. [Paragraph E3.P5.1.2 defines armed conflict as follows:]
>
> > E3.P5.1.2. *Armed conflict.* [] The physical disability is a disease or injury incurred in the line of duty as a direct result of armed conflict. The fact that a member may have incurred a disability during a period of war or in an area of armed conflict, or while participating in combat operations is not sufficient to support this finding. There must be a definite causal relationship between the armed conflict and the resulting unfitting disability.
> >
> > E3.P5.1.2.1. Armed conflict includes a war, expedition, occupation of an area or territory, battle, skirmish, raid, invasion, rebellion, insurrection, guerrilla action, riot, or any other action in which Servicemembers are engaged with a hostile or belligerent nation, faction, force, or terrorists.
> >
> > E3.P5.1.2.2. Armed conflict may also include such situations as incidents involving a member while interned as a prisoner of war or while

detained against his or her will in custody of a hostile or belligerent force or while escaping or attempting to escape from such confinement, prisoner of war, or detained status.

E3.P5.2.2.2. *While engaged in hazardous service.* Such service includes, but is not limited to, aerial flight duty, parachute duty, demolition duty, experimental stress duty, and diving duty.

E3.P5.2.2.3. *Under conditions simulating war.* In general, this covers disabilities resulting from military training, such as war games, practice alerts, tactical exercises, airborne operations, leadership reaction courses; grenade and live fire weapons practice; bayonet training; hand-to-hand combat training; rappelling, and negotiation of combat confidence and obstacle courses. It does not include physical training activities, such as calisthenics and jogging or formation running and supervised sports.

E3.P5.2.2.4. *Caused by an instrumentality of war.* Incurrence during a period of war is not required. A favorable determination is made if the disability was incurred during any period of service as a result of such diverse causes as wounds caused by a military weapon, accidents involving a military combat vehicle, injury, or sickness caused by fumes, gases, or explosion of military ordnance, vehicles, or material. However, there must be a direct causal relationship between the instrumentality of war and the disability. For example, an injury resulting from a Servicemember falling on the deck of a ship while participating in a sports activity would not normally be considered an injury caused by an instrumentality of war (the ship) since the sports activity and not the ship caused the fall. The exception occurs if the operation of the ship caused the fall.

Based on all of the above, it is clear that when a veteran receives a medical discharge based on a disability resulting from any of the above circumstances then such disability constitutes a "combat-related disability" in accordance with section 1413a of title 10, United States Code, and DoD instructions. (*See also* 26 U.S.C. § 104). Therefore, under the plain language of section 1646 of the NDAA and title 10, United States Code, such a veteran is not subject to an offset of VA disability compensation by the amount of any military severance pay.

However, the Under Secretary of Defense for Personnel and Readiness, ("Secretary"), has issued a "directive-type memorandum" dated March 13, 2008, implementing, inter alia, the foregoing provisions of the NDAA. In that memorandum, the Secretary directed that determinations of whether a servicemember's disability was "incurred during performance of duty in combat-related operations" is to be made consistent only with the criteria set forth in DoDI 1332.38 paragraph E3.P5.1.2., which defines *"armed conflict."*

The effect of the Memorandum is to impose an express limitation on NDAA § 1646. Under the Memorandum, the definition of "combat-related operations" excludes hazardous service, duty under conditions simulating war, or disabilities incurred through an instrumentality of war unless the servicemember was engaged in armed conflict. The Memorandum defines "combat-related operations" even more narrowly than "in a combat zone." The interpretation renders the alternative basis upon which Congress intended that a disabled former member should be exempt from the offset of VA disability compensation under the NDAA, "or incurred during performance of duty in combat-related operations as designated by the Secretary of Defense," superfluous. This action has intentionally read *"hazardous service," "conditions simulating war,"* and *"instrumentality of war"* completely out of the law.

In doing so, the Secretary has narrowed the scope of the statute contrary to the intent of Congress, ignored the plain language of the NDAA and associated statutes, and otherwise violated the law. The Secretary's action has rendered it far more difficult for veterans to benefit from this provision of the NDAA than as otherwise intended. It is unlawful to read such a limitation into a statute, thereby narrowing its scope and construing it against veterans. *See Brown v. Gardner,* 513 U.S. 115, 117–18 (1994); *Miller v. United States,* 294 U.S. 435, 439–40 (1935) (regulation or procedural rule that is inconsistent with the authorizing statute constitutes impermissible legislation). Congress must not let the Secretary's action stand.

Essentially, the Secretary has drawn a distinction between "combat-related *operations"* and "combat-related *disability."* Such distinction lies not with the words *"operation"* and *"disability,"* but rather with the established and well-defined meaning of *"combat-related."* We do not view this as an oversight—we view this as an intentional effort to conserve monetary resources at the expense of disabled veterans.

Countless thousands of veterans will be detrimentally affected by this unforgivable situation. Congress must also understand that once this injustice is perpetrated, reconciliation will be nearly impossible. There is currently no procedure

in place for unsuspecting servicemembers that have been and will be harmed by this unlawful and uncaring act that could rectify the injustice and correct their records.

The ultimate result of this interpretation of NDAA § 1646 is that thousands of servicemembers who Congress intended to exempt from offset of their VA disability compensation will be denied that protection. Those who become disabled while performing hazardous service or training for combat will have their VA disability compensation reduced contrary to the intent of Congress.

The foregoing action by the Secretary forces one to question his true resolve to care for those he sends into battle, or orders to train for battle. This same Secretary has stood before this Committee and declared that no unlawful decision that may have deprived servicemembers injured in the line of duty was ever made based on an intention to save monetary resources. If that is the case in this circumstance, then the DAV must ask one simple question. Why? We can think of no other conceivable reason for the Secretary to circumvent the law as he has done here. The offset discussed herein is governed by title 10, United States Code, not title 38, meaning it is a DoD offset, not a VA offset. To answer the question of "why," Congress need only determine in whose budget the disability compensation is deposited once offset by VA. We believe the answer to that question is the DoD budget.

In light of the above, Congress must act to prevent the Secretary from continuing such blatant disregard for the law and for the livelihood and welfare of those that stand up to defend this Country.

Mr. Chairman, this concludes my testimony on behalf of DAV. We hope you will consider our recommendations.

U.S. Department of Defense
Under Secretary of Defense
Personnel and Readiness
Washington, DC
June 9, 2008

The Honorable Ike Skelton
Chairman
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

Section 597 of the National Defense Authorization Act for Fiscal Year 2008 requested that the Secretary of Defense provide a report on administrative separations based on personality disorder.

The Department appreciates the opportunity to provide Congress with information regarding the administrative separation of Servicemembers based on personality disorder who had deployed in support of the Global War on Terror (GWOT) since October 2001. The data requested are enclosed. Analysis of separation data showed that only *3.4K (15* percent) of the 22.6K servicemembers with personality disorder coded separations had deployed in support of GWOT. Additionally, data indicate that the majority, 19.2K (85 percent), of the 22.6K Servicemembers with personality disorder coded separations had two or fewer years in the service. Nevertheless, the Department shares Congress' concern regarding the use of personality disorder as the basis for administratively separating Servicemembers who deployed in support of GWOT and who may have been more appropriately processed for disability.

To address this concern, the Department has been working over the past few months to implement changes that add additional rigor to the personality disorder separation policy. The new policy guidance, expected to be released later this month, will include allowing personality disorder separations only if diagnosed by a psychiatrist or PhD-level psychologist. The proposed change would require members who are being considered for administrative discharge based on personality disorder who had deployed or are currently deployed to designated imminent danger pay areas to have their personality disorder diagnosis corroborated by a peer, psychiatrist or PhD-level psychologist who must address post traumatic stress disorder or other mental illness comorbidity in their diagnosis. An additional change under consideration would require The Surgeon General of the Military Department concerned to review and endorse the personality disorder case for this class of Servicemember.

Finally, each Military Department has well established processes and procedures for former Servicemembers who believe that their discharges were incorrectly characterized or processed to request adjudication through their respective Military Department's Discharge Review Board. The Department encourages former Servicemembers to utilize these processes and procedures to request review of their specific cases.

A similar letter is being sent to the Chairman and Ranking Member of the House Armed Services Committee.

Sincerely,

David S.C. Chu
Under Secretary of Defense
Personnel and Readiness

Enclosure:
As stated
cc: The Honorable Duncan Hunter Ranking Member

REPORT TO CONGRESS ON
ADMINISTRATIVE SEPARATIONS BASED ON PERSONALITY DISORDER

Fiscal Years 2002 thru 2007

Prepared By:
Office of the Under Secretary of Defense
Personnel and Readiness

The Department appreciates the opportunity to provide Congress with information regarding the administrative separation of Servicemembers on the basis of personality disorder for those members who had deployed in support of the Global War on Terror from October 2001 through 2007. To meet the specific requirements of Section 597 of the National Defense Authorization Act (NDAA) for Fiscal Year 2008 (FY08), the Secretary of Defense provides the following review and advice on administrative separations based on personality disorder.

FY08 NDAA, Section 597, Report Requirements

Section 597 of the FY08 NDAA requires:

(a) SECRETARY OF DEFENSE REPORT ON ADMINISTRATIVE SEPARATIONS BASED ON PERSONALITY DISORDER.—

(1) REPORT REQUIRED.—Not later than April 1, 2008, the Secretary of Defense shall submit to the Committees on Armed Services of the Senate and the House of Representatives a report on all cases of administrative separation from the Armed Forces of covered members of the Armed Forces on the basis of a personality disorder.

(2) ELEMENTS.—The report required by paragraph(1) shall include the following:

(A) A statement of the total number of cases, by Armed Force, in which covered members of the Armed Forces have been separated from the Armed Forces on the basis of a personality disorder, and an identification of the various forms of personality disorder forming the basis for such separations.

(B) A statement of the total number of cases, by Armed Force, in which covered members of the Armed Forces who have served in Iraq and Afghanistan since October 2001 have been separated from the Armed Forces on the basis of a personality disorder, and the identification of the various forms of personality disorder forming the basis for such separations.

(C) A summary of the policies, by Armed Force, controlling administrative separations of members of the Armed Forces based on personality disorder, and an evaluation of the adequacy of such policies for ensuring that covered members of the Armed Forces who may be eligible for disability evaluation due to mental health conditions are not separated from the Armed Forces on the basis of a personality disorder.

(D) A discussion of measures being implemented to ensure that members of the Armed Forces who should be evaluated for disability separation or retirement due to mental health conditions are not processed for separation from the Armed Forces on the basis of a personality disorder, and recommendations regarding how members of the Armed Forces who may have been so separated

from the Armed Forces should be provided with expedited review by the applicable board for the correction of military records.

(b) COMPTROLLER GENERAL REPORT ON POLICIES ON ADMINISTRATIVE SEPARATION BASED ON PERSONALITY DISORDER.—

(1) REPORT REQUIRED.—Not later than June 1, 2008; the Comptroller General shall submit to Congress a report evaluating the policies and procedures of the Department of Defense and of the military departments relating to the separation of members of the Armed Forces based on a personality disorder.

(2) ELEMENTS.—The report required by paragraph (1) shall—

(A) include an audit of a sampling of cases to determine the validity and clinical efficacy of the policies and procedures referred to in paragraph (1) and the extent, if any, of the divergence between the terms of such policies and procedures and the implementation of such policies and procedures; and

(B) include a determination by the Comptroller General of whether, and to what extent, the policies and procedures referred to in paragraph (1)—

(i) deviate from standard clinical diagnostic practices and current clinical standards; and

(ii) provide adequate safeguards aimed at ensuring that members of the Armed Forces who suffer from mental health conditions (including depression, post traumatic stress disorder, or traumatic brain injury) resulting from service in a combat zone are not separated from the Armed Forces on the basis of a personality disorder.

(3) ALTERNATIVE SUBMISSION METHOD.—In lieu of submitting a separate report under this subsection, the Comptroller may include the evaluation, audit and determination required by this subsection as part of the study of mental health services required by section 723 of the Ronald W. Reagan National H.R. 4986—139 Defense Authorization Act of 2005 (Public Law 108–375; 118 Stat. 1989).

(c) COVERED MEMBER OF THE ARMED FORCES DEFINED.—In this section, the term "covered member of the Armed Forces" includes the following:

(1) Any member of a regular component of the Armed Forces who has served in Iraq or Afghanistan since October 2001.

(2) Any member of the Selected Reserve of the Ready Reserve of the Armed Forces who served on active duty in Iraq or Afghanistan since October 2001.

Data on Personality Disorder Administrative Separations

(A) A statement of the total number of cases, by Armed Force, in which covered members of the Armed Forces have been separated from the Armed Forces on the basis of a personality disorder, and an identification of the various forms of personality disorder forming the basis for such separations.

Paragraph (a)(2)(A), above, of section 597 of the FY08 NDAA specifically asks for, "A statement of the total number of cases, by Armed Force, in which *covered members of the Armed Forces* have been separated from the Armed Forces on the basis of a personality disorder, and an identification of the various forms of personality disorder forming the basis for such separations." Paragraph (c) of section 597 defines "covered members" as Servicemembers who served on active duty in Iraq or Afghanistan since October 2001. Based on the definition of "covered members" the information requested by paragraph (a)(2)(A) is the same as what is requested by paragraph (a)(2)(B), which specifically asks for:

(B) A statement of the total number of cases, by Armed Force, in which covered members of the Armed Forces who have served in Iraq and Afghanistan since October 2001 have been separated from the Armed Forces on the basis of a personality disorder, and the identification of the various forms of personality disorder forming the basis for such separations.

The Department assumes that Paragraph (a)(2)(A) was intended to request the total number of ALL cases, by Armed Force, in which members of the Armed Forces have been separated on the basis of a personality disorder since October 2001 (beginning of Fiscal Year 2002), and an identification of the various forms of personality disorder forming the basis for such separations. Given this assumption the Departments submits the information in Table 1 to meet the requirements of paragraph (a)(2)(A) of section 597 of the FYO8 NDAA. The data include the total number of separations coded for personality disorder, by Armed Force, from fiscal year 2002, which began October 2001, through fiscal year 2007.

Table 1—Number of Administrative Separations Coded as Based on Personality Disorder from Fiscal Year 2002–2007.

Armed Forces	Number of Personality Disorder Separation Cases
Army	5,652
Navy	7,554
Marine Corps	3,527
Air Force	5,923
Total	**22,656**

Table 2 lists the various forms of personality disorder forming the basis for the personality disorder coded separations of Servicemembers from fiscal years 2002 through 2007.

Table 2—The Various Forms of Personality Disorder Forming the Basis for the Personality Disorder Coded Separation of Servicemembers from Fiscal Year 2002–2007.

Paranoid Personality Disorder	Explosive Personality Disorder
Affective Personality Disorder, Unspecified	Obsessive-Compulsive Personality Disorder
Chronic, Hypomanic Personality Disorder	Histrionic Personality Disorder, Unspecified
Chronic Depressive Personality Disorder	Unspecified Personality Disorder
Cyclothymic Disorder	Other Histrionic Personality Disorder
Schizoid Personality Disorder, Unspecified	Dependent Personality Disorder
Introverted Personality	Antisocial Personality Disorder
Schizotypal Personality Disorder	Narcissistic Personality Disorder
Avoidant Personality Disorder	Borderline Personality Disorder
Passive-Aggressive Personality	Other Personality Disorders
Chronic Factitious Illness with Physical Symptoms	

Paragraph (a)(2)(B) of section 597 of the FYO8 NDAA specifically asks for:

> *(B) A statement of the total number of cases, by Armed Force, in which covered members of the Armed Forces who have served in Iraq and Afghanistan since October 2001 have been sepatated from the Armed Forces on the basis of a personality disorder, and the identification of the various forms of personality disorder forming the basis for such separations.*

The Department submits the information in Table 3 to meet the requirements of Paragraph (a)(2)(B). The data include the total number of separations coded for personality disorder, by Armed Force, of Servicemembers who deployed in support of the Global War on Terror during fiscal years 2002 through 2007. The Department included all Servicemembers who had deployed in support of the Global War on Terror as opposed to only those who had deployed to Afghanistan and Iraq in an attempt to identify a more comprehensive class of Servicemembers for Congressional consideration.

Table 3—Number of Administrative Separations Coded as Based on Personality Disorder of Servicemembers Who Deployed in Support of the Global War on Terror for Some Period of Time Between 2002–2007.

Armed Forces	Number of Personality Disorder Separation Cases
Army	1,480
Navy	1,155
Marine Corps	455
Air Force	282
Total	**3,372**

The various forms of personality disorder forming the basis of personality disorder coded separations of Servicemembers who deploy in support of the Global War on Terror are the same as those previously listed in Table 2.

Summary of Policy Controlling Personality Disorder Administrative Separations

(C) A summary of the policies by Armed Force, controlling administrative separations of members of the Armed Forces based on personality disorder, and an evaluation of the adequacy of such policies for ensuring that coveted members of the Armed Forces who may be eligible for disability evaluation due to mental health conditions are not separated from the Armed Forces on the basis of a personality disorder.

Department Policy governing the administrative separation of Servicemembers for personality disorder is contained in DoD Directive, 1332.14, *Enlisted Administrative Separations*. The policy states that the Secretary concerned may authorize separation on the basis of other designated physical or mental conditions (may include, but not limited to, personality disorder, air sickness, and seasickness) not amounting to disability, that potentially interfere with assignment to or performance of duty under the separation guidance set forth in the directive.

Specific guidance on personality disorder separations is contained in DoD Directive 1332.14, Section E3.A1.1.304.8, *Other designated physical or mental conditions.* Separation processing may not be initiated on the basis of personality disorder "until the Servicemember concerned has been counseled formally concerning deficiencies and has been afforded an opportunity to overcome those deficiencies as reflected in appropriate counseling or personnel records." Additionally, "separation on the basis of personality disorder is authorized only if a diagnosis by a psychiatrist or psychologist, completed in accordance with procedures established by the Military Department concerned, concludes that the disorder is so severe that the member's ability to function effectively in the military environment is significantly impaired. Furthermore, Department policy states that separation for personality disorder is not appropriate when separation is warranted for any of the following: expiration of Service obligation; selected changes in Service obligations; disability; defective enlistments and inductions; entry-level performance and conduct; unsatisfactory performance; homosexual conduct; drug abuse rehabilitation failure; alcohol abuse rehabilitation failure misconduct; separation in lieu of trial by court martial; security; unsatisfactory participation in the ready reserve or reasons estab1ished by the Military Departments. Finally, Department policy requites the written notification to Servicemembers prior to being involuntarily separated on the basis of personality disorder.

The written notification to Servicemembers dictated by Department policy in DoD Directive, 1332.14, Section E3.A3.1.2, *Notification Procedure,* requires the Servicemember to be notified, in writing, of:

- The basis of the proposed separation, including the circumstances upon which the action is based and a reference to the applicable provision of the Military Department's regulation.
- Whether the proposed separation could result in discharge, release from active duty to a Reserve component, transfer from the Selected Reserve to the Individual Ready Reserve, release from custody or control of the Military Services, or other form of separation.

- The least favorable characterization of service or description of separation authorized for the proposed separation.
- The right to obtain copies of documents that will be forwarded to the Separation Authority supporting the basis of the proposed separation.
- The respondent's right to submit statements.
- The respondent's right to consult with counsel qualified under Article 27(b)(1) of the Uniform Code of Military Justice. Non-lawyer counsel may be appointed when the member is deployed and aboard a vessel or in similar circumstances of separation from sufficient judge advocate resources as determined under standards and procedures specified by the Secretary of the Military Department concerned. The respondent also may consult with civilian counsel at the member's own expense.
- If the respondent has 6 or more years of total active and Reserve military service, the right to request an Administrative Board.
- The right to waive the preceding four rights (right to obtain copies of documents; right to submit statements; right to consult with qualified counsel; and, right to request an Administrative Board) after being afforded a reasonable opportunity to consult with counsel, and that failure to respond shall constitute a waiver of the right.

In addition to Department policy each Military Department has supplemental guidance controlling the administrative separation of Servicemembers on the basis of personality disorder. They are listed below:

Army Policy: Army policy for administrative separation of enlisted Soldiers on grounds of personality disorder is contained in Army Regulation 635–200, *Active Duty Enlisted Administrative Separations,* paragraph 5–13 titled, "Separation because of personality disorder." The policy is not unilateral, but rather derives from governing Department of Defense policy (DoD Directive 1332.14, *Enlisted Administrative Separations).* The basis is a deeply ingrained maladaptive pattern of behavior of long duration, not amounting to a disability, which it interferes with the Soldier's ability to perform duty. A key provision is that the diagnosis of personality disorder must be established by a psychiatrist or a doctoral-level municipal psychologist. In addition, the local Military Treatment Facility Chief Behavioral Health must review the finding of personality disorder to ensure accurate diagnosis. Separation is authorized only if the diagnosis concludes that the personality disorder is so severe that the Soldier's ability to function effectively in the military environment is significantly impaired. Based on the medical diagnosis and conclusion, the Soldier's unit commander initiates involuntary separation proceedings and refers them to the separation authority, who is the special court martial convening authority (a colonel).

Navy Policy (includes Marine Corps): Navy policy for administrative separation on the basis of personality disorder is contained in Department of the Navy Military Personnel Manual (MILPERSMAN) 1910–122, *Separation by Reason of Convenience of the Government—Personality Disorder(s).* Marine Corps policy is contained in *Marine Corps Order (MCO) P1900.16F, Marine Corps Separation and Retirement Manual,* Section 3, titled Personality Disorder. Both references state that administrative separation on the basis of personality disorder is allowed only if the disorder is so severe that the member's ability to function effectively in a military environment is significantly impaired.

Servicemembers recommended for administrative separation on the basis of personality disorder must receive a Mental Health Evaluation (MHE) conducted by a Mental Health Professional. A Mental Healthcare Provider is defined in Secretary of the Navy (SECNAV) Instruction 6320.24A, *Mental Health Evaluation of Members of the Armed Forces,* Enclosure 1, as a psychiatrist, doctoral-level clinical psychologist, or doctoral-level social worker with necessary and appropriate professional credentials who is privileged to conduct mental health evaluations for DoD components. According to the same reference, the mental health evaluation "shall consist of, at a minimum, a clinical interview and mental status examination and may include, additionally: a review of medical records; a review of other record, such as the Service personnel record; information forwarded by the Servicemember's commanding officer; psychological testing; physical examination; and laboratory and/or other specialized testing."

Navy MILPERSMAN 1910–120, *Separation by Reason of Convenience of the Government—Physical and Mental Conditions,* is currently being revised to ensure alignment with guidance contained in MILPERSMAN 1910–122. The Department of the Navy Manual of the Medical Department, Chapter 18–5 lists personality disorders as "conditions not meriting a Medical Evaluation Board."

Air Force Policy: For enlisted Airmen, Personality Disorder discharges are processed under Air Force Instruction 36–3208, *Administrative Separation of Airmen,* Chapter 5, Involuntary Convenience of the Government (COG) Discharge. Specifically, paragraph 5.11., "Conditions That Interfere With Military Service," states that Airmen may be discharged when the commander determines that the condition interferes with assignment or duty performance. A recommendation for discharge under this provision must be supported by a report of evaluation by a psychiatrist or clinical psychologist (doctoral level) that confirms the diagnosis of a disorder as contained in the Diagnostic and Statistical Manual of Medical Disorders (DSM–IV). This report must state the disorder is so severe that the Airman's ability to function effectively in the military environment is significantly impaired. This report may not be used as, or substituted for, the explanation of the adverse effect of the condition on assignment or duty performance. When a psychiatrist or psychologist confirms diagnosis of a mental disorder that is so severe that the Airman's ability to function effectively in the military environment is significantly impaired, and the commander chooses not to initiate separation action, the commander must have that decision reviewed by the discharge authority. Conditions that warrant disability processing will not be used to justify a separation under this instruction. A recommendation for discharge must be supported by documents confirming the existence of the condition and showing the member is medically qualified for worldwide duty. Except when enuresis or sleepwalking is involved, the commander must explain the adverse effect on assignment or duty performance. Similarly, administrative discharges of officers with Personality Disorder are processed under the guidance of API 36–3206, *Administrative Discharge Procedures for Commissioned Officers.*

Current DoD and Military Department policies, regarding the use of personality disorder as the basis for administrative separations of Servicemembers, allow for the controlled separations of Servicemembers by the Military Departments, enabling the Military Department Secretaries to manage separations to ensure their forces are fit to fight. The requirement for the Military Departments to notify Servicemembers, in writing, and to allow them to consult with legal counsel helps ensure Servicemembers are not wantonly discharged at the convenience of the Military Department Secretaries on the basis of personality disorder and that the separation proceedings receive due diligence. The Department believes that existing policy could be strengthened and has been working over the past few months to implement more rigorous policy regarding the use of personality disorders the basis for separation of Servicemembers who have deployed to designated imminent danger pay areas (e.g., Iraq, Afghanistan, Kuwait, Saudi Arabia, Pakistan, Serbia, and Djibouti).

Measures Being Taken Regarding Personality Disorder Separations

(D) A discussion of measures being implemented to ensure that members of the Armed Forces who should be evaluated for disability separation or retirement due to mental health conditions are not processed for separation from the Armed Forces on the basis of a personality disorder, and recommendations regarding how members of the Armed Forces who may have been so separated from the Armed Forces should be provided with expedited review by the applicable board for the correction of military records.

The Department is in the final phase of adding additional rigor to the personality disorder administration separation policy. The revised policy would authorize personality disorder separations only if diagnosed by a psychiatrist or PhD-level psychologist. Moreover, members who are being considered for administrative discharge based on personality disorder who have served or are currently serving in designated imminent danger pay areas (e.g., Iraq, Afghanistan, Kuwait, Saudi Arabia, Pakistan, Serbia, and Djibouti) would have their personality disorder diagnosis corroborated by a peer, psychiatrist or PhD-level psychologist, or another higher level mental health professional. The diagnosis would address post traumatic stress disorder or other mental illness comorbidity. Finally, before a member who has served or is currently serving in an imminent danger pay area can be separated on the basis of personality disorder their case would be reviewed and endorsed by The Surgeon General of the Military Department concerned. The Department anticipates implementing the revised policy by July 2008.

Separation data show that only 3.4K of the 23K Servicemembers administratively discharged with personality disorder coded separations between fiscal years 2002 and 2007 had deployed in support of the Global War on Terror. There is no indication that personality disorder diagnoses for members who were deployed in support of the Global War on Terror were prone to systematic or widespread error. Moreover, Department mental health providers are competent professionals who regu-

larly screen and diagnosis post traumatic stress disorder and related mental health disorders. Furthermore, the Department is aware of no studies that show a strong correlation between personality disorder separations and post traumatic stress disorder, Traumatic Brain Injuries, or other Global War on Terror related mental health disorders. Still, the Department shares Congress' concern regarding the possible use of personality disorder as the basis for administratively separating this class of Servicemember. This concern led to the aforementioned pending policy change which specifically provides additional protections to ensure Servicemembers who suffer from post traumatic stress disorder are not separated on the basis of personality disorder.

The Department encourages all former Servicemembers who believe that their discharges were incorrectly characterized or processed to request adjudication through their respective Military Department's Discharge Review Board. Given that there are no indications that Servicemembers suffering from post traumatic stress disorder were systematically processed for administrative separation based on personality disorder, the Department believes that members from this class of veterans should utilize the existing Discharge Review Board processes. These boards have well established processes and procedures in place to fairly evaluate each veteran's request in an expeditious fashion.

Conclusion

In conclusion, the Department appreciates the opportunity to provide Congress with information regarding the administrative separating of Servicemembers based on personality disorder for those members who deployed in support of the Global War on Terror. There is no indication that personality disorder diagnoses for members who were deployed in support of the Global War on Terror were prone to systematic or widespread error. Moreover, Department mental health providers are competent professionals who regularly screen and diagnose post traumatic stress disorder and related mental health disorders.

The Department, however, has been working over the past few months to implement policy that adds additional rigor to the personality disorder administrative separation policy. The revised policy would specifically require personnel being considered for personality disorder separations who have served or are currently serving in designated imminent danger pay areas to be evaluated for post traumatic stress disorder or other mental illness co-morbidity prior to being separated on the basis of personality disorder.

Committee on Veterans' Affairs
Washington, DC
June 19, 2008

The Honorable James B. Peake, M.D.
The Secretary
Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Mr. Secretary:

In reference to our Full Committee hearing on "Implementing the Wounded Warrior Provisions of the National Defense Authorization Act for Fiscal Year 2008" on June 11, 2008, I would appreciate it if you could answer the enclosed hearing questions by the close of business on August 4, 2008.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all Full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Debbie Smith by fax your responses at 202–225–2034. If you have any questions, please call 202–225–9756.

Sincerely,

BOB FILNER
Chairman

Questions for the Record

The Honorable Bob Filner, Chairman
House Committee on Veterans' Affairs
June 11, 2008

Implementing the Wounded Warrior Provisions of the National Defense Authorization Act for Fiscal Year 2008

Question 1(a): Section 1615 of the NDAA, requires the two agencies to submit a final report on the comprehensive policy that is required to be developed in section 1611 of the NDAA on improvements to care, management, and transition of recovering servicemembers. Could you tell the Committee what the status of the final report is?

Response: Section 1615 of the National Defense Authorization Act (NDAA) requires a comprehensive final report regarding care management and transition of recovering servicemembers. The Department of Veterans Affairs (VA) has provided input to the Department of Defense (DoD) section. Letters dated June 26, 2008, were sent to the Committees on Armed Services and the Committees on Veterans' Affairs, signed by Admiral Patrick Dunne, Co-Chair VA, Wounded, Ill and Injured Overarching Integrated Product Team and Mr. Michael L. Dominquez, Co-Chair DoD, Wounded, Ill and Injured Overarching Integrated Product Team indicating that the report would be submitted by August 2008.

Question 1(b): If you do not believe that it will be finished on time; do you have an expected completion time?

Response: The report will be delivered by August 2008.

Question 1(c): What, in your experience, has been the biggest barrier in carrying out section 1611?

Response: VA has not experienced any significant barriers.

Question 2(a): Oftentimes we find that implementing policy can be very difficult. section 1611 of the NDAA required a program for the assignment to recovering servicemembers of recovery care coordinators. Could you discuss with the Committee the implementation of the Federal Recovery Coordinator Program in terms of patient ratios and where the Agencies believe the program will be in the future?

Response: The Federal Recovery Coordination Program (FRPC) was recently moved from it's location within the Veterans' Health Administration and will now report directly to the Secretary. Karen Guice, MD, MPP, was hired as the Executive Director to run the program. Dr. Guice served as the Deputy Director of the President's Commission on Care for America's Wounded Warriors."

The ratio of Federal Recovery Coordinators (FRC) to patients is being determined based on the complexity and intensity of needed services and the acuity level of the patient. An electronic workload reporting system is in place and data are being collected. Analysis of these data will allow appropriate allocation of resources. The program will also examine best practices in administrative and clinical care staffing models to better inform staffing decisions.

For now, the FRCP will continue to identify individuals classified as catastrophically wounded, ill or injured Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) servicemembers. These individuals clearly need the support offered by the FRC program. The FRCP office is hiring a full time registered nurse to review records of patients who have already been through the acute phase of care and may now living in the community. Targeted patient populations, such as those who have been through the VA polytrauma, spinal cord injury treatment or blind rehabilitation will be evaluated and offered enrollment or referral to other existing programs as appropriate. Similarly, the FRC program will work with TRICARE and DoD partners to identify those catastrophically wounded, ill or injured servicemembers and veterans who have not enrolled in VA care, but may still benefit from the FRCP.

Question 2(b): Do you have any preliminary feedback as to the effectiveness of the program?

Response: FRCs report that the feedback from servicemembers, veterans, and families participating in the FRC program has been uniformly positive.

Question 3: Have either of the agencies worked on satisfaction surveys with veterans and caregivers who participate in the program? If not, are there any plans to conduct a survey in the future?

Response: VA has not administered an official satisfaction survey of participants in the FRC program yet. However, VA expects to initiate a satisfaction survey in fiscal 2009.

Question 4: Federal Recovery Coordinators have to be proficient in not only DoD and VA benefits, but also those benefits that wounded servicemembers and their families will need to access under the Department of Labor and Social Security. How have the agencies dealt with training the coordinators so they are able to address all of the aspects required of them in assisting recovering servicemembers?

Response: FRCs received training in both DoD and VA benefits, as well as Department of Labor and Social Security Administration benefits. More importantly, FRCs have access to experts from each of these Departments to assist with questions and concerns.

Question 5: In your testimony you state that VA is putting a charter group together comprised of specialty care managers across VA including OEF/OIF teams, spinal cord, blind rehabilitation, mental health, polytrauma and others. This group is to make recommendations on a systemwide approach to care management with emphasis on the coordination between programs. Are DoD personnel involved in this group or is this just VHA?

Response: The charter group is composed of VA members only. It is responsible for developing Veterans Health Administration (VHA) policy for care management, with an emphasis on coordinating care throughout the VA system.

Question 6(a): In reference to section 1612 of the NDAA for fiscal year 2008, could you discuss the progress made in VA and DoD's improvement in the medical and disability evaluation processes in terms of: The VA/DoD single exam that was initiated at the Washington, D.C. VA Medical Center?

Response: One of the major tenants of the disability examination system (DES) pilot is that there be one disability examination for the servicemember that meets the requirements of both VA and DoD. That examination, currently being conducted at the Washington, D.C. VA Medical Center using VA protocols, meets that requirement. As of June 28, 2008, the most recent period for which we have data, examinations have been completed for 261 servicemembers in the pilot and an additional 99 servicemembers are currently in the examination process.

Question 6(b): Have cost sharing issues been resolved between VA and DoD for the exam process? How will the costs be allocated between the Departments?

Response: VA and DoD are working collaboratively to come up with a cost sharing mechanism for the examination process as the pilot expands and, if warranted, becomes the standard business practice. DoD is paying for the examinations in the pilot in the National Capital Region. An initial draft of a memorandum of understanding on examinations and cost sharing is being reviewed in both departments.

Question 6(c): Have appeals issues been addressed and what will be the process?

Response: To address your question we must make a distinction between the DoD appeals process while a member is still on active duty and the VA appeals process once a servicemember has become a veteran and been formally notified of his or her VA rating decision.

In the DoD environment, a member has a specified period of time to rebut a decision of either the medical evaluation board (MEB) or the informal or formal physical evaluation board (PEB) decision. VA does not have a role in any attempted rebuttal of a MEB determination. At the PEB stage in the pilot a member may attempt to rebut three items: 1) the basic fitness determination by the PEB, 2) what conditions are considered in the fitness determination by the PEB, and 3) the evaluation assigned for conditions found unfitting by the PEB. VA does not have a role to play in the first two situations. If the member wishes to rebut the evaluation assigned by VA, the member is entitled to a review of the decision on a one-time basis if the member presents an argument that there is an error in the application of the schedule and/or submits additional medical evidence supporting the assignment of a higher evaluation. A VA decision review officer (DRO) conducts the review in such rebuttals. Once the DRO has conducted the appropriate review, the PEB is advised that either the previous decision is affirmed or a revised decision is provided. This completes VA's involvement in the DES appeals process. Thus far three servicemem-

bers have requested review by a DRO. In one case, request for review was denied because the evaluation with which the member disagreed was not for a DoD-determined unfitting condition. In the other two cases the DRO affirmed the initial VA evaluation assignment.

The rebuttal process while a member is still on active duty in no way limits his or her appeal rights once the member is separated from service and provided with the formal VA decision on all unfitting and claimed conditions. Once separated, the veteran has 1 year from date of decision notification to file an appeal.

Question 6(d): Can DoD refute a rating rendered by VA for a servicemember whose disability is not agreed upon?

Response: Current DoD policy in the pilot generally requires the PEB to use the ratings assigned by VA. NDAA of 2008 requires that DoD use the rating schedule used in VA as governed by VA policy and governing court precedent. DoD can request that VA reconsider evaluations assigned; however DoD cannot direct VA to change evaluations assigned. The military services have the ability to decrease the evaluation if the current level of disability is shown to be associated with the member's failure to comply with medical direction regarding the treatment of the condition. Additionally, the services can determine that a medical condition pre-existed entry into service and was not aggravated by the military service.

Question 7: Referring to section 1614 of the NDAA for fiscal year 2008, in spite of efforts by a Joint Executive Council, Health Executive Council and a Senior Oversight Committee, veterans still fall through cracks when transitioning between DoD and VA. Have the Departments considered creating a Seamless Transition Office jointly staffed by DoD and VA representatives instead of operating across systems and with collaterally assigned staff?

Response: DoD and VA are considering multiple venues to continue joint work. This includes realigning the Joint Executive Council (JEC) and Senior Oversight Committee (SOC) into a single chain of command or into a hybrid organization. This would align the strategic management of the JEC with the tactical capabilities of the SOC into a long-term combined staff organization with rapid response capability.

Question 8: In reference to section 1621 of the NDAA for fiscal year 2008, how will the new TBI Center of Excellence coordinate with already existing experts in neurological care in other sectors?

Response: The Center of Excellence for Psychological Health and traumatic brain injury is a Department of Defense organization. VA routinely collaborates and coordinates with this Center, as well as many other Federal and private sector agencies and organizations. How this Center will coordinate with other sectors is best addressed by DoD.

Question 9: Competency is often an issue with TBI patients. How will the participation of family members and other caregivers be ensured?

Response: VA works proactively to ensure the involvement of family members. For example, VA encourages and supports the involvement of family members in their role as caregivers through a combination of educational, logistical and administrative assistance interventions. Collaboration with the family begins prior to admission to one of the polytrauma/traumatic brain injury (TBI) system of care facilities, during which time the social worker case manager (SWCM) assigned to each patient initiates a relationship with the family. Within 24 hours of admission of the TBI patient, the SWCM establishes a communication plan with the family, which is documented in the social work assessment.

Furthermore, the primary goals of the TBI patient and family, including the plan of care, and expected length of stay, are discussed to ensure that the family's input is incorporated into the treatment plan. Daily contact is made with the family members and they are encouraged to participate in all rehabilitation therapies, activities, outings and therapeutic passes. Weekly meetings between the family and the healthcare team are held to address questions, concerns, and patient and family educational needs. Family needs and skills are continually re-assessed and addressed throughout the inpatient rehabilitation process.

Prior to discharge from the hospital, the caregiver's ability to adequately care for the veteran is assessed through such means as trials in independent living apartments, home passes, and home visits by medical center staff. During these visits, a VA staff member assesses the adequacy of the home environment and identifies any need for home equipment and home modifications. After the veteran returns home, services provided to ensure that the veteran receives appropriate care and

that family members are supported in providing that care include: homemaker and home health aid services, respite care, home-based primary care, and adult day care. Ongoing access to an assigned care case manager is also maintained to coordinate medical and psychosocial services, and serve as the first line responder to emerging needs and potential problems.

Finally, extensive educational resources are also provided to patients and caregivers including the *Polytrauma Rehabilitation Family Education Manual,* and accessible materials on My HealtheVet Web site. The recently developed *Family Care Map* will identify and standardize best practices for working with families across the VA polytrauma/TBI rehabilitation centers, and provide the patient and family with a guide or *roadmap* of the rehabilitation process. The foundation of the rehabilitation process is VA's emphasis that family participation is critical to effective rehabilitation, especially when patients have diminished decisionmaking capacity as a consequence of the TBI.

Question 10: In reference to section 1622 of the NDAA for fiscal year 2008, how will the PTSD Center of Excellence differ from the existing National Center for PTSD already funded by VA? How will they be detailed to interact?

Response: VA believes that the *post traumatic stress disorder (PTSD) Center of Excellence* mentioned in the question refers to the program commonly known as the DoD Centers of Excellence (DCoE) for psychological health and TBI. The VA's National Center for PTSD (NCPTSD) and the DCoE for psychological health and TBI have complementary, but distinct missions.

Generally, the NCPTSD's mission is to provide a VA center of excellence for research with education on the prevention, understanding, and treatment of PTSD. The NCPTSD has seven divisions across the country, with the purpose of improving the well-being and understanding of American veterans.

The DCoE leads a collaborative effort toward optimizing psychological health and TBI treatment for DoD. The DCoE establishes quality standards for clinical care; education and training; prevention; patient, family and community outreach; and program excellence. The DCoE currently has four component centers, the Defense and Veterans Brain Injury Center, the Deployment Health Clinical Center, the Center for the Study of Traumatic Stress, and the Center for Deployment Psychology.

Significant interaction and collaboration between the two centers are planned, due to their missions. VA will provide three staff members to work directly in the DCoE, including a Deputy Director, and two VA senior consultant/liaisons to ensure close coordination between VA and DoD. In fact, VA has already provided an Acting Deputy Director in the DCoE, who herself trained for 2 years at the NCPTSD and has significant connections to the NCPTSD. In addition, several members of the DCoE have visited the NCPTSD for consultation, and four members of the NCPTSD have attended strategic planning summits for the DCoE. Coordination of ongoing training efforts in evidence-based practice is already ongoing, as well.

Question 11: Employability and quality of life are significant issues for those with mental health conditions. How will PTSD Center of Excellence deal with those issues?

Response: A patient's reintegration into the community following deployment is a major focus of the DCoE for psychological health and TBI. The DCoE, in partnership with VA, has consulted with the Department of Labor to develop programs of employability. Further, the Deployment Health Clinical Center (one of the component centers of the DCoE) is conducting ongoing studies of quality of life and disease burden in individuals with PTSD. It is expected that the results of these studies will improve our understanding of quality of life decrements for individuals with PTSD. Finally, the Deputy Director from VA for the DCoE will explore opportunities for collaboration with VA vocational rehabilitation programs for those with mental health problems.

Question 12: Interpersonal relationships are often difficult for those with PTSD and other mental illnesses. How will those issues be addressed and significant others included?

Response: PTSD and other mental disorders can significantly impact interpersonal relationships, as they may lead to disturbance or deficit in an individual's social functioning and/or promote stress on family and significant others. VA is committed to providing the best available treatments for PTSD and other mental illnesses to not only reduce symptoms, but to also allow individuals to live full and meaningful social lives.

VHA is actively working to disseminate evidence-based psychotherapies for a variety of mental health conditions throughout the VA healthcare system to help pa-

tients live full and meaningful social lives. Two programs are currently underway to provide clinical training to VA mental health staff in the delivery of cognitive processing therapy (CPT) and prolonged exposure therapy (PE) for PTSD. CPT and PE are recommended in the VA/DoD Clinical Practice Guidelines for PTSD at the highest level, indicating "a strong recommendation that the intervention is always indicated and acceptable." These treatments often enable individuals who have suffered from PTSD to more comfortably and meaningfully interact and engage with others.

VA is also working to promote state-of-the-art treatments that involve working with the families of veterans with serious mental illness to improve individual functioning and family relationships. VA is disseminating family psychoeducation (FPE), a compilation of evidence-based practice whereby the clinician works with a patient's family to provide the family with the skills and attitudes that have been shown to reduce relapse in individuals with serious mental illnesses. Components of FPE include careful assessment, provision of education, problem-solving, and an emphasis on improving current functioning in many areas including interpersonal relationships.

In addition, VA has funded a national initiative to integrate mental health providers on each VA home based primary care (HBPC) team. A major component of the HBPC mental health provider's responsibility is working with family caregivers of homebound veterans to address neuropsychiatric or psychological symptoms associated with dementia or mental illness that may affect individual and family functioning.

Individuals with serious mental illness, such as schizophrenia, may have skill deficits that limit interpersonal relationships. For these veterans, VA is implementing a national initiative to disseminate social skills training, and an evidence-based psychological intervention for individuals with serious mental illness that has been consistently found to increase skill-acquisition and improve social functioning.

Finally, depression and anxiety can significantly reduce interest, motivation, and ability to engage in meaningful interpersonal relationships. VA is currently implementing national initiatives to train VA mental health staff in the delivery of cognitive behavioral therapy and acceptance and commitment therapy for depression and anxiety. These treatments promote changes in perceptions of self and others and work to increase positive behaviors that often lead to improvements in social functioning and interpersonal relationships.

Question 13: In reference to section 1635 of the National Defense Authorization Act of 2008, why won't both Departments simply use VistA?

Response: VA and DoD are currently working toward developing systems that are interoperable. This strategy will best serve the needs of veterans, those transitioning to veteran status, and beneficiaries of military heath care. Sharing information permits each department to meet the needs of the specific patient population while simultaneously sharing information to ensure it is available when and where it is needed. VA and DoD have both distinct information needs and areas of commonality. The departments have built their information systems to best support these distinct needs but allow for the necessary interoperability to care for shared populations.

For example, DoD's armed forces health longitudinal technology application (AHLTA) includes capabilities that are used to treat DoD beneficiaries and soldiers on the ground and in theater. This capability is crucial to the care of our armed forces. VA clinicians do not provide treatment to patients in theater and therefore VistA is not built to support that requirement. To the extent VA clinicians need theater information to treat wounded warriors, VA and DoD data exchanges have the capability to electronically share this information.

VA and DoD are now sharing most of the available electronic health data that is essential to the care of patients. The departments are working to expand data sharing to include other key areas, such as inpatient care. They are working together to determine the best way forward in the development of an inpatient solution. A joint study is in place to scrutinize the inpatient healthcare requirements and business practices of both communities. The study will then recommend a solution representing the best in inpatient healthcare for our Nation's soldiers and veterans.

VistA has enabled VA to earn the highest healthcare quality ratings, and VistA is ranked as best in class by independent groups. Yet, it is now necessary to leverage improved technologies and tools to modernize VistA and improve VA information capabilities. As VA moves toward developing the next generation of VistA, Health*e*Vet, and as DoD continues its enhancement of AHLTA capabilities, the departments are working closely to leverage commonalities for information needs. This

methodology permits the departments to jointly support common requirements and also best serve the information needs of those requirements that are unique to each community. VA and DoD will continue to assess new clinical and business applications for potential joint application and ensure their incorporation into Health*e*Vet, where it is technically and economically feasible to do so.

Question 14(a): VA/DoD IT interoperability efforts have been underway for several years at this point. Why has there not been more success thus far?

Response: VA and DoD have achieved significant success toward the development of interoperable health systems. VA and DoD are now sharing almost all essential health information that is available electronically in a bidirectional viewable format. This information includes outpatient pharmacy and allergy information, outpatient and inpatient laboratory orders and results, radiology reports, select inpatient information such as discharge summaries from key DoD military treatment facilities, and vital signs. DoD also sends clinical theater information, which is available to all VA hospitals, and scanned inpatient records and radiology images from key military treatment facilities to the four VA polytrauma centers receiving DoD's wounded warriors. In addition to sharing viewable information, VA and DoD have begun sharing computable allergy and pharmacy information that supports automatic drug-drug and drug-allergy interaction checks.

Question 14(b): What are the current obstacles?

Response: VA and DoD are sharing an unprecedented amount of health information at a level that is not achieved anywhere else in the industry. Despite this accomplishment, VA and DoD acknowledge that there are several layers of interoperability and that the departments are sharing most information in viewable format. In order to expand this capability to share more computable data, VA and DoD must leverage information standards that are mature and robust enough to support the exchange of information for patient care. Such standards do not yet exist in all clinical domain areas. VA and DoD are leading partners in the National effort to identify and implement health data standards that will support increased interoperability.

Not all information needs to be shared in computable format to deliver high quality healthcare to patients. VA and DoD have formed a Joint Clinical Information Board (JCIB) that consists of clinicians from both departments. The JCIB is currently evaluating the additional data types that should be shared in computable format as well as identifying and prioritizing the next set of data to be shared between DoD and VA.

Question 14(c): What are the next milestones?

Response: On April 17, 2008, VA and DoD formed the Interagency Program Office, as required by the 2008 NDAA, for the purpose of guiding the departments to an interoperable electronic health record by September 2009. The departments are on target to meet this milestone and will achieve this, in part, based on the work of the JCIB. Also included in this work is the expanded bidirectional viewable data that are shared. For example, at the end of June 2008, VA and DoD expanded data sharing to include the capability to share vital sign information on patients. By September 2008, VA and DoD will begin sharing family and social history information on patients. The departments also are working on expanding a bidirectional image sharing pilot in six locations, and are finalizing an enterprise-wide plan for sharing images that will be delivered on October 2008.

Question 15(a): The Dole/Shalala Commission recommended a singular Federal benefits portal last summer. a. What efforts have been made to make this a reality?

Response: The following has been accomplished:

- Designation of VA as project lead for the e-benefits portal.
- VA/DoD e-benefits portal plan approved by Joint Executive Council co-chairs, 31 December 2007.
- Completion of requirements definition.
- Development of phased acquisition strategy, schedule, and key milestone.
- Development of technical approach.
- Approval of Joint Incentive Funds proposal to support funding the e-benefits portal initiative.

Question 15(b): What other departments have been involved in providing information?

Response: DoD (Personnel and Readiness, and Health Affairs/TRICARE Management Activity) and the Department of Labor are active participants in the development and implementation of an e-benefits portal in support of wounded, ill or injured servicemembers and veterans.

Committee on Veterans' Affairs
Washington, DC
June 19, 2008

The Honorable Robert M. Gates
Secretary of Defense
U.S. Department of Defense
The Pentagon, Room 3E718
Washington, DC 20301–1000

Dear Mr. Secretary:

In reference to our Full Committee hearing on "Implementing the Wounded Warrior Provisions of the National Defense Authorization Act for Fiscal Year 2008" on June 11, 2008, I would appreciate it if you could answer the enclosed hearing questions by the close of business on August 4, 2008.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all Full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Debbie Smith by fax your responses at 202–225–2034. If you have any questions, please call 202–225–9756.

Sincerely,

BOB FILNER
Chairman

Hearing Date: June 11, 2008
Committee: HVA
Member: Congressman Filner
Witness: Hon. Dominguez

Care, Management, and Transition of Recovering Servicemembers

Question 1: Section 1615 of the NDAA requires the two agencies to submit a final report on the comprehensive policy that is required to be developed in section 1611 of the NDAA on improvements to care, management, and transition of recovering servicemembers.

a. Could you tell the Committee the status of the report?
b. If you do not believe that it will be finished in time, do you have an expected completion time?
c. What, in your experience, has been the biggest barrier in carrying out section 1611?

Response: Both Departments have made significant progress on developing a joint comprehensive policy on improvements to care, management and transition of recovering servicemembers since we issued our interim report. We are developing uniform standards for curriculum, training, workload, and processes to support the management and transition of recovering servicemembers to include development and execution of a comprehensive recovery plan for this patient population. Both agencies have conducted a review of existing policies and procedures that apply to or will be covered by the comprehensive policy to identify the most effective and patient-oriented approaches for care and management of our recovering servicemembers. The biggest barrier in carrying out section 1611 is that developing this policy requires extensive coordination between the military services as well as between both agencies, requiring additional time for coordination and policy development. We will provide a report to Congress detailing the comprehensive policy by August 15, 2008. The Department of Defense (DoD) in consultation with the Department of Veterans Affairs will issue a Directive Type Memo to provide interim guidance

for improvements to care, management and transition of our recovering servicemembers no later than September 15, 2008, to be followed by a DoD Instruction.

Recovery Coordinators

Question 2: Oftentimes we find out that implementing policy can be very difficult. section 1611 of the NDAA required a program for the assignment to recovering servicemembers of recovery coordinators.

a. Could you discuss with the Committee the implementation of Federal Recovery Coordinator Program in terms of patient ratios and where the agencies believe the program will be in the future?
b. Do you have any preliminary feedback as to the effectiveness of the program?

Response: The Federal Recovery Coordinator (FRC) program and the FRC cadre will expand to meet the needed number to serve the severely/catastrophically ill or injured recovering servicemember or veteran with the development and implementation of a Federal Individual Recovery Plan (FIRP). The initial proposed workloads of 1 to 20–30 will be adjusted based on acuity of recovering servicemembers/veterans being served according to the Department of Veterans Affairs clinical practice guidelines.

The evaluation of the FRC program, in its first few months of operation, was a process evaluation not an outcome evaluation, and intentionally did not focus on measurements of "effectiveness." Demographics of number and profile of individuals served are available along with first hand comments on experience in the program by the FRCs. The evaluation of the program in Phase 2 (May-Dec 2008) will capture experience and level of satisfaction of the wounded, ill or injured servicemember and their family with the FRC program and the FIRP. The evaluation will also look at the National Resource Directory and how it was used, by whom, and the level of helpfulness to those using it.

Satisfaction Surveys with Veterans and Caregivers

Question 3: Have either of the agencies worked on satisfaction surveys with veterans and caregivers who participate in the program? If not, are there any plans to conduct a survey in the future?

Response: Yes. An assessment of the recovering servicemember, veteran and family experience in the Department of Defense/Department of Veterans Affairs Federal Recovery Coordination Program will be conducted by gathering data and capturing experience and level of satisfaction with the program and the Federal Individual Recovery Plan.

Federal Recovery Coordinators

Question 4: Federal Recovery Coordinators have to be proficient in not only DoD and VA benefits but also those benefits that wounded servicemembers and their families will need to access under the Department of Labor and Social Security. How have the agencies dealt with training the coordinators so they are able to address all of the aspects required of them in assisting recovering servicemembers?

Response: In January 2008, the Department of Defense (DoD) and the Department of Veterans Affairs (VA) provided an initial 2 week training course for our first group of Federal Recovery Coordinators. Both the Social Security Administration (SSA) and the Department of Labor (DoL) participated in this training, ensuring that the coordinators were provided with the most current information from these two organizations. A second session for reach-back training was conducted June 17–19, 2008. We have developed and implemented an online, web based training tool that provides refresher training and acts as a resource for the coordinators when addressing benefits for wounded servicemembers and their families. All newly hired coordinators are required to complete training prior to being deployed to the medical treatment facilities to support our wounded servicemembers and their families. In addition, DoD will continue to collaborate closely with Federal agencies with programs, services, benefits or compensation for recovering servicemembers or veterans. SSA has an ongoing relationship with DoD in care for wounded warriors, and is participating in the development of the DoD/VA National Resource Directory in concert with DoL. As an additional resource, the National Resource Directory will provide recovering servicemembers and their care coordinators with a national linkage to state, local, private and non-profit services and resources.

Committee on Veterans' Affairs
Washington, DC
June 18, 2008

The Honorable James B. Peake, M.D.
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Secretary Peake:

On Wednesday, June 11, 2008, Admiral Patrick V. Dunne, Acting Under Secretary for Benefits and Assistant Secretary for Policy and Planning, testified before the House Committee on Veterans' Affairs on Implementing the Wounded Warrior Provisions of the National Defense Authorization Act for Fiscal Year 2008. As a follow-up to the hearing, I request the enclosed questions be answered in written form for the record by close of business, 5 p.m. on Tuesday, July 29, 2008.

It would be appreciated if the responses could be provided consecutively on letter size paper, single-spaced. Please restate the question in its entirety before providing the answer.

If you or your staff have any questions, please contact Dolores Dunn, Republican Staff Director for the Subcommittee on Health, at 202–225–3527.

Sincerely,

Steve Buyer
Ranking Republican Member

Questions for the Record

The Honorable Steve Buyer
Ranking Republican Member
House Committee on Veterans' Affairs
June 11, 2008

Implementing the Wounded Warrior Provisions of the National Defense Authorization Act for Fiscal Year 2008

Question 1: What is the status of the review of all policies and procedures that relate to the care, management, and transition for recovering servicemembers required under section 1611 of Public Law 110–181, of the National Defense Authorization Act (NDAA) for Fiscal Year 2008? Are there any policies and procedures that have yet to be reviewed?

Response: The Department of Veterans Affairs (VA) has completed the review of all policies and procedures that relate to the care, management, and transition of recovering servicemember and veterans required under section 1611 of Public Law 110–181, the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2008. VA has chartered a group of clinical staff to review the systems of care for severely ill/injured servicemembers and veterans, a report will be provided later this year.

Question 2: I understand that the Senior Oversight Committee was expecting to complete a full review of all policies and procedures relating to the care and management of wounded, ill, or injured servicemembers/veterans and their families by April 27, 2008. Were these reviews completed? If so, please provide documentation.

Response: VA has completed the review of all policies and procedures that relate to the care, management, and transition for recovering servicemember and veterans required under section 1611 of Public Law 110–181, the NDAA for FY 2008.

VA policies reviewed:

Veterans Health Administration (VHA) Directive 2007–012 *Eligibility Verification Process for VA Healthcare Benefits* (April 2007)

VHA Directive 2005–045 *Treatment of Active Duty Servicemembers in VA Healthcare Facilities* (October 2005)

VHA Directive 2005–020 *Determining Combat Veteran Eligibility* (June 2005)

VHA Directive 2007–013 *Screening and Evaluation of Possible traumatic brain injury (TBI) in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) Veterans* (April 2007)

VHA Directive 2006–041 *Veterans Healthcare Service Standards* (June 2006)

VHA Directive 2006–055 *VHA Outpatient Scheduling Processes and Procedures* (October 2006)

VHA Directive 2006–038 *Considerations for VA Support for the Department of Defense (DoD) Post Deployment Health Reassessment (PDHRA) Program for Returning Deployed Servicemembers* (June 2006)

VHA Directive 2006–59 *Active Patients in the Primary Care Management Module (PCMM)* (November 2006)

VHA Directive 2007–016 *Coordinated Care for Traveling Veterans* (May 2007)

VHA Directive 2006–028 *Process for Ensuring Timely Access to Outpatient Clinical Care* (May 2006)

VHA Directive 2003–003 *Provision of Hospital Outpatient Care to Enrolled Veterans* (January 2003)

VHA Handbook 2007–1010.01 *Transition Assistance and Case Management of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) Veterans*

VHA Handbook 2005–1172.1 *Polytrauma Rehabilitation Procedures*

Question 3: What progress has been made since the issuance of the *Interim Report on Policy Improvements on the Care, Management, and Transition of Recovering Servicemembers?* If the final report will not be ready for release on July 1, 2008, please provide an explanation for the delay. Please provide the Committee with a copy of the final report when it is issued for the Committee's records.

Response: The Federal Recovery Coordination Program (FRPC) was recently moved from it's location within the Veterans' Health Administration (VHA) and will now report directly to the Secretary. Karen Guice, MD, MPP, was hired as the Executive Director to run the program. Dr. Guice served as the Deputy Director of the President's Commission on Care for America's Wounded Warriors.

Standards for the Federal recovery coordinator's (FRC) training curriculum and processes to support the management and transition of recovering servicemembers/veterans are in place. The FRCs are using an electronic tool to develop and execute the Federal individual recovery plan. Policies and procedures relating to care of recovering servicemembers and veterans have been reviewed by both agencies. The Departments have the appropriate clinical and non-clinical case management strategies in place and these programs are compatible between the Departments. Further, both Departments continue to fine tune their clinical care programs. DoD has established an on-going clinical practice group, attended by nurses from VA, to synchronize clinical models used across the services. VHA has convened a workgroup to develop a comprehensive VHA policy to integrate all aspects of care management. The report on *Policy Improvements on the Care, Management, and Transition of Recovering Servicemembers* is under review by both Departments, and will be provided to Congress by August 15, 2008. VA and DoD are jointly developing a directive to provide guidance for improvements to care, management and transition of our recovering servicemembers which will be available September 15, 2008.

Question 4: To what extent will the Department of Veterans Affairs (VA) collaborate with other Federal agencies, such as the Social Security Administration and Department of Labor to develop policies on the care, management, and transition of recovering servicemembers and veterans?

Response: FRCs receive training in both DoD and VA benefits, as well as Department of Labor and Social Security Administration benefits. More importantly, FRCs can readily access experts from each of these Departments to answer questions and address concerns.

Question 5(a): Both VA and the Department of Defense (DoD) have promised to provide a Federal Recovery Coordinator (FRC) for every seriously injured servicemember who requests one. As of April 2008, eight FRCs had been placed in selected facilities. What is the target number of FRCs?

Response: The total number of FRCs has not been determined. The program is in the process of tracking the current workload of each FRC as well as the complexity and intensity of needs of the servicemembers and veterans currently enrolled in the program. The program will also examine best practices in administrative and clinical care staffing models to better inform staffing decisions.

Question 5(b): What is the target number of facilities that will have FRCs and where will they be located? How many FRCs will be at each facility?

Response: The number of facilities and number of FRCs assigned to each facility will be determined following the collection and analysis of program workload and case complexity of the severely injured servicemembers and veterans served by the program.

The FRCP office is recruiting staff to review the records of patients who are already in the community. The review process should be complete over the next 12 months. VA will work to expedite the placement of FRCs in additional facility locations.

At the present time, site locations and FRC staffing are:

Current FRC FTEE	Location
2	Walter Reed Army Medical Center, Washington DC
2	National Naval Medical Center, Bethesda, MD
2	Brooke Army Medical Center, San Antonio, TX
1	Naval Medical Center, San Diego, CA
1	Providence VA Medical Center
1	Michael E. DeBakey VA Medical Center

Question 5(c): What progress has been made to hire additional coordinators?

Response: VA has nine FRCs in place and is recruiting additional FRCs on a continuous basis. In addition, VA is recruiting a registered nurse case reviewer position to be located VA Central Office to review cases and determine if the patient would benefit from the services of an FRC.

Question 5(d): What is the ideal ratio of coordinators to injured servicemembers and what is the basis for this ratio?

Response: The ideal ratio of servicemembers assigned to an individual FRC coordinator has not been determined. FRCP is tracking and analyzing workload and case complexity of servicemembers and veterans enrolled in the program.

Question 5(e): Is the role of the coordinator to work closely with individual servicemembers, or only to provide oversight for problems relating to the warrior transition units?

Response: The FRC develops and oversees, the Federal individualized recovery plan (FIRP). The plan describes the resources necessary to assist the severely wounded, ill and injured servicemembers, veterans and families through recovery, rehabilitation, and reintegration into the community. The FRC will work closely with severely ill/injured servicemembers, veterans and their families, as well as DoD and VA case managers and State, local, private and public service organizations in assisting servicemembers and veterans as they transition from DoD to the community.

Question 5(f): Will servicemembers who were discharged prior to the creation of FRCs have access to them?

Response: In May 2008, the FRCP was expanded to include those severely wounded, ill and injured servicemembers, veterans discharged prior to the creation of the FRCP. The FRCP is working to identify those individuals who were or are being treated in VA rehabilitation programs (spinal cord injury, blind rehabilitation, and polytrauma units) and who might still benefit from the FRCP services. Case management data from DoD and TRICARE will also be reviewed to identify catastrophically wounded, ill and injured who are not currently enrolled in, or using VA healthcare.

Question 6(a): Given that the number of servicemembers diagnosed with post traumatic stress disorder and traumatic brain injury has increased by almost 50 percent from 2006 to 2007, how is VA ensuring that adequate resources are available to address the needs of veterans?

Response: The statement about a 50-percent increase in the diagnosis of post traumatic stress disorder (PTSD) and TBI appears to be related to a May 27, 2008 news release from the Pentagon about servicemembers diagnosed with PTSD in 2006 and 2007. It is not a statement about overall prevalence of PTSD. VA anticipates seeing more veterans with concerns related to PTSD and other war related disorders than those identified by DoD. However, the increase in DoD servicemembers with PTSD refers only to OEF/OIF era individuals. In FY 2006, a total of 345,844 veterans with primary or secondary diagnosis of PTSD received treatment at VA medical centers and clinics, 27,049 of whom (7.8 percent) were OEF/OIF vet-

erans. In FY 2007, VA saw 392,743 veterans with a primary or secondary diagnosis of PTSD; 45,675 of them (11.6 percent of the total) were OEF/OIF veterans. Therefore, while there have been reports of a 50-percent increase in the diagnosis of PTSD and TBI among active duty personnel in the Army, increases in these conditions in VA have been lower; from 2006 to 2007, the increase in OEF/OIF veterans seen by VA with a provisional diagnosis of PTSD has increased only 23 percent and the overall number of veterans seen with PTSD has increased less than 14 percent.

VA implemented a TBI screening program in April 2007, to screen all OEF/OIF veterans who seek healthcare at a VA facility. Over 171,000 OEF/OIF veterans have been screened positive for possible TBI. Those who screen positive do not necessarily have a TBI, they are referred for a secondary comprehensive evaluation to confirm or rule out a diagnosis of TBI. This new initiative will provide the basis for determining the prevalence of mild TBI among OEF/OIF veterans, and monitoring increases or decreases from year to year. Presently, data are being compiled and analyzed for those veterans who have completed the screening and comprehensive secondary evaluation.

Beginning FY 2007, 154 severe cases of TBI have received inpatient rehabilitation. Of these, 40 were combat injured treated in polytrauma rehabilitation centers.

VA has provided supplemental funding to enhance the care of veterans with TBI/polytrauma. Additional funding for advanced technologies to provide state-of-the-art care for veterans with TBI/polytrauma was provided in the following areas:

- Equipment for pain management, body weight support and rehabilitation in mobilization of individuals with musculoskeletal and neurological impairments
- Technologies to evaluate function and provide therapeutic interventions and rehabilitation for physical, neurological and cognitive functions; e.g., speech, voice, hearing, balance, low vision/blindness, mobility
- Drivers training for patients with limited mobility or ambulation
- Assistive technologies (AT) labs with skilled personnel, AT assessment processes, and credible AT outcomes data to augment rehabilitation and provide injured veterans with the greatest potential for independent functioning

Additional funding for dedicated core staff with specialized training and expertise in assessment and management of TBI/polytrauma at polytrauma system of care (PSC) facilities was also provided for a core staffing model that includes: nursing, psychology, social work and rehabilitation disciplines such as physiatrist, occupational therapy and speech language pathology.

Question 6(b): What strategies are being employed to hire the number of mental health professionals needed to meet the increased need for mental health services for veterans and their families? What is the status of these efforts?

Response: VA has taken several actions at multiple levels to promote the recruitment of qualified mental health professionals in VHA. In collaboration with the VA Healthcare Retention and Recruitment Office and the Office of Management Support, the Office of Mental Health Services has developed a comprehensive mental health enhancement recruitment initiative with several new recruitment resources, including:

- Mental health education debt reduction program (effective February 17, 2007);
- Mental health employee incentive referral initiative (effective February 17, 2007);
- Targeted and general advertising, including online and print job ads in leading professional journals and local and national newspapers;
- Development of a public relations toolkit;
- Brochure development; and
- Educational conferences and job fairs.

The mental health education debt reduction program (EDRP) provides loan repayment for qualified student debt to mental health providers who previously had limited access to such resources, since in the past there has not been significant difficulty hiring in most mental health disciplines. As of June 24, 2008, total funding authorized for the mental health EDRP since its initiation last fiscal year was $5.9 million. The employee incentive referral program provides a bonus to VA employees who refer mental health providers who are hired into VA positions.

In addition to the above national recruitment initiative, VHA has established additional opportunities for facilities to engage in local advertising and recruitment activities, and to cover interview-related costs, relocation expenses, and provide hiring bonuses for exceptional applicants. VA has also established opportunities for supporting individual training and education activities for mental health employees, demonstrating an investment in staff that can have a positive impact on retention.

VA has also funded several initiatives to provide comprehensive clinical training to VA mental health staff in the delivery of state-of-the-art, evidence-based treatments for PTSD, depression, and psychosocial rehabilitation.

VHA closely tracks the hiring status of newly awarded mental health positions and backfill positions on a monthly basis through an online reporting and tracking system. Monthly reports on hiring activity and monthly change are reviewed by program staff and VHA leadership. In addition, VA has implemented a mental health staffing performance monitor that tracks the hiring status of newly awarded mental health positions and backfill positions against pre-set targets.

Rates of hiring have increased significantly, following the implementation of these new recruitment resources. Since FY 2005, when VA began implementing its Mental Health Strategic Plan, VA has funded an additional 4,330 mental health enhancement positions; as of May 31, 2008, 92 percent (3,983) have been hired.

VA has also significantly expanded the number of VA psychology internship and postdoctoral fellowship positions, which provide a strong pipeline of highly qualified psychologists to VA. In fact, 73 percent of psychologists hired in VA in the past 2 years have had VA training. The new training positions include 61 new internship positions and 98 post-doctoral fellowship positions, bringing the national number of training positions in psychology to 620 per year.

The vet center program expansion began in FY 2004, and is scheduled to be complete by FY 2009, with results in increases in all vet centers staff from 943 in FY 2004 to 1,526 by the end of FY 2009. This is a result of adding 65 new vet centers, 100 outreach specialists and staff augmentations at existing vet centers.

Question 6(c): What other strategies are in place to expand the mental health services available to returning servicemembers and veterans?

Response: VA has a comprehensive treatment system for veterans with mental disorders that include inpatient, residential and outpatient services. Special programs for veterans with serious mental disorders who require intensive case management and for veterans who are homeless exist in all VA medical centers. Since FY 2005, VA mental health programs have had an expansion to enhance the continuum of care and improve clinical services through disseminating evidence based practices in psychotherapy and recovery and rehabilitation services for the seriously mentally ill. Programs for PTSD, special mental health teams for OEF/OIF veterans and substance use disorders have had significant expansions. As of the close of FY 2007, there were 238 specialized PTSD programs and program modules across the Nation and 90 specialized mental health OEF/OIF programs. Every VA medical center has outpatient PTSD specialty capability as do an increasing number of Community Based Outpatient Clinics (CBOCs). As of the end of the first quarter of FY 2008, 93 percent of CBOCs reported visits to mental health professionals either onsite, by telemental health or fee basis. There are increasing numbers of PTSD programs or tracks within PTSD programs to meet special needs such as veterans with co-occurring PTSD and substance use disorders and veterans who are survivors of military sexual trauma. Mental health programs, especially those for OEF/OIF veterans, have ties to the national, regional and local rehabilitation programs for polytrauma and TBI.

Question 7(a): What lessons have been learned from the implementation of the disability evaluation system pilot currently underway in Washington, DC-area facilities?

Response: A number of lessons have been learned from the disability evaluation system (DES) pilot in the National Capitol region. Among the most important are the following:

- VA and DoD can work collaboratively to successfully streamline the DES process; making it more transparent to the member.
- VA can meet the timeliness standards for examinations that are adequate for both DoD and VA.
- VA can produce timely ratings to meet the needs of the physical evaluation boards.
- VA can award benefits within days of the member's separation from service.
- Except for the war-wounded members in the DES, participants have similar disabilities as non-DES veterans.
- The amount of time spent by military service coordinators with participants is significant, and demonstrates a need for more staff in this area.
- Information technology (IT) connectivity issues can be significant processing bottlenecks but joint VA/DoD efforts can resolve them.
- This process needs to become paperless.

- More members are placed on the temporary or permanent disability retired list than historically has been the case.

VA and DoD need to have the correct procedures and resources to assist servicemembers in more challenging environments.

Question 7(b): GAO reported in February 2008 (GAO–08–514T), the departments had not finalized their criteria for expanding the pilot and had not developed measures to assess the performance of the pilot. What steps have the departments taken to develop the expansion criteria and performance measures for the pilot? What is the current status of the departments' plan to expand the pilot?

Response: VA and DoD developed measures to assess the performance of the pilot. We believe that the key metrics for success of the pilot include:

- Customer satisfaction
- A significant reduction in the time from military evaluation boards (MEB) referral to receipt of VA disability benefits for those separated or retired
- Quality and consistency of decisionmaking across services with regard to disability evaluations
- Greater transparency and information to the member going through the process
- Savings to the government through use of only one examination for both agencies
- In the final analysis the over-arching metric is "Is it better?"

Early presentations to the Senior Oversight Committee (SOC) by DoD demonstrate that the pilot process is "better" in many ways.

DoD has identified nine installations as the pool from which to select the first expansion site(s). A site checklist has been developed to assess the facilities' staffing, examination requirements, and the number of DoD physical evaluation board liaison officers (PEBLO) and VA military services coordinators needed for the expansion. A decision to expand the pilot requires the approval of the SOC.

VA and DoD have also identified the minimum IT requirements needed to support the expansion. VA is moving aggressively to begin integration of paperless processing into the DES pilot.

Question 7(c): I understand that even after DoD and VA combine the disability assessment examination, there will be two disability ratings assigned to a servicemember. What measures have been taken to reconcile the dual rating assignment given to an individual servicemember when determining disability benefits?

Response: Although only one rating is prepared for a servicemember found unfit, the rating decision has two components. The first is the evaluation of those conditions identified as unfitting by DoD. When more than one condition is found unfitting, a combined evaluation for all unfitting conditions is provided.

The second evaluation is of those additional conditions, if any, that the servicemember believes may have been incurred or aggravated by their military service. A combined evaluation for VA purposes for all conditions, unfitting and claimed, is provided. It is important to understand that for each condition only one evaluation is assigned. Prior to the pilot, it was possible for VA and DoD to evaluate the same condition differently.

Question 8(a): What is the status of the planned September 30, 2008 target date for the electronic exchange of medical records between the departments? Has the interagency program office encountered any barriers to meeting this date? If so, what have they done to address them?

Response: The 2008 NDAA required the departments to form an Interagency Program Office (IPO) and achieve an interoperable electronic health record by September 30, 2009. On April 17, 2008, VA and DoD formed the IPO and are now on target to achieve the interoperability milestone.

By October 2008, the departments will achieve the ability to share all "essential" electronic health information bidirectionally, as determined by the Joint Clinical Information Board (JCIB). "Essential information includes: outpatient pharmacy and allergy information; outpatient and inpatient laboratory orders and results; radiology reports; inpatient information such as discharge summaries, inpatient consults, operative reports, history, physical reports, and vital signs. DoD also sends scanned inpatient records and radiology images from three key military treatment facilities to the four VA polytrauma centers receiving DoD's wounded warriors. The JCIB will evaluate additional data types, determine whether they should be shared in computable format or viewable format, and identify and prioritize the next set of data to be shared between DoD and VA.

The departments do not anticipate any barriers to meeting the NCAA date of September 2009 for sharing of essential health information. However, the IPO faces the same challenges faced by the departments when working toward interoperability. For example, although not all data needs to be shared in computable format, in order to increase the sharing of computable data, the departments must identify and implement robust health data standards. To address this issue, the IPO will continue to support the standards-related efforts of the Health and Human Services Office of the National Coordinator for Health IT, and the VA and DoD subject matter experts that lead this effort.

Question 8(b): Will medical records of National Guard and Reserve servicemembers be included in this effort?

Response: The electronic exchange of medical records will include health information on deployed Guard and Reserve servicemembers.

Question 8(c): What is the status of the reports on information technology (IT) interoperability that were mandated in conference report language for the 2008 NDAA legislation?

Response: On April 29, 2008, VA and DoD delivered the first report to Congress detailing the steps it had taken to establish the interagency program office under section 1635 of the 2008 NDAA. VA and DoD are now on target to deliver the first annual report on the status of interoperability by December 2008, and updated annually thereafter, through 2014, as mandated by the legislation.

Additionally, Conference Report 110–424 of H.R. 3043 and Conference Report 110–434 of H.R. 3332 required an interim joint report describing steps taken by the departments to achieve interoperability. The departments are currently finalizing the report and anticipate providing it to Congress by August 31, 2008.

Question 9: When will VA publish its handbooks for the Transition Assistance and Case Management of OEF/OIF Veterans and for the Federal Recovery Coordinators?

Response: On May 31, 2007, VA published Handbook 1010.01 *Transition Assistance and Case Management of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) Veterans.* This handbook established procedures for the transition of care, coordination of services, and care management of OEF/OIF active duty servicemembers and veterans by VHA and Veterans Benefits Administration.

A joint VA/DoD handbook for the FRCP is being developed and is expected to be published by the end of summer 2008.

Question 10: On April 2, 2008, VA and DoD testified that they were working on a joint Military Eye/Vision Injury Registry. Please provide a timeline for the implementation of the eye registry.

Response: We defer to DoD for this response.

Committee on Veterans' Affairs
Washington, DC
June 18, 2008

Honorable Robert M. Gates
Secretary
U.S. Department of Defense
The Pentagon, Room 3E718
Washington, DC 20301–1000

Dear Secretary Gates:

On Wednesday, June 11, 2008, Michael L. Dominguez, Principal Deputy Under Secretary of Defense for Personnel and Readiness, testified before the House Committee on Veterans' Affairs on Implementing the Wounded Warrior Provisions of the National Defense Authorization Act for Fiscal Year 2008. As a follow-up to the hearing, I request the enclosed questions be answered in written form for the record by close of business, 5 p.m. on Tuesday, July 29, 2008.

It would be appreciated if the responses could be provided consecutively on letter size paper, single-spaced. Please restate the question in its entirety before providing the answer.

If you or your staff have any questions, please contact Dolores Dunn, Republican Staff Director for the Subcommittee on Health, at 202–225–3527.

Sincerely,

Steve Buyer
Ranking Republican Member

Hearing Date: June 11, 2008
Committee: HVA
Member: Congressman Buyer
Witness: Hon. Dominguez

Care, Management, and Transition for Recovering Servicemembers

Question 1: What is the status of the review of all policies and procedures that relate to the care, management, and transition for recovering servicemembers required under section 1611 of Public Law 110–181, the National Defense Authorization Act (NDAA) for Fiscal Year 2008? Are there any policies and procedures that have yet to be reviewed?

Response: The Department of Defense (DoD) has completed our review of all policies and procedures that relate to the care, management and transition of recovering servicemembers. Our review covered United States Code, DoD level policies and procedures, military services' regulations, and other pertinent documents such as the Joint Federal Travel Regulations. We extracted the best practices and possible shortfalls as required by the National Defense Authorization Act Fiscal Year 2008 and have included them in our Report to Congress. In addition to identifying possible shortfalls, we identified several issues that may require either legislative or administrative actions to correct. We also reviewed the Department of Veterans Affairs policies that pertain to recovering servicemembers.

SOC Review of Policies and Procedures

Question 2: It my understanding that the Senior Oversight Committee (SOC) was expecting to complete a full review of all policies and procedures relating to the care and management of wounded, ill, or injured servicemembers/veterans and their families by April 27, 2008. Were these reviews completed? If so, please provide documentation.

Response: The Department of Defense (DoD) has completed our review of all policies and procedures that relate to the care, management and transition of recovering servicemembers. Our review covered United States Code (U.S.C.), DoD level policies and procedures, military services' regulations, and other pertinent documents such as the Joint Federal Travel Regulations. We extracted the best practices and possible shortfalls as required by the National Defense Authorization Act for Fiscal Year 2008 and have included them in our Report to Congress. In addition to identifying possible shortfalls, we identified several issues that may require either legislative or administrative actions to correct. We also reviewed the Department of Veterans Affairs (VA) policies that pertain to recovering servicemembers.

The list of the most critical policies and procedures reviewed by DoD is provided below.

Policies and Procedures Relating to the Care and Management of Wounded, Ill, or Injured Servicemembers/Veterans and Their Families Reviewed by DoD:

Legislative

U.S.C. Title 10
U.S.C. Title 32
Code of Federal Regulations, 199.17.32 Ch. I
Joint Federal Travel Regulation Volume 1
Joint Federal Travel Regulation Volume 2

DoD

DoDD 1342.17 Family Policy (Dec 88)
DoDD 5136.12 TRICARE Management Activity (TMA) (May 01)
DoDD 5154.06 Armed Services Medical Regulating (Jan 05)

DoDD 6010.14 Healthcare for Uniformed Services Members and Beneficiaries (Mar 07)

DoDI 1300.18 Military Personnel Casualty Matters, Policies, and Procedures (Dec 00)

DoDI 1332.38 Physical Disability Evaluation (Nov 96)

DoDI 1332.39Application of the Veterans Administration Standards for Rating Disabilities (Nov 96)

DoDI 1342.22 Family Centers (Dec 92) DoDI 6000.11 Patient Movement (Sep 98)

DoDI 6000.14 Patient Bill of Rights and Responsibilities in the Military Health System (MHS) (Sep 07)

DoDI 6010.23 Department of Defense and Department of Veterans Affairs Healthcare Resource Sharing Program (Sep 05)

DoDI 6025.20 Medical Management (MM) Programs in the Direct Care System (DCS) and Remote Areas (Jan 06)

DoDI 6490.03 Deployment Health (Aug 06)

DoD Health Affairs Interim Policy for Clinical Case Management for the Wounded, Ill, and Injured Servicemember in the Military Health System UPDATE January 22, 2008

DoD Health Affairs Policy 08–001 Implementation of New Medical Expense and Performance Reporting System Codes to Track Case Management Associated with Global War on Terror Heroes (Mar 08)

DoD Health Affairs Policy 07–030 traumatic brain injury Definition and Reporting (Oct 07)

DoD Health Affairs Policy 05–018 Expediting Veterans Benefits to Members with Serious Illnesses and Injuries (Sep 05)

DoD Health Affairs Policy 04–031 Coordination of Policy to Establish a Joint Theater Trauma Registry (Dec 04)

DoD Health Affairs Policy 03–026 Personnel on Medical Hold (Oct 03)

DoD Health Affairs Policy 02–022 Department of Veterans Affairs Participation in TRICARE (Dec 02)

DoD Health Affairs Policy 99–023 Inclusion of Department of Veterans (VA) Affairs Health Facilities TRICARE Network Providers (May 99)

DoD Health Affairs Policy 99–028 Establishment of DoD Centers for Deployment Health (Sep 99)

DoD Financial Management Regulation, Volume 7A, Chapter 35 (Nov 05)

DoD Financial Management Regulation, Volume 7A, Chapter 50 (May 06)

TMA—Medical Management Guide (Jan 06)

VA

VHA Directive 2007–012 Eligibility Verification Process for VA Healthcare Benefits (Apr 07)

VHA Directive 2005–045 Treatment of Active Duty Servicemembers in VA Healthcare Facilities (Oct 05)

VHA Directive 2005–020 Determining Combat Veteran Eligibility (Jun 05)

VHA Directive 2007–013 Screening and Evaluation of Possible traumatic brain injury in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) Veterans (Apr 07)

VHA Directive 2006–041 Veterans Healthcare Service Standards (Jun 06)

VHA Directive 2006–055 VHA Outpatient Scheduling Processes and Procedures (Oct 06)

VHA Directive 2006–038 Considerations for VA Support for the Department of Defense (DoD) Post Deployment Health Reassessment (PDHRA) Program for Returning Deployed Servicemembers (Jun 06)

VHA Directive 2006–59 Active Patients in the Primary Care Management Module (PCMM) (Nov 06)

VHA Directive 2007–016 Coordinated Care for Traveling Veterans (May 07)

VHA Directive 2006–028 Process for Ensuring Timely Access to Outpatient Clinical Care (May 06)

VHA Directive 2003–003 Provision of Hospital Outpatient Care to Enrolled Veterans (Jan 03)

Army

Warrior Transition Unit Consolidated Guidance (Mar 2008)

Comprehensive Care Plan (Draft—Feb 2008)

Soldier and Family Assistance Handbook

Army Regulation 40–400 Patient Administration (Feb 08)

Army Regulation 40–501 Standards of Medical Fitness (Dec 07)

Army Regulation 635–40 Physical Evaluation for Retention, Retirement or Separation (Feb 06)

Army Regulation 600–8–4 Line of Duty Policy, Procedures and Investigations (Apr 04)

OTSG/MEDCOM Policy Memo 07–019 Guidance for MEDCOM Reunion and Reintegration of Redeploying Soldiers (Jun 07)

OTSG/MEDCOM Policy Memo 07–029 Physical Evaluation Board Liaison Officer (PEBLO) Training and Certification (Jul 07)

OTSG/MEDCOM Policy Memo 07–031 Access to Veterans Benefits Counseling (Aug 07)

OTSG/MEDCOM Policy Memo 07–036 Escorts for non-Medical Caregivers and Families Traveling on Official Orders (Aug 07)

OTSG/MEDCOM Policy Memo 07–038 Ombudsman Program in Support of Warriors in Transition (Sep 07)

OTSG/MEDCOM Policy Memo 07–040 Metrics and Continuous Process Improvement for Medical Evaluation Board (MEB) and Physical Evaluation Board (PEB) (Sep 07)

OTSG/MEDCOM Policy Memo 07–041 Patient Movement from Outside Continental United States (OCONUS) and Reception of Warriors in Transition to Continental United States (CONUS) Military Treatment Facilities (MTFs)

Navy

Navy Policy Memorandum (Unnumbered) traumatic brain injury (TBI) Definition and Reporting (Dec 07)

Navy Policy Memorandum 07–018 Case Management Policy (Jun 07)

Navy Policy Memorandum 05–002 Implementing Traumatic Injury Protection Under the Servicemembers Group Life Insurance (Dec 05)

SECNAVINST 1850 Severely Injured Marines and Sailors (SIMS) Pilot Program (Sep 06)

SECNAVINST 1850.4E Department of the Navy Disability Evaluation Manual, Part 6—Policy Governing the Temporary Disability Retired List (Apr 02)

JAGINST 5800.7D Reporting Requirements for Line of Duty (LOD) Determinations (Feb 05)

BUMED Directive 5370.3 Navy Medicine Hotline Program (Apr 06)

BUMED Directive 6300.10A Customer Relations (Aug 01)

BUMED Directive 6320–12 Transfer of Patients of the Naval Service to Veterans Administration Facilities (Jan 87)

Marine Corps

Casualty Care Process (Dec 07)

Wounded Warrior Regiment Marine Reserve MEDHOLD Checklist Marine Corps Order 1754.8A Marine for Life (May 03)

Marine Corps Order 6320.2E Administration and Processing of Injured/Ill/Hospitalized Marines (Nov 07)

Leaders Guide for Managing Marines in Distress (web based)

Air Force

Air Force Instruction 36–2910 Line of Duty (Misconduct) Determination (Oct 02)

Air Force Instruction 36–3212 Physical Evaluation for Retention, Retirement and Separation (Feb 06)

Air Force Instruction 36–3009 Airman and Family Readiness Centers (Jan 08)

Air Force Instruction 44–102 Medical Care Management (May 06)

Air Force Instruction 44–147 Air Force Order SISUP Medical Evaluation Boards (MEB) and Continued Military Service (Nov 07)

Memorandum: PALACE HART (Helping Airmen Recover Together) (Feb 06)

Report on Policy Improvements on the Care, Management, and Transition of Recovering Servicemembers

Question 3: What progress has been made since the issuance of the Interim Report on Policy Improvements on the Care, Management, and Transition of Recovering servicemembers? If the final report will not be ready for release on July 1, 2008, please provide an explanation for the delay. Please provide the Committee with a copy of the final report when it is issued for the Committee's records.

Response: Both Departments have made significant progress on developing a joint Comprehensive Policy on Improvements to Care, Management and Transition of Recovering servicemembers since we issued our interim report. We are developing uniform standards for curriculum, training, workload, and processes to support the

management and transition of recovering servicemembers to include development and execution of a comprehensive recovery plan for this patient population. Both agencies have conducted a review of existing policies and procedures that apply to or will be covered by the comprehensive policy to identify the most effective and patient-oriented approaches for care and management of our recovering servicemembers. Developing this policy requires extensive coordination between the Services as well as between both agencies. We will provide a report to Congress detailing the comprehensive policy by August 15, 2008. The Department of Defense in consultation with the Department of Veterans Affairs will issue a directive type memo to provide interim guidance for improvements to care, management and transition of our recovering servicemembers no later than September 15, 2008, to be followed by a Department of Defense Instruction.

Inter-Agency Collaboration

Question 4: To what extent will the Department of Defense (DoD) collaborate with other Federal agencies, such as the Social Security Administration and Department of Labor to develop policies on the care, management, and transition of recovering servicemembers?

Response: The Department of Defense (DoD) is, and will continue to collaborate closely with the Department of Veterans Affairs (VA) and other Federal agencies with programs, services, benefits or compensation for recovering servicemembers or veterans. The Social Security Administration (SSA) has been engaged with DoD in care for wounded warriors since their participation in the DoD Military Severely Injured Center and the Department of Navy Seriously Injured Sailors and Marines programs. SSA is a member of the DoD/VA Case Management Working Group and participates in the development of the DoD/VA National Resource Directory. DoD is reaching beyond the Federal agencies in their identification and coordination of care, management and transition for recovering servicemembers through the National Defense Authorization Act mandated Comprehensive Recovery Plan. Through the National Resource Directory, recovering servicemembers and their care coordinators will have a national link to state, local, private and non-profit services and resources that the servicemember and care provider can interact with in developing the Comprehensive Recovery Plan.

Federal Recovery Coordinators (FRCs)

Question 5: Both the Department of Veterans Affairs (VA) and DoD have promised to provide a Federal Recovery Coordinator (FRC) for every seriously injured servicemember who requests one. As of April 2008, eight FRCs had been placed in selected facilities.

a. What is the target number of FRCs?
b. What is the target number of facilities that will have FRCs and where will they be located? How many FRCs will be at each facility?
c. What progress has been made to hire additional coordinators?
d. What is the ideal ratio of coordinators to injured servicemembers and what is the basis for this ratio?
e. Is the role of the coordinator to work closely with individual servicemembers, or only to provide oversight for problems relating to the warrior transition units?
f. Will servicemembers who became wounded, ill, or injured, prior to the creation of FRCs have access to them?
g. Have VA and DoD established performance measures for the FRC program?
h. What are the requirements for the FRC program?
i. How will those not meeting the criteria for the FRC program be served?

Response: Federal Recovery Coordinator positions are established in four major military Treatment facilities: Walter Reed Army Medical Center, National Naval Medical Center, Naval Hospital San Diego (Balboa), and Brooke Army Medical Center. Although the Department of Defense (DoD) and the Department of Veterans Affairs (VA) are integrated in the Federal Recovery Coordination Program, the personnel and management aspects are under VA auspices. Therefore, DoD defers to VA to further address this issue.

PTSD

Question 6: Given that the number of servicemembers diagnosed with post traumatic stress disorder and traumatic brain injury has increased by almost 50 percent

from 2006 to 2007, how is DoD ensuring that adequate resources are available to address the needs of these servicemembers?

a. What strategies are being employed to hire the number of mental health professionals needed to meet the increased need for mental health services for veterans and their families? What is the status of these efforts?
b. What other strategies are in place to expand the mental health services available to returning servicemembers?
c. Does DoD have any efforts specifically targeted for suicide prevention?

Response: We received $900 million to address the psychological health and traumatic brain injury needs of our servicemembers, of which approximately $300 million was targeted toward psychological health programs across the continuum of care. An additional $150 million was directed toward research in the areas of psychological health. Additionally, a comprehensive strategy has been developed to improve our ability to prevent, screen, diagnose, treat, and assist with the transition of our servicemembers who are exposed to the stresses of combat. We repeatedly assess this continuum for gaps as we evaluate the outcomes of newly established programs to ensure we are meeting emerging needs. Of particular note is the fact that under the auspices of the Senior Oversight Committee, we are aggressively partnering with the Department of Veterans Affairs (VA) to make the system as cooperative and supportive to the servicemember as possible.

Several strategies are employed to increase the number of mental health professionals. Recruiting and retention bonuses are offered for military service as a mental health professional. TRICARE is currently working to increase the number of network providers available to care for beneficiaries and to support a 7-day access standard for initial mental health evaluation. Contract providers are being hired across the enterprise by the Services. The VA has already increased the number of mental health providers by 1172 since May 1, 2007. We entered into an agreement with the Department of Health and Human Services to assign 200 Public Health Service Officers who are also mental health professionals to support the Department of Defense (DoD). We are expanding infrastructure and technological solutions to provide mental health services and support via Telehealth systems which will allow us to use difficult to recruit specialists in a more efficient manner.

A comprehensive population- and risk-based staffing model is being validated by the Center for Naval Analyses that will account for meeting mental health needs through a variety of mechanisms to include:

- expanding embedding mental health providers into operational units;
- increasing integration of mental health providers into primary care clinics (approaching 70 percent of clinics in one Service);
- developing collaborative care models focused upon enhancing screening and treatment of PTSD and depression in primary care (Army's Re-Engineering Systems for the Primary Care Treatment of Depression and PTSD in the Military program);
- implementing Telehealth and technology initiatives including mental health clinical care;
- continuing to maximize pre-clinical support through MilitaryOneSource online and face-to-face counseling; and
- rolling out in July 2008 after-deployment resources for confidential online self-assessment and self-help.

DoD and the Services have numerous programs targeted at suicide prevention including:

- annual suicide prevention training of servicemembers and DoD civilian employees;
- leadership training in suicide prevention;
- military leadership training to manage Service and family members in distress;
- frontline supervisor training;
- dissemination of suicide prevention training materials, videos, and posters;
- monitoring and analyzing lessons learned from suicides;
- risk assessment advanced training for providers;
- executing nationally recognized best practice suicide prevention initiatives;
- multiple initiatives to reduce stigma from seeking mental health support;
- chaplains' initiatives in suicide prevention and absolute confidentiality;
- Suicide Prevention Week activities;
- Signs of Suicide (SoS) programs in DoD school systems for children/adolescents;

- Train-the-Trainer workshops in various suicide prevention modalities as Ask your buddy, Care for your buddy, Escort your buddy, Applied Suicide Intervention Skills training, safeTALK;
- chain teaching programs for suicide prevention;
- case discussions for suicide prevention;
- improved access to care with more mental health providers and 7-day routine access standard;
- post-intervention support programs for unit members/families of those who suicide;
- confidential behavioral health surveys to monitor risk factors and substance abuse;
- relationship building programs such as the Chaplains' Strong Bonds Program;
- civilian services staff training (Morale, Welfare and Recreation, Gym, hobby/auto shops, etc.) such as the "Are You Listening?" program to help recognize those in distress and facilitate help;
- substance abuse education and training;
- military family life consultant program;
- family support programs;
- family advocacy programs;
- sexual abuse recovery and support programs;
- community health promotion councils;
- integration delivery systems of community assets for psychological support;
- community action information boards;
- family readiness units;
- financial management training programs;
- responsible drinking educational programs;
- deployment support programs—Battlemind, Landing Gear, Operational Stress Control;
- web-based distance learning programs for suicide prevention;
- suicide prevention pocket cards and brochures;
- community awareness marketing for support services;
- drug demand reduction and prevention services/education programs;
- personal readiness summits;
- standardized suicide data reporting and DoD comprehensive database to monitor suicide;
- annual DoD/Department of Veterans Affairs suicide prevention conferences with leading academics and government agencies;
- academic collaborations developing suicide nomenclature;
- DoD-produced public announcements/videos re: suicide prevention; and
- active DoD Suicide Prevention and Risk Reduction Committee coordinating dissemination and coordination of programs

Lessons Learned from Disability Evaluation System Pilot

Question 7: What lessons have been learned from the implementation of the disability evaluation system pilot currently underway in Washington, DC-area facilities?

a. As GAO reported in February 2008 (GAO–08–514T), the departments had not finalized their criteria for expanding the pilot and had not developed measures to assess the performance of the pilot. What steps have the departments taken to develop the expansion criteria and performance measures for the pilot? What is the current status of the departments' plan to expand the pilot?
b. I understand that even after DoD and VA combine the disability assessment examination, there will be two disability ratings assigned to a servicemember. What measures have been taken to reconcile the dual rating assignment given to an individual servicemember when determining disability benefits?

Response: The Department appreciates the Committee's interest in the performance evaluation, expansion, and further implementation of the pilot and the rating schematic. These questions require lengthy answers, which have been included in reports required by the National Defense Authorization Act for Fiscal Year 2008, Public Law 110–181. Specifically, the Department refers you to the initial report required by section 1644 (Authorization of Pilot Programs to Improve the Disability Evaluation System for members of the Armed Forces) and a forthcoming report required by section 1612(c), "Assessment of Consolidation of Department of Defense and Department of Veterans Affairs Disability Evaluation Systems." The section 1644 report was submitted to Congress on April 30, 2008. We anticipate providing the section 1612(c) report to the Committee by August 1, 2008.

Electronic Exchange of Medical Records Target Date

Question 8: What is the status of the planned September 30, 2009 target date for the electronic exchange of medical records between the departments? Has the interagency program office encountered any barriers to meeting this date? If so, what have they done to address them?

a. Will medical records of National Guard and Reserve servicemembers be included in this effort?
b. What is the status of the reports on information technology (IT) interoperability that were mandated in conference report language for the fiscal year 2008 NDAA?

Response: We are on track to electronically exchange essential medical data between the Department of Defense (DoD) and the Department of Veterans Affairs (VA). A Joint Clinical Information Board (JCIB), comprised of DoD and VA Board Certified Physicians, was established to define, prioritize and validate health data deemed "essential" to continuity of care. The JCIB members examined the five criteria established by the Institute of Medicine (IOM) that define the core functionalities of an electronic health record (EHR). The five criteria from IOM [1] are: 1) Improve patient safety, 2) Support the delivery of effective patient care, 3) Facilitate management of chronic conditions, 4) Improve efficiency, and 5) Feasibility of implementation. Using the IOM model and their own clinical experience, JCIB members then made a determination of essential health data elements to share between the VA and DoD EHRs. The list of data elements below are identified by the JCIB members as "essential" for sharing between the two agencies based on these established criteria and the DoD Medical Readiness mission.

Information Type	One-Way [2]	BiDirectional [3]
Demographics	May 2002	Oct 2004
Outpatient Medication	May 2002	Oct 2004
Allergies and adverse reaction	May 2002	Oct 2004
All radiology reports	May 2002	May 2005
Labs: chemistry, hematology, microbiology, serology, virology, toxicology, anatomical pathology	May 2002	May 2005
Outpatient progress notes		Dec 2007
Inpatient Notes: • Discharge summary • Operative report, history and physical, inpatient consult		 Jul 2006 Dec 2007
Diagnosis and problem list		Dec 2007
Vital Signs		Jun 2008
Questionnaires: • Pre/Post Deployment Health Assessment • Post Deployment Health Reassessment	 Jul 2005 Sep 2006	 N/A N/A
Family History	Sep 2008	
Polytrauma Image Sharing (Diagnostic Radiology)	Mar 2007	

[2] Uni-directional: information "pushed" from DoD to VA
[3] Bidirectional: data made viewable between DoD and VA

Currently, all health data determined to be "essential" by JCIB members is either being exchanged electronically between the DoD and VA electronic health records or will be exchanged by October 2008.

The Interagency Program Office (IPO) does not anticipate any unforeseen difficulties meeting the planned October 2008 date for sharing essential health data

a. This electronic exchange will include health data captured on deployed Reserve and Guard servicemembers.

[1] Key Capabilities of an Electronic Health Record System, National Academies Press, 2003

b. Section 1635 of the Fiscal Year 2008 National Defense Authorization Act mandated two information technology reports:

1. No later than 30 days after enactment, the Secretary of DoD and the Secretary of VA shall jointly establish a schedule and benchmarks for the discharge of the office by its function:

This report was submitted to the Chairs of the Senate Armed Services, Senate Veterans' Affairs, House Armed Services and the House Veterans' Affairs Committees on April 29, 2008, along with appointment letters for the Acting Director and Acting Deputy Director of the IPO.

2. No later than January 1, 2009, and each year thereafter through 2014, the Director shall submit a report to Congress on the activities of the office during the preceding calendar year:

Both Departments are actively engaged in the assembly and production of this requirement with expected delivery to the appropriate Congressional committees in December 2008.

VA's "F" Grade on FISMA Report

Question 9: With VA's "F" grade on their recent Federal Information Security Management Act (FISMA) report, how does this affect their status as a trusted agent for DoD/VA medical records sharing?

Response: We do not believe the Federal Information Security Management Act (FISMA) report grade impacts the Department of Defense (DoD)/Department of Veterans Affairs (VA) medical records sharing. The FISMA report addresses high-level Federal agency information assurance (IA) efforts and does not necessarily represent the status of specific initiatives such as DoD/VA sharing.

The Military Health System (MHS) oversees an aggressive, vigilant IA program to help ensure the protection of medical data shared with the VA. The MHS IA program ensures compliance with Federal, DoD, and MHS policies such as the Health Insurance Portability and Accountability Act of 1996, DoD Directive 8500.01E, and DoD Instruction 8500.2 to protect medical information systems and data. The MHS manages a rigorous DoD Information Assurance Certification and Accreditation Process (DIACAP) to assess electronic and physical security controls and ensure compliance with DoD security requirements. Additionally, the MHS follows industry best practices, using state of the art assessment tools developed by the Defense Information Systems Agency and the National Security Agency.

In compliance with the FISMA of 2002, DoD and VA have developed a Memorandum of Understanding and an Interconnection Security Agreement as required by Chairman of the Joint Chiefs of Staff Instruction 6211.02B, "Defense Information System Network: Policy, Responsibilities and Processes" and recommended by the National Institute of Standards, Special Publication 800–47, "Security Guide for Interconnecting Information Technology Systems," September 2002. Routine security audits are conducted to ensure compliance.

The information shared between DoD and VA is encrypted via an MHS managed virtual private network (VPN) device. The VPN device is part of the MHS VPN Mesh, which encrypts protected health information between each military treatment facility and key business partners, to include the VA. As DoD and VA work together to improve methods for sharing healthcare information, both agencies will continue to ensure compliance with Federal and DoD IA policies and guidance and take appropriate security measures to protect the health information of our beneficiaries.

Policies Related to Recovering Servicemember's Return to Active Duty

Question 10: What progress has DoD made toward developing policies related to a recovering servicemember's return to active duty?

Response: On March 13, 2008, the Department of Defense (DoD) issued a Directive Type Memo (DTM) that provides supplemental and clarifying guidance on implementing those disability-related provisions of the National Defense Authorization Act of 2008 that are time sensitive and impact immediate decisions pertaining to the rating of conditions and the calculation of separation severance pay. Within this DTM, a revision to paragraph 3.12 of DoD Directive 1332.18, "Separation or Retirement for Physical Disability," November 4, 1996, is required to reflect: "The Secretary concerned, upon request of the member or upon the exercise of discretion based on the needs of the Service, may continue in a permanent limited duty status either on active duty or in the Ready Reserve, a member determined to be unfit because of physical disability when the member's service obligation or special skill and

expertise justifies such continuation. Transfer to another Service may also be considered."

Wounded Warrior Resource Center

Question 11: Section 1616 of the "Wounded Warrior Act" required the Secretary of Defense to establish a Wounded Warrior Resource Center to provide a single point of contact for assistance servicemembers, families, including a toll-free telephone number and a website. Please provide a timeline for compliance with this section.

Response: The Wounded Warrior Resource Center will operate under the universally known Military OneSource call center and take hotline calls, track all calls and responses, refer the issue for remediation, and conduct follow-up. The development, coordination, and resourcing of this requirement is complex and has required extensive examination. We continue to receive and refer calls for the wounded, ill, and injured through Military OneSource, which we will augment with all of the National Defense Authorization Act requirements by October 1, 2008.

Committee on Veterans' Affairs
Washington, DC
July 16, 2008

The Honorable James B. Peake, M.D.
Secretary
Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Secretary Peake:

On June 11, 2008, the Committee held a hearing on the implementation of the "Wounded Warrior" provisions of Public Law 110–181, the FY 2008 National Defense Authorization Act. When fully implemented, this law will significantly enhance the access to care and benefits for servicemembers injured in Operation Iraqi Freedom and Operation Enduring Freedom (OIF/OEF).

The progress the Department of Veterans Affairs (VA) has made to improve the transition process for servicemembers, including the establishment of the Combat Veteran Call Center and the Federal Recovery Coordinator program is notable. I know that the wounds of wartime service are not always as visible as those caused by bullets or shrapnel and your actions to address the mental health needs of veterans and their families, especially those mental disorders associated with traumatic brain injury (TBI), post traumatic stress disorder (PTSD), and substance use disorder is also commendable. However, there is more that still must be done by both VA and the Department of Defense (DoD) to meet the needs of our returning servicemembers and the intent of the law to provide a truly seamless transition from active duty to veteran status.

I am very concerned that a substantial number of the benchmarks set forth in Public Law 110–181 are not being met. Of critical importance are the requirements for VA and DoD to jointly develop and implement standards and policies for a comprehensive care, management, and transition improvement plan and physical disability evaluations. Further, the requirement for the development of an interoperable and bidirectional electronic health record that provides real-time transfer of information between VA and DoD is vital and long overdue. The exchange of electronic medical information between VA and DoD has been an issue of importance to the Committee for many years. I respectfully request immediate action be taken to ensure that the milestones are fulfilled in accordance with the law and the Committee is kept informed of the Department's progress.

Returning OEF/OIF veterans present a broad range of injuries and illnesses that require some new approaches and present new challenges for healthcare and for research. It is also of the utmost importance that we aggressively support research to gain a better understanding of these complex injuries. To encourage innovative research across healthcare delivery systems and facilitate the nationwide sharing of information, I also ask for your leadership to promote greater collaboration of research activities with other Federal partners. Better coordination with the National Institutes of Health (NIH) and DoD will allow us to take full advantage of science-based information and maximize the adoption of evidence-based care and "best practices" in all settings to address the needs of this new generation of veterans.

I thank you for your prompt consideration and attention to these matters and appreciate your continued cooperation with the Committee.

Sincerely,

Congressman Steve Buyer
Ranking Republican Member

THE SECRETARY OF VETERANS AFFAIRS
Washington, DC
August 8, 2008

The Honorable Steve Buyer
Ranking Republican Member
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Congressman Buyer:

This is in response to your letter regarding the implementation of "Wounded Warrior" provisions of Public Law 110–181, the National Defense Authorization Act for fiscal year 2008 (NDAA).

You requested information on the progress the Department of Veterans Affairs (VA) and the Department of Defense (DoD) are making on meeting the requirements of sections of the 2008 NDAA, specifically:

- Developing joint VA/DoD policies for comprehensive care, management, and transition improvement;
- Exchanging electronic medical records;
- Collaborating research activities with other Federal partners, such as National Institutes of Health (NIH); and
- Developing joint VA/DoD policies for physical disability evaluations.

VA and DoD are making progress toward meeting the requirements of the NDAA as it relates to these areas. The enclosed fact sheet provides details on our accomplishments and progress in these areas.

I hope this information is helpful to you. If you require additional information, please contact Karen Malebranche, who is Executive Director of VA's Operation Enduring Freedom/Operation Iraqi Freedom Program. She may be reached at 202–461–8457.

Sincerely yours,

James B. Peake, M.D.

Enclosure

Department of Veterans Affairs Fact Sheet

VA Progress on Implementing Sections of National Defense Authorization Act Fiscal Year 2008 (NDAA) Public Law 110–181

1. Comprehensive Care Management and Transition Efforts

Through the structure provided by the joint Department of Veterans Affairs (VA) and Department of Defense (DoD) Senior Oversight Committee, VA's Care Management and Social Work Service has participated in a review of all policies and procedures that relate to the care, management, and transition for recovering servicemembers and veterans as required by section 1611 of the Fiscal Year (FY) 2008 NDAA. The review included clinical care management and non-clinical management. Both Departments identified best practices and possible shortfalls resulting in many modifications and improvements to current processes.

VA and DoD are jointly developing a directory for the comprehensive care and management of catastrophically injured servicemembers and veterans served by the Federal Recovery Coordination Program.

On May 31, 2007, VA published Handbook 1010.01, *Transition Assistance and Case Management of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) Veterans.* This handbook established procedures for the transition of

care, coordination of services, and care management of OEF/OIF active duty servicemembers and veterans by Veteran Health Administration (VHA) and Veterans Benefits Administration. In May 2008, VA established a charter group comprised of specialty care managers across VA to include OEF/OIF teams, spinal cord, blind rehabilitation, mental health, polytrauma and others to make recommendations for improving the systemwide approach to care management with an emphasis on coordination between programs. This group is expected to submit its report to VA leadership by the end of FY 2008. The findings of this group, as well as the best practices and shortfalls identified by the comprehensive VA/DoD review, will lay the foundation for updating VHA's policy for care management. This document will be finalized by December 31, 2008.

2. Development of Interoperable and Bidirectional Electronic Health Records

VA and DoD responded to the NDAA by immediately taking steps to implement Section 1635, the requirement for interoperable electronic health records between the Departments. On April 17, 2008, VA and DoD met a major milestone of the NDAA by forming the Interagency Program Office (IPO). By leveraging the prior accomplishments of the Departments toward the development of interoperable bidirectional electronic health records, the IPO is on target to meet the September 2009 target date for interoperable health records identified in the law.

To achieve interoperable and bidirectional electronic health records, VA and DoD will leverage the bidirectional capabilities that already exist. For example, VA and DoD are now sharing almost all essential health information that is available electronically in a bidirectional viewable format. This information includes outpatient pharmacy allergy information, vital signs, outpatient and inpatient laboratory orders and results, radiology reports, and select inpatient information such as discharge summaries from key DoD military treatment facilities. DoD also sends clinical theater information which is available to all VA hospitals as well as scanned inpatient records and radiology images from key military treatment facilities to the four VA polytrauma centers receiving DoD's wounded warriors. In addition to sharing viewable information, VA and DoD have begun sharing computable allergy and pharmacy information that supports automatic drug-drug and drug-allergy interaction checks. By September 2008, VA and DoD will begin sharing family and social history information on patients. The Departments also are working on expanding a bidirectional image sharing pilot at six locations and are finalizing an enterprise-wide plan for sharing images that will be delivered in October 2008.

To expand the current sharing and to achieve interoperable health records, the Departments formed the Joint Clinical Information Board (JCIB), which consists of VA and DoD clinicians and end users who are defining the clinical data elements that are needed to treat the Departments' shared patients and support transition of wounded warriors. The JCIB has just recently identified the full set of prioritized data elements that must be made viewable and bidirectional between DoD and VA in order to support these requirements. Upon approval of the requirements by the DoD/VA Health Executive Council, the Departments will execute the development and testing necessary to implement the capabilities by September 2009.

The JCIB is currently evaluating the additional data types that should be shared in computable format as well as identifying and prioritizing the next set of data to be shared between DoD and VA.

Despite this accomplishment, VA and DoD acknowledge that there are several layers of interoperability and that the Departments are sharing most information in viewable format, rather than computable. In order to expand this capability to share more computable data, VA and DoD must leverage information standards that are mature and robust enough to support the exchange of information for patient care. Such standards do not yet exist in all clinical domain areas.

Conference Report 110–424 of H.R. 3043 and Conference Report 110–434 of H.R. 3332 required a joint report describing steps taken by the Departments to achieve interoperability pursuant to the law. On April 29, 2008, VA and DoD delivered an interim report to Congress detailing the steps taken to establish the IPO under section 1635 of the NDAA. The Departments are currently finalizing a draft of the Final Report and anticipate providing it to Congress by August 31, 2008.

The NDAA also required that VA and DoD deliver a series of reports to Congress advising it of the status of efforts to implement the law. VA and DoD are on target to deliver the first annual report on the status of interoperability by January 1, 2009. VA and DoD anticipate delivering an updated annual report every January thereafter, through 2014, as mandated by the legislation.

3. Research Support

VA agrees that there should be aggressive support of research to gain a better understanding of the complex injuries that OEF/OIF veterans present and that we must promote better collaboration of research activities with our Federal partners. Toward these ends, VA is collaborating with DoD, the National Institutes of Health (NIH), the National Science Foundation (NSF), other Federal agencies, and the private sector. For example, VA participates on the Federal Interagency traumatic brain injury (TBI) Research Board of Scientific Administrators, designed to facilitate collaboration. This interagency group has begun collecting risk factor and health information from military personnel prior to their deployments to Iraq. Plans are to reassess them upon their returns from deployment to identify their needs.

VHA's Office of Research and Development (ORD) has sponsored several meetings to develop mechanisms to facilitate DoD and VA Investigation Review Boards' (IRB) approvals of DoD/VA collaborative research and to transfer clinical data for research purposes between DoD and VA investigators. To increase awareness of research skills and interests, ORD is creating an electronic list server of DoD and VA investigators. Over 700 scientists have submitted their names to be part of this project.

Other ongoing partnerships (and focus) include:

- Walter Reed Army Medical Center (WRAMC) (investigating immediate challenges faced by returning service personnel);
- Brooke Army Medical Center (examining challenges faced by amputees with burns);
- Defense Center on Psychological Health and TBI seeking collaborative research opportunities and helping to plan the National Intrepid Center of Excellence currently under construction at the National Naval Medical Center, Bethesda, Maryland;
- Founding member of the Defense and Veterans Brain Injury Center (DVBIC), which consists of three military treatment facilities (WRAMC, Wilford Hall Air Force Medical Center, and San Diego Naval Medical Center) and four VA medical centers (Richmond, Tampa, Minneapolis, and Palo Alto) (conducting clinical trials examining the effects of anxiety disorders, post concussion syndrome, agitation, and problems with memory and attention/concentration in TBl patients);
- Collaboration with DoD and NIH investigators to develop a family intervention program with spouses of servicemembers being treated for traumatic limb loss or TBI;
- Millennium Cohort Study participation following as many as 140,000 military personnel for up to 21 years to track changes in their health;
- Collaboration with DoD on projects to examine the short- and long-term benefits of advanced regional anesthesia techniques for pain control following combat-related traumatic injuries to extremities;
- ORD sponsored a TBI State of the Art Conference on Research to Improve the Lives of Veterans: Approaches to traumatic brain injury: Screening, Treatment, Management, and Rehabilitation, April 30–May 2, 2008. Participants included DoD, NIH, and DVBIC. Recommendations are being used to inform the Departments' priorities and activities; and
- VA and National Institute of Mental Health (NIMH) and DoD have issued a call for collaborative research focusing on combat-related mental disorders and stress reactions.

VA will continue to aggressively pursue enhanced coordination to ensure efficient, high quality research that contributes to optimal adoption of evidence-based care for this new generation of veterans.

4. Disability Evaluation System

VA and DoD are currently in the eighth month of the pilot of a joint disability evaluation system (DES) for those servicemembers who, due to disease, illness, or injury, are being considered for separation or retirement from service. As of July 20, 2008, almost 500 servicemembers have entered the pilot. Over 100 disability evaluations have been prepared for the DoD, resulting in eight servicemembers having been separated to date and the balance in pre-separation leave status. Of those separated, six have been placed on the retired list, and two have been found less than 30 percent disabled. VA awarded benefits on the day that the member was retired or separated in seven of the eight cases. A slight delay to appoint a fiduciary to manage one servicemember's funds was needed, but that servicemember is also currently in pay status. VA and DoD are further refining and improving the DES transition process. Among the enhancements being studied or addressed are:

- VA will move the DES process into a paperless environment for all new entrants on or about September 1, 2008;
- The Services are moving to support this effort through the provision of imaged documents;
- Site assessments are being finished on nine potential pilot expansion locations that will allow further tests of the system and ensure that the new DES model is effective, efficient, transparent, and fair;
- Customer and stakeholder surveys will be conducted for the initial stages of the process in the near future; and
- The Senior Oversight Committee will be briefed on August 12 on the progress of the pilot and possible expansion.

VA agrees that it is essential that an effective transition plan exist for all returning veterans, whether returning wounded, ill, injured, or safely and we have been active in providing information and services for those who do not have immediate medical needs. VA continues to work closely with the Reserve components to ensure that returning citizen warriors receive appropriate briefings and claims assistance at the earliest possible opportunity following their demobilization. We have expanded the options available to servicemembers to file claims prior to separation with our quick start program for those servicemembers with less than 60 days of active duty remaining prior to separation. We are consolidating decisionmaking for all pre-separation claims, both benefits delivery at discharge (BDD) and quick start, into a focused number of offices to ensure rapid and consistent decisionmaking. And, we are aggressively moving to a paperless environment for BDD claims processing to enable VA to be more flexible and responsive to these combat veterans.

Office of Operation Enduring Freedom/Operation Iraqi Freedom
Veterans Health Administration
August 2008

U.S. Department of Defense
Office of the Under Secretary of Defense
Personnel and Readiness
Washington, DC
August 20, 2008

The Honorable Bob Filner
Chairman, House Committee on Veterans' Affairs
United States House of Representatives
Washington, DC

Dear Mr. Chairman:

I am writing to correct the record regarding RAND Corporation's June 11, 2008 testimony to your Committee. We value research that advances the science on care for our Wounded Warriors. That said, some of the testimony provided by RAND's witnesses inaccurately characterized their research conclusions, and I respectfully request the public record be corrected. The following points are provided (page numbers refer to the draft hearing transcript):

Issue #1, page 7

In her testimony, Dr. Jaycox states, "Our telephone survey representing all previously deployed individuals found substantial rates of mental health problems in the past 30 days, with 14 percent screening positive for PTSD and 14 percent for major depression."

The accurate statement is, ". . . with 14 percent screening positive for PTSD symptoms and 14 percent for major depressive symptoms." Positive clinical screens do not constitute actual prevalence. Although telephone survey tools may be sound in research and clinical screening methodology, only a full clinical evaluation can diagnose these conditions. A diagnosis of PTSD or depression requires a determination that the disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. RAND's telephonic interview measures do not support evaluation of these factors for either condition.

Issue #2, page 7

Dr. Jaycox goes on to state, "Only about half of those with current PTSD or a major depression had sought help for a mental health problem in the past year."

The accurate statement is, "Only about half of those who report PTSD or major depressive symptoms had sought help for a mental health problem in the past year." As noted above, in the absence of a full clinical evaluation, it cannot be determined that symptoms meet full diagnostic criteria for "current PTSD or a major depression".

Issue #3, page 21

In her testimony, Ms. Tanielian states, "Only about half of those who've sought care from a professional in the past year have received what we define as minimally adequate . . ."

This statement should be stricken, along with any other conclusions regarding "minimally adequate treatment" of PTSD and major depression. According to RAND's full published report, their criteria for "minimally adequate treatment" of PTSD and major depression were developed by Wang et al. (2005) based on a comprehensive review of available guidelines for therapies that have demonstrated efficacy. However, these are based on guidelines for *diagnosed* cases and should not be considered the standard of care for individuals who seek relief from symptoms that do not meet full diagnostic criteria for these disorders. It should also be noted that in 2007 a Committee from the Institute of Medicine reviewed scientific studies of PTSD treatment and was unable to draw conclusions regarding optimal length of treatment with psychopharmacology or psychotherapy. Clearly this is an area that deserves further research.

Issue #4, page 8

Dr. Jaycox later indicates, "In our survey, we found 19 percent reported a probable TBI during deployment."

The accurate statement is ". . . we found 19 percent reported an injury event during deployment and an associated transient alteration in mental status suggesting a *possible* TBI, which requires a clinical evaluation to confirm." Symptoms Mayor may not occur after concussion (mild TBI) and are not necessary for the inclusion of the definition of mild TBI. The interviewers had no means or expertise to assess for current symptoms or loss of function. It should be noted that VA post-deployment screening and evaluation demonstrated that of 18½ percent of veterans who screened positive for TBI symptoms, 5 percent were diagnosed with residual symptoms of TBI following a full clinical evaluation. Studies of clinically treated civilian populations and sports populations have found that concussion (mild TBI), which is estimated to comprise 80 percent to 90 percent of all TBI, results in symptoms that generally resolve within days to months in 85 percent of these cases.

The Department maintains its unwavering commitment to our Wounded Warriors and their families. The Military Health System continues to improve its support, investing $600 million from Fiscal Year 2007 Supplemental Appropriations to fund more than 25 major new programs. Furthermore, the recently established Defense Centers of Excellence for Psychological Health and traumatic brain injury is planning a comprehensive study to address surveillance and epidemiological knowledge gaps as well as develop a "stress test model" applied to PTSD. An Expert Consensus meeting is convening shortly to identify directions, opportunities, needs, sustainability, and concepts. We will invite RAND to partner with us in this important endeavor and use the opportunity to share the best and most accurate ideas with the broader scientific community.

I appreciate your support of the health and welfare of our military Servicemembers and for our Military Health System.

Michael L. Dominguez
Principal Deputy

U.S. Department of Defense
Office of the Under Secretary of Defense
Personnel and Readiness
Washington, DC
August 20, 2008

James A. Thomson
President and Chief Executive Officer
RAND Corporation
1776 Main St
Santa Monica, CA 90401

Dear Dr. Thomson:

I sincerely appreciate RAND's interest in the health and welfare of our military Servicemembers and your invaluable support to the Department. I do have concerns however regarding testimony presented by Dr. Lisa Jaycox and Ms. Terri Tanielian to the House of Representatives Committee on Veterans' Affairs (HVAC) on June 11, 2008 (Implementing the Wounded Warrior Provisions of the National Defense Authorization Act for Fiscal Year 2008).

I respectfully request you correct the record with the Congress and retract statements on the Arroyo Center website that claim one in five servicemembers returning from Iraq and Afghanistan are "afflicted" with PTSD or major depression. Those are certainly not substantiated by your research. I have, in the attached letter to Chairman Filner, identified the specific instances in which RAND researchers mischaracterized the results of their study. A RAND Arroyo Center Newsletter (also attached) repeats this unfortunate misrepresentation of your research findings. I ask for your assistance in correctly interpreting data from the study and in ensuring that future references to the data are accurately portrayed.

As to the prevalence of PTSD for our active duty military population, we are planning a comprehensive study that will address surveillance/epidemiological knowledge gaps as well as develop a "stress test model" applied to PTSD. Dr. Casscells will host an Expert Consensus meeting to identify directions, opportunities, needs, sustainability, and concepts. We invite and would very much appreciate RAND's participation in this project.

Thank you for your continued support of the Military Health System.

Michael L. Dominguez
Principal Deputy

Attachments

Excerpt From:

RAND Arroyo Center, Army Research Fellows Newsletter, August 2008, Issue 24

Serving the Army with Objective Analysis

Policy Forum

Mental Health of Returning Soldiers

On June 12, RAND hosted the Policy Forum "Invisible Wounds of War: Addressing the Mental Health Needs of Returning Soldiers" in the Santa Monica office. The event included introductions by Jim Thomson and Joe Sullivan, chair of the RAND Health Board of Advisors, and featured a panel discussion with Terri Tanielian, co-director of the RAND Center for Military Health Policy Research; Fred D. Gusman, Executive Director of The Pathway Home, California Transition Center for Care of Combat Veterans; and Paul Rieckhoff, Executive Director and founder of Iraq and Afghanistan Veterans of America. Lisa Jaycox, who co-led the research project with Tanielian, moderated the discussion. Panel Members addressed the issues raised by a recent RAND study, which found that nearly one in five servicemembers returning from Iraq and Afghanistan are afflicted with post traumatic stress disorder or major depression, yet only slightly more than half have sought treatment.

The discussion addressed reasons that some servicemembers do not seek care-including challenges in accessing quality care and the stigma associated with treatment-as well as the individual and societal costs of failing to treat this population.

The event drew nearly 200 attendees, including members of the RAND Policy Circle and RAND advisory boards, healthcare providers, regional government and community leaders, and members of the media. Organized by the Office of External Affairs, the presentation was part of RAND's Policy Forum series. Policy Forums are public, nonpartisan programs designed to inform and inspire debate on specific, timely policy issues.

http://search.rand.org/search?input-form=rand-simple&v%3Asources=rand-bundle&query=invisible+wounds

territ@rand.org

The RAND Corporation is a non-profit institution that addresses the challenges facing the public and private sectors around the world

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April 24, 2008

CALL BACK SCRIPT FOR BOTH PHASES

Data points provided to contractor

1. Names from DMDC
2. Addresses (DMDC/MAP–D)
3. Phone Numbers (IRS, MAP–D and VADIR)

Message to contractor:

Emergency Calls: If you feel that the veteran is experiencing an emergency—having chest pains, or indicates that he wants to harm himself, etc. please let the veteran know that you are connecting his/her call to a nurse who can assist. Keep veteran on the line and contact the Dayton Nurse Call Center. (Number of the Dayton Call Center)

Complaint Calls: If a veteran or family member begins to complain about their care at VA or bad experience when accessing VA care, explain that their concerns are very important to us and a VA hospital staff member (near their home) will call them back within 48 hours to ensure that we address the issues they are raising.

1. Answering Machine

Good morning/afternoon/evening. I am (Agent Name) calling (name of veteran) again from the Department of Veterans Affairs. We spoke to (him/her) about 2 weeks ago and wanted to follow-up and ensure that (he/she) got the answers or information that we spoke about. Sorry to not reach you but please call us back at 1–866–606–8215 during business hours to confirm that you have the information we promised.

Thank you very much

End call

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2. Introduction

Good morning/afternoon/evening. My name is (Agent Name) and I am calling (name of veteran) again on behalf of the Department of Veterans Affairs, to ensure that he/she received the information we spoke about several weeks ago. May I speak with (Mr/Ms _____)?

Can go to:

3—leave message with person,
4—veteran answers,
5—Caregiver or Guardian Answers

---

3. Message

Sorry he/she is not available. Could you please have him/her call us back at 1–866–606–8215 during business hours to confirm that he/she got the information we promised.

Thank you very much

End call

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4. Veteran Answers

You received a call about 2 weeks ago and we wanted to follow-up to ensure that you got the answers or information that we spoke about.

Did you hear back from us?

If no, go to 9.

If yes, continue with:

I hope the information or contact was satisfactory. Is there anything else we can do for you?

If yes go to 7,

If they were not satisfied, go to 7a.

If they heard from us and do not need anything else, go to 8

---

5. Other person answering phone (guardian or caregiver) theoretically we would want this person case managed

You received a call about 2 weeks ago and we wanted to follow-up to ensure that you got the answers or information that we spoke about.

Did you hear back from us?

If no, go to 9.

If yes, continue with:

I hope the information or contact was satisfactory. Is there anything else we can do for you?

If yes go to 7,

If they heard from us and do not need anything else, go to 8

---

6. More Information

OK, it may be best for me to have a staff member at the local VA contact you within 48 hours to ensure that we have met your needs. I have your contact information and will have the appropriate staff member contact you. Thank you very much for letting us serve you.

End of call

---

7. Contact was made or information was sent but veteran needs more.

I am sorry that we did not get you the information that you wanted. It may be best for me to have a staff member at the local VA contact you within 48 hours to ensure that we have met your needs. I have your contact information and will email the appropriate staff member contact you. Thank you very much for letting us serve you.

End call

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8. All went well and veteran needs no more assistance

Thank you again for (your or his/her) time and service. I am glad you got the information you needed. I would again like to leave you with our 1–800 number in case you need or have any questions. The number is 1–866–606–8212. It is staffed during business hours and will be able to provide information about a VA facility in your area.

End call

---

9. Did not hear back from us

Ok, I really apologize that you have not heard back from us. Let me again verify your contact information

I have your phone number which is _____

Your home address is _____

And your email address is _____

And your best time to call _____

Let me check into this and we will be back in touch with you in 48 hours.

Thank you

End call.

Care Management Candidate Interview Call Script (Phase 1)

(Care Management)

Data points provided to contractor

4. Names from Veterans Tracking Application (VTA/CMO and SWS Database)
5. Addresses (VTA/IRS/MAP–D/CMO Database)
6. Phone Number (VTA/CMO/VADIR Database)
7. Care Manager's Name if populated (PCCM)

Message to contractor:

Emergency Calls: If you feel that the veteran is experiencing an emergency—having chest pains, or indicates that he wants to harm himself, etc., please let the veteran know that you are connecting his/her call to a nurse who can assist. Keep veteran on the line and contact the Dayton Nurse Call Center.

Complaint Calls: If a veteran or family member begins to complain, explain that their concerns are very important to us and a VA hospital staff member will call them back within 48 hours to ensure that we address the issues they are raising.

1. Answering Machine

Good morning/afternoon/evening. I am (Agent Name) calling (name of veteran) on behalf of the Secretary of the Department of Veterans Affairs, Dr. Jim Peake. Dr. Peake has asked us to speak with you so that we can provide you with information about a change in VA benefits and to see if you are in need of our assistance. Please call the VA Combat Veteran Information Line at 1–866–606–8198 during business hours to speak with someone about this important information.

Thank you for your service.

End call

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2. Introduction

Good morning/afternoon/evening. My name is (Agent Name) and I am calling (name of veteran) on behalf of the Secretary of the Department of Veterans Affairs, Dr. Jim Peake, to inform (him/her) of changes to veteran benefits recently adopted by Congress and approved by the President. May I speak with (Mr./Ms. _____)?

Can go to:

3—leave message with person,
3a—veteran deceased,
4—wrong number,
5—veteran answers,
6—guardian or caregiver.
7—hang up (Document and try three times to reach veteran)

---

3. Leave Message

Several of the changes to the benefits program are time sensitive, and the Secretary does not want any veteran to miss out on any services to which they are entitled. Could you please have him/her call the VA Combat Veteran Information Line at 1—866–606–8198 during business hours so that we can provide him/her with this valuable information?

Thank you.

End call

3a. Veteran Deceased

I am very sorry to hear that (Mr./Ms. _____) has passed away. Please know that the Secretary and the entire VA Family are grateful for his/her service to our country. As you may or may not know, the VA has several programs for families of fallen servicemembers. Would you be interested in information from the VA regarding any survivor's benefits?

If the answer is yes, continue with: Sure, we will have someone call you back within 48 hours to assist you. Would that be okay?

If yes: go to 11

If no: Once again Dr. Peake has asked me to convey his sincerest sympathies for the loss to your family.

End call

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4. Inconvenience

Sorry for your inconvenience. Hope you have a nice day.
End call

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5. Veteran Answers

The Secretary wanted you to be aware that the eligibility for combat veterans has been changed. Previously, individuals discharged from the military would receive 2 years of cost free VA healthcare for any condition potentially related to your combat service. This has been extended to 5 years. If you were discharged prior to January 28, 2003, you will have the enhanced enrollment benefits and cost free VA healthcare until January 27, 2011.

Would you like to know more about another change underway to help veterans gain employment?
If yes, go to 5b
If no, go to 5c

5b. Employment Program Information

The VA's new Veterans Employment Coordination Service, was established to oversee the Department's program to recruit new veterans into the VA workforce. The new office will work with military transition programs, VA managers, and human resource offices to ensure supervisors are aware of programs for hiring veterans.

If you're interested in employment with the Department of Veterans Affairs, please contact the VECS team at VECS@va.gov or (866) 606–6206 for more information.
Go to 5c

5c. VA Usage

Finally, the primary reason for the call is Dr. Peake wanted to make sure that you were receiving the medical care you needed from the VA.

Are you receiving the care you need?
If yes: go to 12
If no: If not would you share what issues you are having or reasons for not coming to the VA? (List the issues)

Do you have any other healthcare or benefit questions that we can assist you with or would you like more information about your benefits?
If yes: Go to 7
If no: Go to 18

---

6. Other person answering phone (guardian or caregiver) theoretically we would want this person case managed

As the primary caregiver for (name of veteran) the Secretary wanted you to know that the eligibility for combat veterans has been changed. Previously, individuals discharged from the military would receive 2 years of cost free VA healthcare for any condition potentially related to (his/her) combat service. This has been extended to 5 years. If (he/she) discharged prior to January 28, 2003, (he/she) will have the enhanced enrollment benefits and cost free VA healthcare benefits until January 27, 2011.

As the first Medical Doctor to ever lead the VA, Dr. Peake knows the difficulties associated with being a primary caregiver. He wanted us to inquire if (name of veteran) or you on (name of veteran's) behalf have ever tried to enroll in the VA healthcare system?
If they have enrolled: go to 12
If they have not tried to enroll: go to 6b

6a. If there are reasons you have not come to the VA, would you share those with us?
If yes: List the reasons
If no: go to 7

6b. He also asked that we ensure you were receiving the information and assistance you needed.

If yes: go to 7
If no: go to 7

---

7. More Information

Do you want to speak with a clinical staff member at a nearby VA hospital?
If yes, go to 12
If no, continue to next question
Can we provide you with any general information about your VA benefits?
If yes, go to 9
If no, go to 18
If both are no answers, go to 18

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8. (Blank)

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9. How?

OK, I want to make this as easy and convenient for you as possible, how can we best serve you?
I can have someone call from the local VA hospital.
I can mail you information, or
I can e-mail information to you,
Which would you prefer?
Go to 11

---

10. Call Back

The Department of Veterans Affairs would like to ensure that everything we discussed or promised to do today is getting done in a timely manner. Would you mind if we also called you back in 10 to 14 days to ensure that you received the information you requested and any questions or issues you raised were addressed to your satisfaction?
Go to 18

---

11. Demographic confirmation

In order to accomplish everything that I have promised I want to confirm some information:

- Is your mailing address still?
- What is the best phone number for us to contact you?
- Is there a time you would prefer us to try to contact you?
- Can I have your primary e-mail address?

Go to 10

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12. Care Manager

Do you currently have a care manager?
If no, go to 14
If they answer yes and they don't have a care manager listed then go to 15
If yes and the system has a care manager listed ask:
I have (name of care manager from database) from (location of care manager from database) as your VA care manager. Is this correct?
If the information is correct, go to 13
If the information is incorrect, go to 14

---

13. Would you like a call from CM?

Do you have any questions or concerns that you would like me to have your care manager give you a call about?
If yes, go to 11

If no, go to 18

---

14. Was another care manager assigned?

As I previously told you our system has (name of care manager in database) as your care manager but you didn't recognize that individual, was another one assigned?

If yes, go to 15
If no, go to 17b.

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15. Update CM

Okay. Can you tell me his/her name and the name of the VA hospital where he/she works?

Do you have any questions or concerns or would you like (him/her) to call you?

If yes, go to 11
If no, go to 18

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16. More Care Management Info

Our records do not show that you have an assigned care manager. Is this correct?

If yes, go to 17a
If no, go to 15

17a. VA has a program called care management that provides a staff member to assist you in getting the services you need and answers to your questions. If you would like to know more about our care management program,

Continue to 17b

17b. (start here) I can arrange for someone from the VA to call you and talk with you about the program. Would you like us to call you back, and if so, at what time would it be convenient?

If yes, go to 11
If no, go to 18

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18. Thank you

Thank you again for your/their time in service to our country, we are grateful for your/their sacrifice. I'd like to leave you with an 800 number in case you need or have any other questions. The number is 1–800–827–1000. It is staffed during business hours and will be able to provide information about a VA facility in your area.

End Call

Combat Veteran Interview Call Script (Phase 2)

(Global)

Data points provided to contractor

8. Names from DMDC
9. Addresses (DMDC/MAP–D)
10. Phone Numbers (IRS, MAP–D and VADIR)

Message to contractor:

Emergency Calls: If you feel that the veteran is experiencing an emergency—having chest pains, or indicates that he wants to harm himself, etc., please let the veteran know that you are connecting his/her call to a nurse who can assist. Keep veteran on the line and contact the Dayton Nurse Call Center. (Number of the Dayton Call Center)

Complaint Calls: If a veteran or family member begins to complain about their care at VA or bad experience when accessing VA care, explain that their concerns

are very important to us and a VA hospital staff member (near their home) will call them back within 48 hours to ensure that we address the issues they are raising.

1. Answering Machine

Good morning/afternoon/evening. I am (Agent Name) calling (name of veteran) on behalf of the Secretary of the Department of Veterans Affairs, Dr. Jim Peake, to inform (him/her) of a new benefit recently put in place by the President and Congress. Please call the VA Combat Veteran Information Line at 1–800–606–8212 between the hours of _____ and _____ so that we can provide you with more information about this benefit.

Thank you very much for your service.

End call

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2. Introduction

Good morning/afternoon/evening. My name is (Agent Name) and I am calling (name of veteran) on behalf of the Secretary of the Department of Veterans Affairs, Dr. Jim Peake, to inform (him/her) of changes to veteran benefits recently adopted by Congress and approved by the President. May I speak with (Mr./Ms. _____)?

Can go to:

3—leave message with person,
3a—veteran deceased,
4—wrong number,
5—veteran answers,
6—Caregiver or Guardian Answers
7—Hang up (Document and try three times to reach veteran)

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3. Leave Message

Several of the changes to the benefits program are time sensitive, and the Secretary does not want any veteran to miss out on any services to which they are entitled. Could you please have him/her call the VA Combat Veteran Information Line at 1–800–606–8212 during business hours so that we can provide him/her with this valuable information?

Thank you.

End call

3a. Veteran Deceased

I am very sorry to hear that (Mr./Ms._____) has passed away. Please know that the Secretary and the entire VA Family are grateful for his/her service to our country. As you may or may not know the VA has several programs for families of fallen servicemembers. Would you be interested in information from the VA regarding any survivor's benefits issues or questions?

If the answer is yes, go to 9:

If no:

Once again Dr. Peake has asked me to convey his sincerest sympathies for the loss to your family.

Thank you.

End call

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4. Inconvenience

Sorry for the inconvenience. Hope you have a nice day.

End call

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5. Veteran Answers

The Secretary wanted to be sure that if you are not enrolled in the VA healthcare system that you were aware that the eligibility for combat veterans has been changed. Previously, individuals discharged from the military would receive 2 years of cost free VA healthcare for any condition potentially related to combat service. This has been extended to 5 years. If you were discharged prior to January 28, 2003, you will have the enhanced enrollment benefits and cost free VA healthcare benefits until January 27, 2011.

The second reason for the call is Dr. Peake wanted to make sure that you were receiving the medical care you needed and asked us to inquire if you have ever tried to enroll in VA healthcare? If you haven't we hope that it is because you haven't needed any healthcare since your military discharge. However, if there are other reasons you have not come to the VA, would you share those with us?

If yes, gather comments and go to next question

If no, go to next question

Do you have any other healthcare or benefit questions that we can assist you with now or would you like more information about your benefits?

If yes, go to 9

If no, go to 8

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6. Other person answering phone (guardian or caregiver) theoretically we would want this person case managed

As the primary caregiver for (name of veteran) the Secretary wanted you to know that the eligibility for combat veterans has been changed. Previously, individuals discharged from the military would receive 2 years of cost free VA healthcare for any condition potentially related to their combat service. This has been extended to 5 years. If (he/she) were discharged prior to January 28, 2003, (he/she) will have the enhanced enrollment benefits and cost free VA healthcare benefits until January 27, 2011.

As the first Medical Doctor to ever lead the VA, Dr. Peake knows the difficulties associated with being a primary caregiver. He wanted us to inquire if (name of veteran) or you on (name of veterans) behalf have ever tried to enroll in the VA healthcare system?

Capture Comments if any

If no ask:

If there are reasons you have not come to the VA, would you share those with us?

Move to the next question

If yes: move to the next question

Because there are several special programs that (veterans name) may qualify for, I would like to suggest that I have a staff member from the local medical center call you back with more detailed information, would that be alright?

If yes:

Go to 10

If No;

Go to 8

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7. More Information

Would you be interested in receiving more information about the changes to the benefits plan?

If no, go to 8

If yes, go to 9

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8. Thank you

Thank you again for (your or his/her) time in service to our country, we are grateful for your/their sacrifice. I'd like to leave you with an 800 number in case you need or have any other questions. The number is 1–800–827–1000. It is staffed during business hours and will be able to provide information about a VA facility in your area.

End call

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9. How?

Ok, I want to make this as easy and convenient for you as possible, so there are several ways I can get you the information you're requesting:

- I can have someone call from the local VAMC,
- I can mail you information, or
- I can e-mail the information to you

Which would you prefer?

Go to 10.

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10. Call Back?

The Department of Veterans Affairs would like to ensure that everything we discussed or promised to do today is getting done in a timely manner. Would you mind if we also called you back in 10 to 14 days to ensure that you received the information you requested and any questions or issues you raised were addressed to your satisfaction?

Go to 8

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11. Demographic Confirmation

In order to accomplish everything that I have promised I want to confirm some information:

- Is your Mailing address still?
- What is the best phone number for us to contact you?
- Is there a time you would prefer us to try to contact you?
- Can I have your primary e-mail address?

Go to 10.

Status of Congressionally Mandated Requirements for Implementing the Wounded Warrior Provisions of the National Defense Authorization Act 2008 (As of December 18, 2008)

2008 NDAA Sect	Description from Act	Reporting Requirement	Due Date	Revised Due Date	Status/Milestones (Updates/progress (by date))
1618	COMPREHENSIVE PLAN ON PREVENTION, DIAGNOSIS, MITIGATION, TREATMENT, AND REHABILITATION OF, AND RESEARCH ON, TRAUMATIC BRAIN INJURY, POST TRAUMATIC STRESS DISORDER, AND OTHER MENTAL HEALTH CONDITIONS IN MEMBERS OF THE ARMED FORCES. The SecDef and the Sec VA shall direct joint planning among the DoD, the military departments, and the VA for the prevention, diagnosis, mitigation, treatment, and rehabilitation of, and research on, TBI, PTSD, and other mental health conditions in members of the Armed Forces, including planning for the seamless transition of such members from care through the DoD to care through the VA.	Directs joint planning among the DoD, the Military Departments, and the VA for the prevention, diagnosis, mitigation, treatment, and rehabilitation of, and research on, TBI, PTSD, and other mental health conditions in members of the Armed Forces, including planning for the seamless transition of such members from care through the DoD to care through the VA.	07/26/08	09/15/08	Defense Center of Excellence (DCoE) concept of operations approved, Interim Director named, staff in process of being hired. DCoE announced 11/30/07. VA Legislative Affairs has this item for action and is currently working to change legislation. **04/22/08:** Force Health Protection and Readiness (FHP&R) and DCoE are working this. **05/20/08:** Ground breaking at Bethesda scheduled for 06/05/08. **05/27/08:** FHP&R staff is working with Price Waterhouse & Cooper contractors to develop a report. **05/30/08:** Memo signed. **09/20/08:** Interim response submitted to Congress. Extension letters signed. **10/08: Report submitted to Congress, COMPLETE.**
1624	REPORT ON ESTABLISHMENT OF CENTERS OF EXCELLENCE. The SecDef shall submit report on: the establishment of the center of excellence in prevention, diagnosis, mitigation, treatment, and rehabilitation of TBI; the establishment of the center of excellence in prevention, diagnosis, mitigation, treatment, and rehabilitation of PTSD and other mental health conditions; and the establishment of the center of excellence in prevention, diagnosis, mitigation, treatment, and rehabilitation of military eye injuries.	Report on establishment of centers of excellence.	07/26/08	10/31/08	**04/22/08:** Legislative tasking to FHP&R with LoA 2 as lead; DCOE is established; Report is being written by DCoE, with Army input on Eye CoE. **07/25/08:** Letter to Congress. **09/05/08:** This report is well underway but requires extensive work and coordination and will be submitted 10/31/08. **11/08: Report submitted to Congress, COMPLETE.**

Status of Congressionally Mandated Requirements for Implementing the Wounded Warrior Provisions of the National Defense Authorization Act 2008 (As of December 18, 2008)—Continued

2008 NDAA Sect	Description from Act	Reporting Requirement	Due Date	Revised Due Date	Status/Milestones (Updates/progress (by date))
1645	REPORTS ON ARMY ACTION PLAN IN RESPONSE TO DEFICIENCIES IN THE ARMY PHYSICAL DISABILITY EVALUATION SYSTEM. The SecDef shall submit a report on the implementation of corrective measures by the DoD with respect to the Physical Disability Evaluation System (PDES). The Secretary shall post such report on the Internet website of the DoD that is available to the public.	Report on Army Action Plan in response to deficiencies in the Army Physical Disability Evaluation System.	06/01/08 06/01/09	07/14/08	**04/15/08:** Army is lead. **06/02/08:** DA updated OSD (P&R). **06/18/08:** Forwarded to Office of General Counsel. **07/14/08: Report submitted to Congress via USD P&R. COMPLETE.**
1650	REQUIRED CERTIFICATIONS IN CONNECTION WITH CLOSURE OF WALTER REED ARMY MEDICAL CENTER, DISTRICT OF COLUMBIA. The SecDef shall submit a certification of each of the following: that a transition plan has been developed, and resources have been committed, to ensure that patient care services, medical operations, and facilities are sustained at the highest possible level at Walter Reed until facilities to replace Walter Reed are staffed and ready to assume at least the same level of care previously provided at Walter Reed; that the closure of Walter Reed will not result in a net loss of capacity in the major medical centers in the National Capitol Region in terms of total bed capacity or staffed bed capacity; and that the capacity of medical hold and outpatient lodging facilities operating at Walter Reed as of the date of the certification will be available in sufficient quantities at the facilities designated to replace Walter Reed by the date of the closure of Walter Reed.	Certifications in connection with closure of Walter Reed.	04/27/08	09/30/08	**04/24/08:** Plan due 09/08, certifications due after plan submitted. **05/07/08:** Certification will be complete in the next few days. ASA (M&RA) is the owner of this requirement. **06/25/08:** Submitted for approval. **08/01/08:** Awaiting USD P&R signature. **09/08: COMPLETE.**

1662	ACCESS OF RECOVERING SERVICEMEMBERS TO ADEQUATE OUTPATIENT RESIDENTIAL FACILITIES. All quarters of the U.S. and housing facilities under the jurisdiction of the Armed Forces that are occupied by recovering Servicemembers shall be inspected on a semi-annual basis for the first 2 years after the enactment of this Act and annually thereafter by the inspectors general of the regional medical commands.	All quarters of the U.S. and housing facilities under the jurisdiction of the Armed Forces that are occupied by recovering servicemembers shall be inspected on a semi-annual basis for the first 2 years after the enactment of this Act and annually thereafter by the inspectors general of the regional medical commands.	07/28/08 01/28/09 07/28/09 01/28/10	Inspection completed 09/01/08 1st report signed out 11/01/08	**09/09/08:** The inspections were to be completed 09/01/08. **11/01/08:** First report submitted. **COMPLETE and ongoing**
1664	REPORT ON TRAUMATIC BRAIN INJURY CLASSIFICATIONS. The SecDef and the Sec VA jointly shall submit a report describing the changes undertaken within the DoD and the VA to ensure that TBI victims receive a medical designation concomitant with their injury rather than a medical designation that assigns a generic classification (such as "organic psychiatric disorder").	Report on Traumatic Brain Injury classifications.	04/27/08	Interim report 08/01/08 Final Report 01/31/09	**04/15/08:** FHP&R lead for DoD; drafted initial report but need VA inputs; expect long coordination cycle, so began developing an interim report to meet deadline. **04/22/08:** Interim report drafted, but not yet reviewed and approved by Ms Embrey. **04/28/08:** Received input from VA; interim report drafted; in coordination awaiting DCoE and OGC replies. **05/06/08:** No change. **05/20/08:** Coordination is underway in the DoD & VA; report is being reviewed by DoD OGC. ICD–9 codes must be coordinated with National Committee that meets in December. Final report will follow. **05/27/08:** Changes made per DoD OGC guidance, coordination resumed 23 May. **07/08/08:** in ASD(HA) for coordination. **08/04/08:** Report signed and to VA for coordination on 07/16/08. **08/07/08:** Interim signed by cochairs and submitted to Congress.

Status of Congressionally Mandated Requirements for Implementing the Wounded Warrior Provisions of the National Defense Authorization Act 2008 (As of December 18, 2008)—Continued

2008 NDAA Sect	Description from Act	Reporting Requirement	Due Date	Revised Due Date	Status/Milestones (Updates/progress (by date))
Conf. Rept. Overview 1611	COMPREHENSIVE POLICY ON IMPROVEMENTS TO CARE, MANAGEMENT, AND TRANSITION OF RECOVERING SERVICEMEMBERS. The SecDef and the Sec VA shall, to the extent feasible, jointly develop and implement a comprehensive policy on improvements to the care, management, and transition of recovering servicemembers. The policy shall cover each of the following: the care and management of recovering servicemembers; the medical evaluation and disability evaluation of recovering servicemembers; the return of servicemembers who have recovered to active duty when appropriate; the transition of recovering servicemembers from receipt of care and services through the DoD to receipt of care and services through VA.	Requirement contained in the Conference Report Overview, not in HR 1585 language. Report on standards for recovery coordinator and case management.	02/27/08 05/27/08 08/25/08 11/23/08		**04/07/08**: USD P&R signed February report. **04/10/08:** Documents submitted to Congress. **05/27/08:** USD P&R signed May report. **06/12/08:** Documents submitted to Congress.
HAC 110–424	A joint DoD/DVA report to the congressional defense Committees detailing the actions being taken by each department to achieve an interoperable electronic medical record (EMR).	The report should include a detailed spending plan for the use of funding, identify all other ongoing and planned projects and programs and identify the Departments' goals for interoperability and how these projects and programs will address those goals	08/30/08		**05/08/07 OIPT and 05/20/07 SOC:** Reporting requirement is from 10/30/07 memo signed by both Secretaries. **08/08: Electronic Medical Record Interoperability Report and Information Interoperability Plan submitted to Congress. COMPLETE.**
HAC 110–434	A joint DoD/DVA report to the congressional Defense Committees detailing the actions being taken by each department to achieve an interoperable electronic medical record (EMR).	The report should include a detailed spending plan for the use of funding, identify all other ongoing and planned projects and programs and identify the Departments' goals for interoperability and how these projects and programs will address those goals	04/01/08	08/31/08	**04/29/08:** Interim report sent to Congress. A final report will be sent in August 2008. **08/08: Electronic Medical Record Interoperability Report submitted to Congress. COMPLETE.**

1634a (741)	REPORTS. The SecDef shall submit a report describing the progress in implementing the requirements of sections 721 and 741 of the John Warner National Defense Authorization Act for Fiscal Year. The SecDef shall submit a report setting forth the amounts expended by the DoD during the preceding calendar year on activities including the amount allocated during such calendar year to the Defense and Veterans Brain Injury Center of the Department.	Report on implementation of certain requirements.	04/27/08	12/31/08 Final	**04/10/08:** Army provided a copy of their current policy. **04/28/08:** TBI Longitudinal study interim report in coordination today; PTSD report—DCoE is working. **05/06/08:** TBI longitudinal study report is in coordination with TMA legislative staff. PTSD pilot projects report is being written with DCoE taking the lead. **05/15/08:** FHP&R lead; Study is underway; Report is being written. Report on pilot projects from 741—C&PP lead. **05/20/08:** The TBI report is being reviewed by DoD OGC; The PTSD report is being reviewed by the Dir. DCoE—to HA on 05/21/08. **5/27/08:** TBI report—DoD OGC concurred on 05/23, package forwarded to DoD Legislative Affairs for coordination. **06/12/08: TBI report forwarded to Congress.** **08/18/08: PTSD report forwarded to Congress. COMPLETE.**
1634b	REPORTS. The SecDef shall submit a report describing the progress in implementing the requirements of sections 721 and 741 of the John Warner National Defense Authorization Act for Fiscal Year. The SecDef shall submit a report setting forth the amounts expended by the DoD during the preceding calendar year on activities including the amount allocated during such calendar year to the Defense and Veterans Brain Injury Center of the Department.	Annual reports on expenditures for activities on TBI and PTSD.	03/01/08		**04/15/08:** FHP&R lead, draft report submitted, waiting for HA leg chop before ASD signature. **04/22/08** Interim report is with OGC and OLA for review before ASD signature. **04/28/08:** Coordination from OGC to HA for signature. **05/06/08: Signed 05/01/08 as a final report satisfying the requirement—COMPLETE. Annual Reports forthcoming.**
1635	Establishes an Interagency Program Office (IPO) of the DoD and the VA to act as a single point.	Jointly establish a schedule and benchmarks for the discharge by the Office of its functions.	02/27/08		**04/08/08:** Letter sent. **04/29/08:** Cover letter to be co-signed. Plan being vetted through VBA/VHA. **04/29/08: Cover letter signed. Draft of IPO plan sent to Congress. COMPLETE**

Status of Congressionally Mandated Requirements for Implementing the Wounded Warrior Provisions of the National Defense Authorization Act 2008 (As of December 18, 2008)—Continued

2008 NDAA Sect	Description from Act	Reporting Requirement	Due Date	Revised Due Date	Status/Milestones (Updates/progress (by date))
1635	FULLY INTEROPERABLE ELECTRONIC PERSONAL HEALTH INFORMATION FOR THE DEPARTMENT OF DEFENSE AND DEPARTMENT OF VETERANS AFFAIRS. The SecDef and the Sec VA shall jointly develop and implement electronic health record systems or capabilities that allow for full interoperability of personal healthcare information between the DoD and the VA; and accelerate the exchange of healthcare information between the DoD and the VA in order to support the delivery of healthcare by both Departments. Establishes an interagency program office of the DoD and the VA to act as a single point of accountability for the DoD and the VA in the rapid development and implementation of electronic health record systems or capabilities that allow for full interoperability of personal healthcare information between the DoD and the VA. The function of the Office shall be to implement electronic health record systems or capabilities that allow for full interoperability of personal healthcare information between the DoD and the VA.	Activities of the DoD/VA Interagency Program Office.	01/01/09		**12/03/08:** VA concurred. **12/04/08:** IPO's Annual Report is in coordination at DoD. **Status:** On track.

1635	FULLY INTEROPERABLE ELECTRONIC PERSONAL HEALTH INFORMATION FOR THE DEPARTMENT OF DEFENSE AND DEPARTMENT OF VETERANS AFFAIRS. The SecDef and the Sec VA shall jointly develop and implement electronic health record systems or capabilities that allow for full interoperability of personal healthcare information between the DoD and the VA; and accelerate the exchange of healthcare information between the DoD and the VA in order to support the delivery of healthcare by both Departments. Establishes an interagency program office of the DoD and the VA to act as a single point of accountability for the DoD and the VA in the rapid development and implementation of electronic health record systems or capabilities that allow for full interoperability of personal healthcare information between the DoD and the VA. The function of the Office shall be to implement electronic health record systems or capabilities that allow for full interoperability of personal healthcare information between the DoD and VA.	Comptroller General assessment of the progress of the DoD/VA Interagency Program Office.	07/28/08		**07/28/08: Report sent to Congress—COMPLETE**

Status of Congressionally Mandated Requirements for Implementing the Wounded Warrior Provisions of the National Defense Authorization Act 2008 (As of December 18, 2008)—Continued

2008 NDAA Sect	Description from Act	Reporting Requirement	Due Date	Revised Due Date	Status/Milestones (Updates/progress (by date))
1636	ENHANCED PERSONNEL AUTHORITIES FOR THE DEPARTMENT OF DEFENSE FOR HEALTHCARE PROFESSIONALS FOR CARE AND TREATMENT OF WOUNDED AND INJURED MEMBERS OF THE ARMED FORCES. The SecDef may exercise any authority for the appointment and pay of healthcare personnel under chapter 74 of title 38 for purposes of the recruitment, employment, and retention of civilian healthcare professionals for the DoD if the Secretary determines that the exercise of such authority is necessary in order to provide or enhance the capacity to provide care and treatment for members who are wounded or injured on active duty and to support the ongoing patient care and medical readiness, education, and training requirements of the DoD. The Secretaries of the military departments shall each develop and implement a strategy to disseminate among appropriate personnel of the military departments authorities and best practices for the recruitment of medical and health professionals. The authority of the SecDef to exercise authorities available under chapter 74 of title 38 for purposes of the recruitment, employment, and retention of civilian healthcare professionals for the DoD expires September 30, 2010.	Reports on strategies on recruitment of medical and health professionals.	07/28/08		**05/07/08:** DASD for Clinical Programs and Policies is the owner of this requirement. **06/23/08:** Memos to Military Departments asking them to report to him on their progress. **07/26/08:** Services will have reports to Congress NLT 07/28/08. **08/01/08: Report sent to Congress—COMPLETE.**

1644	AUTHORIZATION OF PILOT PROGRAMS TO IMPROVE THE DISABILITY EVALUATION SYSTEM FOR MEMBERS OF THE ARMED FORCES. The SecDef may establish and conduct pilot programs with respect to the system of the DoD for the evaluation of the disabilities of members of the Armed Forces who are being separated or retired from the Armed Forces for disability. In establishing and conducting any pilot program, the SecDef shall consult with the Sec VA. Each pilot program conducted shall be completed not later than 1 year after the date of the commencement of such pilot program. The SecDef shall submit a report on each pilot program that has been commenced as of that date. Not later than 90 days after the completion of all pilot programs conducted, the Secretary shall submit a report setting forth a final evaluation and assessment of the pilot programs. The report shall include such recommendations for legislative or administrative action as the Secretary considers appropriate in light of such pilot programs.	Initial report on pilot programs to improve the Disability Evaluation System.	04/27/08		**04/28/08:** Report is in coordination. **05/01/08: Report sent to Congress—COMPLETE.**

Status of Congressionally Mandated Requirements for Implementing the Wounded Warrior Provisions of the National Defense Authorization Act 2008 (As of December 18, 2008)—Continued

2008 NDAA Sect	Description from Act	Reporting Requirement	Due Date	Revised Due Date	Status/Milestones (Updates/progress (by date))
1644	AUTHORIZATION OF PILOT PROGRAMS TO IMPROVE THE DISABILITY EVALUATION SYSTEM FOR MEMBERS OF THE ARMED FORCES. The SecDef may establish and conduct pilot programs with respect to the system of the DoD for the evaluation of the disabilities of members of the Armed Forces who are being separated or retired from the Armed Forces for disability. In establishing and conducting any pilot program, the SecDef shall consult with the Sec VA. Each pilot program conducted shall be completed not later than 1 year after the date of the commencement of such pilot program. The SecDef shall submit a report on each pilot program that has been commenced as of that date. Not later than 90 days after the completion of all pilot programs conducted, the Secretary shall submit a report setting forth a final evaluation and assessment of the pilot programs. The report shall include such recommendations for legislative or administrative action as the Secretary considers appropriate in light of such pilot programs.	Interim report on pilot programs to improve the Disability Evaluation System.	11/01/08 (180 days after submission of the initial report)		**09/05/08:** The pilot program is on track. **12/01/08: Report submitted—COMPLETE.**

1644	AUTHORIZATION OF PILOT PROGRAMS TO IMPROVE THE DISABILITY EVALUATION SYSTEM FOR MEMBERS OF THE ARMED FORCES. The SecDef may establish and conduct pilot programs with respect to the system of the DoD for the evaluation of the disabilities of members of the Armed Forces who are being separated or retired from the Armed Forces for disability. In establishing and conducting any pilot program, the SecDef shall consult with the Sec VA. Each pilot program conducted shall be completed not later than 1 year after the date of the commencement of such pilot program. The SecDef shall submit a report on each pilot program that has been commenced as of that date. Not later than 90 days after the completion of all pilot programs conducted, the Secretary shall submit a report setting forth a final evaluation and assessment of the pilot programs. The report shall include such recommendations for legislative or administrative action as the Secretary considers appropriate in light of such pilot programs.	Final report on pilot programs to improve the disability evaluation system.	90 days after completion of all pilot programs		12/08: Awaiting completion of all pilot programs.
1647	ASSESSMENTS OF CONTINUING UTILITY AND FUTURE ROLE OF TEMPORARY DISABILITY RETIRED LIST. The SecDef shall submit a report containing a statistical history since January 1, 2000, of the numbers of members who are returned to duty or separated following tenure on the TDRL and, in the case of members who were separated, how many of the members were granted disability separation or retirement and what were their disability ratings.	Report on the assessment of the Temporary Disability Retired List.	07/26/08	09/30/08	**06/18/08:** forwarded to OGC. **09/11/08 Report submitted—COMPLETE.**
1663	STUDY AND REPORT ON SUPPORT SERVICES FOR FAMILIES OF RECOVERING SERVICEMEMBERS. The SecDef shall conduct a study of the provision of support services for families of recovering servicemembers. The SecDef shall submit a report on the results of the study, with such findings and recommendations as the Secretary considers appropriate.	Conduct a study of the provision of support services for families of recovering servicemembers.	07/26/08	11/14/08	**09/05/08:** On 25 Jul 08 a letter regarding the status of this section was sent to Congress. The study is underway and expected to be completed 30 Sep 08. **12/04/08:** Report has been finalized and forwarded to P&R for signature (OIPT). Distribution only remains, therefore, considered **COMPLETE**.

Status of Congressionally Mandated Requirements for Implementing the Wounded Warrior Provisions of the National Defense Authorization Act 2008 (As of December 18, 2008)—Continued

2008 NDAA Sect	Description from Act	Reporting Requirement	Due Date	Revised Due Date	Status/Milestones (Updates/progress (by date))
1665	EVALUATION OF THE POLYTRAUMA LIAISON OFFICER/NON-COMMISSIONED OFFICER PROGRAM. The SecDef shall conduct an evaluation of the Polytrauma Liaison Officer/Non-Commissioned Officer program. The evaluation shall include an evaluation of the program's effectiveness, manpower requirements, and expansion of the program to incorporate Navy and Marine Corps officers and senior enlisted personnel.	Evaluation of the Polytrauma Liaison Officer/Non-Commissioned Officer program.	04/27/08	09/30/08	**04/09/08:** HA/TMA held a conference call with VA and Service Polytrauma Liaison program managers. Interim report is pending signature by ASD HA office with follow-on transmission to the Hill. Interim report will state an anticipated completion date by the end of FY 2008 and includes status of the Marine Corps liaisons and MOU development progress with VA to formalize the program for each service. (POC: HA/TMA). **4/18/08:** Interim report to Congress signed by OASD(HA). Report delivered to Congress. New projected completion date is end of FY 2008. **05/01/08:** An interim report signed and delivered to Congress on 4/18 with an anticipated completion date by the end of FY 2008. **05/15/08:** Ongoing. **07/02/08:** First site visit complete, others planned. **09/30/08: Report submitted to Congress—COMPLETE.**

1674	GUARANTEED FUNDING FOR WALTER REED ARMY MEDICAL CENTER, DISTRICT OF COLUMBIA. The amount of funds available for the commander of Walter Reed for a fiscal year shall be not less than the amount expended by the commander of Walter Reed in fiscal year 2006 until the first fiscal year beginning after the date on which the SecDef submits a plan for the provision of healthcare for military beneficiaries and their dependents in the National Capital Region. The Secretary shall certify on a quarterly basis that patients, staff, bed capacity, functions, or parts of functions at Walter Reed have not been moved or disestablished until the expanded facilities at the National Naval Medical Center, Bethesda, Maryland, and DeWitt Army Community Hospital, Fort Belvoir, Virginia, are completed, equipped, and staffed with sufficient capacity to accept and provide, at a minimum, the same level of and access to care as patients received at Walter Reed during fiscal year 2006.	Walter Reed certification.	01/01/09 04/01/09 07/01/09 10/01/09		**04/28/08:** Plan due will be completed 09/2008; certifications due quarterly after the plan is submitted. **12/04/08: COMPLETE and on track with ongoing quarterly updates.**
1612	MEDICAL EVALUATIONS AND PHYSICAL DISABILITY EVALUATIONS OF RECOVERING SERVICEMEMBERS. The SecDef shall develop a policy on improvements to the processes, procedures, and standards for the conduct by the military departments of medical evaluations of recovering servicemembers. The SecDef and the Secretary of the VA shall develop a policy on improvements to the processes, procedures, and standards for the conduct of physical disability evaluations of recovering servicemembers by the military departments and by the VA. The SecDef and the Sec VA shall jointly submit a report on the feasibility and advisability of consolidating the disability evaluation systems of the military departments and the disability evaluation system of the VA into a single disability evaluation system.	Feasibility and advisability of consolidating the disability evaluation systems of the military departments and the disability evaluation system of the Department of Veterans Affairs into a single disability evaluation system.	07/01/08	07/30/08	**07/03/08:** Report signed **07/07/08: Submitted to Congress via VA—COMPLETE.**

Status of Congressionally Mandated Requirements for Implementing the Wounded Warrior Provisions of the National Defense Authorization Act 2008 (As of December 18, 2008)—Continued

2008 NDAA Sect	Description from Act	Reporting Requirement	Due Date	Revised Due Date	Status/Milestones (Updates/progress (by date))
1615	REPORTS. Upon the development of the policy required by section 1611. The SecDef and the Sec VA shall jointly submit a report on the policy, including a comprehensive and detailed description of the policy and of the manner in which the policy addresses the detailed elements and the findings and recommendations of the reviews. The SecDef shall submit a report on the number of instances during the period beginning on October 7, 2001, and ending on September 30, 2006, in which a disability rating assigned to a member by an informal physical evaluation board of the DoD was reduced upon appeal, and the reasons for such reduction.	Comprehensive policy on the care, management, and transition of recovering Servicemembers.	07/01/08	Report to Congress 08/15/08	The pilot tests a new DoD and VA disability system. The pilot will be a Servicemember centric initiative designed to eliminate the duplicative, time-consuming, and often confusing elements of the two current disability processes of the Departments. Key features of the DES Pilot include: one medical examination and a single-sourced disability rating. One goal of the pilot is to cut in half the time required to transition a member for veteran status and provide them with their VA benefits and compensation. **11/06/07:** MOA signed to allow for a single examination process. **10/07/08: Technical Compliance Report delivered to the Hill on 09/16/08. Action COMPLETE.**
1615	REPORTS. Upon the development of the policy required by section 1611. The SecDef and the Sec VA shall jointly submit a report on the policy, including a comprehensive and detailed description of the policy and of the manner in which the policy addresses the detailed elements and the findings and recommendations of the reviews.The SecDef shall submit a report on the number of instances during the period beginning on October 7, 2001, and ending on September 30, 2006, in which a disability rating assigned to a member by an informal physical evaluation board of the DoD was reduced upon appeal, and the reasons for such reduction.	Interim report on comprehensive policy on the care, management, and transition of recovering Servicemembers.	02/01/08		**02/28/08: Submitted to Congress—COMPLETE.**

1615	REPORTS. Upon the development of the policy required by section 1611. The SecDef and the Sec VA shall jointly submit a report on the policy, including a comprehensive and detailed description of the policy and of the manner in which the policy addresses the detailed elements and the findings and recommendations of the reviews. The SecDef shall submit a report on the number of instances during the period beginning on October 7, 2001, and ending on September 30, 2006, in which a disability rating assigned to a member by an informal physical evaluation board of the DoD was reduced upon appeal, and the reasons for such reduction.	Comptroller General assessment on the progress of DoD and VA in developing and implementing policy.	07/28/08 07/28/09 07/28/10	Feb or Mar 2009	**12/04/08:** Actual submission to date to Congress soft per GAO. Meeting with GAO scheduled for 12/10/08 (OIPT).
1615e	REPORTS. Upon the development of the policy required by section 1611, the SecDef and the Sec VA shall jointly submit a report on the policy, including a comprehensive and detailed description of the policy and of the manner in which the policy addresses the detailed elements and the findings and recommendations of the reviews. The SecDef shall submit a report on the number of instances during the period beginning on October 7, 2001, and ending on September 30, 2006, in which a disability rating assigned to a member by an informal physical evaluation board of the DoD was reduced upon appeal, and the reasons for such reduction.	Report on reduction in disability ratings by the DoD.	02/01/09		**04/28/08:** OSD P&R is working, it is labor intensive and cases must be pulled out of retirement to review. **05/20/08:** OSD DTM pending Navy approval. **12/04/08:** On track. With contractor. Requires significant data mining (OIPT).
HAC Rpt 110–279	Warriors in Transition Physical Disability Evaluation System Report to the Defense Committees on plans to update the Physical Disability Evaluation System to more accurately reflect the injuries of war. This report should include a review of the differences among the Services' rating systems and the Department of Veterans Affairs system, and provide a process for how and when these various rating systems will be standardized. SecDef report.	This report should include a review of the differences among the Services' rating systems and the Department of Veterans Affairs system, and provide a process for how and when these various rating systems will be standardized.	01/15/08 then Quarterly		**12/05/08:** Quarterly Report—regularly provided independently by SecDef. **COMPLETE** and ongoing.

Source: U.S. Department of Defense.