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REEVALUATING THE TRANSITION FROM SERVICEMEMBER TO VETERAN: HONORING A SHARED COMMITMENT TO CARE FOR THOSE WHO DEFEND OUR FREEDOM

HEARING

BEFORE THE

SUBCOMMITTEE ON DISABILITY ASSISTANCE AND MEMORIAL AFFAIRS

OF THE

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

SECOND SESSION

WEDNESDAY, MARCH 28, 2012

Serial No. 112–53

Printed for the use of the Committee on Veterans' Affairs

U.S. GOVERNMENT PRINTING OFFICE

73–774 WASHINGTON : 2013

For sale by the Superintendent of Documents, U.S. Government Printing Office
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REEVALUATING THE TRANSITION FROM SERVICEMEMBER TO VETERAN: HONORING A SHARED COMMITMENT TO CARE FOR THOSE WHO DEFEND OUR FREEDOM

Wednesday, March 28, 2012

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON DISABILITY ASSISTANCE
AND MEMORIAL AFFAIRS,
Washington, D.C.

The Subcommittee met, pursuant to notice, at 10:05 a.m., in Room 334, Cannon House Office Building, Hon. Jon Runyan, [Chairman of the Subcommittee] presiding.

Present: Representatives Runyan, Stutzman, McNerney, Walz, Carnahan.

OPENING STATEMENT OF CHAIRMAN JON RUNYAN

Mr. RUNYAN. Good morning and welcome, everybody. The Oversight Hearing of the Subcommittee on Disability Assistance and Memorial Affairs will now come to order.

We are here today to examine the current framework in the ongoing efforts to streamline the transition process between active duty soldier to veteran. The streamlining of this process has been the implementation of the Integrated Disability Evaluation System, otherwise known as IDES. This program was created in December of 2007, following the recommendations of the Veterans Disability Benefits Commission and the President's Commission on Care for American Returning Wounded Warriors, otherwise known as the Dole-Shalala Commission.

The IDES goal was to improve the timeliness, effectiveness and transparency of the former legacy DES review process which has been in place for over 60 years. In October of 2010, the VA and the DoD worked in concert to begin the permanent shift to IDES around the country in 139 locations.

The ultimate objective remains to fully close the gap which occurs between the separation from active duty service to the receipt of VA benefits and compensation.

I am pleased to see the process being made to meet this objective under the new system, specifically helping to cut the transition time between active duty and veteran status. However, there are several issues and unforeseen problems which need to be addressed. First, issues with the processing times remain problematic; whereas some recovering warriors experience lengthy delays

in their attempt to navigate through the IDES system, others are rushed through without receiving the proper medical attention that they need.

Secondly, many recovering warriors reported that they find the IDES process to be extremely confusing and difficult to understand. Further efforts must be made to work directly with our recovering warriors to ensure that they are making the right decision for themselves, their families and their futures.

Finally, IDES is not as simple in practice as the various Commission reports were hoping it would be when it was first proposed. Now, nearly five years after its inception, it is important for both the VA and the DoD to continue evaluating the system and their efforts to achieve its goals of increasing transparency, improving consistency and eliminating duplicate processes.

As a new generation of active duty servicemen and women return home from conflicts overseas, we must be prepared to meet our commitment to see that their transition to civilian and veteran life is as efficient and as simple as possible. This is our duty to see that their service is honored as best as our resources will permit.

It is my hope that this Oversight Hearing will shed some light on some of the problems that we have encountered in the implementation of IDES so we may work together to find the best solution possible.

I want to thank the VA, the DoD, and the present VSOs, Dr. Wilensky, Mr. Fisher and General Scott for their valuable input as we work together to find important solutions.

We welcome today's witnesses and we now call on the Ranking Member for his opening statement.

[THE PREPARED STATEMENT OF CHAIRMAN JON RUNYAN APPEARS IN THE APPENDIX]

OPENING STATEMENT OF HON. JERRY MCNERNEY, RANKING DEMOCRATIC MEMBER

Mr. MCNERNEY. Thank you, Mr. Chairman. I would like to thank you for holding today's hearing.

The purpose of this hearing is to focus on the transition process of servicemembers to veterans, with a particular focus on the implementation of the Integrated Disability Evaluation System, also known as IDES, which is a joint VA/DoD examination and records integration effort initiated in 2007 as a result of the fallout from deplorable conditions and disjointed care found for our wounded warriors at the Walter Reed Army Hospital.

This hearing will allow us to not just to assess the effectiveness of the Integrated Disability Evaluation System, but other components of the Pre-Discharge Program established by the Departments of Defense and Veterans Affairs to streamline servicemembers' transition from active duty to veterans' status.

Today's discussion on IDES also follows up on our work implementing the Veterans' Benefits Improvement Act of 2008, Public Law 110–389, which also paved the way for a number of initiatives targeting the VA claims backlog.

In 2007, the Dole-Shalala Commission, set recommendations for the care of wounded warriors, and concluded that it is not nearly

enough to patch a system for transition to civilian life, as has been done in the past. The experiences of our men and women returning home complaining about lack of a clear outline of access to care, benefits, and services available to them highlighted the need for fundamental changes in the care management and disability systems.

The Dole-Shalala findings marked the siren call for the creation of a joint effort between DoD and VA to move to a one-exam platform which today we know as the Integrated Disability Evaluation System or IDES.

We must make every effort to focus our resources toward assisting transitioning servicemembers with the comprehensive, coordinated care and benefits that they deserve. This must occur at the very beginning of a servicemember's reintegration.

To this end, any member of the Armed Forces who has seen active duty, including those in the National Guard or Reserves, is eligible to apply for VA disability benefits prior to leaving military service through the Benefits Delivery at Discharge, Quick Start, or IDES pre-discharge programs.

During the application process, servicemembers can get help in completing forms and preparing other required documentation from VA personnel located at their bases. Additionally, IDES combines the health exam required by the DoD upon exiting the military and the VA Disabilities Assessment Exam into a single process, albeit for different purposes.

In the meantime, in an effort to provide even greater transition assistance, more elements and players, like the Federal Recovery Coordination Program, have been added to assist our wounded warriors.

I know the intent of these programs are well meaning and have helped numerous veterans across our country, but I still hear from veterans in my district who have gone through these programs and continue to experience significant delays, confusion and other problems with effective reintegration.

In fact, to that end, I would like to mention that Mr. Barrow, my colleague, has a helpful bill pending before the Health Subcommittee, H.R. 3016, that would improve reintegration efforts and require that the Federal Recovery Coordination Program operate jointly under the DoD and VA.

Since its full implementation at the end of 2011, IDES has been expanded from 3 military bases to more than 139 sites globally and nationally.

With the draw down of troops over the next few years, I am particularly concerned by the fact that the average processing time takes 400 days and that there are about 200,000 servicemembers already in the system. We don't need another backlog and want to avoid that kind of outcome at all costs.

I look forward to having an open dialogue with the panels here today, and with my colleagues, on ways to overcome challenges within the IDES system, and to accelerate processing without sacrificing quality. Separating servicemembers should not wait more than a year for assessments and benefits.

It is my hope that through our examinations of the IDES and other pre-discharge programs today, coupled with the electronic in-

tegration and other business reformation efforts accomplished over the last few years, we will continue to improve and transform today's VA claims processing system and help our servicemembers successfully transition back into our communities, and not into another backlog.

I look forward to hearing from our esteemed witnesses, and I thank you, Mr. Chairman. I yield back.

[THE PREPARED STATEMENT OF HON. MCNERNEY APPEARS IN THE APPENDIX]

Mr. RUNYAN. Thank you, Mr. McNerney. With that being said, in the order of business I would like to welcome our colleague, Mr. Carnahan, here. I ask unanimous consent that he participate in this hearing.

Hearing no objection, so ordered.

Do any other Member wish to make an opening statement?

Mr. Carnahan is recognized.

OPENING STATEMENT OF HON. RUSS CARNAHAN

Mr. CARNAHAN. Thank you, Mr. Chairman and Ranking Member McNerney. I am pleased to be sitting with the Subcommittee today and especially proud to have an organization from my district in St. Louis that has grown nationally. I had the pleasure of working with them. Testifying for them today will be their CEO, Eric Greitens of The Mission Continues.

The Mission Continues is truly a remarkable organization that empowers veterans to transform their lives and the lives of others by participating in community service fellowships. The Mission Continues fellows serve six months as community nonprofit organization and afterwards either obtain full-time employment, pursue higher education or permanent roles in service.

This is truly a remarkable program that not only gives veterans a much needed sense of purpose following military service, but also eases an often extremely difficult transition to civilian life and is an organization that is run by a Navy SEAL and many former members of the military. The Mission Continues has a keen understanding of the many challenges facing our servicemembers when they return home.

As this organization continues to make this model more accessible and available to veterans across our country, my colleagues and I stand ready to continue to support them and their work in this life-changing mission for our veterans.

With that, Mr. Chairman, again, I want to thank you for allowing me to join in the Subcommittee today. I look forward to hearing the testimony, not only of The Mission Continues but the other organizations who are here today to talk about these important issues.

I yield back.

[THE PREPARED STATEMENT OF HON. RUSS CARNAHAN APPEARS IN THE APPENDIX]

Mr. RUNYAN. Thank you very much. I would like to welcome panel one, now. First, we will be hearing from Mr. John Medve with the Office of VA–DoD Collaboration and the Department of

Veterans Affairs. And next we will hear from Mr. Jim Neighbors who is the Director of Requirements and Strategic Integration of Department of Defense.

Your complete written statements will be entered into the hearing record. And Mr. Medve, you are now recognized for five minutes for your oral statement.

STATEMENT OF JOHN MEDVE, OFFICE OF VA–DOD COLLABORATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; JIM NEIGHBORS, DIRECTOR, REQUIREMENTS AND STRATEGIC INTEGRATION, U.S. DEPARTMENT OF DEFENSE.

STATEMENT OF JOHN MEDVE

Mr. MEDVE. Thank you, Mr. Chairman.

Good morning, Chairman Runyan, Ranking Member McNerney, and Members of the Subcommittee. My name is John Medve, Executive Director of the Department of Veterans Affairs Office of VA–DoD Collaboration within the VA's Office of Policy and Planning. I am pleased to be joined by Mr. Jim Neighbors from the Department of Defense, as well as Mr. Michael McDonald from the Federal Recovery Care Coordination Program, Ms. Debbie Ender from the VHA, Mr. Tom Murphy from VBA.

I ask that my complete statement be included in the record.

The Subcommittee asked that I focus my testimony on the status of the transition process from DoD to VA, with an emphasis on the Integrated Disability System, IDES, and the Federal Recovery Coordination Program, FRCP, as well as VA's Veterans Affairs Schedule for Ratings Disabilities, VASRD, modernization efforts.

With respect to IDES, much has been accomplished to improve the DoD disability process in the wake of the issues identified in 2007 at Walter Reed Army Medical Center.

In early 2007, VA partnered with DoD to make changes to DoD's legacy Disability Evaluation System, which resulted in the implementation of IDES. IDES is now the standard process for all servicemembers who are being medically transitioned out of their respective service.

The goals of the joint process were to eliminate the benefits gap, increase transparency for servicemembers, reduce the processing time and improve the consistency of ratings for those who are ultimately medically separated. We have accomplished those goals. We are now focused on continuing improvement to that process.

With respect to the Federal Recovery Coordination Program, FRCP, it was created in October 2007 in direct response to the Dole-Shalala Commission's recommendation for improved care coordination for wounded, ill and injured servicemembers. Federal Recovery Coordinators, FRCs, are located in 12 facilities across the country, including four military treatment facilities, two VA Medical Centers, three VA poly-trauma centers, and three Wounded Warrior Program offices.

FRCs assist severely wounded, ill, and injured servicemembers, veterans and their families through each client's recovery, rehabilitation, and reintegration. The FRC creates a Federal Individual Recovery Plan for each client based on the goals expressed by the cli-

ent, with input from his or her family and/or caregiver and health care team.

FRCP is unique to other programs in that once an FRC is assigned to a client, the FRC is the constant point of contact for that client throughout all transitions.

With respect to the Veterans Affairs Schedule for Ratings Disabilities, the VASRD, it is a regulatory framework through which VA provides veterans with compensation for diseases and injuries they incur while serving our Nation. It is this rating schedule that guides the disability rating personnel of VA and DoD in making the correct determination of the compensation benefit level applicable for Veteran's service-connected conditions.

VA has partnered with DoD and the academic community to collaborate on revisions to the rating schedule. The collaboration involves public forums in which medical experts, members of the Advisory Committee on Disability Compensation, DoD officials, Veterans Service Organizations, and other stakeholders provide input and subsequently form working groups to substantively revise the rating schedule.

The VA remains fully committed to meeting the needs of our Nation's heroes and their families. VA and DoD are partners and will continue to work together diligently to resolve transition issues while aggressively implementing improvements and expanding existing programs.

Thank you again for your support of our wounded, ill and injured servicemembers, veterans and their families. This concludes my testimony and I will be happy to respond to any questions.

[THE PREPARED STATEMENT OF JOHN MEDVE APPEARS IN THE APPENDIX]

Mr. RUNYAN. Thank you, Mr. Medve.

Mr. Neighbors, you are now recognized for your oral testimony.

STATEMENT OF JIM NEIGHBORS

Mr. NEIGHBORS. Good morning, Chairman Runyan, Ranking Member McNerney and Members of the Committee. My name is Jim Neighbors and I am the new Executive Director for DoD–VA Collaboration Office within the Office of Personnel and Readiness.

It is my pleasure to be here with my friend, John Medve, to testify on the transition of our servicemember to veterans status. I would also like to take this opportunity to thank John publicly for helping to bring me up to speed on our very important work.

Taking care of our servicemembers is the highest priority of the Department of Defense. Over the past five years, DoD and VA have worked together with assistance and guidance from Congress to reform the cumbersome and often confusing bureaucratic processes which provide care and benefits to our servicemembers when and where they need them.

Working closely, deliberately and collaboratively, our departments have established governance at the highest levels to facilitate continuous improvements and to achieve our goal of seamless transition from servicemember to veteran. The duty of VA to an executive council co-chaired by the Deputy Secretary of Veterans Affairs and the Under Secretary of Defense for Personnel and Readi-

ness is the body created by Congress to formalize the collaboration between our departments ensuring interagency oversight to streamline, deconflict and expedite efforts to improve health care, disability processing and the seamless transition of servicemembers to veteran status.

Additionally, the Secretary of Defense and the Secretary of Veterans Affairs meet on a quarterly basis to discuss high priority matters that span both departments such as the Integrated Disability Evaluation System and electronic health records. They will continue the dialogue toward resolving any issues and critical areas of collaboration between our departments.

There are three areas I would like to particularly highlight on our work and focus on servicemembers. First, Recovery Care Coordination Program was established by Congress to provide recovery care coordinators or RCCs whose responsibilities include ensuring servicemembers' non-medical needs are met during recovery, rehabilitation, reintegration and in addition to assisting with the development and implementation of individual comprehensive recovery plans.

Currently, there are 171 RCCs and 198 Army advocates in 84 locations worldwide within the service Wounded Warrior Programs. More than 3,800 servicemembers and families have received the assistance of an RCC.

Second, the Integrated Disability Evaluation System, streamlining the DES process with servicemembers receiving a single set of physical disability examinations conducted according to VA examination protocols, proposed disability ratings prepared by VA that both DoD and VA can use and processing by both departments to ensure the earliest possible delivery of disability benefits.

The IDES is in use at 139 locations across all services. The Department is continuously monitoring statistics on IDES and exploring ways to improve the system and drive down processing time to reach our 295-day goal. As long as one servicemember is in the system longer than perceived helpful, we are obligated and committed to do all that we can to enhance the experience and make improvements.

Finally, DoD and VA spearhead numerous interagency electronic health data-sharing activities and delivering IT solutions that significantly improve the secure sharing of appropriate electronic health information. Interagency health information exchange capabilities that levers the existing electronic health records of each department are in use today, and as both departments work to address the need to modernize our EHRs, we are working together to synchronize planning activities and identify a joint approach to modernization.

To date, DoD has transmitted health data on more than 5,800,000 retired or separated servicemembers to VA. Of those, approximately 2,300,000 have presented to VA for care, treatment or claims to termination.

Mr. Chairman, I cannot overstate how far DoD has come in partnership with VA in recent years and we realize there is still more to do on these extremely important efforts. We will continue work with all of our partners to do anything and everything we can to provide our servicemembers with the absolute best care in treat-

ment that they so rightfully deserve in return for their service to our Nation.

Thank you again for the opportunity to be with you today. I look forward to your questions.

[THE PREPARED STATEMENT OF JIM NEIGHBORS APPEARS IN THE APPENDIX]

Mr. RUNYAN. Thank you very much. And with that, we will begin questioning in the order of arrival, which I think everybody here was at gavel call, or sitting in.

First of all, Mr. Neighbors, according to the DoD Recovering Warrior Task Force 2011 Report, there is still work to be done identifying the recovery team and acknowledging the role VA has in the system. In previous hearings and testimony before this Committee, veterans seem to be confused on what part of the process is VA and what is DoD. Can you really explain why this is happening because I'm going to drill into many avenues of confusion? This is just the first one.

Mr. NEIGHBORS. I understand. Mr. Chairman, I apologize. The Recovery Care Coordination Program that we have within DoD and then the FOC program that VA has, we consider them very complementary programs. We see different things that are involved with what DoD brings to this process and what the VA brings to the process.

As I stated in my oral remarks, we look at non-clinical kinds of care things to help both the servicemember and the family. Now, if I could, I would like to kind of put a philosophy or a statement that we take very seriously and that is never alone known, as a servicemember who has come through a very, very traumatic happening obviously with some traumatic injury that has occurred to their body and even their mind, we take the efficacy very, very important to be very efficient, excuse me, very effective in what we are doing. And we realize that does, at times, appear to be— what is the word—redundant within our own selves and even across the boards but we are going to look at the things that we provide to a servicemember all along this continuum as that approach and philosophy "never alone," so there may be some things there where we are making very good warm handoffs to the person, which I think is very true between not only the DoD entities and the VA, but there may be times when the person thinks they have four or five people, but we will err on the side of being very, very effective to that person 24 hours a day, seven days a week, always to have somebody that they can call on even if it is one or two or three levels deep within the points of contact that they have.

And we also ensure that there is a warm handoff. And what I mean by that is there is notification through a number of channels that VA knows very directly every servicemember goes from a RCC to an FRC. Thank you, sir.

Mr. RUNYAN. And just talking to the FRC and the RCC, I have experienced, through the veterans I have talked to, a lot of confusion on who is the go-to guy, where do I go when I have a problem if something is not working as I anticipated and/or the lack of the communication throughout that process. Can you touch on that be-

cause that obviously, is going to come up in a later panel with some of the VSOs that have a lot more experience with it.

Mr. NEIGHBORS. I understand, sir, and I will obviously yield over to my VA counterpart to talk about the FRC piece of this since this is obviously within their daily work.

I grant you and we have within the DoD continuous process improvements efforts that are always ongoing and looking at different things, not only within just the specific area, but with electronic records and everything else in transition that we are talking about. So I do recognize and agree that there are better ways to do things. We do take inputs and we work those regularly with VA. In fact, I think we have one coming up on Friday in which we are meeting again to discuss outputs from some of the things we have had in this area, so I agree, I guess, from my point of view as we are working these continuously and moving forward.

Mr. MEDVE. Mr. Chairman, clearly if somebody is assigned a Federal Recovery Coordinator, that person should be the prime individual for the veteran or servicemember to go to and should be the one directing them across the whole set of issues that they are dealing with.

The advantage of an FRC, clearly, is they handle both clinical and nonclinical issues. They are masters trained, nurses, social workers, and so part of the issue has been that the services want to ensure that they got kind of activity with that servicemember, and so the team of having an FRC and an RCC is complementary. In talking to the program directors in the field, this seems to be working better, that there is better coordination between the two, that the Federal Recovery individual recovery plan that is developed is now aligning better so there isn't confusion for the servicemember on what the plan is since it is their plan.

So there have been confusions in the past. We believe we are seeing improvement and we are working, obviously, to continually improve that.

Mr. RUNYAN. And how are you actually educating them— obviously we are talking about servicemember and veteran in transition, how are you educating them to the process so they can understand it more when these problems do arise?

Mr. MEDVE. If you don't mind, Mr. Chairman, I would defer to Mr. McDonald who is here from the program to answer that question because he has got more hands-on experience than I do.

Mr. RUNYAN. Okay.

Mr. MCDONALD. Mr. Chairman, the purpose of the FRC to work with the individual is to let them know what responsibilities the FRC will handle. Being both clinical and non-clinical, they can work on both sides there. They can work on the DoD side and the VA side and what they try to do is to let the servicemember know, the servicemember and the family in some cases, know what they can do and what they can assist them with, and if they need that assistance, they can reach out and touch them. They will, at a minimum, stay in contact with their folks every 30 days and a lot of time when they are working on specific issues, that will be much more often obviously. Does that answer your question, sir?

Mr. RUNYAN. Somewhat, but it goes back, just to make a point, with what Mr. Medve said, who the point of contact should be. I

think that part of the confusion is who is the go-to guy as we move through this process, and I think making that definition clear to everyone, because you said it three times in your answer to that question.

Mr. MCDONALD. The problem, the reality is, sir, sometimes we will tell them we are available to reach out and they will sometimes call someone else. That's the reality. What we try to inform them is, if they have an issue, let us know so we can be working on it with all the members of the team, which will include the RCC, the treatment team, the various case managers, such as that.

One of the things that the FRC does is a continuous availability in terms of if they are assigned a client whether in the medical treatment facility, they will stay with that client using various transitions to other MPFs to PA poly-traumas, sometimes to private treatment centers, and the same MRCC stays with that person so that they are familiar, build a trust with the individual so that they know that that is the person to come back and advise us.

In the first part, as with any relationship, is it is a developing thing and sometimes it is not clear. We can explain to please let us know what the issue is, but if they don't come back to us, then that is difficult sometimes to manage that relationship.

Mr. RUNYAN. Thank you. And I obviously, in dealing with it by speaking to veterans, know that clarity in the way we move forward in the process is essential—the process a lot of times is the issue. The process is unclear to a lot of people and obviously it falls on all of us not only to educate veterans, servicemembers and their families, but to have the system as a resource to where, we can access it and understand how we move through it, so thank you.

And with that I will recognize the Ranking Member, Mr. McNerney for his questions.

Mr. MCNERNEY. Thank you, Mr. Chairman. I think we made a little progress here in your questioning, so good work there.

I think the goal is to make it seamless for the servicemember, obviously that is the goal. Are there technical issues, like communication between computers or any of that? Is that a problem at all? Can we just put that one to bed now, or do we need to talk about that for a little while?

Mr. MEDVE. So, Congressman, thanks for the question. We are working on that. You know, I am sure you are familiar with that word, trying to develop or out on the boards developing an integrated electronic health record which once that comes into fruition, will, I think, be a great asset for us. In terms of the Integrative Disability Evaluation System and moving people through that process, we have one system called the Veterans Tracking Application that we use to manage where people are in the process so that we have the metrics and understand where they are at.

We monitor those things every two weeks at the VA. The VA Chief of Staff holds a biweekly performance meeting with every senior executive that manages a part of that process down to the local level. As part of those discussions, if there are issues that we are having in terms of transmissions of data or anything like that, he immediately calls our Office of Information Technology to bore in on the problem and to fix it.

Mr. MCNERNEY. Well, that sounds good. Except, I want to get an idea of when these medical records are going to be standardized so that we can get this transition, that part of it, out of the way. So do you have an idea about when that can be expected to be finished?

Mr. MEDVE. Sir, I know the two secretaries, as Mr. Neighbors alluded to, meet every quarter. At the last meeting at the end of February 27th, one of the marks on the wall is that we are putting the Integrated Electronic Health Record at the James A. Lovell Federal Health care Center. That's the pilot site for it. They have required that there be two additional sites be in place by 2014 in order to build this, and so it is going to be a rolling development over the next several years.

Mr. MCNERNEY. That is not good enough. That is just not even good enough. Yes, Mr. Neighbors.

Mr. NEIGHBORS. Sir, if I could chime in and thank you for your question. DoD and VA are actually sharing more health information right now than any two organizations in the Nation. If I could just give you some statistics, please, on what that sharing is.

Servicemembers' data, again, that has been shared with VAs over a million times already, and what that turns into is for laboratory results. We have shared 23,000,000 of them to date, and these are in IT form. This is machine readable things that we push for, so they are not paper in this area— radiology, 3,600,000 million reports; pharmacy, 24,000,000 records. And patients have engaged on their medication, allergy information from what was about 27,000 to now 1,200,000, which is a significantly improving patient safety.

Those are just some areas. It is an entire IEHR.

So between our organizations, we actually are doing some of the sharing already. And if I could, there are actually four locations pilot-wise which we are including private providers, such as a Kaiser Permanente or something, what we would bring to them into the fold here to.

So between governmental entities, we have that actually going on right now. So you are right. We are not where we need to be. We are not completely there, absolutely, but there is stuff going on that is servicing our veterans.

And the second thing I would like to say, sir, if I could, please, that is entity to entity. As far as giving a VA, excuse me, a veteran, or even a servicemember their health records, we can do that right now. We are working very closely with VA to enroll our servicemembers as they come in the door, into a platform, an IT platform called the E–Benefits Platform, that allows—we have got 1,400,000 of them already signed up right now, but at any point in time after that from anywhere in the world, 24/7, they can actually download their medical records and hand them off to a private provider or anybody that they are involved with through that continuum right now, and that's called the blue button capability. Maybe you have heard that or not.

Mr. MCNERNEY. No, I haven't heard that. One of the things that Mr. Medve was saying is that you can track an individual through the process, but is there an advocate for that individual or does that get passed on and the individual finds himself or herself calling in and getting the runaround.

I mean, what we need is an advocate, whether it is DoD or VA or the joint effort—Mr. McDonald started going into that—but an ombudsman or an advocate or some coordinator that that person can go to when they are in trouble from start to finish.

Mr. MEDVE. Sir, yes. Thank you for your question, again, Congressman. In IDES, when someone is enrolled in it, there is the PEBLO, the Physical Evaluation Board Liaison Officer. When that individual is referred is who greets them at the entrance to that process. That is the single point of contact that will shepherd them through IDES. As they are in each different stage, they are briefed by that person where they stand, whether they are medical, when their medical evaluations are done, when they are supposed to appear before any boards, all that.

Once we get to a point where they are going to be determined to be separated, we, the VA sitting with the DoD PEBLO, we call the military service coordinators, that then sit down with the individual as a team and explain to that individual what their VA benefits are, so that is what happens inside the IDES.

Mr. MCNERNEY. Does the servicemember or former servicemember get to check off on that and say that they are okay with that transition?

Mr. MEDVE. I will defer to Mr. Neighbors since that gets into the military's administrative process.

Mr. NEIGHBORS. Absolutely, sir. At any point in time when an evaluation takes place, that servicemember has reclama capability at a number of venues. Each one of the services has a local board that does exactly what we are talking about here, which is the evaluation of their disability and the rating. They can then take that to a department-wide—excuse me, let me say this again. The service-wide board is more of a formal activity in which they make sure that the rulings have been applied equally across from the local board itself.

If the servicemember doesn't believe that is equitable, they actually can go to another level and they can actually go to what is called the Board of Correction for Military Records level, also. So there are a number of points that the person can say, you know what, this wasn't fair, I need another look, and they can be reversed or they can be upheld as any kind of board would do, but yes, sir, there is.

Mr. MCNERNEY. Okay. I am going to yield at this point.

Mr. RUNYAN. I thank the gentleman. Mr. Walls.

Mr. WALZ. Thank you, Mr. Chairman, for holding this hearing. Thank you both for being here. This issue of singles transition, like you, I feel like I have spent most of my adult life talking about it and trying to get us there and I am please to see both of you sitting here. It certainly is a move forward where we have both DoD and VA, and I know the things you have talked about and trying to get us there through electronic records, through the coordination and collaboration. It is not only the right thing to do. It will save us resources and money in the long run preparing for our veterans, and so I appreciate what both of you do, and I know that you are two representatives sitting there and if the Chairman will indulge me a bit, I am going to—I am very thankful, I think, listening to

the name of this hearing, honoring the Shared Commitment to Care for those who defend our freedom.

I am thinking about this and watching the two of you set this idea of a handoff or whatever, there was some more news this week again. And those of you on this Committee, I have been here long enough, I certainly don't turn to the sensational to highlight this, but I am going to highlight this issue of the discharges from DoD on personality disorder.

I am truly troubled by this. If this is truly about honoring the Commitment to Care, this is the third hearing I have set here where we have talked on something like this. In 2007 we were going to get this fixed. We were going to get it fixed in 2010, September 15th, and there is a report today and my friends over at the Vietnam Veterans of America, through a Freedom of Information Act, were at it again.

So we got soldiers. They go to war, they come back and they are being diagnosed with adjustment disorder or personality disorder. It gets stamped on their discharge papers, "Discharge for Personality Disorder." They are denied VA benefits and that is on their permanent record to follow them for employment.

So Mr. Neighbors, I know this is not your area of expertise, if I could say. I am not putting you on the spot for the entire Department of Defense, but I would like you to—what do you think when you hear this again because all the issues you are talking about, I don't want to distract us from this very, the broader issue, but I do feel like I need to speak up for these 31,000. I do need to try and figure out how we right this wrong because the idea that you would be diagnosed with an adjustment disorder after being in Afghanistan, I don't know, if I could just turn it over to you, and I thank you, and I know it is very general but it just troubles me.

Mr. NEIGHBORS. I understand and I really appreciate the question. It is a very important issue. I am going to go out on the limb a little bit here and try to narrow it a little bit. I think what you are referring to is what has happened maybe at Madigan out on the West Coast. Am I correct on that or is it——

Mr. WALZ. Well, there was a new—I had the thing, we just had a Freedom of Information Act request and the study was put together on this from Vietnam Veterans of America. I will make sure we get a copy to you——

Mr. NEIGHBORS. Okay.

Mr. WALZ. —to let you see that. But it is pretty much we are on the same pace as we have been in the last 10 years, releasing these folks. This came to our attention when Joshua Kors wrote the piece, "The Disposable Soldiers in the Nation."

We had three hearings on it again. Vietnam Veterans brought it up again, and it is probably the most striking example for me of how somebody does fall through the cracks or how we are not seamlessly to handing off folks and I am just curious on your part.

Mr. NEIGHBORS. Okay. And I appreciate that, sir.

Mr. WALZ. Yeah.

Mr. NEIGHBORS. If I could, I would like to yield back to one of my SMEs that I have brought that I think can more, give you much——

Mr. WALZ. That would be greatly appreciated.

Mr. BURDETT. Councilman, I think you are calling an issue—I am Phillip Burdett. I work with——

Mr. RUNYAN. Would the gentleman, please, speak into the microphone, please.

Mr. BURDETT. Councilman, I am Phillip Burdett and I am Mr. Neighbors' colleague and we work in the IDES system. And particularly, I think the behavioral health issue that you've highlighted is a critical one for us. As we have made non-visible injuries a priority, we have seen them skyrocket in diagnosis, we struggle to hire behavioral health professionals, and I think the answer to your strategic question is how do we train those behavioral health professionals correctly and then how do we administer the policies and regulations, and we have made some great steps in 2010, think we had this issue fixed, and when it flares up, I think it comes back to training those behavioral health professionals, making sure we have the right and adequate ones at our bases' posting stations, give them the diagnoses.

Mr. WALZ. Are we benchmarking now because my question, I think what the public comes up to is how do you know that person came in with a preexisting condition of a personality disorder? How are you making that judgment?

Mr. BURDETT. I think two issues come to mind here. It is such a new science in so many areas. We have talked of PTSD, directly the TBI, and then the manifestation of both of those conditions with the incredible physical problems at the same time, so as our diagnoses have skyrocketed, we have invested a tremendous amount, especially with our Assistant Secretary of Health Affairs. The investments in that have been significant.

Now, we need to then recognize are we using some good medical standards across the board, are we then making sure that our doctors are using those diagnoses, following the regulations that we have implemented in the accordance with the laws that you have passed. We owe that. I think we have made a great effort in acknowledging what we know and don't know about behavioral issues and then putting together solid policies and regulations.

Mr. WALZ. And I appreciate that and I do acknowledge the progress we have made and this is a difficult area. And I guess my question is how do we right what I think is an egregious wrong for some for these folks? I think they went in and the horrific experience they experienced, they are coming out with what others have, which I would say in some cases is a normal reaction. They have been diagnosed with this, which is basically a black ball to them, that they are not welcome at the VA, they are not welcome at the employers.

Do you have a suggestion? And I appreciate your candidness from both of you on this issue of trying to address it.

Mr. BURDETT. I think, Congressman, I would say that I think that Mr. Neighbors highlighted is we have made this a servicemember centric policy and regulations since the beginning and the ability for a servicemember either on the VOD side of the equation or the VA side to then challenge and come back and open these cases and say I would like you to look at it again. Those have not been abridged. They have been extended. And the opportunity for those servicemembers to recognize, you know, I may have got-

ten out in 2004 and then had this condition that I need to have reevaluated.

The VA has done fantastic work at making those avenues available to those veterans to come back and say, let us look at that case again.

Mr. WALZ. You think it is too harsh where VVA (Vietnam Veterans of America) is just point blank calling these illegal discharges?

Mr. BURDETT. I think the role of the VSOs is critical. I sometimes refer to them as our conscience, making sure, holding us accountable to make sure that we understand things. I appreciate their flexibility and also understanding that the behavioral health issue is such a new area of science for the medical community, for the policy makers, and then for the——

Mr. WALZ. Well, I am going to try and figure out a route to figure out how we get these folks back, how we give a fair shake at them because I think we got folks—and I say this again from the moral perspective, but also from an economic perspective. They are probably not working. Our suicide rates can be tied to some of this. There are just different issues that we have got to go back and capture them with the new data that has gone—and I will be the first to tell you that I think in the ten years in seeing what we were first doing in the war zones, what we are doing now, great kudos to everybody involved, behavioral health and integration.

Mr. NEIGHBORS. I just want to add one other thing, Mr. Congressman, to what Mr. Burdett said, and that is the basic military training, you touched a little bit on preexisting conditions. There is a vast array of medical diagnoses—not diagnoses, evaluations that take place even as a person is coming in the door for basic military training in which you alluded to preexisting conditions. Those are all documented.

Mr. WALZ. Why did we keep them then?

Mr. NEIGHBORS. Oh, no, no. There is a wash out period there also, sir.

Mr. WALZ. But you know, we got some of these folks that went, they served their time, some up to eight years, went to Iraq, came back and then they were stamped on their as a preexisting condition for personality disorder. Why the heck did we keep them if that was the case? Why didn't we get them out otherwise? I mean, how do I respond to those people? You see where this is going?

Mr. NEIGHBORS. I do.

Mr. WALZ. And we are this close to a class action suit against DoD on this. You feel that coming. My case is I just want to correct the problem and make sure it doesn't go forward.

Mr. NEIGHBORS. And I understand completely, sir. Again, they have multiple avenues to go back to up to include Board of Corrections for military records, which I sat on for the Air Force. I saw many of those kinds of cases and saw some actually overturned also, so there are avenues for people. You are absolutely correct. There is more that needs to be done, and there are more things that I believe we can do and we are working on those with the services to move forward, but I do——

Mr. WALZ. You think the avenues exist without us getting—my take is is to help and figure out a channel through the proper exist-

ing process of appeals or rectifying these. You think those set out there and are ready to go?

Mr. NEIGHBORS. I will be happy to work with you. Obviously, I——

Mr. WALZ. Yeah, and we will be following up with others, but I thank you, Mr. Chairman. I know you gave me extra time, but I want to thank both of you for your candidness and attempt to get out this. I appreciate it.

Mr. RUNYAN. I thank the gentleman. Mr. Carnahan.

Mr. CARNAHAN. Thank you, Mr. Chairman. I really just had one quick question I wanted to ask our two witnesses. I understand there have been some informal sessions for demobilized and separating National Guard and Reserve members. Can you talk about some of the unique challenges associated with educating and processing these servicemembers and do you have any thoughts on how to deal with them more effectively? Go ahead. Jump in.

Mr. NEIGHBORS. I apologize. Sir, a great question. There is no doubt that there are differences, especially in timeliness as far as how servicemembers from the Guard Reserve come through the IDES specifically, but I do know that we are taking, as for us, especially Recovery Care Coordinators, and things have a standardized training regime. They all receive 40 hours of training or more to make sure that they are engaging with servicemembers, not only active duty, but Guard and Reserve, so that they understand all the processing the same.

There is no doubt, as far as transition is concerned, servicemembers that are Guard Reserve have issues of employment that are in and out of their employment. There is a large—in fact, thank you, gentlemen, for the VOW Act that you graciously gave to the DoD last year. As far as transition is concerned, we are working very hard. Some of, I think, what answers what you are saying there is an involved in implementing that Act which we are working with the White House on right now.

Many issues in making sure that Guards and Reservists get that exact same training that is funding, that it's moving forward in the same way that the active duty is getting. We are working very hard with the VA in ensuring that that transition takes place. Does that kind of get to what we are talking here?

Mr. CARNAHAN. Yeah.

Mr. NEIGHBORS. Okay. All right, sir.

Mr. MEDVE. Congressman, again, thanks for the question. In terms of overall in the process of demobilization, I know that we have VA reps at the de-mobe sites there to work people through to ensure they understand what they are eligible for. In terms of IDES, you know, we currently have a major effort going down on Pinellas Park with a number of Reservists' records that are being gone through to determine whether or not they had profiles that had to be validated to see if they were such a level to require medically being separated from the service. We are working hand in hand with DoD.

We have a number of Reservists and National Guard who do collect VA benefits when they are off of active duty, and as part of that process we share with the DoD as they are looking at these records in terms of medically separating people to validate condi-

tions that exist and all that, so we have got good information sharing between the departments on that.

But a Reservist going through IDES gets the same attention going through the process because they are still on active duty when they are going through IDES, so the PEBLO that I talked about before, they are walking them through the process. They have access to the military's service coordinators that go through the process, so they are treated no different from our point of view, than active duty, somebody who is on active duty all the time. servicemen are going through the process.

Mr. CARNAHAN. Thank you, gentlemen. I yield back.

Mr. RUNYAN. Thank you, gentlemen—and on behalf of this Subcommittee, I thank you for your testimony and your time. Obviously, we have a lot of work ahead of us trying to make sure that we take care of our warriors, our true heroes of this country, so with that being said, I look forward to working with you on that and continuing to make this process what it truly deserves and needs to be.

So with that being said, both of you are excused. Thank you.

I want to call the second panel to the witness table at this time. At this time I welcome Dr. Gail Wilensky, a Senior Fellow with Project HOPE. Dr. Wilensky also served as a Commissioner on the Dole-Shalala Commission. And next we will hear from Mr. Ken Fisher, Executive Officer of the Fisher House Foundation. Mr. Fisher also served as a Commissioner on the Dole-Shalala Commission. And finally we will hear from Lieutenant General James Terry Scott who served on the Advisory Committee on Disability Compensation.

We appreciate all of your attendance here today. Your complete and written statements will be entered into the hearing record.

And Dr. Wilensky, you are now recognized for five minutes for your oral statement.

STATEMENTS OF DR. GAIL WILENSKY, SENIOR FELLOW, PROJECT HOPE; KEN FISHER, CHIEF EXECUTIVE OFFICER, FISHER HOUSE FOUNDATION, INC.; LIEUTENANT GENERAL JAMES TERRY SCOTT USA, (RET.), CHAIRMAN, ADVISORY COMMITTEE ON DISABILITY COMPENSATION.

STATEMENT OF GAIL WILENSKY

Ms. WILENSKY. Thank you, Chairman Runyan and Ranking Member Mr. McNerney and Members of the Subcommittee.

I am pleased to be here to talk about the transition from servicemember to veteran with particular emphasis on the Integrated Disability Evaluation System.

As you mentioned, I am currently a Senior Fellow at Project Hope, an International Health Education Foundation. I also serve as a regent for the Uniformed Services University of the Health Sciences, USUHS. I have had the honor and privilege of being on the Dole-Shalala Commission as you mentioned. I was also a Co-Chair of the congressionally mandated study on the future of military health care and earlier in the decade I co-chaired the President's task force to improve health care delivery for our Nation's veterans, initially with your colleague, Gerald Solomon, who unfor-

tunately died early in that period, and then with John Paul Hammerschmidt. The views I am going to express are my own, however, not those of these other organizations.

Before the introduction of the IDES, servicemembers needed first to separate from his or her service and then to enter the VA process, requiring as you have mentioned, two different exams. The process and criteria for determining fitness differed across services. They differed between the services and the VA. The result was real and as important, perceived differences, in equity across the services and between the services.

It was frequently a lengthy process, as you have mentioned. It was also frequently a contentious process which was equally bound to have happen.

The difference now with the IDES is that there is a single exam done by a VA certified physician that serves both as the basis for determining fitness to serve and also by the VA to establish a level of disability. The services continue importantly to determine fitness to service and the VA, the disability level.

The time has been reduced substantially, although not as much as it should be. The goal that was talked about this morning of 295 days is a substantial improvement. Initially, there has been some discussion of a goal of 100 days. That is obviously still a long way out.

And there are some lengthy and inexplicable delays that occasionally reported. Last summer at a Senate hearing there was a discussion of a marine who had been in Afghanistan in 2010, lost both his arms and legs and had his papers sitting on someone's desk for 70 days; clearly, not something acceptable to anyone.

There are some questions that remain in my mind as somebody who had run Medicare and Medicaid in the early 1990s, as to why it is taking quite so long to fully roll out the IDES, until the fall of 2011. It has now happened and I am glad, but that length of time is inexplicable to me.

There are also questions about what are the real goals of the program, and that means not just reducing time but what actually is it that you are trying to do.

I also want to talk for a minute about another area where we had recommended change and that was the Disability and Compensation System, trying to make sure that it was speedy with, reduced inequities and, most importantly, helped veterans return to their productive lives as fully and completely as possible.

We recommended a transition payment be made while individuals are receiving rehab and training, and that this was to be followed up by an earnings-loss estimate which may remain after training, but in our service-oriented information economy may not remain. There was also to be a quality-of-life payment recognizing that even if there was a loss, there was not a loss of earnings capability, there may well be a real quality of life decrement which should be compensated.

Two of the young men on our Commission really fit into that role. One was getting an MBA at Harvard. One was having a double major at George Mason. Both of them would probably not experience earnings losses, but they had major injuries that would result in quality of life decrements.

We also need to make sure that other recommendations that we made in Dole-Shalala are carried out, making sure that care is available for those needs of PTSD and TBI services. We recognize that is going to be a challenge because of the shortage of mental health providers and professionals in the country in general and, therefore, afflicting those services as well.

And we have recommended extending respite care and extending the FMLA, the Family Leave Act, for up to six months for spouses and parents of seriously injured people. This, of course, is going to be difficult in our fiscally challenged environment, but it is one that is important.

Let me just end on a positive note. While the recommendations we made are important and we are glad to see some of them being carried out, we also noted that the problems were not quality-of-care problems, but rather problems with the handoff, the transitioning from inpatient to outpatient, from active duty to veteran.

We, of course, need to make sure that both are appropriate for our returning wounded warriors, but I would hate to have people think that it was a quality of care that we found wanting after 2007. It was not. It was these other processes which we are pleased that you are taking on.

Thank you.

[THE PREPARED STATEMENT OF GAIL WILENSKY APPEARS IN THE APPENDIX]

Mr. RUNYAN. Thank you very much. Mr. Fisher.

STATEMENT OF KEN FISHER

Mr. FISHER. Chairman Runyan, Members of the Committee, on behalf of Co-Chairs Dole and Shalala who could not be with us today, the Members of the Commission, and my fellow Commissioner Gail Wilensky, I appreciate the opportunity to appear before you today.

Both as a Commissioner and as Chairman of the Fisher House Foundation, I have devoted the last 12 years of my life towards improving both the care and the quality of life of our military, those wounded, veterans and their families. Today's hearing on the DES and the seamless transition are critical to this Nations' security and I am proud to discuss my work on the Commission, recommendations and action steps, and how this system must be made simple, easily understandable and easier to navigate.

But I must admit to being a bit confused. This is the greatest Nation on earth, with the greatest equipped and best trained military in the history of the world. What puzzles me is we are here five years after the roll out of this report.

Before I begin, I feel compelled to preface my statement by explaining our mission. We were charged by President Bush to examine, evaluate, and analyze the care and process related to our returning wounded global war on terror servicemen and women. We looked at the system through the eyes of the wounded service people. We were solution driven. We held numerous field hearings, interviewed wounded, interviewed commanders, doctors, family

members as well as others who played a role in the recovery process.

We not only examined problems and inadequacies but also looked for best practices that might help improve their care. Our goal was to simplify and help eliminate the log jam, which was the result of fighting lengthy two front wars with a VA that was already challenged by the weight of an intolerable bureaucratic system. And by doing this, we sought to eliminate the backlog and claims that had reached at the time approximately 800,000 to 900,000.

While the living conditions at Walter Reed were indeed horrendous, this was only the tip of a massive iceberg. We found hundreds of troops waiting months for follow up appointments or awaiting the ratings process. This gap in benefits caused massive problems known to but a few.

The Commission was given six months to evaluate the entire disability evaluation system and our findings were thoughtful, inclusive, and implementable. It was not our intention to put forth hundreds of recommendations that would have been difficult to implement or too expensive as a whole.

And by the way, as a side bar I would like to join my colleague and say that I want to compliment this Nation's military health care professionals whose work and use of the latest technologies resulted in a battlefield survivor rate of better than 95 percent, which is unprecedented.

Today, five years after our report was made public, there has been progress, to be sure, but with all due respect, not nearly fast enough, and with not nearly enough sense of urgency. Tracking the results of the Commission has been difficult, as admittedly I would not expect the process to be transparent. But again, the task we were given with that of OEF/OIF, and I hope of its adoption would have moved the system along faster.

Now, rather than go in and be redundant on points already covered, I would like to—we have heard about disability and the new IDES, although I feel that there are staffing problems which are causing problems in the implementation of IDES. I also am confused as to why a VA doctor would be doing a DoD physical, but I don't want to get into that either at this point.

What I would like to discuss is the—pardon me—is the PTSD and I would like to remove the word or the letter "D" because I don't believe that post-traumatic stress is a disorder. We recommended lifetime treatment for post-traumatic stress. These men and women have endured multiple deployments, have been in intense urban fighting, often against civilian insurgents who too often hide behind innocent women and children. They have seen horrific injuries caused by IEDs. And the stigma associated with coming forward and asking for help leaves too many to suffer in silence, and if they are home, their families to suffer as well.

We believed this was a major problem when our report was made public, and it has been for any servicemember who has fought in battle be it World War II, Korea, Vietnam or today.

Today it is evident why this was a major recommendation. Five years after our report was made public, there have been well over 1000 suicides, outpacing the civilian population, domestic violence,

and divorce, drug and alcohol abuse, homelessness, joblessness, all at unacceptable levels.

Just the other day in USA Today, an article appeared discussing alcohol within the ranks of the Army and the fact that they have delayed for three years a confidential counsel program for treatment. They had begun a pilot program in 2009, but it was ended after a high dropout rate. According to the article, 25 percent had a drinking problem.

In the interest of time, Mr. Chairman, I will end my statement there, and I thank you for the opportunity to appear here and look forward to your asking questions.

[THE PREPARED STATEMENT OF KEN FISHER APPEARS IN THE APPENDIX]

Mr. RUNYAN. Thank you, Mr. Fisher.

General Scott.

STATEMENT OF LIEUTENANT GENERAL JAMES TERRY SCOTT (RET.)

Lieutenant General SCOTT. Chairman Runyan, Ranking Member McNerney and Committee Members, it is a pleasure to appear with you today representing the Advisory Committee on Disability Compensation and the Veterans Disability Benefits Commission that met from 2005 to 2007 and reported out to you in October of that year.

It is also a distinct honor to serve on a panel with Mr. Kenneth Fisher whose contributions to servicemembers and veterans are known and appreciated.

Mr. FISHER. Thank you.

Lieutenant General SCOTT. The Advisory Committee is chartered by the Secretary of Veterans Affairs in compliance with Public Law 110–389 to advise the Secretary with respect to the maintenance and periodic readjustment of the VA Schedule for Rating Disabilities. Our charter is to, "Assemble and review relevant information relating to the needs of veterans with disabilities; provide information relating to the character of disabilities arising from service in the Armed Forces; provide an on-going assessment of the effectiveness of the VA's Schedule for Rating Disabilities; and to provide ongoing advice on the most appropriate means of responding to the needs of veterans relating to disability compensation in the future".

Your letter asked me to testify on the Advisory Committee's views regarding the transition from servicemember to veteran, with a particular focus on the implementation of the IDES.

At the time the Veterans Disability Benefits Commission was created by the National Defense Appropriations Act of 2004 it was already apparent that the peacetime system for transitioning sick and injured servicemembers to veteran status was overwhelmed. From the outset, and well before the reprehensible situations at the Walter Reed Barracks and other locations were recognized, the Commission saw the need for a rapid and seamless process that protects the servicemember while he or she progressed to veteran status. Transition became one of the major issues studied by the Commission. Interim recommendations addressing transition issues were offered as deliberations progressed.

The VDBC examined the policies and processes within the Departments of Defense, Veterans Affairs, Labor, Health and Human Services, and the Social Security Administration that affected separation or retirement. Each of these entities plays a significant role in the transition of veterans and their families.

Of the many recommendations the Commission made, many of them pertained to improving the transition process. I am providing for the record a list of the key transition recommendations and the status of their implementation as I understand it.

Of the recommendations pertaining to transition of both the Veterans Disability Benefits Commission and the Advisory Committee on Disability Commission have offered, the one with the most potential to reduce the time to process claims and improve accuracy and consistency is the ongoing plan to revise the VASRD, the rating schedule. This complex, multi-year revision will incorporate current medical knowledge and technology as well as streamline the diagnosis, evaluation, and adjudication processes.

Another key recommendation with potential long term positive effect is the movement to an electronic claims record. This is another example of an extremely complex challenge that VA has accepted and is working on. When fully implemented, it will simplify and expedite the claims process. As well, the Integrated Electronic Health Record which was mentioned in the previous testimony.

The Advisory Committee on Disability Compensation took up where the VDBC left off on making recommendations for improvements to the systems and processes to transition servicemembers to veteran status. Particular emphasis has been on the injured and the ill servicemembers who are eligible for the IDES program. However, the scope of our activities, it covers all servicemen transitioning to veterans.

Our recommendations have included specific statutory and regulatory changes such as increased family support services, educational, vocational training and rehabilitative support. Many of these recommendations have been adopted in whole or in part. We have recommended the VA undertake an in depth longitudinal and independent evaluation of the VR&E Program as soon as possible to determine the effectiveness of the program in serving disabled veterans. We believe there are significant opportunities for improving access offerings and management.

We have offered recommendation for reducing a number of contact points a veteran must touch in order to understand and receive benefits, also mentioned in previous testimony. We are in the process of reviewing the availability of mental health programs for veterans. The Committee is also tasked to look at unique Reserve and National Guard transition issues and we recently added a U.S. Air Force Reserve medical officer to the Committee to assist us in that regard.

The current IDES program incorporates many of the recommendations of the Veterans Disability and Benefits Commission and the Advisory Committee on Disability Compensation. It represents a tremendous effort on the part of VA and DoD to focus on the transition of members who are sick or injured to veteran status.

All parties, including the Congress, are frustrated by the average time still required to complete the transition. From the perspective of someone who has the opportunity to work on this effort over the last eight years, I do believe that progress is significant and more importantly that the progress will continue.

On behalf of the Advisory Committee, thank you for the opportunity to testify on this important matter.

[THE PREPARED STATEMENT OF LIEUTENANT GENERAL JAMES TERRY SCOTT APPEARS IN THE APPENDIX]

Mr. RUNYAN. Thank you very much, General Scott, and I thank you for your service to this country and your continuing service to our heroes. I appreciate it.

With that, we will begin a round of questioning. My first question is for Dr. Wilensky. In your testimony you mentioned the importance of recognizing that there are different functions that medical exams can serve and there are many different goals. How would you incorporate your suggestion of the ongoing periodic medical evaluations into a single disability exam process?

Ms. WILENSKY: It is a good question, Mr. Chairman. The reason I mention that is having spoken with many medical officers, those currently and previously in the military, they reminded me of the different functions that a medical exam can fill, a physician maybe determining the diagnosis or the process of treatment and then the progress in terms of that individual over time, which may be on an ongoing basis. When it comes to an exam that is done in order to determine fitness to serve or a disability status, that is a moment in time. I mean, it is an important moment in time. It needs to be on a single basis as is being done. But it needs to be recognized within the context that there will be ongoing periodic evaluations, both in order to be able to treat the individual, whether he or she returns to duty or becomes a veteran, and also periodically should be done in order to establish whether or not the disability is continuing as it was initially established.

It's important to recognize that a single exam may include different components, it will be a snapshot and a moment in time, but it doesn't mean that it is the only medical exam that will be occurring over time. If you have a medical problem, you would want to have your medical professional seeing you when carrying out the course of treatment. It is to recognize that the focus on having this one exam done by a VA certified physician is appropriate for the particular purpose of establishing fitness to serve or a VA disability as of that moment, but there will be, should be continuing medical exams over time for these other purposes.

It's really to remind people this is not once and never again will you have a medical exam because that would not provide optimal care.

Mr. RUNYAN. Thank you for that. And also, talking about disability and payment steps as we begin to deal with the transition and then loss of earnings and finally quality of life, can you give your assessment of the current state of these steps and how we can improve that process?

Ms. WILENSKY. Thank you very much, Mr. Chairman. This is an area that for me as an economist was particularly important. We

on our Commission recognize that the payment, the orientation and thinking of the disability payment was heavily tied to post-World-War-II thinking where the loss of a limb or a certain type of injury could have very major impacts on earnings-potentials of individuals of post World War II, Korean and Vietnam eras.

We were recognizing that we are now in an information and service oriented economy. And what that means is that with the help of the VA, the GI bill and others, even seriously injured individuals can be helped to reach a higher functioning state with the proper support, both VRA for those who need vocational, but higher education for those who are in a position to do so, and may be able to reduce or eliminate any earnings loss per se. Even for those individuals, they may well merit a quality of life decrement payment such as was the case for two out of the three injured on our Commission.

I mentioned in my testimony that the wife of a third individual, Tammy Edwards, her husband is not somebody who is ever going not to have a major earnings loss as well as a quality of life decrement, no matter how much training and education was provided because of the severity of his injuries, including brain injuries as well as major burns.

So it is important to recognize that even in an information and service society, there will be people who will continue to have significant earnings losses and quality of life decrements. But for people, like, two of our members, they would not have earnings losses. They would require a lot of support, payments while they were going to school, as well as what was as expensive support for their education.

To the best of my knowledge, we have not made much progress in this area, although as you know, there has been a significant improvement in the educational support to people post service.

Mr. RUNYAN. I have one question for Mr. Fisher quickly. I assume you have communication insight into the world of Wounded Warrior support, obviously through your organization. What is the general feel in this area pertaining to how the DoD and the VA utilize and communicate to organizations such as The Fisher House? Obviously, a lot of what we are talking about today deals with the lack of communication or lack of knowing the pathway forward.

Mr. FISHER. Thank you, Mr. Chairman, and I would say in general we have maintained a very, very good dialogue with both the DoD and the VA. It is necessary for us to do so because the way we determine where a house is located is by dealing with the VA or the Surgeons General. So communication for us is absolutely essential so that we don't waste money. Every donation we get is precious. So we can't afford to have a house built where it doesn't belong.

So the communication with the VA and the DoD has been fairly good in terms of our ongoing dialogue.

Mr. RUNYAN. Thank you very much. With that, I recognize Mr. McNerney.

Mr. MCNERNEY. Thank you, Mr. Chairman.

Mr. Fisher, I would just like to thank you for dedicating so much of your life to the service of other people.

In your experience, what if anything can be done to ensure a better continuity of care for wounded warriors before they go home to live with their families, especially ones without PTSD and traumatic brain injuries? I know this is a tremendous burden on the families. Is there anything we could do or that the DoD or the VA could do to make that transition easier so the families can deal with this enormous burden?

Mr. FISHER. Thank you, sir. I would, I think in my prepared statement I suggested that there potentially could be kind of a spousal education program upon deployment or as they entered the military and if a serviceman or woman enters the military as a single person and gets married while in the military, that their spouse at the time join a program.

I think it is essential for the spouses to learn what the signs are or what to look for. They don't always manifest themselves with violence off the bat or the screaming and mood swings and so forth. I think that sometimes it could be just, you know, something as simple as not sleeping at night after deployment.

So I think some kind of a spousal educational program that would kind of educate them, let them know what the signs or what the early warning signs are when they come home.

Mr. MCNERNEY. So this education would have to start before they come home basically.

Mr. FISHER. Well, in terms of the spousal program, I would like to see something like that happen upon deployment before they leave, and I mean the first time, not if we are talking about multiple deployments.

Mr. MCNERNEY. Thank you. Ms. Wilensky, I was struck by something you said, the starkness of your statement that the problem is in the handoff, not in the quality of care, but then you also said that the IDES exam is just a single point in time. Things change and so I would like to get your idea of how we could make this work better. I mean, you must have a vision of how this would work.

Ms. WILENSKY. The good news, as I indicated, was that our observations, and that is supported by others as well, is that the actual quality of care being delivered. Once the person is in the place they are supposed to be, either active duty military or in the VA system, has been very good, and that the problems have occurred whenever they are making a change. There is not a single handoff.

When they move from inpatient to outpatient care, there were major problems. It was why the Wounded Warrior Recovery Program was so important to put in place. And while that has reportedly helped, there are still concerns about whether it is completely getting the job done, whether those transitions and handoffs are occurring for the especially very seriously wounded as well as they need to be and whether that will continue as we go out because we are still seeing very seriously wounded individuals coming out of Afghanistan and other places.

So it is not even there a single handoff. It is every time somebody moves to a different part of their care is when the problems have been occurring and those are the places where we remain vulnerable.

With regard to the point in terms of evaluation, something like a three year evaluation of a disability is appropriate, so that there can be an assessment as to how the person is progressing and the kinds of needs that they have at that point, and again it was the emphasis that this is not anything other than a snapshot. It needs to be a really good snapshot because you are making a decision about fitness to serve and disability for the person who is leaving the service, but it has to be a series of follow-on snapshots, and three years is the time that was recommended to us.

Mr. MCNERNEY. Thank you.

Ms. WILENSKY. We did, by the way with respect to your question to Mr. Fisher, specifically recommend for the families of those who are severely wounded that the legislation be passed to allow them a six month family leave period as well as extended respite care to the parents or spouse of the severely injured.

Mr. MCNERNEY. Okay. I want to yield back to the Chairman.

Mr. RUNYAN. I apologize to everyone. We just had a bill called in Natural Resources and I don't have any other Members on my side, so we are going to have to go into a recess for about a half an hour and reconvene at that point. I apologize and we will be back shortly. Return at noon.

[Recess.]

Mr. RUNYAN. The Committee will again come to order and I apologize for the delay and appreciate your patience in working with this. I have a question for General Scott. Based on what you heard this morning in respect to DoD and the VA's testimony on the progress of IDES as this point, generally how would you grade their progress with the recommendations of the Veterans Disability Benefits Commission?

Lieutenant General SCOTT. Well, I think that both departments picked up on the problem after it was brought to their attention. As I said, it was pretty clear early on that some peacetime arrangement where the VA and the DoD was not satisfactory for large numbers of returning soldiers.

Again, like you, sir, I was present when there was nothing, you know, when the VA and DoD essentially were not communicating at all about how to transition particularly injured or ill servicemembers, but all servicemembers to VA.

It was basically, it was, well, here are your discharge papers, period. So I would say that I would give them a B to B+, and to get to an A they have got to reduce the average time, understanding that there are always going to be some cases that are just really complex, that are going to take an inordinate amount of time, and that makes the average, that runs the averages up.

But I am pretty sure from what I heard this morning and from what I know from working with the VA in particular, that they are working to get these numbers down. And of course, numbers are not everything because we have got to be sure that we are taking care of the servicemember. As was said earlier, you have to be careful about trading off efficiency for effectiveness of speed for accuracy.

Having said that though, I think that anyone who was testifying here or the backups would agree that we can do better and I can't

tell you what the right number is, but I believe that these two departments are going to get it lower in that regard, so I give them a B to a B+ for progress certainly higher than that for an effort.

Mr. RUNYAN. Thank you. Just one final question. Mr. Fisher, you talked about how the communication back to the departments is good. Are they providing you with the right amount of information and access to the wounded warriors to fulfill your mission? Or are there other things that you would like to be able to help?

Mr. FISHER. No. We are being provided with the information and the access to the wounded warriors, absolutely. We are doing fine in terms of our interaction on that front.

Mr. RUNYAN. Thank you for that. Okay. With that being said, again I apologize for the delay and I thank the panel for their testimony and look forward to continuing to have these discussions as we work to help our warriors transition into their life, so with that being said, the panel is excused. Thank you very much.

I call the third panel up at this time. First we will hear from Mr. John Wilson, Legislative Director from Disabled American Veterans, and then we will be hearing from Mr. Phil Riley, the Senior Benefits Liaison for the Wounded Warrior Project, and then, Mr. Eric Greitens, the Chief Executive Officer from The Mission Continues.

We appreciate your attendance today, and your complete and written statements will be entered into the hearing record. And Mr. Wilson, you are now recognized for five minutes for your oral statement.

STATEMENTS OF JOHN WILSON, ASSISTANT LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; PHIL RILEY, SENIOR BENEFITS LIAISON, WOUNDED WARRIOR PROJECT; ERIC GREITENS, CHIEF EXECUTIVE OFFICER, THE MISSION CONTINUES.

STATEMENT OF JOHN WILSON

Mr. WILSON. On behalf of the Disabled American Veterans and our 1,200,000 million members all of whom are wartime and disabled veterans, I am pleased to be here today to testify before the Subcommittee on Disability Assistance and Memorial Affairs about the Integrated Disability Evaluation System or IDES.

IDES is the result of a recommendation of several commissions, as we know, with the goal of DoD and VA creating a single, comprehensive standardized medical exam that the DoD administers serving DoD'S purpose of determining fitness and VA's of determining initial disability ratings.

A comparison between the DES pilot that was launched in 2007 by the DoD and the VA, and the legacy DES found Active Component military members completed the pilot in an average of 289 days, and Reserve Component military members completed it in an average of 270 days, compared to the legacy DES average of 540 days.

Surveys revealed significantly higher satisfaction among DES pilot participants from those in the legacy system, and on July 30, 2010, the DoD Senior Oversight Committee Co-Chairs directed that IDES expand worldwide and it was by October of 2011.

While the DAV is generally pleased with the IDES, there are two topics I wish to address in my oral testimony. First, we are concerned about the military members going through the IDES not having ready access to representation from a veteran service organization as they did under the legacy DES.

The issue of access to counsel to advise military members on the disability claims process is a concern of DAV and other VSOs and is also cited as a concern by the Recovering Warrior Task Force. The Task Force conducted surveys to determine the effectiveness of DoD programs and policies of for Recovering Warriors to include IDES. Their survey results reinforce the importance of providing legal counsel for the Medical Evaluation Boards as well as Physical Evaluation Boards. And even though the surveys clearly demonstrate the value of having legal counsel available throughout the disability evaluation process, the majority of Task Force focus group participants said they do not have any personal experience with or knowledge of these specialized legal services.

As a result, they may be accepting PEB decisions that are not in their best interest, and the benefits they receive, may be less than what they would received have had if they understood the long term consequence of their acceptance of a particular PEB decision.

We believe that all those going through the IDES process should have a clear understanding about it. That understanding would be best provided if they had access to the free assistance from certified representatives of VSOs who can not only explain the process and their rights, but can also act as their advocates.

There has been some positive movement in this area that partially addresses VSO representation. The VA's Integrated Disability Evaluation System Implementation Guide issued in December of last year states that VA Military Services Coordinators will "explain the availability of Veterans Service Organizations and provide a VA Form 21–22, Appointment of Veterans Service Organization Claimant's Representative, if the servicemember expresses interest."

While this is an improvement, we find it too passive. We recommend this guidance be modified so the Military services Coordinator explain the option of VSO representation whether or not the military member "expresses an interest."

The second area to address is the effectiveness of the Physical Evaluation Board Liaison Officers or PEBLOs, who are supposed to guide servicemembers through IDES on the DoD side of the process, to ensure they are aware of their options.

The Task Force found that many participants had limited knowledge about the role of PEBLOs. More often than not, comments about PEBLOs were negative and military members seemed to expect them to be more of an advocate than they are. That is not their role.

While DAV has received information from the field that indicates the performance of PEBLOs has improved generally, there have been occasions when PEBLOs have incorrectly advised members. Recently, a PEBLO advised a member that he could not personally appear before the Formal Physical Evaluation Board to appeal the Informal Physical Evaluation Board's decision. This is clearly in

error. But one of DoD's National Service Officers was able to provide the correct information to the member.

And another case, a PEBLO incorrectly advised a master sergeant that he would received 10 percent as his retirement pay as a result of the IDES decision, even though he had been in the military 22 years. We clarified for the member that, in fact, he would be eligible for 55 percent of his base pay due to his 22 years of service, and that 10 percent that he would receive was his VA disability rating, not his retirement pay, and that would be offset.

In order to prevent these types of errors and improve satisfaction levels, we believe it is imperative that training and quality control be reviewed and strengthened to make sure that VA is getting the rating decision right for the first time.

As stated earlier, military members expect PEBLOs to be more of an advocate. The role of advocacy is key. Most servicemembers may not realize how complex the disability adjudication process is and have little time to learn, given the new time constraints. DAV believes that military members best interests would be served with greater access to the free assistance from representatives of VSOs who not only help them understand the claims' process, but will also act as their advocates.

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

[THE PREPARED STATEMENT OF JOHN WILSON APPEARS IN THE APPENDIX]

Mr. RUNYAN. Thank you very much.

Mr. Riley.

STATEMENT OF PHIL RILEY

Mr. RILEY. Chairman Runyan, Members of the Board, Subcommittee, rather, Wounded Warrior Project welcomes this opportunity to share our views in the Integrated Disability Evaluation System, IDES.

As a Senior Benefits Liaison with Wound Warrior Project, it is my privilege to represent wounded, injured and ill as they go through the IDES leading to military retirement, separation or possible return to duty.

Wounded Warrior Program recognizes that VA and DoD staffs have worked hard to improve disability evaluation process. We have seen some improvement, but much more work needs to be done to realize the goals set for IDES.

As we see it, VA is meeting its commitments to IDES, but DoD has more work to do. IDES was created as a streamlining effort to replace separate DoD and separate VA medical evaluations and disability ratings. The goals were to create a less complex non-adversarial system that was faster, produced more consistent evaluations and compensation and led to a seamless transition from military to civilian life. In large part these critical and important goals have not yet been achieved.

IDES begins with the warrior being referred to a Medical Evaluation Board or MEB for short. A board of several medical officers charged with evaluating, if the warrior is able to meet medical retention standards and return to full duty. When MEB determines

that the warrior does not meet retention standards, it makes recommendation to the final deciding authority, the Physical Evaluation Board or PEB.

The MEB's findings are documented in a narrative summary called the NARSUM. That summary (NARSUM) becomes the most important evidence the PEB uses. But in doing its work, the MEB does not examine or usually does not even meet with the servicemember.

In our experience the critical summary the MEB prepares is often incomplete and inaccurate, and the servicemember has limited time to review and challenge the MEB summary. As a result, critical errors frequently go uncorrected.

Allow me to share a case study from case experience of one of many wounded warriors we have worked with to illustrate some of these problems. The Army officer sustained a penetrating head injury in Iraq. Early in the course of his rehabilitation, he and his wife were pressured into signing papers and rushed him into the MEB and cut short some treatment.

The NARSUM ultimately prepared by the MEB failed to include any description of the officer's day-to-day functional impairment. Instead, it simply listed medical conditions. Even at that, one of those conditions, loss of the use of an arm was omitted from the critical document.

Later, the warrior transition unit he was assigned to actively discouraged him from appealing the PEB decision as "that would slow the process down." Their experience illustrates that IDES is subject to troubling, disruptive pressures.

Overall, this profoundly wounded officer was prematurely pushed into a Medical Board process that produced a deeply flawed decision document that led to an erroneous decision and ultimately a lengthy but fortunately successful appeal.

A less experienced young warrior with similar injuries and without the expert representation this officer secured might have fared much differently. It would be a mistake to judge IDES solely by reference to timeliness. That would overlook the dangers of moving too quickly, focusing only on the major unfitting conditions, at the expense of all medical conditions. Moving quickly often results in erroneous rating decisions and in servicemembers not getting needed medical care.

IDES is highly vulnerable to quality control issues, incomplete exams, exam reports that fail to include new diagnosis, incomplete or insufficient NARSUMs and missing critical documentation.

MEBs often don't have the time to review a warrior's medical records or do needed research on depth. The NARSUMs too often are not fully developed, not comprehensive and inaccurate, and too often fail to identify and fully document all of the warrior's medical conditions or minimizes them. These problems are often due to pressures to move cases along but errors ultimately prove harmful to the warrior. Wounded warriors and caregivers themselves generally are both poorly informed and under represented in navigating IDES.

In theory, the PEBLO, that is Physical Evaluation Board Liaison Officer, should close any information gaps. In reality some of those liaison officers don't fully understand the system themselves and

have such large caseloads that they can't provide adequate assistance to everyone.

Also, there is considerable variability in the JAG's expertise on the IDES and there are just not enough JAG officers with necessary expertise.

For recommendations, the Wounded Warrior Project has a number of recommendations to offer to more fully realize the goals set for IDES. We urge the Committee to work with Armed Services Committee to spur the executive branch to make needed changes.

High among the recommendations in our written submission, we urge that DoD be directed to re-engineer and institute quality controls on its part of the IDES process.

In conclusion, today, almost five years after the bipartisan commission called for streamlining the complicated Disability Evaluation System, the goals and vision for that system have yet to be realized.

Thank you for this opportunity to testify.

[THE PREPARED STATEMENT OF PHIL RILEY APPEARS IN THE APPENDIX]

Mr. RUNYAN. Thank you very much.

Mr. Greitens, you are now recognized.

STATEMENT OF ERIC GREITENS

Mr. GREITENS. Thank you. Mr. Chairman, Congressman Carnahan, Members of the Subcommittee, thank you for the opportunity to testify this morning as the Founder and CEO of The Mission Continues. The Mission Continues is a national nonprofit organization that challenges veterans to serve and lead in communities across America.

We believe that any system that is designed to create successful transitions for veterans, will only work if veterans are recognized for the immense abilities that they bring back to their communities. We have learned that by focusing on these strengths, despite some of the most severe disabilities, we can facilitate successful transitions from warrior to citizen.

As a Navy SEAL, I served four tours in the Global War on Terrorism. On my last deployment in Iraq, my unit was hit by a suicide truck bomb. I was treated at the Fallujah surgical hospital and returned to full duty 72 hours later, but some of my friends—some of whom were standing an arms length from me—were hurt far worse than I was.

When I returned home, I visited them and went to Bethesda Naval Hospital to visit other wounded servicemembers. When I asked them, "What do you want to do when you recover," each one of them said, "I want to return to my unit." Their bodies had been injured, but their spirit of service had endured.

My experience at Bethesda that day was not unique. In a recent survey of post-9/11 veterans, 92 percent strongly agreed or agreed that serving their community is important to them.

At The Mission Continues we create successful transitions by challenging veterans to continue their service and engaging them in six-month fellowships at nonprofit and public service organizations in their communities. Today, an Army specialist from the

82nd Airborne now trains service dogs for the disabled; an airman now serves at a women's shelter; a Marine Corps sergeant now builds homes with Habitat for Humanity.

During their fellowships, our veterans are provided with stipends and mentors, and are engaged in a comprehensive curriculum designed to achieve one of three post-fellowship goals. They go on to full-time employment, full-time education, or participate in an ongoing role of service in their communities. To date, we have awarded fellowships to 255 post-9/11 veterans, who have served with 168 organizations across the country.

For example, in Mississippi County, Arkansas, Anthony Smith served his fellowship working with under-privileged youth. In 2004, Anthony was serving as a major in the Army when he was hit by a rocket-propelled grenade. After spending 64 days in a medically induced coma, he awoke to find that he was blind in one eye, had lost his right arm underneath the elbow, and that parts of his leg, hip and spinal cord were damaged. Like many of the veterans that we work with, his transition was difficult, and he started to doubt whether or not he was needed here at home.

After Anthony became a Mission Continues Fellow, he found a renewed sense of purpose. Through his fellowship, Anthony is using martial arts to mentor at-risk youth. Using pushups, modeling patience, and teaching self-control, Anthony teaches character lessons to dozens of students every day.

In two independent research reports, the George Warren Brown School of Social Work at Washington University has found that nearly 80 percent of the participants in our program reported that serving in the community had a positive effect on their future employability, performance, and promotion; 86 percent of participants reported transferring their military skills to civilian employment; and 100 percent of fellows reported that they will probably or definitely stay involved in volunteer activities and public service in the future.

Mr. Chairman, Congressman Carnahan, the story of this generation of veterans is still being written. Some have a tendency to rely on PTSD figures, unemployment statistics, and suicide rates to tell us how our veterans are transitioning. But these statistics do not tell the whole story. These statistics do not capture a veteran's desire to continue to serve and their willingness to lead in communities upon their return.

They do not tell the story of Shawn, an Army veteran who is now a youth football coach in Massachusetts, or April, the Army veteran who serves as a mentor to refugee children in the Chicago classrooms.

Across America veterans are serving again. In fact, the majority of the members in this Committee have Mission Continues fellows serving in their district or neighboring districts. And last year, with our fellows as examples, The Mission Continues engaged over 15,000 Americans to spend a day of service with veterans in their communities. Our Mission Continues fellows are enduring leaders who have overcome pain and turned it into wisdom. They are veterans whose commitment to our country did not end on the battlefield.

In order for veterans to transition successfully, communities across America must begin to recognize the service they still have to give. We believe that when the story of this generation of veterans is written, it will not only be a story of the wars they have fought overseas; it will also be a story of the homes built, the parks restored, the young minds engaged by veterans whose mission continues here at home.

Mr. Chairman, we are grateful for your support and the support of this Subcommittee. I would welcome any questions that you or other Members may have. Thank you.

[THE PREPARED STATEMENT OF ERIC GREITENS APPEARS IN THE APPENDIX]

Mr. RUNYAN. Thank you, Mr. Greitens. I appreciate that. I thank you for your service and what you are doing to help our servicemen and women. On a personal note, I am fortunate enough to have in my district office a wounded warrior. I would say she is probably one of the top employees we have around there and she deals with all of our veterans case work.

Mr. GREITENS. Yes.

Mr. RUNYAN. And does a very good job at it. So I agree with pretty much everything you said.

Mr. GREITENS. Thank you.

Mr. RUNYAN. Especially as to on how motivated these individuals are, and how giving and service oriented they are.

Mr. GREITENS. Yes.

Mr. RUNYAN. Mr. Wilson, I have a question for you. Do you think the VA and DoD have adequately taken the recommendations of the various Commission reports into account and of those recommendations, which of those recommendations have or have not been implemented?

Mr. WILSON. There are certainly a number of recommendations that the Commission has put forward. One of the ones that we were most concerned about had to do with the single comprehensive exam, letting the VA, in fact, do what they do best, which is evaluate disabilities and provide overall rating examinations. They have now done that and generally it seems to be an effective program. There continues to be concerns with the DoD and VA staffing levels for physicians in order to make sure the exams are being timely that the narrative summaries are fully developed by the DoD, and again that there are a sufficient number of physicians on staff to make this as timely as possible.

The other issue is JAG representation. It is critical for an individual to know their legal rights. You have to have a sufficient number of JAG officers, Judge Advocate Generals, to advise personnel about what those rights are. They may not fully understand them, and that is a concern to us. The staffing levels of the PEBLOs is also a concern because they need to have a certain number of PEBLOs in order to manage the cases.

PEBLOs are asked to address issues that are cross functional which leads to some of the problems that I alluded to in my testimony.

Mr. RUNYAN. And in talking about knowing your rights, whether it is getting to a JAG or dealing with a PEBLO, do you see the possibility of the VSO having a role in that?

Mr. WILSON. Yes, sir. In my written testimony, I highlight some statistics that we had for DAV exclusively and other Veteran Service Organizations could provide additional information I am sure.

We have seen a steady decline in the number of individuals we have represented over the years since the implementation of the IDES program. Now, that may be as a result of individuals thinking that a 30 percent disability rating with VA is good. It gives me retirement so I move on.

Our concern is that 30 percent may not be an accurate rating of their disabilities and some of those individuals who may have gotten a 10 or 20 and severance pay instead, may not have received an accurate rating of disabilities either. It depends on what information you provide and how well it is documented in your medical record, of course.

Veterans Service Organizations can advise military members on the IDES and are excellent at doing so. That is DAV's forte, as a matter fact.

Mr. RUNYAN. Thank you.

Mr. Riley, if you could identify one fundamental problem with the IDES program that should be addressed immediately, what would that be?

Mr. RILEY. The NARSUM preparation needs much better quality control by DoD and the Services.

Mr. RUNYAN. Okay. In dealing with how the VA and the DoD, and the contrast between recovering warriors that have the long delays and those others that are expedited right through it, how do we bring that gap together where it is more consistent, because obviously some of them do need to be expedited, but there is always going to be a breakdown there and try to, obviously cut that down—I think you mentioned or someone in the other panel mentioned we would like it to be at 100 days if we could. How do we get there?

Mr. RILEY. I think that is a question that the medical command has to come to grips with but basically if there are serious conditions, not just unfitting conditions that need treatment, the treatment should be given, and there should be some control over that, instead of just pushing them through as soon as they have gotten identified as unfitting or several unfitting conditions and making it go fast at that point. The other thing, of course, is getting good advice to some of the people to make sure they make the most of their medical treatment availability, don't miss their appointments and administrative things of that nature.

Mr. RUNYAN. Thank you. Mr. Greitens, I just have one question for you, specifically because you deal with a lot of these wounded warriors day in and day out. What is the feedback you get from them about this program?

MR. GREITENS. Sir, generally, with this program there has been a lot of——

Mr. RUNYAN. Is your mic on?

Mr. GREITENS. Yes, sir. Yes, sir. With this program, what we have seen from a number of veterans, certainly a broad spectrum

of responses, but I think with many of the veterans there has been frustrations, though with this process, and the frustration, sir, is that as they are coming back, it is not just dealing with the system for getting a solid disability rating. The larger point is that there is not a clear avenue for them out of this process, so there in a disability process. But the question is, of course, for them, what comes next.

Our answer at The Mission Continues is that you can continue your service to your country as you come back, and of course we need to have answers to them both around employment and education.

And what we believe is that in order for this transition process to be successful, what those veterans have to see very early on is that there is this light at the end of tunnel, and one of the things that I would recommend, we found that oftentimes the very best people who can actually advocate for and work with wounded veterans are oftentimes wounded veterans themselves because they have been through the process, they have lived through it and one of the things that they can also offer to their colleagues is some hope that at the end of this process there is a way to turn this pain into wisdom, there is a way to turn the suffering and the strength, and there is a way for them to continue their mission of public service to their country, sir.

Mr. RUNYAN. Thank you very much.

Mr. GREITENS. Yes, sir.

Mr. RUNYAN. Mr. Carnahan.

Mr. CARNAHAN. Thank you, Mr. Chairman. I want to start with Mr. Wilson and Riley and really follow up on the things you touched on about getting a good advice and to what extent that you mentioned, Mr. Riley, the shortage of JAG officers, but also, Mr. Wilson, you mentioned the legal counsel that is available through your organizations. How are those coordinated and are there ways that that can begin, try to maximize the resources that are out there to be sure they are getting that good advice in the process?

Mr. WILSON. To address the issue of access to Disabled American Veterans, representatives or other certified Veteran Service Organizations, we know when we look at the guidance currently available from DoD and VA, the VA and Military Services Coordinator, his task, as I said in my testimony, with the task of letting you know you have an interest, that there are VSOs who can assist you.

Having an interest is a concern to us. If a person is rather passive in their discussion, the VA Military Services Coordinator may not pick up on the fact that, yes, they would like to know about this, so we would prefer that it would be very direct information sharing from the VA's Military Services Coordinator. We also believe strongly that the PEBLO who is supposed to be key to driving the train on the DoD side of this process, also clearly lets them know that Veteran Service Organizations are available to assist them as well. You don't have to be a veteran in order to get Veteran Service Organization representation and that shift thinking of someone on active duty versus thinking of themselves as soon to be veterans may be a part of a problem. As individuals are going through this IDES process which is new to them, they are learning

as they go. They get many months of training through the various military specialties but they don't get very many months of training when it comes to the IDES process, They are focused first, getting healthy. Later in the healing process they focus on, what they are going to do when they get out of the military. In trying to make that transition they then come to understand they need legal representation which we can provide.

Mr. CARNAHAN. And let me ask Mr. Riley to respond as well.

Mr. RILEY. Well, I find that oftentimes when I meet Wounded Warriors families and the warriors in the wards that they really want to know something about the benefits process, but they don't know who to ask, and they don't get information right up front.

First of all, I think, when you have got seriously wounded people, you need to get information right up front and we do a number of bedside briefings and what have you if we are allowed to.

The PEBLO gives basically a PowerPoint briefing to the servicemember, and unfortunately most of the time we don't get engaged until we have been called in by someone who is concerned about their narrative summary and also they don't take advantage of the JAGMEB/PEB Officers. There are some good JAGs and real trusted JAGs out there now, but there weren't a few years ago, and soldiers tend to resist, thinking that they have got a lawyer that is not on their side when it is a government lawyer, but now they actually have MEB and PEB lawyer JAGs that are very helpful. I have worked several cases in conjunction with JAG officers and that has worked very well.

So what I would finally say is if the Department of Defense would encourage and bring us on to do more, we could really help with the success of the IDES process.

Mr. CARNAHAN. Thank you. Let me turn to Mr. Greitens. You mentioned this avenue out of the process which I think obviously is a critical component. What is the biggest challenge that you have found for your fellows in being able to get to that avenue?

Mr. GREITENS. Yes, you know, well, Congressman, one of the challenges is, is to make sure that as a community organization, that we have the opportunity to work with men and women who are interested in this program. Over 50 percent of our recommendations are coming from Mission Continues Fellows and Mission Continues alumni who are saying to their servicemembers, saying to men and women who they are in the hospital with, this really changed my life, you should get in touch with The Mission Continues.

We have, at present, a number of excellent advocates, individuals in the VA system who have seen their patients go on to become Mission Continues Fellows. But one of the challenges at present is that for an organization like The Mission Continues or other organizations that offer services to help veterans make this transition, there is no central way to become accredited as a high quality service organization that can actually work within the DoD and the VA.

And so what happens is that for many small nonprofit organizations who might have a national footprint but don't have the ability to go to every military base around the country, right now you

would have to get an individual memorandum of understanding to work on that base.

One of the things that would be incredibly helpful is if there is a joint VA and DoD process that could accredit organizations who are often very high quality services. As you know, Congressman, there also is a great number of veterans organizations that are out there. Not all of them provide high quality services, and so if the VA and the DoD create an accreditation process, it would help these organizations to get that accreditation. It would kind of serve as a way to certify organizations who could help with this transition.

Mr. CARNAHAN. Thank you.

Mr. GREITENS. Yes, sir.

Mr. CARNAHAN. I have got a couple more that I want to ask you about and that Chairman has given me leave to ask a few others.

Mr. GREITENS. Yes, sir.

Mr. CARNAHAN. But to your point.

Mr. GREITENS. Yes, sir.

Mr. CARNAHAN. About the VA and DoD, the role that they are playing in helping to do that now, and sort of where is that room for improvement, if you could elaborate on what you just talked about.

Mr. GREITENS. Yes, sir. I think just to elaborate and what I would like to see is a joint process by which the VA and the DoD come up with a certain criteria that organizations need to meet in order to be accredited to provide services to servicemembers and returning veterans. Currently, that process oftentimes varies from base to base. It can sometimes vary from hospital to hospital.

And so, in the same way The Mission Continues today, it is a Better Business Bureau accredited charity. The Better Business Bureau has 20 standards that we have to meet in order to get that accreditation. I think there is some room here for the Secretary of the VA and the Secretary of Defense to put together a joint Committee which would then say these are the standards that organizations have to meet in order to be welcome both on military bases and in VA institutions.

Mr. CARNAHAN. I think that is a great idea and I think it is a conversation really worth digging into. And also I wanted to follow up and ask within what you do, do you see actions that Congress could do to better assist community-based organizations like yours to again help with this transition?

Mr. GREITENS. Thank you, Congressman. I think there are probably two things that Congress can do. One is, I think, because of the sort bully-pulpit power that individual members have, Congress has, that this Subcommittee has, I think it is very important for us to get the message out to the public about the capabilities that this generation of veterans has. Too often when people think about veterans, if you pulled ten people off of the street right now and you asked them to give you their top ten words about veterans, they would certainly say service, they would certainly say honor. But somewhere in that list of ten, they would also say post-traumatic stress disorder, they would say traumatic brain injury, they would say unemployment, they would say suicide.

And I believe, Congressman, that we have a battle on our hands right now to determine what the future, what the legacy of this generation of veterans is going to be. So first, I think there is a kind of bully pulpit function of individual congressmen going out and talking about the wounded warriors who they have, who are doing incredible work, and let us get that message in front of the public about the capabilities that these men and women have.

Secondly, my team and some of our other partners in the veterans service space right now are exploring ways that we might actually engage with existing Federal programs, existing Federal dollars that would help to enable veterans to begin to serve again in their communities.

Our plan is to do this research and then come back to you, Congressman, and come back to the Subcommittee with a set of recommendations about how Congress could actually help to facilitate veterans coming home and continuing to serve in their communities and executing these successful transitions, and we welcome the opportunity to follow up with your staff and the staff of this Subcommittee on those ideas. Thank you so much.

Mr. CARNAHAN. Thank you.

Mr. RUNYAN. I just have one final question, for Mr. Wilson. In your written testimony, you stated that overall satisfaction rates are higher in the IDES program than the legacy DES program. Other than improved processing times, specifically what else is there that is moving that line?

Mr. WILSON. I think it would be interesting to see what the individuals who are going through the processes themselves have thought thus far. If I recall correctly, they would like to have a better understanding of who their advocate is in this process, who is that person. How would the DoD and the VA go about improving this so that it is very clear to an individual that their advocate is going to be a certain single individual that they can go to? That is one area, I think, that is of great interest to us, and we would hope that the briefings are provided are not death by PowerPoint, but in fact but are given by PEBLO's who are well trained and understand the process well enough to explain IDES clearly.

So quality control of the work done by PEBLOs or a Military Services Coordinators, or others, requires continued review and assessment.

Mr. RUNYAN. I was looking to end on a positive note, other than the speed at which we do it, of the new system, what would that be, or isn't there one?

Mr. WILSON. Oh, are there positives with new system besides the speed? Yes, sir. We are very pleased with the fact that we now have a single comprehensive exam done by VA, since they are experts in this area of providing disability ratings. It is much more efficient than it was previously and the combining of efforts and eliminating repetition or competition between the DoD and VA. No longer are disability ratings done by the DoD and then by the VA taking out unnecessary steps in this process. That has made a significant improvement. Timeliness has improved as well, and I think satisfaction rates are higher with this program, as a result of those kinds of modifications.

Mr. RUNYAN. Thank you. You don't have any questions, do you?

I want to, gentlemen, on behalf of this Subcommittee, I want to thank each of you for your testimony and we welcome working closer with you in addressing these issue that have an enormous impact on our American veterans and you all are excused now. I recognize Mr. Carnahan for a closing statement.

Mr. CARNAHAN. Just again, Mr. Chairman, thank you for your leadership on the Committee and I want to thank our witnesses, all three panels today. This is, I think, been a really good overview. Some really good positive ideas have come out of this and we really look forward to working with you to be sure we can get these implemented. Thanks again.

Mr. RUNYAN. With that, I ask unanimous consent that all members have five legislative days to revise and extend their remarks and include any extraneous material.

Hearing no objection, so ordered. I thank the members for their attendance today, and this hearing is now adjourned.

[Whereupon, at 12:59 p.m. the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Hon. Jon Runyan, Chairman

Remarks

Good morning and welcome everyone. This oversight hearing of the Subcommittee on Disability Assistance and Memorial Affairs will now come to order.

We are here today to examine the current framework in the ongoing efforts to streamline the transition process between active duty soldier to veteran.

The lynchpin of this streamlining process has been the implementation of the Integrated Disability Evaluation System, otherwise known as "I.D.E.S." This program was created in December 2007 following the recommendations of the Veterans' Disability Benefits Commission, and the President's Commission on Care for America's Returning Wounded Warriors, otherwise known as the Dole/Shalala Commission.

I.D.E.S.'s goal is to improve the timeliness, effectiveness, and transparency of the former legacy DES review process, which had been in place for 60 years prior. In October of 2010, VA and DoD worked in concert to begin the permanent shift to I.D.E.S around the country in 139 locations. The ultimate objective remains to fully close the gap which occurs between separation from active duty service and receipt of VA benefits and compensation.

I am pleased to see progress being made to meet this objective under the new system, specifically, helping to cut the transition time between active duty and veteran status. However, there are several issues and unforeseen problems which need to be addressed.

First, issues with processing times remain problematic. Whereas some Recovering Warriors experience lengthy delays in their attempt to navigate through the IDES system, others are rushed through without receiving the proper medical attention that they need.

Second, many Recovering Warriors report that they find the IDES process to be extremely confusing and difficult to understand. Further efforts must be made to work directly with our Recovering Warriors to ensure that they are making the right decision for themselves, their families and their futures.

Finally, IDES is not as simple in practice as the various Commission Reports were hoping it would be when it was first proposed. Now, nearly five years after its inception, it is important for both VA and DoD to continue evaluating the system and their efforts to achieve its goals of increasing transparency, improving consistency, and eliminating duplicate processes.

As a new generation of active duty servicemen and women return home from conflicts oversees, we must be prepared to meet our commitment to see that their transition to civilian and veteran life is as efficient and simple as possible. It is our duty to see that their service is honored as best as our resources will permit.

It is my hope that this oversight hearing will shed some light on some of the problems we have encountered in the implementation of IDES so that we may work together to find the best solutions possible.

I want to thank the VA, the DoD, the present VSOs, Dr. Wilensky, Mr. Fisher, and General Scott for their valuable input as we work together to find important solutions.

I welcome today's witnesses and would now call on the Ranking Member for his opening statement.

Prepared Statement of Hon. Jerry McNerney, Ranking Democratic Member

Thank you, Mr. Chairman. I would like to thank you for holding today's hearing.

The purpose of this hearing is to focus on the transition process of servicemembers to veterans, with a particular focus on the implementation of the Integrated Disability Evaluation System (IDES), a joint VA/DoD examination and records integration effort initiated in 2007 as a result of the fallout from deplorable conditions and disjointed care of Wounded Warriors at Walter Reed Army Hospital.

This hearing will allow us to not just assess the effectiveness of the Integrated Disability Evaluation System (IDES), but other components of the Pre-Discharge Program established by the Departments of Defense (DoD) and Veterans Affairs (VA), and to streamline servicemembers' transition from active duty to veterans' status.

Today's discussion on IDES also follows up on our work implementing the Veterans' Benefits Improvement Act of 2008, Public Law 110–389, which also paved the way for a number of initiatives targeting the VA claims backlog.

In 2007, the Dole-Shalala Commission, set recommendations for the care of wounded warriors, and concluded that it is not enough to merely patch the system for transition to civilian life, as has been done in the past. The experiences of our men and women returning home complaining about a lack of a clear outline of the access to care, benefits, and services available to them highlighted the need for fundamental changes in the care management and disability systems.

The Dole-Shalala findings marked the siren call for the creation of the Disability Evaluation System—a joint effort between DoD and VA to move to a one-exam platform, which today we know as the Integrated Disability evaluation System or IDES.

We must make every effort to focus our resources toward assisting transitioning servicemembers with the comprehensive, coordinated care and benefits they deserve. This must occur at the very beginning of a servicemember's reintegration.

To this end, any member of the Armed Forces who has seen active duty—including those in the National Guard or Reserves—is eligible to apply for VA disability benefits prior to leaving military service through the Benefits Delivery at Discharge, Quick Start, or IDES pre-discharge programs.

During the application process, servicemembers can get help in completing forms and preparing other required documentation from VA personnel located at their bases. Additionally, IDES combines the health exam required by the DoD upon exiting the military and the VA disabilities assessment exam into a single process, albeit for different purposes.

In the meantime, in an effort to provide even greater transition assistance, more elements and players, like the Federal Recovery Coordination Program have been added to assist our wounded warriors.

I know the intent of these programs are well-meaning, and have helped numerous veterans across the country. But I still hear from veterans in my district who have gone through these programs, and continue to experience significant delays, confusion and other problems with effective reintegration.

In fact, to that end, I would like to mention that Mr. Barrow has a helpful bill pending before the Health Subcommittee, H.R 3016, that would improve reintegration efforts and require that the Federal Recovery Coordination Program operate jointly under both DoD and VA.

Since its full implementation at the end of 2011, IDES has been expanded from 3 military bases to more than 139 sites globally and nationally.

With the drawdown of troops over the next few years, I am particularly concerned by the fact that the average processing times takes 400 days, and that there are about 200,000 servicemembers already in the system. We don't need another backlog and want to avoid that outcome at all costs.

I look forward to having an open dialogue with the panels here today, and with my colleague, on ways to overcome challenges within the IDES system, and accelerate processing without sacrificing quality. Separating servicemembers should not wait more than a year for their assessments and benefits.

It is my hope that through our examination of the IDES and other pre-discharge programs today, coupled with the electronic integration and other business reformation efforts accomplished over the last few years, we will continue to improve and transform today's VA claims processing system and help our servicemembers successfully transition back into our communities. And NOT into another backlog.

I look forward to hearing from all of our esteemed witnesses. Thank you, Mr. Chairman. I yield back.

Prepared Statement of Hon. Russ Carnahan

Thank Chairman Runyan and Ranking Member McNerney for recognizing me here today.

This isn't the normal Subcommittee that I sit on, but today I am proud to have an organization from my district that I've had the pleasure of working with testifying before this Committee. I'd like to use my opening remarks to recognize and introduce to the Committee Eric Greitens of the Mission Continues.

The Mission Continues is truly a remarkable organization that empowers veterans to transform their lives and the lives of others by participating in community service fellowships. These Mission Continues fellows serve six months at community non-profit organization and afterwards either obtain full-time employment, pursue higher education or a permanent role of service. This is truly a remarkable program that not only gives veterans a much needed sense of purpose following military service, but also eases an often extremely difficult transition to civilian life.

And as an organization that is run by a Navy Seal and many former members of the military, the Mission Continues has a keen understanding of the many challenges facing our servicemembers when they return home. As this organization continues to make this model more accessible and available to veterans across our country, my colleagues and I stand ready to continue to support them in this life-changing work.

With that, Mr. Chairman, I again thank you for recognizing me, and I look forward to hearing the testimony of not only the Mission Continues, but the other organizations who are present here today to talk about this important issue.

Prepared Statement of John P. Medve

Good morning Chairman Runyan, Ranking Member McNerney, and Members of the Subcommittee. My name is John Medve, Executive Director of the Department of Veterans Affairs (VA) Office of VA–DoD Collaboration within VA's Office of Policy and Planning. I am pleased to be joined by Mr. Jim Neighbors from the Department of Defense (DoD). My testimony will focus on the status of the transition process from DoD to VA, with an emphasis on the Integrated Disability System (IDES), the Federal Recovery Coordination Program (FRCP), and Veterans Affairs Schedule for Ratings Disabilities (VASRD) modernization. I will provide the Subcommittee with an overview of the status of the IDES, the process used to transition the wounded, ill, and injured who are unfit for continued military service. I will also provide an overview of care coordination efforts designed to assist severely wounded, ill, and injured servicemembers and Veterans through recovery, rehabilitation, and reintegration as it relates to the FRCP, and explain how VA and DoD are communicating about additions and revisions to the VASRD.

Integrated Disability System (IDES)

VA and DoD's joint efforts have resulted in improvements and created an integrated disability process for servicemembers who are being medically retired or separated.

Much has been accomplished to improve the DoD disability process in the wake of the issues identified at the Walter Reed Army Medical Center in 2007. In early 2007, VA and DoD partnered to develop a modified, integrated Disability Evaluation System (DES) and a DES Pilot was launched in November 2007. This new, joint process was designed to eliminate the duplicative, time consuming, and often confusing elements of the separate disability processes within VA and DoD. The goals of the joint process were to: (1) increase transparency of the process for the servicemember; (2) reduce the processing time; (3) improve the consistency of ratings for those who are ultimately medically separated; and (4) reduce the benefits gap that existed between the point of separation or retirement and before receipt of VA disability compensation. Authorization for the DES Pilot was included in the National Defense Authorization Act for Fiscal Year 2008.

The DES Pilot was launched at three operational sites in the National Capital Region (NCR): Walter Reed Army Medical Center, National Naval Medical Center, and Malcolm Grow Medical Center on Andrews Air Force Base. The DES Pilot was recognized as a significant improvement over the legacy DES process, and, as a result of the Senior Oversight Committee (SOC) findings and the desire to extend the benefits of the Pilot to more servicemembers, VA and DoD expanded the Pilot. By the end of March 2010, the DES Pilot had expanded to 27 sites and covered 47 percent

of the DES population. In July 2010, the co-chairs of the SOC agreed to expand the DES Pilot and rename it IDES. Senior leadership of VA, the Services, and the Joint Chiefs of Staff strongly supported this plan and the need to expand the benefits of this improved process to all servicemembers. Expansion and full implementation of IDES was completed by September 30, 2011. Currently, there are 139 IDES sites operational worldwide, including the original 27 DES Pilot sites.

In contrast to the DES legacy process, the IDES provides a single set of disability examinations and a single-source disability rating, used by both Departments in executing their respective responsibilities. This results in more consistent evaluations, faster decisions, and timely benefits delivery for those medically retired or separated. As a result, VA can deliver benefits in the shortest period allowed by law following discharge thus reducing the "benefit gap" that previously existed under the legacy process, i.e., the lag time between a servicemember separating from DoD due to disability and receiving his or her first VA disability payment. This also prevents the servicemember from having to navigate the VA disability system on his or her own after separation. The DoD/VA integrated approach has also eliminated many of the sequential and duplicative processes found in the legacy system. Yet, there is more to be done.

To monitor our overall performance for the IDES process, VA and DoD track the performance of the core processes on a bi-monthly basis for the over 25,000 servicemembers in IDES. In addition, VA's Chief of Staff conducts bi-monthly internal Video Teleconferences (VTCs) with Central Office and Field Executive staff. VA also has joint monthly VTCs with both Army and Navy/Marine Corps to discuss site performance and general collaboration opportunities.

VA is responsible for four core processes within IDES: claims development, medical examination, proposed rating, and VA benefits. VA average processing time for VA core processes has decreased from 186 days in February 2011 to 134 days as of February 2012. The VA target for combined processes is 100 days of the 295 day combined VA–DoD target. While VA is currently meeting the goals for claims development and medical examinations, it is still falling short of meeting the standards for developing the proposed rating and the delivery of VA benefits. To address these shortcomings, VA assigned additional raters to Disability Rating Activity Sites (DRAS), increasing the number of Ratings Veterans Service Representative (RVSRs) to 167 among the three IDES rating sites in Seattle, Baltimore and Providence, which represents a 35 per cent increase in personnel. To address the timeliness of benefit delivery, VA identified a process to receive servicemember separation data electronically. This functionality is scheduled to be deployed in May of this year.

Despite the overall reduction in combined processing time achieved to date, challenges remain and there is room for significant improvement in IDES execution.

VA and DoD are committed to supporting our Nation's wounded, ill, and injured Warriors and Veterans through an improved IDES. As such, VA believes that its continued partnership with DoD is critical and is nothing less than our servicemembers and Veterans deserve.

Federal Recovery Coordination Program (FRCP)

The FRCP was created in October 2007 in direct response to the Dole-Shalala Commission's recommendation for improved care coordination for seriously wounded, ill and injured. The FRCP is designed to work and interact with existing military and VA health care teams, case managers, benefit coordinators, other Federal agencies and the private sector. FRCP provides seamless support from the servicemember's arrival at the initial Military Treatment Facility (MTF) in the United States through the duration of his or her recovery, rehabilitation, and reintegration. The FRCP staff at the policy level coordinates with their DoD counterparts under the umbrella of the Joint Executive Council. The FRCP is an integral part of VA and DoD efforts to address issues raised about the coordination of care and transitions between the two Departments for recovering servicemembers. Federal Recovery Coordinators (FRCs) are located in 12 facilities across the country including four MTFs, two VA Medical Centers, three VA Polytrauma Centers, and three Wounded Warrior Program offices.

FRCs assist severely wounded, ill, and injured servicemembers, Veterans and their families through each client's recovery, rehabilitation, and reintegration. They are Masters-prepared nurses or clinical social workers who provide high-level care coordination for their clients. The FRC creates a Federal Individual Recovery Plan (FIRP) for each client based on the goals expressed by the client, with input from his or her family and/or caregiver and health care team. To show greater transparency with servicemembers and Veterans, the FIRP is available through the eBenefits portal 24 hours a day, seven days a week. eBenefits is a web-based toll that is now available all servicemembers and Veterans and currently has over 1.2

million subscribers. FRCs provide client-centric assistance by coordinating all clinical and non-clinical care, benefits, and services, that are aligned with their clients' FIRP goals, regardless of medical diagnosis, geographic location of injury or illness or place of medical treatment. Clients remain enrolled in the program as long as there is a perceived need and benefit to the client. FRCP is unique to other programs in that once a FRC is assigned to a client, the FRC is the constant point of contact for that client throughout all transitions.

Veterans Affairs Schedule for Ratings Disabilities (VASRD)

The VA Schedule for Rating Disabilities (VASRD) is the regulatory framework through which VA provides Veterans with compensation for diseases and injuries they incur while serving our Nation. It is this rating schedule that guides the disability rating personnel of VA and DoD in making the correct determination of the compensation benefit level applicable for a Veteran's service-connected condition(s). The VASRD contains disability percentages ranging from 0 to 100% that translate into monthly compensation for Veterans based, by statute, on "the average impairments of earning capacity." (38, U.S.C., section 1155) VA is proactively updating and comprehensively revising the entire VASRD, which currently includes 15 body systems. This effort is the result of an October 2009 Secretarial directive to revise and update all parts of the VASRD, using current medical science and econometric earnings loss data. The update process is statutorily required under Section 1155 of Title 38, which states that "[t]he Secretary shall from time to time readjust this schedule of ratings in accordance with experience." VA has partnered with DoD and the academic community to collaborate on revisions to the rating schedule. The collaboration involves public forums in which medical experts, members of the Advisory Committee on Disability Compensation, DoD officials, Veterans Service Organizations, and other stakeholders provide input and subsequently form working groups to substantively revise the rating schedule.

While the public forums and working groups gather input from these important entities, under title 38 U.S.C., section 1155, VA has ultimate responsibility for adjustments to the VASRD. The Veterans Benefits Administration (VBA) has implemented a project management plan detailing the organizational, developmental, and supporting processes to modernize the rating schedule by 2016. The plan calls for eight medical officers and six attorneys to work with the subject-matter experts and cross-agency working groups as described above. The public forum and working group system is based on a methodology consistent with the Institute of Medicine's method of involving medical subject matter experts across disciplines, agencies, and private sectors. During this ongoing update process, VBA is engaged in a seamless partnership with VHA.

The VA remains fully committed to meeting the needs of our Nation's heroes and their families. VA and DoD are partners and will continue to work together diligently to resolve transition issues while aggressively implementing improvements and expanding existing programs. These efforts continue to enhance the effectiveness of support for Wounded Warriors and their families. While we are pleased with the quality of effort and progress made to date with our joint collaboration, we fully understand our two Departments have a responsibility to continue to improve these efforts.

Thank you again for your support to our wounded, ill, and injured servicemembers, Veterans, and their families. This concludes my testimony and I will be happy to respond to any questions.

Prepared Statement of James G. Neighbors

Chairman Runyan, Ranking Member McNerney, and members of the Subcommittee, thank you for inviting us to testify before you on the care and transition of our recovering Service members from the Department of Defense (DoD) to the Department of Veterans Affairs (VA). Taking care of our wounded, ill and injured Service members is one of the highest priorities of the Department, the Service Secretaries and the Service Chiefs. The 2007 revelations regarding Walter Reed Army Medical Center were a stark wakeup call for us all. During the past five years, DoD has worked in tandem with VA to improve policies, procedures, and legislation that impacts the care of our wounded warriors.

Due to efforts by both Departments, we have reached important milestones in improving care for our recovering Service members. These milestones include a new disability evaluation system and improved case management that are the result of a programmatic cohesion with VA that is better than ever before. More so than at

any other time in our Nation's history, separating Service members are greeted by more comprehensive mental and physical care; by greater opportunity for education, and by a deeper societal commitment to ensuring their welfare.

The Department's leaders continue to work to achieve the highest level of care and management and to standardize care among the Military Services and with other Federal agencies, while maintaining focus on the individual.

Disability Evaluation System/Integrated Disability Evaluation System

The genesis of the Disability Evaluation System (DES) was the Career Compensation Act of 1949, and it remained relatively unchanged until November of 2007. As a result of public concern and congressional interest, the joint DoD and VA SOC chartered a DES pilot designed to create a "Service member-centric" seamless and transparent DES. The DES pilot implemented many of the changes recommended by groups like the Veterans' Disability Benefits Commission and the President's Commission on Care For America's Returning Wounded Warriors to the degree allowed within current law.

The pilot launched at the three major military medical treatment facilities (Walter Reed Army Medical Center, National Naval Medical Center, Bethesda, and Malcolm Grow Air Force Medical Center) in the National Capital Region on November 21, 2007, and successfully created a seamless process that delivers DoD benefits to wounded, ill and injured Service members and VA benefits to Veterans as soon as possible following release from duty. We found the DES Pilot to be a faster, fairer and more efficient system. As a result, in July 2010, the Deputy Secretary of Defense and Deputy Secretary of Veterans Affairs directed worldwide implementation to start in October 2010 and to complete in September 2011. On December 31, 2010, the pilot officially ended and the first Integrated Disability Evaluation System (IDES) site became operational.

The IDES, similar to the pilot, streamlines the DES process so that the Service member receives a single set of physical disability examinations conducted according to VA examination protocols, proposed disability ratings prepared by VA that both DoD and VA can use, and processing by both Departments to ensure the earliest possible delivery of disability benefits. Both Departments may use the VA protocols for disability examination and the proposed VA disability rating to make their respective determinations. Under Title 10 authority, DoD determines fitness for duty and compensates for unfitting conditions incurred in the line of duty, while under Title 38 authority, VA compensates for all disabilities resulting from disease or injury incurred or aggravated in line of duty during active military, naval, or air service for which a disability rating of ten percent or higher is awarded, and also determines eligibility for other VA benefits and services. The IDES permits both Departments to provide disability benefits at the earliest point allowed under both titles. It is important to point out that Service members who separate or retire (non-disability) may still apply to the VA for service-connected disability compensation.

The National Defense Authorization Act (NDAA) for FY 2008, Public Law 110–181, also required the Department to utilize the VA Schedule for Rating Disabilities (VASRD). While the Department recognizes that the VA Secretary has ultimate responsibility and decision authority for the content of the VASRD, we believe DoD should have more developmental input, given the direct connection between the VASRD ratings and the decision to place Service members on the medical retirement list with annuities, benefits and healthcare. We appreciate VA's outreach to include DoD in the body system rating update review that began last year and the Services' participation through their subject matter experts. DoD plans to continue to participate in VA's public meetings as DoD and VA leadership continue discussing how to strengthen DoD's role in the VASRD rewrite process. We look forward to finalizing a memorandum of understanding with VA, which will formalize DoD's active voice in the future development and modernization of the VASRD.

In summary, the IDES features a servicemember-centric design, a simplified process, more consistent evaluations and compensation, a single medical exam and disability rating, seamless transition to Veteran status, case management advocacy, and establishment of a Service member relationship with the VA prior to separation. It also provides increased transparency through better information flow to servicemembers and their families and a reduced gap between separation/retirement from Service to receipt of VA benefits.

As of early this month, IDES enrollment is 24,957 Service members (66 percent Army, 13 percent Marines, 10 percent Navy, and 11 percent Air Force). Since November 2007, cumulative enrollment has been 44,451, with 14,249 completing the process and receiving benefits. Including Service members who are returned to duty by the process, active component Service member IDES completion time averages 370 days as of February 2012, Reserve Component members averaged 358 days, and

Guard members averaged 396 days. These averages are above our targeted goals but still are significantly lower than the 1940-era legacy system it replaced.

This past year, the Department partnered closely with the VA to implement the IDES at all 139 DES sites worldwide; however, we recognize the need to do better in the areas of timeliness to complete the process. This year our focus will be on such timeliness improvements. We have made significant policy adjustments to remove impediments, implemented procedural improvements, enhanced oversight and assistance to the Military Departments, and added resources that should improve Military Department performance in this area, including increasing legal support to advise and counsel Service members undergoing disability evaluation. We will continue to enhance our emphasis on leadership, resourcing and execution of the IDES to handle increased volume while decreasing the time spent in the process.

The Departments are looking closely at the stages of the system that are outside of timeliness tolerances and are developing other options to bring these stages within goal by December 2012 as the Secretaries of Defense and Veterans Affairs have directed. We are fully committed to working closely with Congress to explore new initiatives to further advance the efficiency and effectiveness of the disability evaluation process.

Recovery Coordination Program

The Recovery Coordination Program (RCP) was established by the FY08 NDAA, and was further defined by the Department of Defense Instruction (DoDI) 1300.24, entitled "Recovery Coordination Program." The Department has implemented many of the changes recommended by the President's Commission on Care For America's Returning Wounded Warriors to the degree allowed within current law. The FY 2008 NDAA and the DoDI 1300.24 together provide a comprehensive policy on the care and management of recovering Service members, including the assignment of a Recovery Care Coordinator (RCC) to help wounded, ill and injured Service members and families through the phases of recovery, rehabilitation and reintegration utilizing a Comprehensive Recovery Plan (CRP) that has been developed in coordination with the Recovery Team. The policy also provides for standardized training, and a caseload ratio of not more than 40 recovering Service members per RCC.

Currently, there are 171 RCCs in 84 locations worldwide, placed within the Army, Navy, Marines, Air Force, United States Special Operations Command and Army Reserves Wounded Warrior Programs. More than 3,800 Service members and families have the assistance of an RCC, whose responsibilities include ensuring the Service member's non-medical needs are met, and assisting in the development and implementation of the CRP. An automated solution was developed to increase efficiencies for RCC's to be able to maximize their time and service provision to our Service members and their families. Each RCC receives more than 40 hours of Department-sponsored standardized training, including information on roles and responsibilities and concepts for developing the CRP. After the October 2011 training, 90 percent of students rated the instruction and course materials as "excellent." Additionally, we are now beginning to train Army "Advocates" in order to bring their program into compliance with the legislative mandate that every recovering Service member be provided a DoD-trained RCC. This training is continually enhanced based on feedback from participants. The Department is committed to ensuring redundancies are mitigated with other agencies. We believe the Federal Recovery Coordination Program (FRCP) and the DoD programs are complementary and if there are perceived redundancies, we do not believe that is indicative of a problem.

Over the past five years, we have increased the numbers of RCCs available to provide care coordination to our recovering Service members, and looking ahead, each Military Service will continue to identify and resource their requirements for additional RCCs. Following are descriptions of three priorities that play important parts in recovering members' recovery process. The RCP has expanded to include several other portfolios, many of them identified as key priorities for the non-medical care management of recovering Service members during a Wounded Warrior Care Coordination Summit held in March 2011.

The Wounded Warrior Education and Employment Initiative (E2I) operates on a regional basis and engages recovering Service members early in the recovery process to identify their skills, career opportunities that match those skills, and any additional skills they may need for success as they recover and prepare to leave service. The E2I process relies on collaboration with the Service Wounded Warrior Programs and the VA, operating under a Memorandum of Understanding to provide VA's vocational rehabilitation services earlier in the recovery process than ever before.

The Operation Warfighter program (OWF) works to place wounded, ill and injured Service members in non-paid Federal internship opportunities that positively impact their rehabilitation and augment career readiness by building resumes, exploring

employment interests, obtaining formal on-the-job training, and gaining valuable Federal government work experience. There are currently more than 500 OWF interns working in approximately 75 Federal agencies and sub-components around the country, with a total of more than 2,500 placements in 105 agencies and sub-components since the inception of the program. Going forward, the Regional Coordinators will continue to focus on local and regional outreach to strengthen relationships with Federal agencies to improve and enhance internship and employment opportunities for wounded, ill and injured Service members.

The Military Adaptive Sports Program engages wounded, ill and injured Service members early in individualized physical activities outside of traditional therapy settings, inspiring recovery and encouraging new opportunities for growth and achievement. This new initiative is being implemented throughout the Department, in partnership with the Services and the United States Olympic Committee. The goals of the program include increasing awareness and participation in adaptive sports and recreation at the Service-level, preparing athletes for participation in competitive events such as the Warrior Games, and providing a seamless transition of participation from this program into VA's National Veteran's Sports program.

These measures when taken together, substantially and materially affect the life experience of our men and women in uniform and the families who support them. Our work to improve the care of recovering Service members, especially as they transition from DoD to VA, is the core of our efforts to provide those who have sacrificed so much with the care and benefits they deserve. Despite the significant achievements, we should not underestimate what remains to be done as we care for a new generation of Veterans who have served under very difficult circumstances for sustained periods. We will continue to work with our colleagues at VA and throughout the government to provide our servicemembers with the highest quality care and treatment. Taking care of our wounded, ill and injured Service members is one of the highest priorities for the Department, the Service Secretaries, and the Service Chiefs.

Special Compensation for Assistance with Activities of Daily Living

We recognize the strength of military families and caregivers of recovering Service members. If a Service member returns home wounded, ill or injured, the military family and caregiver are the glue that holds everything together during a Service member's recovery and transition—which can often be confusing, frightening, and overwhelming. On August 31, 2011 DoD promulgated policy, authorized by Public Law 111–84, to compensate all catastrophically wounded, ill, or injured Service members, with line of duty-related medical conditions, who needed caregiver assistance to live outside a resident medical facility or who required supervision to prevent harm to themselves or others. This policy, enacted through DoDI 1341.12, Special Compensation for Assistance in Activities of Daily Living (SCAADL), gives qualified Service members monthly compensation to help offset the economic burden borne by their primary caregivers providing non-medical care, support and assistance. As of February 29, 2012, 505 Service members have received the SCAADL compensation.

Transition Assistance Program (TAP)

Today's Veterans face a number of challenges in making the transition to civilian life among these is embarking on a productive post-military career. For every success story of a Veteran who has turned skills developed in the military into success in the civilian workplace, there are, as President Obama has said, stories of Veterans who come home and "struggle to find a job worthy of their experience and worthy of their talent." We see these struggles most clearly in high unemployment rates for Veterans. As we draw down from the wars in Iraq and Afghanistan and we make difficult decisions about our future force structure in light of the fiscal challenges the Nation faces, the situation becomes more urgent with the increased number of Service members—particularly young Service members—departing the military.

Making a firm commitment to employ America's Veterans, in August 2011, the President called for the creation of a Task Force led by the DoD and VA with and other agencies including the DoL, Department of Education (DoE), Department of Commerce, Small Business Administration, and the Office of Personnel Management, to develop proposals to maximize the career readiness of all servicemembers. In coordination with our VA, DoL, and DoE partners, DoD's implements and sustains a comprehensive plan to ensure all transitioning Service members have the support they need and deserve when leaving the military. This includes working with other agencies in developing a clear path to civilian employment; admission into and success in an academic or technical training program; or successful start-

up of an independent business entity or non-profit organization. The effort is fully aligned with the VOW to Hire Heroes Act of 2011. It is also consistent with DoD's commitment for keeping faith with all of our military members and their families, providing them a comprehensive set of transition tools and support mechanisms as they complete their service to our Nation.

Interagency Electronic Health Data

The collaborative Federal partnership between DoD and VA has resulted in increased integration of healthcare services to Service members and Veterans. DoD and VA spearhead numerous interagency electronic health data sharing activities and are delivering IT solutions that significantly improve the secure sharing of appropriate electronic health information.

Today's interagency health information exchange (HIE) capabilities leverage the existing electronic health records (EHRs) of each Department. As both Departments are currently addressing the need to modernize their EHRs, we are working together to synchronize planning activities and identify a joint approach to modernization.

Current HIE sharing capabilities do support data sharing between DoD and VA. The Federal Health Information Exchange (FHIE), Bidirectional Health Information Exchange (BHIE), and the Clinical Data Repository/Health Data Repository (CHDR) support continuity of care for millions of Service members and Veterans by facilitating the sharing of health care data as beneficiaries move beyond DoD direct care to the VA. The data shared includes information from DoD's inpatient documentation system which is in use in DoD's inpatient military treatment facilities, including Landstuhl Regional Medical Center, Germany, the evacuation and treatment center Service members pass through if they have a medical problem while deployed in the current theater of operations. The health data shared assists in continuity of care and influences decision-making at the point of care.

Transmission of Data from Point of Separation: At separation, FHIE provides for the one-way electronic exchange of historic healthcare information from DoD to VA for Service members who have separated since 2001. On a monthly basis DoD sends: inpatient and outpatient laboratory results; radiology reports; outpatient pharmacy data; allergy information; discharge summaries; consult reports; admission/discharge/transfer information; standard ambulatory data records; demographic data; pre- and post-deployment health assessments (PPDHAs); and post-deployment health reassessments (PDHRAs). To date, DoD has transmitted health data on more than 5.8 million retired or separated Service members to VA. Of those, approximately 2.3 million have presented to VA for care, treatment, or claims determination. This number grows constantly as health information on recently separated Service members is extracted and transferred to VA monthly.

Access to Data on Shared Patients: For shared patients being treated by both DoD and VA, the Departments maintain the jointly developed Bidirectional Health Information Exchange (BHIE) system that was implemented in 2004. Unlike FHIE, which provides a one-way transfer of information to VA when a Service member separates from the military, the two-way BHIE interface allows clinicians in both Departments to view, in real-time, health data (in text form) from the Departments' existing health information systems. Accessible data types include allergy, outpatient pharmacy, inpatient and outpatient laboratory and radiology reports, demographic data, diagnoses, vital signs, problem lists, family, social, and other history, questionnaires and Theater clinical data, including inpatient notes, outpatient encounters and ancillary clinical data, such as pharmacy data, allergies, laboratory results and radiology reports.

Use of BHIE continues to increase. As of January 2012, there is data available on more than 4.3 million shared patients, including over 293,340 Theater patients, available through BHIE.

To increase the availability of clinical information on a shared patient population, VA and DoD collaborated to further leverage BHIE functionality to allow bidirectional access to inpatient discharge summaries from DoD's inpatient documentation system. Use of this inpatient documentation system at Landstuhl Regional Medical Center plays a critical role in ensuring continuity of care and supporting the capture and transfer of inpatient records of care for recovering Service members. Information from these records including inpatient consultations, operative reports, history and physical reports, transfer summary notes, initial evaluation notes, procedure notes, evaluation management notes, pre-operative evaluation notes, and post-operative evaluation and management notes are accessible stateside to DoD providers caring for injured Service members and to VA providers caring for injured Service members and Veterans. DoD's inpatient documentation system is

now operational at all 59 DoD inpatient sites; ensuring inpatient documentation is available from all DoD inpatient beds.

Recent improvements to BHIE include the completion of hardware, operating system, architecture, and security upgrades supporting the BHIE framework and its production environment. This technology refresh, completed in January 2011, resulted in improved system performance, and reliability.

Exchange of Pharmacy and Allergy Data: The Clinical Data Repository (CDR)/Health Data Repository (HDR) interface (called "CHDR") supports interoperability between AHLTA's CDR and VA's HDR, enabling bidirectional sharing of standardized, computable outpatient pharmacy and medication allergy data. Since 2006, VA and DoD have been sharing computable outpatient pharmacy and medication allergy data through the CHDR interface. Exchanging standardized pharmacy and medication allergy data on patients supports improved patient care and safety through the ability to conduct drug-drug and drug-allergy interaction checks using data from both systems.

The Departments have exchanged computable outpatient pharmacy and medication allergy data on over 1.4 million patients who receive healthcare from both systems.

Wounded Warrior Image Transfer: To support our most severely wounded and injured Service members transferring to VA Polytrauma Rehabilitation Centers (PRCs) for care, DoD sends radiology images and scanned paper medical records electronically. Walter Reed National Military Medical Center and Brooke Army Medical Center are providing scanned records and radiology images electronically for patients transferring to VA PRCs in Tampa, Richmond, Palo Alto, Minneapolis, and San Antonio. From 2007 to the present, images for more than 480 patients and scanned records for more than 585 severely wounded warriors have been sent from DoD to VA at the time of referral.

Virtual Lifetime Electronic Record: The Departments are firmly focused on enhancing our electronic health data sharing and expanding capabilities to share information with the private sector through Nationwide Health Information Network (NwHIN) and the Virtual Lifetime Electronic Record (VLER). NwHIN will enable the Departments to view a beneficiary's healthcare information not only from DoD and VA, but also from other NwHIN participants. To create a virtual healthcare record—and achieve the VLER vision—data will be pulled from EHRs and exchanged using data sharing standards and standard document formats. A standards based approach will not only improve the long-term viability of how information is shared between the Departments, but will also enable the meaningful exchange of information with other government providers and with civilian providers, both of which account for a significant portion of care delivered to the Departments' beneficiaries.

VLER is being implemented iteratively through an operational pilot using incremental sets of functionality. The VLER pilot sites are demonstrations of exchanges of electronic health information between VA, DoD and participating private sector providers. The pilot continues to provide evidence of the power and effectiveness of coordinated development between the Departments for increasing the secure sharing of electronic health information while leveraging existing EHR capabilities. DoD's VLER pilot is underway in San Diego, California; Tidewater, Virginia; Puget Sound, and Spokane, Washington. In addition, VA is participating in seven other pilots with the private sector to expand the VLER capability.

The Integrated Electronic Health Record (iEHR): In 2011, DoD and VA committed to establishing and refining an integrated electronic health record (iEHR). The iEHR will enable DoD and VA to align resources and investments with business needs and programs. Going forward, a joint, common EHR platform will be implemented. Maintenance of AHLTA and VistA throughout the deployment lifecycle of the iEHR will ensure continuity of operations.

DoD and VA will purchase commercially available components for joint use when possible and cost effective. The iEHR will leverage open source and traditional approaches to software acquisition to foster innovation and expedite delivery of products to the user.

The Departments anticipate that iEHR capabilities will evolve from existing service oriented architecture (SOA) compliant capabilities, commercial off-the-shelf (COTS), open source, and custom systems. The use of agile development for the iEHR will allow the Departments to deliver capabilities to customers at a more rapid pace.

The DoD/VA Interagency Program Office (IPO) serves as a single point of accountability and execution for the iEHR and VLER Health initiatives to help ensure synchronization of these efforts.

World-Class Medical Care in the National Capital Region

The Department completed its largest and most complex Base Realignment and Closure (BRAC) projects in history on time last Fall in the National Capital Region (NCR). These BRAC projects closed and transitioned Walter Reed Army Medical Center and inpatient capabilities at Joint Base Andrews to expanded facilities at Bethesda, establishing the Walter Reed National Military Medical Center (WRNMMC), and a replacement hospital at Fort Belvoir (FBCH). Today, wounded, ill, and injured Service members and their families receive care in 3 million square feet of world-class new and renovated facilities, with 160,000 new equipment items and the latest medical technologies available.

These BRAC projects were one part of the larger transformation of Military Medicine in the NCR. The NCR has the largest concentration of healthcare assets in the Military Health System. It contains a mix of nearly 40 Army, Navy, and Air Force Medical Treatment Facilities (MTFs), has 550,000 eligible beneficiaries and 12,000 staff, and runs on an annual operating budget of almost $1.5 billion. Its primary medical mission is care for wounded, ill, and injured Service members, and it receives over 70% of the critical care air transports returning from theater. In order to reduce redundancies inherent in operating three separate Service systems and increase effectiveness and efficiency, the Department directed the establishment of an Integrated Healthcare Delivery System (IDS) in the NCR to be managed by the Joint Task Force National Capital Region Medical (JTF CapMed).

JTF CapMed has command authority over NCR MTFs. The presence of command authority provides a singular authority to drive the transformational change necessary to control unnecessary duplication among the Services and to increase interoperability. This improves responsiveness to our patients by aligning authority, responsibility, and accountability to a single entity that can make changes necessary to improve care. As an example, JTF CapMed has consolidated and co-located appointment and referral processes in the NCR to standardize appointment and referral processes. This has improved services by eliminating the confusion of multiple appointment processes at different MTFs in the NCR and has increased the access to care by offering appointments at any MTF in the NCR in order to meet patient needs. The JTF's efforts have saved the Department $109 million through contract execution and $114 million in cost avoidance through equipment re-use program. Consolidation of the workforces at WRNMMC and FBCH and authorities sufficient to implement shared services will enable further efficiencies and economies of scale that will ultimately result in contractor and civilian personnel savings of approximately $60 million per year in fiscal year 2011 dollars.

The NCR also has a specific congressional mandate to provide world-class healthcare through the NCR IDS. As discussed in the Comprehensive Master Plan provided to Congress, JTF CapMed is implementing the NCR IDS to provide more effective and efficient healthcare in the NCR and is overseeing projects at Bethesda required to achieve the world-class facility standards required by the NDAA for FY 2010. The President has fully funded these efforts in his Budget Request for FY 2013.

Post-Traumatic Stress and Traumatic Brain Injury

The VA–DoD Integrated Mental Health Strategy focuses on developing community organization collaboration and partnerships, such as with the National Institutes of Health and the American Psychological Association. Part of this work involves the creation of a network of experts on mental health issues, to include PTSD, so that there are coordinated efforts to improve access, quality, effectiveness, and efficiency of services for servicemembers, veterans and their families by sharing information and resources that enable partners to stay current with the changing science base and recommended best practices.

The Substance Abuse and Mental Health Services Administration in the Department of Health and Human Services (HHS) maintains strong partnerships with VA and DoD to prepare community behavioral health care systems to provide trauma informed services that reflect an understanding of military culture, servicemembers' experiences, the range of post-trauma effects, and the effects of traumatic brain and other physical injuries. This is primarily accomplished through SAMHSA's Service Members, Veterans, and their Families Policy Academies, through which SAMHSA has provided—and continues to provide—intensive technical assistance to 23 States, two Territories, and the District of Columbia to help them enhance their behavioral health systems.

Additionally, SAMHSA's National Child Traumatic Stress Network (NCTSN) has developed training materials for behavioral health providers who encounter veterans or servicemembers with traumatic brain injury. These materials were developed in collaboration with the VA Palo Alto Health Care Polytrauma Program. This two-

hour comprehensive training is available through the NCTSN's Learning Center Military Families.

In addition, to establish a network of public and private sector expertise in TBI, the Department of Defense has fostered collaboration with inter-Service working groups (Air Force, Army, Marine Corps, and Navy) together with other Department centers to include the Defense Centers of Excellence for PH and TBI and the Defense and Veterans Brain Injury Center (DVBIC) and the National Intrepid Center of Excellence (NICoE) and the Department of Veterans Affairs (VA). In addition, other Federal agencies such as the CDC and NIH have been collaborating partners to further the field of TBI and leverage expertise held within each agency. The working groups have further included public sector expertise through consensus conferences. The collaborative working group and consensus conference process has worked to define best practices for diagnosis and treatment of co-occurring disorders following TBI with focus on mild TBI. The collaborative working group has developed clinical recommendations for vestibular disturbances, vision disturbances, and endocrine dysfunction following TBI. These recommendations are intended to provide guidance to primary care providers in the MHS regarding the consideration and referral process for Service members with co-occurring disorders following mild TBI. The collaborative network efforts also addressed needs in the deployed setting with the revision of clinical practice recommendations/ algorithms for concussion management in the deployed setting. Finally, collaborations with professional sports organizations have been developed to help further common goals of addressing barriers to seeking care for TBI related issues.

The development of a TBI repository of information for and by various Federal agencies via the Federal Interagency Committee has recently been established. This will include the following: mild TBI Translation (mTBI) Grand Rounds (research to clinical practice) through collaboration with Johns Hopkins Institutes; development of DoD centric common outcome measures and/or common data elements in partnership with US Navy and Marine Corps EpiData Center and the Health Analysis Department.

The Department and VA have also produced a suite of co-branded education materials and curricula to train clinicians regarding the effective use of VA/DoD clinical support tools based on clinical practice guidelines for disorders such as Major Depressive Disorders, mild TBI, Co-Occurring Conditions, and Substance Use Disorder. Additionally, the Department has conducted a needs assessment survey for Behavioral Health and TBI providers as well as provided guidelines for training providers in evidence-based best practices for PTSD.

The Department produced materials for insertion into Joint Professional Military Education based on the Chairman Joint Chief of Staff's Special Areas of Emphasis. These materials will be used to provide line leadership with core components for a myriad of topics including PH and TBI. DoD has added a 60-minute overview of PH and TBI in the DoD briefing into the DoD APEX Senior Executive Service Orientation, a two-week requirement for all new executives to the Department.

The DoD and VA have partnered on the Integrated Mental Health Strategy, specifically by releasing the Operation Enduring Families curriculum, information, and support for Afghanistan and Iraq veterans and their families. The curriculum resides online at VA and Military OneSource websites. This guide was designed to assist parents, other family members and health care providers in addressing the mental and emotional health needs of military children through topic-specific, age-related, public-domain literature. Additionally, since its rollout in July 2010, 711 providers have been trained on the Defense and Veterans Brain Injury Center (DVBIC) family caregiver curriculum, a congressionally mandated guide that serves as a roadmap for those caregivers of patients with severe and penetrating brain injury.

In response to the DoD Mental Health Task Force recommendation to address continuity of care, DoD developed the inTransition program. This program provides servicemembers experiencing a transition (location change, change in status or health care system) with a coach to motivate them to remain in treatment. Available 24/7, these coaches are master's level clinical staff trained in deployment- and readjustment- related issues. Between February 2011 and February 2012, the number of inTransition cases increased from 392 to 1660, an increase of over 300%. Of the servicemembers referred to the program, 95% accepted the referral and 100% of those who completed a program survey reported the assistance they received from the inTransition Program increased the likelihood that they would continue their treatment.

The Center for Deployment Psychology (CDP), a Uniformed Services University center, has conducted workshops for civilian providers throughout the United States. To date over 2300 civilian providers have attended these weeklong work-

shops. These workshops include information on the identification, diagnosis and treatment of PTSD and other frequently occurring psychological health issues such as depression, substance use disorders, and suicide. An additional 1200 civilian providers have attended shorter workshops that train evidence-based treatments for treating PTSD. TBI is also a topic presented to address these challenges in Service members and Veterans.

Lastly, the VA and DoD jointly develop Clinical Practice Guidelines (CPGs) to serve as one means of communicating the state of the evidence to clinical providers in the field. VA/DoD CPGs are publically available through either Army Medical Command Quality Management Division's website (*https://www.qmo.amedd.army.mil/pguide.htm*) or the VA's Office of Quality and Safety website (http://www.healthquality.va.gov/). An expert multidisciplinary panel of VA and DoD providers developed the VA/DoD CPGs recommendations by conducting a comprehensive and rigorous review of the currently available studies on psychotherapy and medication. Since the passage of the NDAA 2008, the VA and DoD have jointly developed or revised CPGs for Depression, PTSD, mTBI, Opioid Therapy for Chronic Pain, Substance Use Disorder, and Bipolar Disorder.

The dissemination of existing TBI clinical guidelines and recommendations to various involved providers are conducted in various formats. The most powerful dissemination modality is through the Service TBI program managers who are leading the 56 Army TBI programs, 6 Navy TBI programs and Air Force TBI teleconsultations and joint programs. Ongoing resources are provided in the form of a national level resource fact sheet for military case managers as well as information and educational opportunities via the Military TBI Case Management Quarterly Newsletter to promote and advance access to care. The nationwide dissemination of the Case Management of Concussion/mild TBI Guidance Document was conducted across the MHS. Technology is widely utilized to disseminate TBI information as well. The release of the Mild TBI Pocket Guide mobile application for the iPhone and Android smartphones and the Co-occurring Conditions Toolkit: Mild TBI Psychological Health mobile application for the iPhone and Android smartphones disseminated this information to a new market of users. Additionally six mTBI web-based case studies via MHS Learn for DoD, the VA Employee Education System and civilian healthcare professionals have been released. The web-based case studies use patient vignettes as a way in which to educate healthcare professionals about the clinical recommendations contained within the VA/DoD mild TBI/concussion clinical practice guideline. The technology-based efforts reported more than 4700 downloads of the Mild TBI Pocket Guide mobile application and more than 500 downloads of the Co-occurring Conditions Toolkit mobile application. To improve future efforts of dissemination the Department utilized the Interactive Customer Service Evaluation to obtain user feedback.

Conclusion

While we are pleased with the quality of effort and progress made, we fully understand that there is much more to do. We have, thus, positioned ourselves to implement these provisions and continue our progress in providing world-class support to our Service members and Veterans while allowing our two Departments to focus on our respective core missions. Our dedicated, selfless Service members, 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.

Mr. Chairman, thank you again for your generous support of our wounded, ill, and injured Service members, Veterans and their families. I look forward to your questions.

Executive Summary

Department of Defense Prepared Statement for House Veterans' Affairs Committee Disability Assistance and Memorial Affairs Subcommittee

Hearing on Active, Guard, Reserve, and Civilian Personnel Programs

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As of early this month, IDES enrollment is 24,957 Service members (66 percent Army, 13 percent Marines, 10 percent Navy, and 11 percent Air Force). Since November 2007, cumulative enrollment has been 44,451, with 14,249 completing the process and receiving benefits. Including Service members who are returned to duty

by the process, active component IDES completion time averages 370 days as of February 2012, Reserve Component members averaged 358 days, and Guard members averaged 396 days. These averages are above targeted goals but still are significantly lower than the 1940-era legacy system it replaced.

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The Special Compensation for Assistance in Activities of Daily Living program was established by the FY10 NDAA to provide qualified Service members with monthly compensation to help offset the economic burden borne by their primary caregivers providing non-medical care, support and assistance. As of February 29, 2012, 505 Service members have received the compensation.

Today's Veterans face a number of challenges in making the transition to civilian life, and among these is embarking on a productive post-military career. As a result, the President created a Task Force led by the DoD and VA to develop proposals to maximize the career readiness of all Service members. The effort is fully aligned with the VOW to Hire Heroes Act of 2011 and is consistent with DoD's commitment for keeping faith with all of our military members and their families, providing them a comprehensive set of transition tools and support mechanisms.

The collaborative Federal partnership between DoD and VA has resulted in increased integration of healthcare services to Service members and Veterans. DoD and VA spearhead numerous interagency electronic health data sharing activities and are delivering IT solutions that significantly improve the secure sharing of appropriate electronic health information. Today's interagency health information exchange capabilities leverage the existing electronic health records (EHRs) of each Department as we both address the need to modernize our EHRs, by synchronizing planning activities and identify a joint approach to modernization.

The Department of Defense has fostered collaboration with inter-Service working groups and Department centers such as the Defense Centers of Excellence, the Defense and Veterans Brain Injury Center (DVBIC), the National Intrepid Center of Excellence (NICoE), and the Department of Veterans Affairs (VA). The collaborative working group has developed clinical recommendations to provide guidance to primary care providers in the Military Health System regarding the consideration and referral process for Service members following mild TBI and addressed needs in the deployed setting. Collaborations with professional sports organizations have been developed to help further common goals of addressing barriers to seeking care for TBI related issues.

Prepared Statement of Gail R. Wilensky, Ph.D

Mr. Chairman and Members of the Veterans' Affairs Subcommittee on Disability Assistance and Memorial Affairs: Thank you for inviting me here to testify about the transition from servicemember to Veteran, with a particular focus on the implementation of the Integrated Disability Evaluation System (IDES).

I am currently a senior fellow at Project HOPE, an international health education foundation that works to make health care available to people around the globe. I am also a Regent for the Uniformed Services University of the Health Sciences (USUHS). I have previously served as a Commissioner on the 2007 President's Commission on the Care for America's Returning Wounded Warriors (Dole/Shalala Commission), a co-chair for the Congressionally-mandated study on the Future of Military Health Care (2007–2008) and also as a co-chair on the 2001–2003 President's Task Force to Improve Health Care Delivery for our Nation's Veterans. The views I am presenting here reflect my training as an economist as well as the experiences I have had on these commissions and task forces. However, my testimony today reflects my personal views and not necessarily the views of Project HOPE or any of the other organizations with which I have been associated or continue to be associated.

I am here primarily to discuss the need for an integrated disability evaluation system and what has been reported about its early implementation as well as to remind the Committee about the restructured compensation system that the Dole/Shalala Commission also recommended should be implemented. I will also briefly review some of the other issues that need to be considered in order to facilitate the transition from active duty servicemember to veteran status. Most of these are not

new issues but rather have been recommended by various groups over the course of at least the last decade.

The Problem

Before the introduction of the Integrated Disability Evaluation System, a servicemember needed to first separate from his or her service, with discharge papers in hand, before entering the VA process. Thus, two exams were required—one from the military services that determined fitness to serve and a second exam from the VA to determine a disability rating for purposes of compensation.

The process and the criteria for determining fitness to serve differed across services and the process for determining disability differed between the services and the VA, which raised perceptions of equity of treatment across the different services. Also, servicemembers could potentially be rated at one level by their service and at another level by the VA, again raising questions of equity as well as causing confusion. In addition, these multiple steps ensured that the process was long and frequently contentious—averaging some 540 days.

The IDES

Under the IDES, there is a single, comprehensive exam by VA certified physicians. A single-source disability rating is used that determines both for the purpose of fitness for continuing military service and also serves as the basis for the VA to rate the level of disability. Each military service continues to determine whether someone is able to continue military service.

Service members who are unable to return to active duty are referred to a medical evaluation board, assigned a physician evaluation board liaison officer whose job is to help them through the process. Each servicemember is also assigned a VA military service coordinator to help them navigate through the VA system.

The stated goal is to get the process done in 100 days. The estimates I have seen reported are that the former 540- day process was closer to 295 days as of mid 2011, indicating a clear improvement but also a time frame that is not as expeditious as might be desired. There are also still reports of inexplicable and frustrating delays such as was reported last summer at a Senate hearing where the application of a Marine who had lost both his arms and legs in Afghanistan in 2010 sat on a desk for 70 days, requiring a Senator's personal intervention in order to get it dislodged.

Preliminary Assessment of the IDES

While the overall process is still relatively early in its implantation stage—having only gone fully live in the fall of 2011—there are some observations that can be made at this stage.

First, it is unclear why it has taken so long to get to this stage of the implementation process. The IDES was developed in 2007 in order to shorten the process of transition from active duty to veteran status. It followed from multiple recommendations that the Department of Defense and Veterans Administration use a single comprehensive standardized medical exam—including a recommendation from the Dole/Shalala Commission but certainly not limited to that Commission. While it is true that the Defense Department published guidance for a voluntary, expedited Disability Evaluation System in early 2009 for servicemembers that had sustained catastrophic injuries, the full IDES was not implemented until later in 2011.

Having run the Medicare and Medicaid programs in the early 1990's, I would agree that piloting a new system before taking it on-line is a reasonable and prudent step. Why it should take from 2007 until the fall of 2011 for a full transfer to the IDES is unclear to me.

Second, shortening the time to process a disability claim is important but the time involved per se is only part of the issue. Clearly agreeing on its function and making sure that this is fulfilled is a necessary step as well. Some ways that would shorten the process may not improve its fairness, such as eliminating a servicemember's right of appeal.

Third, while the use of a single disability exam makes sense, it is important to recognize that there are different functions that medical exams serve, even though they may provide overlapping data fields. They can serve to define a course of clinical treatment, providing information about diagnoses and progress as opposed to a medical exam that is a single snapshot "finder of fact" that determines a level of disability. Both uses suggest the need for ongoing, periodic medical evaluations but done for different purposes.

Restructuring the Disability and Compensation System

The Dole/Shalala Commission also recommended a complete restructuring of the disability and compensation system. The purpose of the recommendation was to simplify the disability determination and compensation process, eliminate parallel ac-

tivities, reduce inequities and perhaps, most importantly, provide a basis for veterans to return to productive lives as fully and quickly as possible.

Like the present system, the Commission advocated having the Defense Department determine fitness to serve. For those who are deemed "not fit", the Commission recommended that the DoD provide a pension that reflects a payment for the years served. The payment should be determined only by the individual's rank and the length of service. Those who are not fit because of combat-related injuries should receive TRICARE as should their dependents.

The VA should continue to have the responsibility for establishing the disability rating and compensation and benefits that follow from it. The VA should initiate its education and training programs as early as possible and adopt a policy of reviewing disability states on a three year basis.

The proposed restructuring of the VA disability payments was to work in steps. First, there would be a "transition payment". This payment would be to cover living expenses for injured veterans and their families. It would be defined as three months of base pay in the event there is not further rehab going on or a longer term payment for living expenses if the veteran continues in some form of rehab or education program.

Second, following the completion of the rehab or education program, the disabled veteran would receive an "earnings-loss" payment in order to make up for any lower earning capacity that might remain after training, should that occur. In many cases, there should not be an earnings loss.

Third, a "quality of life" payment would be made to compensate for "non-work related" effects in the event of permanent physical or mental combat-related injuries.

The purpose of these steps is to support and encourage the injured veteran to advance as completely as possible using education and rehab and then to assess the effect on both earnings capacity and quality of life. It is recognition that in an information and service economy such as we have today, even significantly injured veterans may be able to be helped to a position where they would not experience an earnings-loss but would still be entitled to a quality of life payment.

Two of the commissioners on the Dole-Shalala Commission were examples of how VA or GI Bill financed education could put someone in such a position. Marc Giammatteo, an Army Captain had been severely wounded in his leg while in Iraq. He was also attending Harvard Business School, getting an MBA and spending his summer working at an investment bank. Jose Ramos was a Navy Corpsman who had also been serving in Iraq and had lost his right arm to the shoulder. He was completing a double major in Arabic and national security at George Mason. Both of these individuals should be in a position where they would not experience an earnings loss but would experience a quality of life decrement. On the other hand, Tammy Edwards, also on the Commission, is the wife of an Army enlisted man who was severely burned and experienced a brain injury while on active duty. His earnings loss would be significant in addition to his quality of life decrement.

Other Areas Needing Strengthening

As important as integrating the disability evaluation and restructuring the disability and compensations payment are to facilitating the transition from active duty to veterans' status, there are other areas that need to be strengthened. Among the most important of these is making sure adequate care is available for any veteran who is experiencing PTSD or TBI. The DoD and the VA have been working hard to improve the prevention, diagnosis and treatment of both PTSD and TBI but much remains to be done. In addition, reducing the stigma associated with PTSD remains a problem for both active duty and veteran populations.

A major problem for both the Defense Department and the VA is that there is a national shortage of mental health professionals just as there is a national shortage of primary care professionals. Nonetheless, both departments will need to aggressively work on resolving this problem as aggressively and creatively as they can. It would also be helpful to provide programs to family members and caregivers to help them understand and deal with PTSD and TBI. Any efforts that can be undertaken to prevent PTSD and TBI from occurring, would be well worth-while on many fronts.

Efforts also need to continue to strengthen support for families. We had recommended expanding Defense Department respite care and extending the Family and Medical Leave Act for up to six months for spouses and parents of the seriously injured. The latter is especially a challenge in our currently constrained fiscal environment.

One of the most heartening findings of the Dole/Shalala Commission was that the quality of care provided to the wounded servicemembers was of very high quality. Most of the problems that occurred, occurred during the "hand-offs"—that is, the

transitioning from inpatient to outpatient status, from one facility to a second facility or from active duty to veteran status. Both the Defense Department and the VA have worked hard to reduce these problems and to simplify the path to recovery but more still needs to be done for our returning wounded warriors.

Thank you Mr. Chairman. I would be happy to answer any questions you or the Committee may have.

Executive Summary:

Before the introduction of the Integrated Disability Evaluation System (IDES), servicemembers first needed to separate from his or her service and then to enter the VA process, requiring two different exams. The process and criteria for determining fitness differed across services and the process for determining disability differed between the services and the VA. The result was real and perceived differences in equity of treatment across services and between the services as well as a lengthy and frequently contentious process.

The IDES produces a single exam, done by a VA certified physician that serves both as the basis for determining fitness to serve and to establish a level of disability. The services continue to determine fitness to serve; the VA determines the disability level.

The result has been to cut the time from about 540 days to less than 295 days. It is a substantial reduction but far from the stated goal of 100 days. In addition, occasional lengthy and inexplicable delays are still reported. Several issues remain. First, why did it take so long to have the IDES fully rolled-out—from its development in 2007 until the fall of 2011? Second, shortening the time is important but clear agreement on the functions and goals of the disability evaluation program is equally important. Some questions remain here as well. The need also remains for ongoing, periodic medical evaluations to determine whether initial levels of disability continue in the future.

The Dole/Shalala Commission, where I was a commissioner, also recommended the complete restructuring of the disability and compensation system. Like the IDES, the goal was to simplify the disability determination, reduce parallel activities and inequities and most importantly, provide a basis for veterans to return to productive lives as fully and quickly as possible. To do this, we recommended a "transition payment" that would provide living expenses to the disabled veteran and their families during rehab, training and education. This was to be followed by an estimate of earnings-loss which may remain after training and/or education has been completed and which would also be accompanied by a quality of life payment, if appropriate. This division recognized that in an information and service economy, disabilities that previously would have produced earnings losses may no longer do so but quality of life decrements may continue. Three of the commissioners provided examples of how these differences might work.

Other areas also need strengthening to facilitate the transition from active duty servicemember to veteran. These include assuring that care is available to any veteran experiencing PTSD or TBI and working to reduce the stigma attached to both of these. The ongoing shortage of mental health professionals in the U.S. will make this a challenge. Efforts are also needed to continue strengthening support for families. We had recommended expanding respite care and extending FMLA for up to six months for spouses and parents of the seriously injured. The latter is a challenge in our fiscally-constrained environment.

On a positive note, most of the problems that were identified during the work of the Dole/Shalala Commission concerned the "hand-off" process and not the quality of care actually delivered. We need to ensure that both are appropriate for our returning wounded warriors.

Prepared Statement of Kenneth Fisher

Chairman Runyon, Members of the Committee:

On behalf of co-chairs Dole and Shalala who could not be with us today, the members of the commission, and my fellow commissioner Gail Wilensky, I appreciate the opportunity to appear before you today. Both as a commissioner and a Chairman of the Fisher House Foundation, I have devoted the last 12 years of my life towards improving both the care and the quality of life of our military, those wounded, veterans and their families. Today's hearing on the DES and the seamless transition are critical to this Nations security and I am proud to discuss my work on the commission, its recommendations and action steps, and how this system must be made simple, easily understandable and easier to navigate. But I must admit to being a

bit confused. We are the greatest Nation on earth, with the best equipped and the best trained military in the history of the world. What puzzles me is the fact that it has been five years since the findings of Dole Shalala and we are still having hearings on the same issues as 2007.

Before I begin, I feel compelled to preface my statement by explaining our mission. We were charged by President Bush to examine, evaluate, and analyze the care and process related to our returning wounded global war on terror servicemen and women. We looked at the system through the eyes of the wounded service people. We were solution driven, and held numerous field hearings, interviewed wounded, base commanders, doctors and family members as well as others who played a role in the recovery process. We not only examined the problems and inadequacies but also looked for best practices that might help improve their care. Our goal was to simplify and help eliminate the log jam, which was the result of the fighting lengthy two front wars with a VA that was already challenged by the weight of an intolerable beaurocratic system. By doing this, we sought to eliminate the back log and claims that had reached approximately 800,000–900,000.

While the living conditions at Walter Reed were indeed horrendous, this was only the tip of a massive iceberg. We found hundreds of troops waiting months for follow up appointments or awaiting the rating process. This gap in benefits caused massive problems known to but a few.

The commission was given six months to evaluate the entire disability evaluation system and our findings were thoughtful, inclusive, and easily implementable. It was not our intention to put forth hundreds of recommendations that would have been difficult to implement or too expensive as a whole.

And as a side bar, I would like to compliment our Nation's world class military healthcare professionals whose work and use of the latest technologies resulted in a 95% battlefield survivor rate.

Today, five years after our report was made public, there has been progress, to be sure, but, and with all due respect, not nearly fast enough, and the appearance that there is no real sense of urgency. Tracking the results of the commission has been difficult, as admittedly I would not expect the process to be transparent. But again, we were given the task of OEF/OIF, with the hope that its adoption would have moved the system along faster.

Our recommendations were short and to the point.

Our first recommendation called for a recovery care coordination program – a plan to smoothly guide and support servicemembers from start to finish. This would apply to both the VA and the DoD. I believe this has been implemented, although I cannot speak to its success. On this I would have to differ to our VA and DoD representatives. In the interest of time I thought we would focus on the four issues that I think are crucial.

Our second recommendation called for an overhaul of disability. Our plan called for one physical administered by DoD who then determines fitness to serve. If separation is required, they are compensated on rank and length of service, and then they are moved to the VA who determines their rating and benefits along with a series of payments. The joint DoD VA plan that is currently in use is the Integrated Disability Evaluation System which is now out of the pilot program and is in use system wide as they phase out the legacy program over the next two years. It calls for one physical administered by the VA. The DoD component is done simultaneously - they determine fitness to serve through the MEB and PEB. The VA rating systems apply, and the entire process is designed to eliminate the benefit gap. Pilot programs were able to take the legacy process of 500 days down to 300, but as the system was expanded – the waiting time climbed back to 500 days.

According to the GAO, there are some glaring weaknesses – chief among them staffing issues. In addition, VA doctors are having integration issues at DoD facilities, which come as no surprise to me. There were disagreements in diagnosis, which is not uncommon – but it does add more time to the process. And I must admit to being a bit confused as to why VA doctors are performing the DoD physical. I believe an Army doctor, for example, is better suited to determining whether a soldier is fit to serve. This also frees up VA doctors not only to treat the younger veterans as they enter the VA but also an older set of veterans who are reentering the VA system. But I cannot emphasize enough - in the private sector the best possible plans are just words on paper if there isn't enough qualified people to implement said plan. This is an over simplified written in the interest of time constraints. This includes recovery care people as well PEBLO's and other crucial personnel.

Another important recommendation highlighted is the incompatibility of the DoD and VA IT systems and as our report put it, this alone is not the silver bullet. However, if information could be transmitted this way, the veterans would have less

paper work, and find out what is available to them much faster at the push of a button. We believed that information sharing was critical to the help of the system.

We recommended life time treatment for PTSD. These men and women have endured multiple deployments; have been in intense urban fighting, often against civilian insurgents who too often hide behind innocent women and children. They have seen horrific injuries caused by IED's. And the stigma associated with coming forward and asking for help leaves too many to suffer in silence and if they are home their families do suffer as well. We believed this was a major problem when our report was made public, and it has been for any servicemember who fought in battle be it World War II, Korea, Vietnam or today.

Today it is evident why this was a major recommendation. Five years after our report was made public, there have been well over 1000 suicides - out pacing the civilian population, domestic violence, and divorce, drug and alcohol abuse, homelessness, joblessness, are all at unacceptable levels. Just the other day in USA Today, an article appeared discussing alcohol within the ranks of the Army, and the fact that they have delayed for three years a confidential counsel program for treatment. They had begun a pilot program in 2009, but it was ended after high dropout rates. According to the article, 25% have a drinking problem.

The issue's importance is self explanatory because of the collateral damage it causes. Here again, staffing shortages are at the heart of the issue, as with disability. We need to consider engaging the private sector to help with has become the signature wound of this war. The stigma has not completely vanished, and this wound is the worst kind because it cannot be seen until after it manifests itself.

Perhaps we need to reexamine screening before and after deployment, and I believe a spousal educational program is vital. They are the first line of defense, and if they know what to do after seeing their loved one's behavior change.

I believe that progress has been made in our family support recommendation, as the family medical leave act has been extended to six months, and the VA now offers a caregiver stipend to the caregiver.

Military families bear burdens that the average American has no concept of. And for too long, military families bear their stress either alone or with other military families. When one gets wounded, that stress can be unbearable. The private sector has stepped up and numerous foundations are in action and I would encourage Congress, the DoD and the VA to find the ones that work and embellish them, not impede them by making them part of the intolerable beaurcracy that exists system wide. They have the infrastructure, boots on the ground, and the overwhelming desire to help. There will always be unmet needs, but public private partnerships can bridge that gap, and paint the way to the future.

Mr. Chairman, This concludes my statement. In the interest of time, I tried to keep the nuts and bolts of our report to a minimum, and the fact that most people are already familiar with our report, judging by the criticism it generated. It was always our intention to have Congress and the Veterans Service Organizations weigh in and while they objected to certain parts of our report, it must be emphasized that the needs of today's young veterans are immediate and this new generation of veterans are coming into the system by the thousands. Times are different, their wounds are different, but I assure you had we had the time we would have examined all veterans because anyone who has worn this Nation's uniform deserves the best we have to offer. A thank you for your service is not enough anymore. I am now ready to answer any questions you may have.

Prepared Statement of James Terry Scott, LTG USA (RET)

Mr. Chairman and Members of the Subcommittee: It is my pleasure to appear before you today representing the Advisory Committee on Disability Compensation and the Veterans Disability Benefits Commission that met from 2005 to 2007 and reported out to you in October of that year.

The Advisory Committee is chartered by the Secretary of Veterans Affairs under the provisions of 38 U.S.C. in compliance with P.L. 110–389 to advise the Secretary with respect to the maintenance and periodic readjustment of the VA Schedule for Rating Disabilities. Our charter is to "(A)ssemble and review relevant information relating to the needs of veterans with disabilities; provide information relating to the character of disabilities arising from service in the Armed Forces; provide an on-going assessment of the effectiveness of the VA's Schedule for Rating Disabilities; and provide on-going advice on the most appropriate means of responding to the needs of veterans relating to disability compensation in the future".

Your letter asked me to testify on the Advisory Committee's views on the transition from servicemember to Veteran, with a particular focus on the implementation of the Integrated Disability Evaluation System (IDES).

First, a bit of background. At the time the Veterans Disability Benefits Commission was created by the National Defense Appropriations Act of 2004 it was already apparent that the peacetime system for transitioning sick and injured servicemembers to Veteran status was overwhelmed. From the outset, and well before the reprehensible situations at the Walter Reed Barracks and other locations were recognized, the Commission recognized the need for a seamless and rapid transition process that protected the servicemember while he or she progressed to Veteran status. Transition became one of the major issues studied by the Commission. Interim recommendations addressing transition issues were offered as deliberations progressed.

The Veterans Disability Benefits Commission (VDBC)

examined the policies and processes within the Departments of Defense, Veterans Affairs, Labor, Health and Human Services, and the Social Security Administration that affected military separation or retirement. Each of these entities plays a significant role in the transition of Veterans and their families.

Of the 113 recommendations the Commission made, many of them pertained to improving the transition process. I am providing for the record a list of the key transition recommendations and the status of their implementation as I understand it.

4.4 and 4.5: VA should develop a process for updating disability examination work sheets and mandate the use of approved templates. (This is currently being addressed by the adoption of Disability Benefit Questionaires for the use of VA and non-VA medical examiners.)

4.10: VA and the DoD should conduct a comprehensive multidisciplinary medical, psychological, and vocational evaluation of each Veteran applying for disability compensation at the time of service separation. (This is partially addressed by the IDES system for sick or injured servicemembers and by the expanded TAP briefings. Complete physical exams for all separating servicemembers are still not required.)

4.23: VA should immediately begin to update the current rating schedule beginning with those body systems addressing the evaluation and rating of PTSD and other mental disorders and of traumatic brain injury and then proceed through the other body systems until the Rating Schedule has been comprehensively revised. (This is currently being addressed by VA with a projected completion in 2016.)

5.7: DoD should require a mandatory benefits briefing to all separating military personnel, including Reserve and National Guard members prior to discharge from active service. (This is being partially addressed by the services and VA through expanded TAP briefings.)

5.28: VA should develop and implement new criteria specific to posttraumatic stress disorder in the VA Schedule for Rating Disabilities. (This has been done and is awaiting approval.)

6.9: Access to vocational rehabilitation should be expanded to all medically separated servicemembers. (Programs have been expanded but universal access has not been achieved.)

6.10: All service disabled veterans should have access to vocational rehabilitation and employment services. (These programs have been expanded, but are still not available to all service disabled veterans.)

7.11: VA and DoD should adopt a consistent and uniform policy for rating disabilities, using the VA Schedule for Rating Disabilities (VASRD). (This has largely been accomplished by DoD accepting the VASRD. It is an integral part of the IDES.)

7.13: VA and DoD should realign the disability evaluation process so that the services determine fitness for duty and servicemembers who are found unfit are referred to VA for disability rating. All conditions that are identified as part of a single, comprehensive medical examination should be rated and compensated. (The IDES system has adopted this procedure.)

10.1: VA and DoD should enhance the Joint Executive Council's strategic plan by including specific milestones and designating an official to be responsible for ensuring that the milestones are reached. (This has been fully implemented by VA and DoD.)

10.3: DOL and SSA should be included in the Joint Executive Council to improve the transition process. (DOL participation in transition and in follow up has greatly increased.)

10.4: To facilitate seamless transition, Congress should adequately fund and mandate the Transition Assistance Program (TAP) DoD-wide to ensure that all servicemembers are knowledgeable about benefits before leaving the service. (Expansion of TAP is a major ongoing effort in VA today).
10.5: Benefits Delivery and Discharge (BDD) should be available to all disabled exiting servicemembers (to include National Guard, Reserve, and medical hold patients). (Progress unknown).
10.6: DoD should mandate that separation examinations be performed on all servicemembers. (While progress has been made, this is still not a requirement in all services for all separating members. While requiring resources, this policy will pay great dividends in future years by providing a clear picture of physical and mental condition at separation which can be used in determining service-connection for disability.
10.8: DoD should expand existing programs that translate military occupational skills, experience, and certification to civilian employment. (Progress unknown.)
10.11: VA and DoD should expedite development and implementation of compatible information systems including a detailed project management plan that includes specific milestones and lead agency assignment. (This complex issue is under development.)

Of the recommendations pertaining to transition that both the Veterans Disability Benefits Commission and the Advisory Committee on Disability Compensation have offered, the one with the most potential to reduce the time to process claims and improve accuracy and consistency is the ongoing plan to revise the VASRD. This complex, multi-year revision will incorporate current medical knowledge and technology as well as streamline the diagnosis, evaluation, and adjudication processes.

Another key recommendation with potential long term positive effect is the movement to an electronic claims record. This is another extremely complex challenge that the VA has accepted and is working. When fully implemented it will simplify and expedite the claims process.

The Current IDES program incorporates many of the recommendations from the Veterans Disability Benefits Commission and the Advisory Committee on Disability Compensation. It represents a tremendous effort on the part of VA and DoD to focus on the transition of servicemembers who are sick or injured to Veteran status. All parties, including the Congress are frustrated by the average time still required to complete the transition. However, from the perspective of someone who has had the opportunity to contribute to this effort over the last eight years, I believe the progress is significant and, more importantly, that the progress will continue.

On behalf of the Advisory Committee, thank you for the opportunity to testify on this important matter.

Prepared Statement of John L. Wilson

Mr. Chairman and Members of the Subcommittee:

On behalf of the Disabled American Veterans (DAV) and our 1.2 million members, all of whom are wartime disabled veterans, I am pleased to be here today to testify before the Subcommittee on Disability Assistance and Memorial Affairs and address the implementation of the Integrated Disability Evaluation System (IDES). DAV is actively engaged in providing claims assistance to military members before they leave active duty with our 30 Transition Service Officers (TSOs) assisting over 55,900 servicemembers in 2011 and our 250 National Service Officers (NSOs) representing over 259,000 veterans, their families and survivors for that same period.

IDES is the result of a recommendation of several commissions, including the Veterans' Disability Benefits Commission,[1] and the President's Commission on Care for America's Returning Wounded Warriors, which stated that the "DOD and VA should create a single, comprehensive, standardized medical examination that the DOD administers. It would serve DOD's purpose of determining fitness and VA's of determining initial disability level."[2]

The Disability Evaluation System (DES) pilot project was launched in 2007 by the Department of Defense (DOD) and the Department of Veterans Affairs (VA). Using lessons learned from that pilot, the legacy DES began the transition to IDES in October 2010 to include a total of 140 locations, with the goal of expediting the delivery of VA benefits to all out-processing military members.

[1] Veterans' Disability Benefits Commission, October 2007, page 376

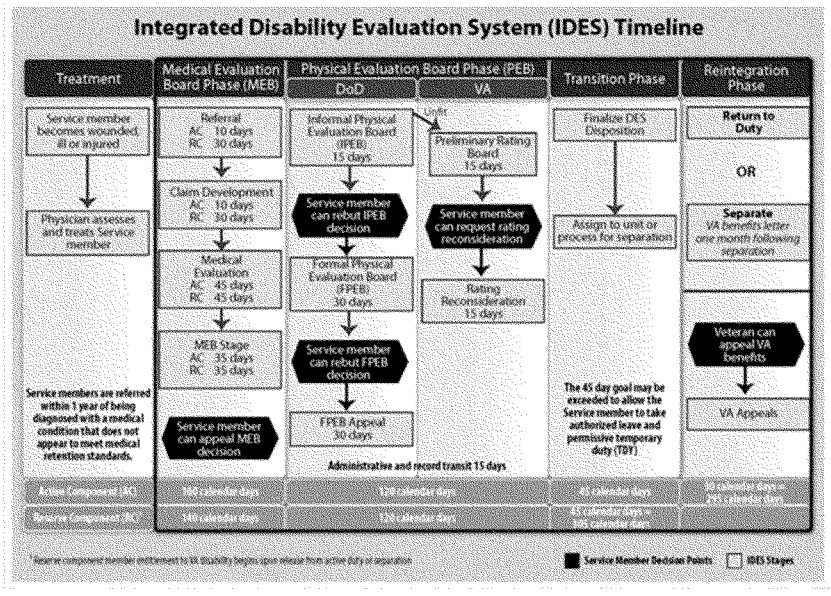
[2] The President's Commission on Care for America's Returning Wounded Warriors (July 2007), page 7.

A comparison between the DES pilot and legacy DES found Active Component military members completed the pilot in an average of 289 days, and Reserve Component military members completed it in an average of 270 days, compared to a legacy DES average of 540 days. Surveys revealed significantly higher satisfaction among DES pilot participants. On July 30, 2010, the DOD Senior Oversight Committee co-chairs directed that IDES expand worldwide.[3]

The legacy DES was replaced with the IDES in four stages[4] and was fully deployed by October 2012.

- Stage I–West Coast and Southeast (October–December 2010)—28 Sites
- Stage II–Mountain Region (January–March 2011)—24 Sites
- Stage III–Midwest and Northeast (April–June 2011)—33 Sites
- Stage IV–Outside Continental United States (OCONUS) (July–September 2011)—28 Sites
- Total IDES locations when complete: 140

Under this system, military members are referred to IDES when their continued service is curtailed as a result of a physical or mental health condition and they are placed on a medical profile making them ineligible for deployment or unable to carry out the duties of their rank or military specialty. The following chart depicts the revised time lines for each step of the IDES process:



[5]

As a result of treatment and being on medical profile, military members are evaluated by a Medical Evaluation Board (MEB), which is typically comprised of at least two physicians. If the MEB determines that the member has a medical condition that is incompatible with continued military service, an MEB Narrative Summary is prepared and the case is referred to a Physical Evaluation Board Liaison Officer (PEBLO).

PEBLOs guide servicemembers through the IDES process to ensure they are aware of the options available to them and to help with the many decisions they need to make while still in on active duty. The PEBLO compiles administrative

[3] *Department Of Defense Task Force On The Care, Management, And Transition of Recovering Wounded, Ill, And Injured Members of the Armed Forces,* Disability Evaluation System, page D–34.

[4] Statement of John R. Campbell, Deputy Under Secretary of Defense (Wounded Warrior Care and Transition Policy), Department of Defense, before Senate Committee on Veterans' Affairs Hearing on Review of the VA And DOD Integrated Disability Evaluation System (November 18, 2010).

[5] IDES Trifold Brochure

data, informs military members of the IDES process and the MEB, and then refers them to the VA Military Services Coordinator (MSC).

The VA MSC then meets with the military members to advise them about the next phase of the IDES process, assist in completion of documentation, establish a formal VA disability claim, and initiate case development. The VA MSC requests the appropriate VA medical examinations, monitors their progress, provides copies of the completed examination reports to the PEBLO, and completes any additional development actions as needed.

Once the medical examinations are completed, the VA MSC provides them to the PEBLO and the VA Disability Evaluation System Rating Activity Site (D–RAS) which prepares the proposed disability rating. The PEBLO incorporates the medical examination results in the IDES case file and provides it to the MEB convening authority. The MTF then conducts an MEB and provides the results back to the PEBLO, including the results of the MEB's response to any rebuttal of the member about the MEB findings. The PEBLO then provides a copy of the MEB findings, to include the completed VA medical examination results, to the military member and forwards the case to the PEB administrator if the MEB did not return the military member to duty. The PEB administrator prepares and provides the member's case to the Informal PEB (IPEB).

The IPEB is typically comprised of a two- or three-member board. The IPEB adjudicates the case and requests the D–RAS provide the proposed ratings for the military members' conditions that the IPEB has determined to be unfit. The D–RAS prepares the proposed disability ratings, and reconsideration of the proposed ratings, if the military member requested this. Once all information is received, the IPEB decides whether the member can continue in the military. If so, they are designated "fit" and returned to duty. If not, they are found "unfit." There are three broad types of medical separations the member can receive as a result of being found unfit: separated without severance pay, separated with severance pay, or retirement.

Once the military member is informed of the IPEB's decision, they can either accept those findings or appeal the decision to the Formal Physical Evaluation Board (FPEB). The FPEB is comprised of a three-member board, two personnel officers and a physician. They review all the information that the IPEB had, with the added feature of the member being able to personally appear before the FPEB and offer additional evidence. The FPEB then holds a hearing, weighs the prior evidence, the member's testimony as well as any new evidence presented, and renders its recommendation. The member can accept the decision of the FPEB, or request reconsideration of the proposed ratings. Just as with the IPEB, there are three broad types of medical separations the member can receive: separated without severance pay, separated with severance pay, or retirement.

Military members have a final appeal option of the FPEB findings regarding fitness for duty through all subsequent levels allowed by their branch of service, such as the Department of the Navy Council of Review Boards and the Department of the Air Force Personnel Council.

The three types of medical separations, separated without severance pay, separated with severance pay, or retirement, can result in several types of medical discharges. Specifically, those who receive a disability rating of 20 percent or less receive a Discharge With Severance Pay or DWSP. Those whose medical conditions were found to exist prior to military service and found unfit can be "discharged under other than Chapter 61, title 10 or (DUOT) without disability compensation if their conditions existed prior to service and were not permanently aggravated through military service. Those who receive a disability rating of 30 percent or more may receive Permanent Retirement, or be placed on the Temporary Disability Retired List and reevaluated at least every 18 months until their conditions become stable with a final disability rating decision rendered at the five year point. An exception would be mental disorders due to traumatic stress on active duty which require re-evaluation within six months after discharge, if assigned a disability rating of not less than 50 percent.

While DAV is generally pleased with the IDES, we are concerned about certain aspects of the program. One area is servicemembers participating in IDES not having ready access to representation from a veterans service organization (VSO) in the same manner as they did under the legacy DES.

The issue of access to counsel to advise military members on the VA disability claims process was cited as a concern by the Recovering Warrior Task Force (RWTF). The RWTF is charged with conducting an assessment of the effectiveness of DOD programs and policies for Recovering Warriors (RWs). In recommendation 19, the RWTF found during RWTF onsite visits that legal personnel indicated that they were greatly understaffed. The Army, Navy, and Marine Corps provide legal

counsel for both MEB and PEB. The Air Force provides specific legal counsel only for the PEB. Air Force base level legal counsel can address IDES issues prior to PEB. However, the Air Force is the service with the lowest satisfaction with legal counsel and the only service who's IDES participants were not more satisfied than their legacy DES participants. These survey results reinforce the importance of providing legal counsel for the MEB as well as the PEB.[6] The relationship between access to legal counsel and satisfaction with the IDES process is clear. Despite survey results demonstrating the value of having legal counsel available throughout the disability evaluation process, the majority of RWTF focus group participants said they lacked personal experience with or knowledge of these specialized legal resources.[7]

Most military members undergoing the discharge evaluation process may not be aware of the complexities of the disability adjudication and retirement systems. As a result, they may be accepting PEB decisions that are not in their best interest and/or the benefits they receive may be less than what they would have been had they understood the long-term consequences of their decision to accept a particular PEB decision. As stated in the latest RWTF report, "Service members going through the IDES process often do not have a clear idea about where they are going and what their futures hold."[8]

Most servicemembers may not know how complex the IDES disability adjudication is and we believe their best interests would be served if they had access to the free assistance from certified representatives from VSOs who can not only provide them with a full understanding about the process and their rights but also act as their advocates. DAV, in accordance with DAV Resolution 177, and also with the other co-authors of The Independent Budget has urged the DOD and VA to address this observed gap in IDES and expand VSO access.

DAV was actively engaged in the legacy DES but VSOs were excluded when the program was redesigned and replaced with IDES. Under the legacy DES, our TSOs represented 282 military members before DOD's Physical Evaluation Boards from July 2008 to June 2009 but those numbers have declined to 92 from July 2009 to June 2010 and to 22 from July 2010 to June 2011. This change was based on the DOD and VA's focus on speeding the delivery of benefits so they could be placed in the hands of separating military personnel closer to the time of their discharge. Just as with the larger disability claims process and its current focus of "breaking the back of the backlog," IDES is similarly focused. It is our view that while speed is an important factor, any claim, whether while on active duty or as a veteran should be done right the first time with an emphasis on timeliness and rating decision accuracy.

DAV brings vast experience and expertise about claims processing with our service officers holding powers of attorney for hundreds of thousands of veterans and their families. Our NSOs and TSOs continue to be actively engaged in informing military members of their eligibility for VA and DOD benefits though briefings at Transition Assistance Program classes. We also provide assistance to those who request accelerated receipt of their VA disability benefits under VA's Benefits Delivery at Discharge (BDD) and Quick Start. To participate in BDD the military member must apply within 180 days of discharge but no less than 60 days. If they are closer than 60 days from separation then they can use Quick Start. We assisted over 55,900 military members in 2011 under these three programs. As a result, DAV and other VSOs play an integral part in the claims process and undeniably make the VA's job easier by helping veterans prepare and submit better claims, requiring less time and resources for them to be developed and adjudicated. If provided broader access, we can make the DOD's job easier as well by ensuring military members going through IDES do have a clear idea about where they are going and what their futures hold.

There has been some positive movement that partially addresses VSO access. The VA Integrated Disability Evaluation System Implementation Guide states that VA Military Services Coordinators (VA MSCs) will "explain the availability of Veterans Service Organizations and provide a VA Form 21–22, Appointment of Veterans Service Organization Claimant's Representative, if the Service member expresses interest in this resource."[9] While this is an improvement, we recommend this guidance be modified so the VA MSCs explain the option of representation by a VSO during IDES, whether or not the military member expresses an interest. Given the

[6] DOD Recovering Warrior Task Force Report, September 2, 20111, page 22.
[7] Ibid.
[8] Ibid, RWTF Service member focus group results. March/April 2011, page 43.
[9] VA Integrated Disability Evaluation System Guide, December, 2011, page 16.

many issues that the member has to handle at this important juncture, changing this interchange to a more positive exchange may be more productive.

While the guidance to VA MSCs is in the right direction, there has been no such change from the DOD directing PEBLOs to raise VSO representation as an option at any point in the process. Therefore, we recommend that PEBLOs be required to inform military members about the option of VSO representation as well. Having PEBLOs provide this option earlier in the IDES process, and on the DOD side of the rating process, would help ensure that military members know that VSOs are available to represent them not just with the VA but also with the DOD as their disability claim is processed.

The last area to address is the effectiveness of the PEBLOs. The RWTF found in its work with focus groups that many participants had limited knowledge as to the role of the PEBLO. Although several spoke favorably, more often than not comments about PEBLOs were negative. Military members seemed to expect them to be more of an advocate that they were.[10] Twenty-eight percent of RWs responding to the RWTF mini-survey indicated that the PEBLO was very or extremely helpful, while 32 percent indicated the PEBLO was moderately helpful. These statistics would indicate that, while 60 percent of respondents had a favorable impression of PEBLOs, a significant minority of 40 percent did not have a favorable impression.

The RWTF mini-survey results are in contrast with the more positive survey findings of the DOD Office of Wounded Warrior Care and Transition Policy (WWCTP). They found PEBLO customer service earned 79 percent to 88 percent satisfaction ratings across the services. DOD WWCTP also found that 65 percent of survey respondents indicated that the PEBLO managing their case was helpful or very helpful to them.

While DAV has received information from the field that indicates the performance of PEBLOs has continued to improve generally, there are occasions in which PEBLOs have incorrectly advised members on what their actual disability ratings are. Recently, a PEBLO advised a member that he could not personally appear before the Formal Physical Evaluation Board to appeal the IPEBs decision. This was clearly in error, but one of DAV's NSOs was able to provide the correct information to the member. In order to prevent these types of errors and improve satisfaction, we believe it is imperative that the training and quality control be reviewed and more closely monitored.

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

Prepared Statement of Phil Riley

Chairman Runyon, Ranking Member McNerney, and Members of the Subcommittee:

Wounded Warrior Project (WWP) appreciates your holding this hearing and welcomes the opportunity to share our perspective on the Integrated Disability Evaluation System (IDES) – a critical, but still troubled pathway in the transition from servicemember to veteran.

I am Phil Riley, a Senior Benefits Liaison with WWP. In that capacity, it is my privilege to assist wounded, ill, and injured servicemembers in navigating the confusing road from medical evaluations to the critical benefits' determinations associated with their military retirement or separation. As a retired Army Colonel who has worked with the disability evaluation process for some six years, including time as a veteran's service officer, it's my assessment – and that of WWP – that much more work is needed to close the wide gap between the goals underlying IDES and realization of those goals. We believe VA is doing its part in the IDES process. In our view, the Department of Defense (DoD) needs to do more remedial work.

IDES, of course, has its roots in the problems wounded warriors experienced under the so-called "legacy Disability Evaluation System," the DES. Under that system servicemembers whose injuries or medical conditions rendered them no longer fit for continued military service went through a very lengthy multi-stage processes, with both DoD and VA conducting their own separate medical evaluations and subsequent disability rating processes. Under DES, servicemembers routinely experienced many-months' waits between discharge from service and receiving their first VA benefits payment as well as inconsistencies in how servicemembers' injuries

[10] DOD Recovering Warrior Task Force Report, September 2, 20111, page 21.

were evaluated in the two systems.[1] In 2007, it took an average of 540 days under the legacy DES for a servicemember to clear both DoD and VA disability-evaluation processes.[2]

The bipartisan Commission on Care for America's Returning Wounded Warriors ("the Dole-Shalala Commission"), formed in that year, urged that DES be overhauled. Among its findings, the Commission reported that fewer than 50% of servicemembers understood the DoD disability evaluation system, and that only 38% of active duty and 34% of the reserve component were "somewhat" satisfied with it.[3] The Commission recommended that the two departments "create a single, comprehensive, standardized medical evaluation that DoD administers,"[4] with DoD maintaining its authority to determine fitness-to-serve and VA becoming solely responsible for setting disability ratings and awarding compensation.[5] Its recommendation aimed to update and simplify the disability determination and compensation process by eliminating parallel activities and to reduce inequities.[6]

Creation of IDES and the Goals of an Integrated System

The Commission's work was carried forward by the congressionally-established Wounded, Ill and Injured Senior Oversight Committee (SOC) which ultimately instituted a more modest reform to integrate the two systems which resulted in establishing a pilot integrated disability evaluation system. The vision was "to create a servicemember-centric, seamless and transparent DES"[7] by developing a jointly-conducted military medical evaluation process under which servicemembers receive a single set of physical disability evaluations and disability ratings, conducted and prepared by VA, with simultaneous processing by both departments—using VA protocols for disability examinations and VA disability ratings to make their respective determinations—to ensure the earliest possible delivery of disability benefits.[8] The goals of the new IDES process were to create: (1) a less complex and non-adversarial system; (2) faster, more consistent evaluations and compensation; (3) a single medical exam and a single-source disability rating; and (4) a smooth transition to veteran status.[9] The IDES pilot began in the National Capital Region in November 2007 with a goal of reducing the time (from referral of a case to the DoD medical evaluation board to delivery of VA benefits) to 295 days for active duty and 305 days for reserve component servicemembers.[10] Following a phased expansion of the IDES pilot over about a year and a half period, IDES became fully operational as of October 2011.[11] Under the new IDES process, a servicemember is to receive a full medical examination conducted by the VA, which is used as the basis for determining both fitness for continued duty in military service and entitlement to DoD benefits and VA compensation.

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[1] U.S. Medicine, Wait Times Heading in Wrong Direction in New Integrated Disability System; VA Blames 'Transition Difficulties'" July 2011; Kimberly Hefling, The Associated Press, "Claim Processing Keeps Injured Troops Waiting," May 18, 2011.

[2] Tom Philpott, "Disability Evaluation Reforms Seen Falling Short," Army Times, March 31, 2011.

[3] The President's Commission on Care for America's Returning Wounded Warriors, July 2007, p. 6.

[4] Id. at 7. Service members found unfit due to their combat-related injuries would then receive payment for years served and comprehensive health care coverage for themselves and their families through DoD's TRICARE program. Id.

[5] Id.

[6] Id. at 6.

[7] Is This Any Way to Treat our Troops? Part III: Transition Delays: Hearing Before the H. Committee on Oversight and Government Reform, 112th Cong. (2011) (prepared statement of Lynn Simpson, Acting Principal Deputy Undersecretary of Defense for Personnel and Readiness, U.S. Department of Defense).

[8] Id.

[9] Integrated Disability Evaluation System Pilot Overview, presentation at VA/DOD Joint Venture Conference, October 2010, available at: *http://www.tricare.mil/dvpco/downloads/lvjvc/Day2-1045—JVConfVADODSpecialtyPanelIDES.ppt*

[10] U.S. GAO, Military and Veterans Disability System: Worldwide Deployment of Integrated System Warrants Careful Monitoring, GAO–11–633T (Washington, D.C., May 2011), 4.

[11] U.S Department of Veterans Affairs Budget Request for Fiscal Year 2013: Hearing Before the H. Committee on Veterans' Affairs, 112th Cong. (2012) (prepared statement of Hon. Eric K. Shinseki, Secretary, U.S. Department of Veterans Affairs).

The IDES Process

The IDES process, while differing in detail from service to service, begins with a servicemember's treating physician [12] or unit commander making a referral to a Medical Evaluation Board (MEB). That board, generally composed of medical care professionals, [13] evaluates the servicemember's injuries and ongoing treatment to determine if the Member is able to meet medical retention standards and return to full duty – and, if not, to make a recommendation (to a Physical Evaluation Board (PEB)) as to whether he or she is fit for continued service following medical treatment. From the start of the MEB referral, the servicemember is to be assigned a Physical Evaluation Board Liaison Officer (PEBLO) to help assist him/her throughout the IDES process. The PEBLO is responsible for assembling all the information included in the servicemember's DES case file: all medical records, test results, and exams performed for the MEB; letters from a servicemember's chain of command related to how the condition impacts duty; and other personnel records the MEB may require. [14]

The MEB does not conduct formal hearings, and the servicemember is not afforded the opportunity to appear before the board. If the MEB determines that a servicemember does not meet medical retention standards, it will forward that recommendation to a PEB. [15] The MEB results and recommendation are documented in a narrative summary (NARSUM) which becomes the single most important piece of evidence the PEB uses. After the servicemember receives the MEB's NARSUM, the PEBLO will review it with the servicemember. A servicemember may ask for an Independent Medical Review (IMR) and/or a Judge Advocate General (JAG) counselor to review the NARSUM to ensure it is fully developed and accurate. [16] The servicemember does have the opportunity to submit a rebuttal to be considered by the MEB. Far too often, in our view, the response to the rebuttal is "no changes accepted."

In the second phase of the process, the informal PEB (IPEB) will evaluate the servicemember's fitness for duty. Generally, the IPEB is comprised of three people, with a mix of military and civilian members, including at least one physician and one nonmedical officer. [17] Again, the servicemember does not attend this meeting. [18] Using the packet compiled by the PEBLO, the IPEB will review the medical records, the NARSUM, personnel evaluations, and letters from the commander and vote as to whether the servicemember is fit to continue service. [19] The PEBLO will then notify the servicemember of the findings of the IPEB. If the IPEB makes a determination of fitness, the servicemember has 10 calendar days to accept the decision and return to duty or offer a rebuttal and request a formal PEB. If the IPEB determines a servicemember is unfit, he/she has 10 calendar days to decide on a course of action; the options are (1) to accept the decision, (2) accept the decision but request a reconsideration of the VA disability rating, (3) offer a rebuttal and request a formal PEB, or (4) request both a formal PEB and reconsideration of the VA disability rating. [20] If a servicemember requests a formal PEB, he/she is allowed to appear before the board with legal representation. The formal PEB hearing must conduct a de novo review– all factual questions must be addressed as if for the first time. The formal PEB's decision may change from the IPEB. The formal PEB will then notify the appropriate service headquarters of its determination. Once service head-

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[12] A doctor is to refer a case to the MEB only upon satisfaction that all has been done medically to improve the condition(s). Department of Defense, Wounded, Ill and Injured Compensation and Benefits Handbook, October 2011, 17.

[13] Id. If a servicemember's condition includes a mental health condition, a mental health care provider should be on the panel, as well. Id.

[14] Id.

[15] If the MEB determines a servicemember does meet medical retention standards (or will be able to perform full duties within one year) the servicemember may return to duty.

[16] Walter Reed Army Medical Center PEBLO Office, Integrated Disability Evaluation System Quick Series Review Guide.

[17] DoD regulations list minimum requirements for PEB membership and leaves the exact determination of who sits on the board for each military department to decide. Department of Defense, Wounded, Ill and Injured Compensation and Benefits Handbook, October 2011, 18.

[18] Id.

[19] The PEB will determine a servicemember's disposition—return to duty, separation, or permanent or temporary retirement. Department of Defense, Wounded, Ill and Injured Compensation and Benefits Handbook, October 2011, 18.

[20] Walter Reed Army Medical Center PEBLO Office, Integrated Disability Evaluation System Quick Series Review Guide.

quarters receives the final PEB determination, the servicemember may be separated, medically retired, or returned to duty.[21]

A servicemember found to be unfit by the PEB will still receive two separate disability ratings under the new IDES process: (1) a rating by the PEB that evaluates only those conditions deemed to make the servicemember unfit for duty (which determines whether or not the servicemember will qualify for medical retirement and what benefits the servicemember is eligible to receive from DoD), and (2) a VA rating of all service-connected conditions (whether the conditions make the servicemember unfit for duty or not). Both the DoD and VA ratings are to be based on the VA Schedule for Rating Disabilities (VASRD).

IDES Goals versus IDES in Practice

In our view, IDES should be judged by reference to the goals it was to achieve – a less complex, non-adversarial system that operates more quickly and with greater transparency and consistency to provide a smooth transition to veteran status. Even today, however, our Wounded Warriors still encounter great difficulty in navigating a system they find to be highly complicated, difficult to understand, unnecessarily contentious, and often ponderously slow. We at WWP who have been representing these servicemembers see a serious lack of quality-control in a system often marked by inconsistent practices, decisions based on incomplete or inaccurate medical records, and wide variability in the reliability of information and advice furnished to servicemembers confronting difficult, life-changing circumstances.

Case Examples

The experiences of two warriors, with whom we at WWP have worked, illustrate the kinds of problems we're describing. In both instances, these warriors are at a sensitive stage of the process and requested that we omit reference to their names.

The Officer: The first, an Army officer sustained a penetrating head injury in Iraq. He has had a long remarkable rehabilitative journey, and his wife was by his side through the course of his painfully slow recovery. As he gradually regained lost function, the couple could begin to think and worry about the future. As she explained it, given her role as a full-time caregiver, his injury deprived two college-educated people of the ability to work. "Don't worry," he was told, "you'll be 100%; you'll be fine." That misplaced expression of confidence reflected a widespread misconception that inured soldiers would collect both retirement pay and VA disability compensation. But, as they ultimately learned—with VA compensation offsetting military retired pay – a 100% disability rating represented only 60% of his monthly military income. The couple faced a very confusing choice as to whether to elect to receive military retirement pay or Combat Related Special Compensation. Making a prudent decision required understanding the relationship between, and the calculations regarding, (1) DoD military retirement, (2) VA compensation, (3) VA special monthly compensation, and (4) DoD Combat Related Special Compensation. The couple came to realize that Army personnel who help the wounded navigate the system are not necessarily knowledgeable on the interrelationship between those financial pieces, and at times those advising them were not helpful. In fact, their JAG, finance office, and PEBLO gave the couple conflicting information on the critical point: would a wounded soldier receive both military retired pay and VA compensation concurrently? Each was unaware of how the above four compensation programs offset each other. Confusion on such a basic point of information highlights the dilemma facing servicemembers with often severe multiple injuries.

Not only are key decisions facing a warrior in the course of the IDES process confusing, but the information from which critical determinations are made is often incomplete or even inaccurate. In the officer's case, for example, the NARSUM failed to include any description of his day-to-day functional impairment, but simply set out a list of his medical conditions. Even at that, one of those conditions – loss of use of an arm – was omitted from this critical document. An Independent Medical Review was, in fact, critical of the NARSUM and included the reviewing physician's observation regarding a section listing residuals from TBI—

> *"[It] is hard to read and almost incomprehensible to the military physician: it is crucial to remember that these reports are intended for the audience of the*

[21] Id. If the Service member appeals the formal PEB findings, the appropriate military department considers the appeal and returns to duty, separates, retires, or assists the servicemember to complete an inter-Service transfer, if appropriate and approved. Under Secretary of Defense, Integrated Disability Evaluation System Directive-Type Memorandum 11–015, Dec. 2011.

PEB and servicemember. The writing should be unequivocal and precise, which is not the case here."

While the MEB accepted some of the officer's points of rebuttal, the Board did not rewrite the NARSUM, which was ultimately the basis of the PEB's determination.

While IDES was intended to foster a smooth transition, it is subject to troublingly disruptive pressures. For example, the Warrior Transition Unit to which the officer was assigned worked intrusively and applied pressure – to include harassing the PEBLO—to hurry the process along. Similarly, while the IDES process provides appeal rights, their experience was that the WTU actively discouraged him from appealing the PEB decision, as that would slow the process down. These weren't isolated experiences. Earlier in the course of his rehabilitation, the couple was subjected to pressure to sign papers that resulted in cutting short still-needed rehab care (against medical advice) and rushing him into the MEB process.

While IDES was designed to achieve greater timeliness, the officer's experience was but the officer's experience in that regard was of a heavy-handed military attempting to push him through prematurely where that early haste led to errors, culminating in a lengthy appeal process that was compounded by long delays in getting needed VA examinations.

This mature, college-educated couple's rough journey through the IDES process certainly calls into question how well a much less sophisticated young warrior with similar injuries and without expert representation might have fared.

The Master Sergeant: An Army Reserve Master Sergeant with a 24-year military career sustained multiple severe physical injuries, a traumatic brain injury, and developed chronic post-traumatic stress disorder after the Humvee under his command was hit by a roadside bomb in Iraq in 2005. This servicemember endured a long, rough road to recovery that included 26 surgeries and over a hundred medical procedures, and that (among other disabling conditions) resulted in loss of function in the dominant hand due to severed nerves.

Given the voluminous body of medical records that had been compiled by the time the MEB process was initiated in 2010, the Sergeant made sure to bring those records – which filled a large suitcase – to the meeting with the PEBLO and asked for the opportunity to review the MEB packet before it was forwarded to the Board. This packet was not made available for the Sergeant to review. Moreover, the VA physician who carried out the MEB physical exam had been provided only with a single medical record file, and even expressed frustration about the inability to conduct the physical exam properly without further records. Upon contacting the PEBLO about the missing medical records, the Sergeant was told, "if additional records are needed, the VA doctors will request them from the MTF."

In February 2011, the Sergeant received a 137-page NARSUM; despite its length, it omitted several service-connected conditions. The Sergeant was overwhelmed by having to review this very lengthy technical document in seven days. This was compounded by not being able to get a face-to-face meeting with the PEBLO. A JAG officer whom the Sergeant asked for help provided only a limited review of the case that didn't allay the concerns; an effort to secure additional JAG assistance at another installation was rebuffed. The Sergeant was later referred to another JAG officer, who seemed stretched thin with a large backlog of cases, but who did eventually assist in drafting a request for an independent medical review (IMR), but the IMR wasn't done because the PEBLO failed to accurately explain the IMR process to the local primary care Air Force doctor who was to conduct the IMR. An IMR was finally done in April 2011, but involved only a review of the NARSUM without any review of the Sergeant's medical treatment records, and resulted simply in upholding the flawed NARSUM. Although the extended process appeared to be nearing an end, the Sergeant was informed by the PEB doctor in July 2011 that disability ratings could not be completed without additional pictures of the injuries. It was only in January 2012 that the Sergeant got notice that VA had "recommended" a 100% rating but with a final decision deferred pending review of medical records regarding service-connection for other medical conditions. The adjudicative process was completed with assignment of a 100% rating 24 months after the Sergeant's unit commander requested MEB initiation.

Timeliness and Lack of Quality-Control

IDES was intended to improve the timeliness of the disability-evaluation process, but rather than realizing the 300-day goal for moving a servicemember through the

system, the process is apparently taking an average of nearly 400 days.[22] To assess IDES solely by reference to timeliness, however, is to overlook the dangers inherent in moving too quickly – and in doing so, foreclosing the servicemember from getting needed medical care and increasing the risk of prejudicial error. In fact, the IDES process is particularly vulnerable to what amounts to quality-control issues—incomplete examinations, examination reports that fail to include new diagnoses, incomplete or insufficient NARSUMs, and missing critical documentation. Such problems – sometimes attributable to pressures to move cases along – ultimately contribute to delay and adversely affect the ultimate disability rating determination. WWP often hears from warriors, especially those in Reserve and National Guard units, who cite long delays in the system, and of having to fight to get needed medical treatment.

Delays encountered during the MEB process can have a compound effect, resulting in medical exams "expiring" or no longer being accurate, requiring nurse case-managers and PEBLOs to order new exams. Too often warriors' medical and mental health conditions are incompletely diagnosed or not even assessed during medical exams, resulting in incomplete exam summaries and delays in needed care. As a result, examiners must take extra time to clarify the summaries, and in some cases, redo the exam.[23]

While substituting a VA evaluative medical examination for what had been duplicative separate DoD and VA exams under the legacy system was to have saved time, IDES has not eliminated sharp differences of view between the two departments.[24] On that point, my experience and that of others representing servicemembers is aptly captured by the following observations:

> *"The MEB places no value in the results of the VA examination. There are many cases in which VA has diagnosed PTSD and other conditions as moderate to severe, and the MEB disregards the findings and bases it on their own evaluation. MEB review of the Service Member's medical treatment records is also not thorough in many cases. The system is full of cases where the treating Psychiatrist and the Examining Psychiatrist at the VA are overruled by the Doctors on the MEB. Often the same thing is done in Orthopedic departments. VA documents the severity of the Service Member's disability by reference to its effect on a variety of normal daily activities including ability for exercise, sports and effect on a job. The MEB consistently disregards these findings and minimizes them in the so-called 'Consolidation of Inconsistencies.' What is obvious is that the MEB has reached a decision often prior to the VA examination and refuses to take the VA examination into proper consideration."*[25]

Given the MEB's mode of operation, the Board findings – documented in the NARSUM—are often flawed. While the NARSUM is the single most important document describing a warrior's physical and mental limitations, it is rarely fully developed, comprehensive, or accurate. Too often the MEB process either fails to identify and fully document in the NARSUM all of the warrior's medical conditions, or it minimizes them. It is particularly troubling, in this regard, that MEBs routinely fail to take the time to review a servicemember's complete medical records or to research those records in depth. In addition, the military seldom affords servicemembers the complete physical examination required by regulation.[26] By law, the armed forces are required to document all service-connected medical conditions, medically acceptable for a VA disability rating.[27] However, MEBs, in preparing the NARSUM, routinely fail to include the servicemember's medically acceptable conditions, and focus only on those conditions affecting the servicemember's ability to serve. The upshot of that narrow focus and resultant omissions is to make it more difficult for the servicemember to establish service-connection for disabilities that are incurred in service but simply not noted in the NARSUM. These failures

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[22] Seamless Transition: Improving VA/DOD Collaboration: Hearing Before the S. Veterans' Affairs Committee, 112th Cong. (2011) (statement of Hon. William J. Lynn, III, Deputy Secretary, U.S. Department of Defense).

[23] U.S. GAO, Military and Veterans Disability System: Worldwide Deployment of Integrated System Warrants Careful Monitoring, GAO–11–633T (Washington, D.C., May 2011), 7.

[24] Id.

[25] Interview with Jerry Johnson.

[26] "A complete physical examination must be recorded in the MEB." AR 40–400 (27 January 2010);

"The overall effect of all disabilities present in a soldier whose physical fitness is under evaluation must be considered." AR 635–40, sec. 3–1b.

[27] Under Secretary of Defense, Integrated Disability Evaluation System Directive-Type Memorandum 11–015, Appendix 8, Attachment 4, Dec. 2011; Department of Defense Instruction 1332.38, July 2006.

also have an impact "downstream" – increasing the number of appeals in the already- backlogged VA adjudication system.

In contrast to the many instances in which warriors experience long delays in moving through the MEB/PEB process, we see instances such as discussed above, where warriors are seemingly rushed through the process, many of them National Guard and Reserve members. These circumstances inevitably create problems ranging from incomplete treatment to erroneous disability ratings. WWP is working with several warriors who were referred to the MEB while still undergoing treatment or had developed new medical problems, and as a result received an incomplete NARSUM. In such instances, the MEB process should be delayed or stopped. All medical conditions should be diagnosed and treated before the MEB process even begins.

Dual-Adjudication Undercuts the Goal of a Timely, Streamlined System

One of the most critical barriers to a timely, streamlined system is that IDES retains the redundancy of a dual-adjudication process. Army Surgeon General, LTG Eric Schoomaker, in testifying before the Senate Appropriations Subcommittee on Defense, acknowledged that the system "remains complex and adversarial," and warriors "still undergo dual adjudication where the military rates only unfitting conditions and the VA rates all service-connected conditions."[28] At the same hearing, the then-Undersecretary of Defense for Personnel and Readiness described the ideal system as one that would produce "a single evaluation based upon one medical record."[29] Eliminating this redundancy would represent an important reform, but would not alone eradicate the range of problems warriors encounter in moving through the disability evaluation system. Substantive errors in decision-making go unaddressed in those many cases when the PEBLO assisting the warrior is not adequately trained and the warrior is either lacks representation or is not effectively represented.

IDES Leaves Too Many Ill-informed and Unrepresented

Generally, warriors and their family members are uninformed or do not understand the IDES process. The system's complexity leads some to become cynical, as in the case of one Wounded Warrior who commented, "they make it convoluted and you get so frustrated that you want to give up. I've never been as stressed out as I am in this process."[30] Servicemembers' lack of understanding of the process also contributes to flawed case-adjudication. With the failure to inform servicemembers at the outset of the MEB referral of the importance of their medical records and the need for supporting documentation, many are wholly unprepared for the challenge associated with establishing service-connection.

In theory, the military's assignment of a PEBLO to each servicemember undergoing the IDES process should close the information-gap. Beginning with an initial briefing before the servicemember's first physical examination for the MEB, the PEBLO's role is to inform the service-member of what to expect at various phases of the process, assist the servicemember in gathering medical information and documentation, and review the MEB and PEB determinations with the servicemember. The reality, however, is that some of these officers do not fully understand the system or have such large caseloads they can't provide each servicemember adequate instruction and assistance. While the nature of the process requires the PEBLO to maintain an ongoing flow of information to the servicemember, warriors often report that they rarely hear from their PEBLO. But even under the best of circumstances, the PEBLO acts as the servicemember's counselor and liaison, but that officer is not the servicemember's advocate before the MEB or PEB.

Servicemembers do have access to JAG representation[31], and some efforts have been made to provide training for the JAGs. In our view, however, there is wide variability in the level of expertise on IDES issues among JAGs, and certainly not enough JAGs have the necessary expertise. Servicemembers themselves often express reluctance to avail themselves of the assistance of a JAG officer, often based on the perception that a military/government lawyer may not represent their best interests.

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[28] Tom Philpott, "Disability Evaluation Reforms Seen Falling Short," Army Times, March 31, 2011.

[29] Id.

[30] Beldock

[31] In our experience, at least one JAG officer and a paralegal are stationed in the military treatment facilities to assist when MEBs take place.

Not only is the servicemember generally unrepresented but that individual is not afforded the opportunity to appear before the MEB to discuss his health status. Accordingly, the MEB's development of a narrative summary is based, and dependent, on the medical records available to the MEB, and its interpretation of those records. Lack of representation is especially problematic at the point that the servicemember receives the MEB determination, because the individual is given just seven working days to review and appeal the NARSUM before it is forwarded to the PEB for a determination of fitness, separation, or military retirement. This is an unreasonably limited period of time for an individual to obtain reliable advice or counsel, particularly in the often complex cases that involve multiple severe injuries, let alone enough time for many warriors to review and comprehend NARSUM findings and the significance of omissions or inaccuracies in that document. The servicemember has only an additional five days within which to seek an IMR to challenge the NARSUM before the case moves to the PEB, and is not afforded the option of providing evidence from a specialist of his/her own. In contrast, the IMR - generally performed by a physician under contract to DoD—is less than "independent," and is seldom a specialist able to address specific issues. In our experience, very few such reviews come back with any change in determination; yet our own reviews often show strong bases for an IMR to challenge the findings.

WWP's representation of growing numbers of Wounded Warriors through this process has highlighted problems under IDES, but has also led us to develop solutions. We offer the following recommendations in the belief that the IDES system can and must be materially improved, and urge this Committee to work with the Armed Services Committee to spur the Executive Branch to make needed changes.

WWP Recommendations

(1) Direct DoD and VA to provide (i) better instruction and outreach on IDES for warriors and their caregivers, and (ii) better instruction on IDES for warrior transition unit and other pertinent staff who work with warriors and their families and caregivers.

(2) Direct DoD to re-engineer, and institute quality-controls on, the "front-end" of the IDES process to—

(a) Provide procedures and safeguards to protect servicemembers, and particularly National Guard and Reserve members, from being pushed into and rushed through the MEB process.

(b) Ensure that the MEB process is not begun until optimum medical care has been provided and the servicemember's conditions have been diagnosed, and that such process will be deferred under circumstances where a significant new medical condition develops.

(c) Ensure that NARSUMs are fully developed and accurately document all service-connected medically acceptable conditions of a warrior, to include (i) requiring MEBs to review thoroughly all medical records, and (ii) providing opportunities for the servicemember to meet with the MEB.

(d) Allow ample time for a warrior to review his/her NARSUM with the assistance of an advocate and/or a medical provider (to include additional time for servicemembers with multiple, severe injuries).

(e) Provide substantially improved avenues for effective assistance to and representation of servicemembers undergoing physical and mental health disability evaluations, including expanding the number – and improved training—of PEBLOs and JAGs, and encouraging the use of certified veterans' service officers throughout the IDES process.

(f) Provide servicemembers the opportunity and sufficient time to obtain a review of the NARSUM and all pertinent medical records by a specialist(s) of the servicember's choosing, and the opportunity to present such specialist findings in rebuttal.

(3) Adopt the key recommendation of the Dole-Shalala Commission by establishing a single adjudication system with a single agency responsible for disability evaluation that would not only provide needed consistency, but help realize a more streamlined, timely process.

(4) Ensure leadership and oversight at the highest level to achieve the required system re-engineering and quality-control measures to realize the goals of IDES.

Conclusion

WWP believes that, whatever the injury, every warrior going through the IDES process should receive comprehensive medical treatment, full and fair adjudication

of their medical conditions and disability evaluation, and accurate compensation for service-related health conditions. Today, almost five years after a bipartisan commission called for streamlining the complicated disability evaluation system that so poorly served Wounded Warriors, the goals envisioned for that system have yet to be realized. WWP recognizes that VA and DoD staffs have devoted much time and effort to improving the disability evaluation process, but more must be done to produce a system worthy of our Wounded Warriors and the sacrifices they have made. We call for a re-engineering of IDES processes, and institutionalization of quality-controls along with continuing Congressional oversight, as the pathway to meeting this obligation to our warriors.

Reevaluating the transition from servicemember to Veteran: Honoring a shared commitment to care for those who defend our freedom

Overview of Wounded Warrior Project Testimony

The Integrated Disability Evaluation System (IDES) was intended to create: (1) a less complex, non-adversarial system; (2) faster, more consistent evaluations and compensation; (3) a single medical exam and a single-source disability rating; and (3) a smooth transition to veteran status. In large part, those critically important goals have yet to be achieved. While VA has done its part, DoD still has much work to be done.

DoD must address both structural and operational problems in the IDES. These include: (1) artificial timelines that create pressures to prematurely push servicemembers into the medical-evaluation process and result in their being rushed through the Medical Evaluation Board (MEB) process; (2) an MEB process that relies on reviewing only partial and often-incomplete medical records (and does not even meet with the servicemember) to produce an often-incomplete and inaccurate narrative-summary, which is the most critical evidence considered by the final decisional authority; (3) resultant errors in the narrative summary that make it more difficult ultimately to establish service-connection and that have the effect of increasing the number of appeals in an already clogged VA adjudication system; (4) lack of sufficient time for the servicemember to understand and challenge the content or accuracy of that decision document; (5) lack of a meaningful mechanism for the Member to secure a truly independent medical review of key decision documents; and (6) wide disparity in the extent of effective assistance and representation of members in the IDES process.

We urge the Committee to work with the Armed Services Committee to spur the Executive Branch to make needed changes. Among those recommendations, we urge that DoD be directed to *re-engineer* and institute *quality-controls* on the "front-end" of the IDES process. Among those needed steps, DoD must provide safeguards to protect servicemembers from being pushed into and rushed through the MEB process. That process should not begin until optimum medical care has been provided and the servicemember's conditions have been diagnosed. System changes are badly needed to ensure that narrative summaries are fully and accurately developed, to include requiring MEBs to review thoroughly *all* medical records, and provide opportunities for the servicemember to meet with the MEB. Servicemembers also need more time to review the MEB summary, and need greater access to effective representation and assistance, as well as the opportunity to have the summary reviewed by a specialist of the servicemember's choosing.

WWP recognizes that VA and DoD staffs have devoted much time and effort to improving the disability-evaluation process, but more must be done to produce a system worthy of our Wounded Warriors and the sacrifices they have made. We call for a re-engineering of IDES' processes, and institutionalizing quality-controls along with continuing Congressional oversight as the pathway to meeting the obligation owed our warriors.

Prepared Statement of Eric Greitens, Phd

Mr. Chairman and Members of the Subcommittee, thank you for the opportunity to testify this morning as the Founder and CEO of The Mission Continues. The Mission Continues challenges veterans to serve and lead in communities across America.

We believe that any system that is designed to create successful transitions for veterans, will only work if veterans are first recognized for the immense abilities that they bring back to their communities. We have learned that by focusing on

these strengths, despite some of the most severe disabilities, we can facilitate successful transitions from warrior to citizen.

As a Navy SEAL, I served four tours in the Global War on Terrorism. On my last deployment in Iraq, my unit was hit by a suicide truck bomb. I was treated at the Fallujah surgical hospital and returned to full duty 72 hours later, but some of my friends - some of whom were standing an arms length from me - were hurt far worse than I was.

When I returned home, I visited them and went to Bethesda Naval Hospital to visit other wounded Marines. As all of you know, when you meet with our wounded servicemembers, you are often talking with young men and women, the balance of their lives still before them. I asked each of them about their units, their hometowns, their deployments, and when I asked, "What do you want to do when you recover?" Each one of them said, "I want to return to my unit." Their bodies had been injured, but their spirit of service had endured.

My experience at Bethesda that day was not unique. In a recent survey of post-9/11 veterans, 92% strongly agreed or agreed that serving their community is important to them.

At The Mission Continues we create successful transitions by engaging returning veterans to continue their service by engaging them in six-month fellowships at nonprofit and public service organizations in their communities: an Army specialist from the 82nd Airborne now trains service dogs for the disabled; a Marine Corps sergeant now builds home with Habitat for Humanity; an enlisted airman who now serves her fellowship as a support attendant at a women's shelter. During their Fellowships, our veterans are provided with stipends, mentors, and broad curriculum to achieve one of three post-Fellowship goals. They go on to full-time employment, full-time education, or participate in an ongoing role of service in their communities. To date, we have awarded Fellowships to 255 post-9/11 veterans, who have served with 168 organizations across the country.

For example, in Mississippi County, Anthony Smith served his Fellowship working with under-privileged youth. In 2004, Anthony was serving as a major in the Army when he was hit by a rocket-propelled grenade. After spending 64 days in a medically induced coma, he awoke to find that he was blind in one eye, had lost his right arm underneath the elbow, and that parts of his leg, hip and spinal cord were damaged. Like many of the veterans that we work with, his transition was difficult, and he started to doubt whether or not he was needed here at home.

After Anthony became a Mission Continues Fellow, he found a renewed sense of purpose. Through his Fellowship, Anthony is using martial arts to mentor at-risk youth. Daily, dozens students from his community enter Anthony's dojo. Using pushups, modeling patience, and teaching self-control, Anthony teaches lessons in his community everyday.

In two independent research reports, the George Warren Brown School of Social Work at Washington University has found that nearly 80% of the participants in our program felt that serving in the community had a positive effect on their future employability, performance, and promotion, or that it instigated them to make a career change. In fact, 86% of participants reported transferring their military skills to civilian employment and 100% of Fellows reported that they will probably or definitely stay involved in volunteer activities and public service in the future.

Mr. Chairmen and Members present, the story of this generation of veterans is still being written. We have a tendency to rely on PTSD figures, unemployment statistics, and suicide rates to tell us how our veterans are transitioning from the military to civilian life. But these statistics do not tell the whole story. These statistics do not capture a veteran's desire to continue to serve and the willingness to lead in communities upon their return.

They do not tell the story of Jake, a former Marine who now coordinates rescue missions to international disasters; or April, the Army veteran from Chicago, who serves as a mentor to refugee children in the classroom. Across America, veterans are serving again. In fact, the majority of the members in this Committee have Mission Continues Fellows serving in their district or neighboring districts. And last year, with our Fellows as examples, The Mission Continues engaged over 15,000 Americans to spend a day of service with veterans in their communities. Our Mission Continues Fellows are enduring leaders who have overcome pain and turned it to wisdom. They are veterans whose commitment to our country did not end on the battlefield.

In order for veterans to transition successfully, communities across America must begin to recognize the service they still have to give. We believe that when the story of this generation of veterans is written, it will not only be a story of the wars they have fought overseas; it will also be a story of the homes built, the parks restored, the young minds engaged by veterans whose mission continues here at home.

Mr. Chairman, we are grateful for your support and the support of this Subcommittee. I would welcome any questions that you or other Members may have. Thank you.

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