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ONE YEAR AFTER WALTER REED: AN INDEPENDENT ASSESSMENT OF THE CARE, SUPPORT, AND DISABILITY EVALUATION FOR WOUNDED SOLDIERS

HEARING

BEFORE THE

SUBCOMMITTEE ON NATIONAL SECURITY AND FOREIGN AFFAIRS

OF THE

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

SECOND SESSION

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ONE YEAR AFTER WALTER REED: AN INDEPENDENT ASSESSMENT OF THE CARE, SUPPORT, AND DISABILITY EVALUATION FOR WOUNDED SOLDIERS

WEDNESDAY, FEBRUARY 27, 2008

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

The subcommittee met, pursuant to notice, at 2:05 p.m. in room 2157, Rayburn House Office Building, Hon. John F. Tierney (chairman of the subcommittee) presiding.

Present: Representatives Tierney, Lynch, McCollum, Hodes, Shays, Platts, and McHenry.

Staff present: Dave Turk, staff director; Andrew Su, professional staff member; Davis Hake, clerk; Andy Wright, counsel; Grace Washbourne and Janice Spector, minority senior professional staff members; Nick Palarino, minority senior investigator and policy advisor; Benjamin Chance, minority clerk; and Mark Lavin, minority Army fellow.

Mr. TIERNEY. A quorum being present, the Subcommittee on National Security and Foreign Affairs will commence.

This hearing is entitled, "One Year After Walter Reed, An Independent Assessment of the Care, Support, and Disability Evaluation for Wounded Soldiers," because we always think of such great titles for our hearings.

I ask unanimous consent that only the chairman and ranking member of the subcommittee be allowed to make opening statements. Without objection, that is so ordered.

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

I want to thank all of you for being here today. About a year ago, as we all recall, we saw that shocking exposé in the Washington Post that revealed appalling conditions and unacceptable treatment of soldiers and their families at Walter Reed, located just a few miles from here in Washington, DC.

The stories about what those injured heroes endured after coming home from Iraq and Afghanistan obviously ignited a public outcry and brought to light hundreds of revelations of similar frustra-

tions and disrespect faced by our injured soldiers and their families.

This subcommittee chose to hold the very first oversight hearing that it had this session on that topic, and we chose to do so on the grounds of Walter Reed, itself, in full view of the soldiers recovering there.

During the course of the year, we have had two other subcommittee hearings, one full committee hearing, and countless briefings and interviews, and during that time we have learned about a maze of complex bureaucracies and hurdles that face patients and their families.

I want to thank all the people who are here today, as well as others, for assisting us with those hearings and briefings and the interviews that we have had. It has been enormously helpful, and I know it is sometimes difficult or burdensome on you, but the only way we can work together on this is if we have that sharing of information, and we appreciate your openness on that, as well as your understanding that the spirit of this entire oversight is a jointly shared goal that we have of improving how this system works.

We have learned about the enormous challenges the soldiers face with traumatic brain injury and post-traumatic stress disorder. We have learned about an archaic, adversarial, and burdensome disability evaluation process. At least that is how many of the people going through it expressed their understanding to us.

Since last February we have also had a host of congressional, White House, Army, Defense Department, Veterans Affairs, and independent commissions and investigations urging a variety of reforms. If past is prologue, none of the work by these groups will mean anything unless there is the political will and the resolve to fundamentally improve the system and to make difficult choices that are necessary to actually implement some of the most wide-ranging recommendations.

Let me be the first to say that much has been done over the past year to improve the military health care system. I think the Government Accountability Office report is going to reflect that, as well, and the public should know that there was great energy and intensity put on this by the Army, in particular. The Army has increased staff, as one example, by nearly 75 percent. I think that is commendable.

But, unfortunately, I think we all recognize it is equally clear that we have a ways to go. So today we are going to hear from the top directors of the Government Accountability Office on their independent assessment of where things currently stand with respect to providing those warriors and their families the care and support they have earned and that they deserve.

The spirit of the GAO's extensive and independent analysis, as well as this oversight more generally, is best captured, I hope, by General Schoomaker's testimony. I am going to quote out of that, General, if you will permit me. You note, "We know that there are obstacles and bureaucracies that still must be overcome. We continue to face challenges that require blunt honesty, continuous self-assessment, [and] humility. . . ." Certainly humility is one thing we have all learned from this process, but we are grateful that you

have been gracious in continuing the self-assessment and the bluntness.

What we are trying to do here today is provide that independent assessment and robust critique in the spirit of fairness and sustained and constructive oversight. I am a firm believer that sustained oversight can be a powerful tool to ensure that the needed reforms are actually implemented this time around and to meet the long-term needs of growing yet diverse populations of wounded soldiers who are likely going to be in the VA system for a good part of their remaining lives.

In a few minutes the Government Accountability Office will fully lay out what they found, but I want to take just a few minutes to highlight some things.

First, according to the GAO, achieving adequate staffing levels continues to pose difficulties, particularly for the so-called PEBLOs, whose job it is to help soldiers navigate through the confusing disability evaluation process.

Moreover, borrowing from other units to fill key positions and utilizing JAG officers rotating in and out from the Reserve component strike me as only temporary fixes. Our wounded soldiers need long-term, permanent solutions, and if any link in the support chain is weak, then the whole model cannot succeed. Once again, it is the wounded soldiers and their families who will suffer.

Second, if there is ever a time when we are actually going to be able to fundamentally fix the overly complicated and adversarial disability evaluation system, it seems to be now. There have been complaints about the disability evaluation system for decades, but over that period of time we have not done enough. If we don't take advantage of this unique opportunity now to fundamentally fix the system, I am concerned that 5 years from now we will still be wringing our hands and saying we had an opportunity to act and did not.

That is why the GAO's testimony about their concerns with respect to the joint Defense Department/Veterans Administration pilot program is so important. We need to make sure this pilot has been created, is being rolled out, and is being evaluated in absolutely the best manner.

But the GAO today will share concerns, among others, about the lack of a control group and transparent criteria to assess the success of the pilot and to evaluate whether to expand it to other facilities.

We will hear all these concerns expressed in greater detail in a few moments, and I hope our executive branch decisionmakers present today will take them seriously and view them as constructive. If the past is any indication, I am sure you will.

Our goals are the same: we want to take care of our wounded soldiers. We want to give them and their families the utmost respect. We want to ensure that these heroes have the best quality of life possible for the rest of their lives.

Just because the 1-year anniversary of Walter Reed stories is passing, it does not mean that we should take our eye off the ball. This subcommittee, for one, certainly will hold additional hearings as long as is necessary to continue to monitor this administrations'

progress and subsequent administration's progress and continue to ask all the questions that need to be asked.

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

Statement of John F. Tierney
Chairman
Subcommittee on National Security and Foreign Affairs

"One Year after Walter Reed: An Independent Assessment of the Care, Support, and Disability Evaluation for Wounded Soldiers"

February 27, 2008

Good afternoon, and thank you all for being here today.

One year ago, a shocking exposé in the Washington Post revealed appalling conditions and unacceptable treatment of soldiers and their families at Walter Reed Army Medical Center, located just a few miles from here in Washington, DC. The stories about what our injured heroes endured after coming home from Iraq and Afghanistan ignited a public outcry, and brought to light hundreds of revelations of similar frustrations and disrespect faced by other injured soldiers and their families.

This Subcommittee chose to hold our very first oversight hearing of the session on this vital topic, and we chose to do so on the grounds of Walter Reed itself in full view of the soldiers recovering there. This all took place one year ago.

Over the course of the year – and two other Subcommittee hearings, one full Committee hearing, and countless briefings and interviews – we've learned about the maze of complex bureaucratic hurdles facing patients and their families. We've learned about the enormous challenges soldiers face with Traumatic Brain Injury – TBI – and Post-Traumatic Stress Disorder – PTSD. And we've learned about the archaic, adversarial, and burdensome disability evaluation process.

Since last February, we've also had a host of Congressional, White House, Army, Defense Department, Veterans Affairs, and independent commissions and investigations urging a variety of reforms. If past is prologue, none of the work by these groups will mean anything unless there is the political will and resolve to fundamentally improve the system and to make the difficult choices necessary to actually implement some of the most wide-ranging recommendations.

Let me be the first to say that much has been done over the past year to improve military health care. The military services – and the Army in particular – have approached these challenges with great energy, resources, and manpower. The Army, for example, has increased key staff by nearly 75 percent.

But let me be equally clear – much work remains.

We will hear today from top directors of the Government Accountability Office on their independent assessment of where things currently stand with respect to providing our wounded warriors and their families the care and support that they have earned and that they deserve.

The spirit of the GAO's extensive and independent analysis – as well as the oversight more generally by this Subcommittee – is best captured, I hope, by something, General Schoomaker included in his written testimony. General Schoomaker, you note, and I quote, "We know that there are obstacles and bureaucracies that still must be overcome. We continue to face challenges that require blunt honesty, continuous self-assessment, [and] humility...."

What we're trying to do here today is to provide you all an independent assessment and a robust critique in the spirit of fair, sustained, and constructive oversight. And I am a firm believer that sustained oversight can be a powerful tool to ensure that needed reforms are actually implemented this time around and to meet the long-term needs of a growing, yet diverse, population of wounded soldiers who will likely be in the VA system the rest of their lives.

In a few minutes, the GAO will fully lay out what they've found. I want to take just a few minutes now to highlight a few things.

First, according to the GAO, achieving adequate staffing levels continues to pose difficulties, particularly for the so called PEBLOs whose job it is to help soldiers navigate through the confusing disability evaluation process. Moreover, borrowing from other units to fill key positions and utilizing JAG officers rotating in and out from the reserve component strike me as only temporary fixes. Our wounded soldiers need long-term, permanent solutions. If any link in the support chain is weak, then the whole model cannot succeed, and once again, it is the wounded soldiers or their families who will suffer.

Second, if there's ever a time when we're actually going to be able to fundamentally fix the overly-complicated and adversarial disability evaluation system it has to be now. There have been complaints about the disability evaluation system for decades, yet not much has been done. If we don't take advantage of this unique opportunity now to fundamentally fix the system, I worry that all of us will be shaking our heads five or ten years from now at the missed opportunity.

That's why the GAO's testimony about their concerns with respect to the joint Defense Department / VA pilot program is so important. We need to make sure this pilot was created, is being rolled out, and is being evaluated in absolutely the best manner. But the GAO today will share concerns, among others, about the lack of a control group and of transparent criteria to assess the success of the pilot and to evaluate whether to expand it to other facilities.

We will hear all of these concerns expressed in greater detail in a few minutes, and I hope our Executive Branch decision-makers present today will take them seriously and view them as constructive. Our goals are the same – to take care of our wounded soldiers, to give them and their families the utmost respect, and to ensure that these heroes have the best quality of life possible for the rest of their lives.

Just because the one-year anniversary of the Walter Reed stories is passing, it does not mean that we should take our eye off the ball. This Subcommittee, for one, certainly will hold additional hearings for as long as is necessary; to continue to monitor the Administration's progress and to continue to ask all the questions that need to be asked.

I now yield to the Ranking Member of the Subcommittee, Congressman Shays, for his opening remarks.

Mr. TIERNEY. I yield now to the ranking member of the subcommittee, Congressman Shays, for his opening remarks.

Mr. SHAYS. Thank you, Mr. Chairman.

Mr. Chairman, if I could, I would like to submit for the record the statement of the ranking Republican member of the full committee, Tom Davis.

Mr. TIERNEY. Without objection, so ordered.

Mr. SHAYS. Thank you, Mr. Tierney, for your unwavering commitment to this subcommittee's ongoing bipartisan inquiry into the administration of medical care for our injured men and women returning from war. I commend you for your continued commitment to holding hearings and keeping the light of oversight on the Federal departments and responsibility for the care of our military wounded.

Hearings have taught us well the many challenges that face our wounded warriors under a system that was not planned to give them the support, service, and treatment they need and have earned, so here we are again today with the Departments of Defense and Veterans Affairs witnesses to take stock of what has been accomplished to date and what still remains to be done.

Secretary Dominguez, Secretary Dunne, we look forward to hearing what the joint Department of Defense/Department of Veterans Affairs Senior Oversight Committee has accomplished since our hearing last September. We look forward to learning what you have done to carry out the recommendations contained in the President's Commission on Care for America's Returning Wounded Warriors, commonly known as the Dole-Shalala Commission.

General Schoomaker, congratulations on your promotion to Surgeon General of the Army. On TV today I still said you were in charge of Walter Reed Hospital, but, at any rate, congratulations on being Surgeon General. Your help with individual soldiers that have come to this committee for assistance has made a difference. We hope you are able to carry this dedication to the individual when you implement the policies of the Army medical action plan throughout the Army bureaucracy.

The true test of what we are trying to accomplish with sweeping process changes, new dedicated personnel and training, and new forms of evaluation and treatment is to better serve the individual wounded soldier. If we do not keep the individual in mind, I feel we will be here again still looking for solutions that work.

A year ago, Walter Reed Army Medical Center became a symbol of dysfunction. Today we look for a detailed accounting of what has been done not only to correct the problems there, but at all medical treatment facilities. Are the new standards of care that have been put into place working? Has service to our wounded and their families improved in their eyes? We look for the Department of Army and the Department of Defense to tell us what system of oversight they have in place to monitor whether or not every facility and every soldier is able to partake of the new programs and services.

Along with Mr. Davis, Mr. Tierney, and Mr. Waxman, I still hold deep reservations about whether or not the Department of Army, the Department of Defense, and the Department of Veterans Affairs initiatives and programs are mindful of the unique needs of the Reserve components. Two weeks ago, Veterans Affairs Sec-

retary Peake told Congress that his Department had not done enough for the National Guard and Reserve in the area of mental health treatment. We look forward to hearing what the Department is going to do to change that.

Although the rate of suicide among returning troops is no higher than other groups of that age, it is shocking to hear that the rate of suicide among returning Guard and Reserves is at a higher percentage than active duty soldiers, which make up a large number of those deployed.

As for the Department of Defense and the Department of Army, I know congressional appropriations are being used to fund new personnel at medical treatment facilities, but, unfortunately, there is a lack of inclusion in funding for mental health directors and transition assistance advisors that serve the members of the National Guard when they return home.

Now pre and 30, 60, and 90-day post-deployment mental health evaluations for the National Guard are only of value if there are trained and competent personnel available in their State administrative headquarters to help secure treatment and other benefits needed for recovery and transition into community and home life.

Today we will hear recruiting and retaining health care personnel is problematic, but I am also concerned about whether all caregivers and administrators are receiving comprehensive training. The process, both old and new, is still vastly convoluted and lacks the connectivity that supports real patient service oriented change.

We will also hear about an update on a new disability evaluation system pilot. Can we completely restructure the disability and compensation systems of the Army, Navy, Air Force, and Marine Corps, the Department of Defense, and the Department of Veterans Affairs to better serve our Nation's military heroes and veterans? And to what effect? Is joint medical evaluation system streamlining, or is it just creating a bigger bureaucracy between two departments? And which department will be responsible if something goes wrong? How successful have DOD and VA been in sharing essential data?

The Government Accountability Office has reported that these departments have been working for almost 10 years to facilitate the exchange of information without success. What has been done in the last year that has been different from past attempts? As long as paper is still part of the process, errors and time lags will cause problems for the wounded and their families.

Of all the Dole-Shalala Commission recommendations, this integration will require a greater deal of cooperation and continuous dedication of resources.

We look forward to hearing from our Government Accountability Office witnesses on current Federal Governmental efforts to address how our wounded warriors are treated. The value of their independent assessment cannot be over-stated.

The President wants the Dole-Shalala recommendations implemented within a year. I know this subcommittee is committed to ensuring the Federal Government properly cares for our wounded veterans and that this care stays a priority until every person treated can say, I answered my country's call, and when I was wounded my country answered my call for help.

Thank you, Mr. Chairman.

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

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM
TOM DAVIS, RANKING MEMBER
http://republicans.oversight.house.gov

News Release

Statement of Ranking Member Chris Shays on Subcommittee Hearing "One Year After Walter Reed: An Independent Assessment of the Care, Support and Disability Evaluation for Wounded Soldiers"

Hearing of the National Security and Foreign Affairs Subcommittee

February 27, 2008

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The true test of what we are trying to accomplish with sweeping process changes, new dedicated personnel and training, and new forms of evaluation and treatment is to better serve the individual wounded soldier. If we do not keep the "individual" in mind, I fear we will be here again, still looking for solutions that work.

A year ago, Walter Reed Army Medical Center became a symbol of dysfunction. Today, we look for a detailed accounting of what has been done not only to correct the problems there, but at all medical treatment facilities.

Are the new standards of care that have been put into place working? Has service to our wounded and their families improved in their eyes? We look for the Department of the Army and the Department of Defense to tell us what system of oversight they have in place to monitor whether or not every facility and every soldier is able to partake of the new programs and services.

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Two weeks ago, Veterans Affairs Secretary Peake told Congress that his Department had not done enough for the National Guard and Reserve in the area of mental health treatment. We look forward to hearing what the Department is going to do to change that.

Although the rate of suicide among returning troops is no higher that other groups, is it shocking to hear that the rate of suicide among returning Guard and Reserve is at a higher percentage than active duty soldiers, which make up a larger number of those deployed.

As for the Department of Defense and the Department of the Army, I know congressional appropriations are being used to fund new personnel at medical treatment facilities, but unfortunately there is a lack of inclusion and funding for mental health directors and transition assistance advisors that serve the members of the National Guard when they return home.

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Is a joint medical evaluation system streamlining or is it just creating a bigger bureaucracy between two departments, and which Department will be responsible if something goes wrong?

How successful has DoD and VA been in sharing essential data? The Government Accountability Office has reported that these departments have been working for almost 10 years to facilitate the exchange of information without success. What has been done in the last year that has been different from past attempts? As long as paper is still part of the process, errors and time lags will cause problems for the wounded and their families.

Of all of the Dole/Shalala Commission recommendations, this integration will require a great deal of coordination and continuous dedication of resources.

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The President wants the Dole/Shalala recommendations implemented within the year. I know this Subcommittee is committed to ensuring the federal government properly cares for our wounded veterans, and that this care stays a priority until every person treated can say: "I answered my country's call, and when I was wounded, my country answered my call for help."

Thank you.

Mr. TIERNEY. Thank you, Mr. Shays.

Now the subcommittee will receive testimony from the witnesses that are before us today.

I want to begin by introducing our witnesses. First, we have two top directors from the Government Accountability Office, Mr. John Pendleton, who is the Acting Director of the Health Care Team, and Mr. Daniel Bertoni, who is the Director of the Education, Workforce, and Income Security Team.

The subcommittee thanks you and everyone working on your staffs for the enormous lift that was done to get this work. We appreciate all the research and the conscientious work that went into it. It took a considerable amount of talent and travel and conversation with families and with injured soldiers, as well, so we really, truly appreciate that.

We also welcome key officials from the Army, Defense Department, and Department of Veterans Affairs. Lieutenant General Eric V. Schoomaker, M.D., the Army Surgeon General and Commander of the U.S. Army Medical Command. General Schoomaker is accompanied today by Brigadier General Reuben Jones, the Adjutant General of the Army.

Michael Dominguez is the Principal Deputy Under Secretary of Defense for Personnel and Readiness for the U.S. Department of Defense.

And Rear Admiral Patrick Dunne, Retired, is the Assistant Secretary for Policy and Planning at the U.S. Department of Veterans Affairs.

Your work and dedication on behalf of all of our men and women in uniform is greatly appreciated. I want to particularly thank General Schoomaker and Admiral Dunne for changing your plans to accommodate our hearing schedule today. I know it is inconvenient, but we greatly appreciate it.

It is the policy of the subcommittee to swear in all of our witnesses before they testify, so I ask you to rise please and raise your right hands.

[Witnesses sworn.]

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

I can tell you that all of your written statements in their entirety will be placed into the hearing record, so you needn't feel compelled to repeat them word-for-word. We do offer 5 minutes for our witnesses oral statements.

Mr. Pendleton and Mr. Bertoni, I know that you are going to be making a joint statement, so you may want to take some license with that and go a little bit over. And I understand there was some talk about a joint statement from some of the other witnesses, but now people are going to take their individual time, and we are pleased with that. We want to hear everything that you have to say.

Mr. Pendleton, why don't we start with you and Mr. Bertoni, please.

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

JOINT STATEMENT OF JOHN PENDLETON AND DANIEL BERTONI

Mr. PENDLETON. Mr. Chairman, Mr. Shays, and members of the subcommittee, thank you for inviting us to testify before you today as you continue your oversight of efforts to improve care for service members who are hurt or fall ill while in service to our country. Our work has continued since our testimony this past September. That work is still ongoing, but we are pleased to provide you with some interim observations today.

Our oral statement will be in two parts. First, I will take a moment to update you on the Army's efforts to improve warrior care. Then my colleague, Dan Bertoni, will describe our ongoing assessment of efforts to improve the disability evaluation processes at DOD and VA.

We have submitted a combined written statement for the record.

First, an update on the Army. Mr. Chairman, I am pleased to report to you that the Army has made progress in the 5-months since our September 2007 testimony. Challenges remain, but the trends are in the right direction.

As the centerpiece of its medical action plan, the Army has established warrior transition units at more than 30 locations to help service members and their families through what is often an extraordinarily difficult time. When we testified in September, the Army had filled roughly half of the key positions authorized for those warrior transition units. The Army still needed many highly sought-after medical personnel like doctors and nurses, as well as enlisted leaders from an Army already stretched thin by operations in Iraq and Afghanistan.

Early this year the Army declared that its warrior transition units had reached full operational capability. This meant that senior commanders reported that the units had sufficient personnel and other resources to perform the key tasks assigned to them.

The Army's assessment is encouraging, but a closer look reveals some challenges.

First, about a third of the locations still have staff shortfalls in the warrior transition units. Most are minor, only one or two staff needed at a location. But some are more significant.

Also, to meet their growing needs in the short term, the Army is still relying on borrowed staff to fill the warrior transition units.

About one in five staff are temporarily borrowed from other units today, and this proportion has changed little actually since we testified in September.

Another challenge is the 2,500 injured or ill soldiers who are eligible for the warrior transition units but have not yet been assigned to one. This is a complicated and fluid calculus for the Army. Because these personnel are outside the warrior transition unit, they are not considered when the Army identifies its staffing shortfalls. Including them would magnify the staffing challenge, because at some locations these personnel represent 40 percent or more of the total warriors in transition there. This group is at risk of getting lost in the shuffle as they attempt to navigate a still confusing disability process, which Dan will discuss in a moment.

Finally, Mr. Chairman, I had hoped to be able to report to you about outcomes; for example, whether all of these efforts have translated into more satisfied soldiers and families. Until the Army obtains more reliable information, however, it will be difficult to adequately gauge the overall progress of their efforts.

Mr. Chairman, that concludes my statement. Thank you. I will turn it over to Dan.

Mr. TIERNEY. Thank you, Mr. Pendleton.

Mr. Bertoni.

Mr. BERTONI. Mr. Chairman, members of the subcommittee, good afternoon. I am pleased to be here to discuss efforts to meet the critical needs of America's wounded warriors. Thousands of service members have been wounded in Iraq and Afghanistan, and many are now navigating the complex and confusing disability process. In September we testified that overhauling the disability evaluation system was key to the reintegration and productive capacity of service members with disabilities. My testimony today draws on our ongoing work for this subcommittee and focuses on two key areas: current efforts to improve the process, and challenges to further progress.

In summary, DOD's and VA's disability programs have been plagued by longstanding problems. In following the unfortunate events at Walter Reed, the Army developed several near-term initiatives to increase supports for those in the disability system. To address underlying systemic issues, DOD and VA currently are piloting a joint disability evaluation system with an emphasis on reengineering the process for the longer term.

To alleviate current pressures, the Army has established an average case load target of 30 service members per Physical Evaluation Board Liaison [PEBLO], and increased hiring by 22 percent. The Army has met its goal at 24 of 35 treatment facilities. The Army is also increasing the number of attorneys and paralegals to meet increasing service member demands, and has established and mostly met its goal of one Medical Evaluation Board physician for every 200 service members in the system.

The Army also reports increasing education and outreach, revising the informational guidance and handbooks, and developing a Web-based tool for soldiers to track their claims.

Despite these many efforts, real challenges remain, especially in regard to hiring staff to help service members navigate the disability process. While average PEBLO caseloads have improved, the

Army has not met its goal of 30 service members per liaison. Eleven of thirty-five treatment facilities continue to face staffing shortages, and over half of all service members currently in the evaluation process are located at these same facilities.

The Army has also noted that the current number of legal personnel are insufficient to provide support during both the physical evaluation and Medical Evaluation Boards.

While the Army plans to hire additional legal staff, current Government hiring policies and Army rotation policies could impede its ability to maintain staff within in-depth knowledge of complex disability issues.

Finally, despite having mostly met its goal for Medical Evaluation Board physicians, some physicians are having difficulty managing their workloads due to the increasing volume of cases with multiple injuries and complex conditions such as TBI and PTSD.

Regarding the pilot, DOD and VA conducted a tabletop exercise using 33 previously decided service member cases to evaluate four potential options. In November 2007 the pilot, which includes a comprehensive medical exam and a single VA disability rating, was rolled out in three Washington area locations. DOD and VA selection approach followed a predetermined selection methodology, captured a broad range of metrics, and involved a number of expert stakeholders. While the exercise yielded sufficient information to select the pilot option, it required some tradeoffs in data collection and analysis that could have implications down the road.

For example, the small, judgmental sample of cases selected was not statistically representative of each military service's workloads, and a larger, more representative sample could have yielded different outcomes.

Further, a key selection variable, expected service member satisfaction, was based on input from pilot officials rather than input from service members, themselves.

While the pilot is expected to last 1 year, officials may expand it to more sites outside the Washington area prior to that time. However, very few cases will have gone through the entire process at this and other critical junctures, and the agencies will have limited data to guide their interim decisions.

Further, current evaluation plans lack key elements such as the criteria for determining how much improvement and timeliness or consistency would justify full expansion, a method for measuring the policy impact compared to the current process, and an approach for measuring service member satisfaction. All of these elements are critical to identifying problem areas or issues that could limit the effectiveness of any new system.

Going forward, it is important that focused attention be placed on the challenges discussed today. For the Army, sustained attention to addressing key staffing and workload imbalances, and continued efforts to enhance the efficiency and transparency of the process is essential. For the pilot, more transparent articulation of the data that will be available at key junctures, and the criteria that will guide decisions on future expansion or modification is needed. Absent such an approach, the performance and credibility of any redesigned system could be in jeopardy.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions that you may have.

Thank you.

[The prepared joint statement of Mr. Pendleton and Mr. Bertoni follows:]

United States Government Accountability Office

GAO

Testimony

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

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DOD AND VA

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

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

Statement of John H. Pendleton, Acting Director
Health Care

GAO-08-514T

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Highlights

Highlights of GAO-08-514T, a testimony before the Subcommittee on National Security and Foreign Affairs, Committee on Oversight and Government Reform, House of Representatives

February 27, 2008

DOD AND VA

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

Why GAO Did This Study

In February 2007, a series of *Washington Post* articles about conditions at Walter Reed Army Medical Center highlighted problems in the Army's case management of injured servicemembers and in the military's disability evaluation system. These deficiencies included a confusing disability evaluation process and servicemembers in outpatient status for months and sometimes years without a clear understanding about their plan of care. These reported problems prompted various reviews and commissions to examine the care and services to servicemembers. In response to problems at Walter Reed and subsequent recommendations, the Army took a number of actions and DOD formed a joint DOD-VA Senior Oversight Committee.

This statement updates GAO's September 2007 testimony and is based on ongoing work to (1) assess actions taken by the Army to help ill and injured soldiers obtain health care and navigate its disability evaluation process; and to (2) describe the status, plans, and challenges of DOD and VA efforts to implement a joint disability evaluation system. GAO's observations are based largely on documents obtained from and interviews with Army, DOD, and VA officials. The facts contained in this statement were discussed with representatives from the Army, DOD, and VA.

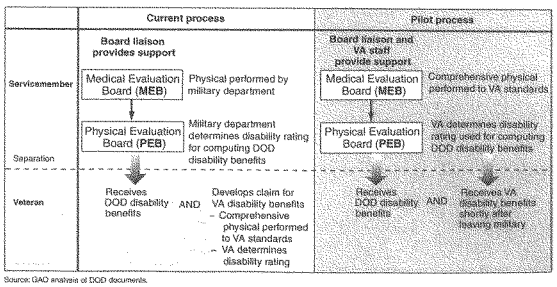
To view the full product, including the scope and methodology, click on GAO-08-514T. For more information, contact Daniel Bertoni at (202) 512-7215 or bertonid@gao.gov; or John H. Pendleton at (202) 512-7114 or pendletonj@gao.gov.

What GAO Found

Over the past year, the Army significantly increased support for servicemembers undergoing medical treatment and disability evaluations, but challenges remain. To provide a more integrated continuum of care for servicemembers, the Army created a new organizational structure—the Warrior Transition Unit—in which servicemembers are assigned key staff to help manage their recovery. Although the Army has made significant progress in staffing these units, several challenges remain, including hiring medical staff in a competitive market, replacing temporarily borrowed personnel with permanent staff, and getting eligible servicemembers into the units. To help servicemembers navigate the disability evaluation process, the Army is increasing staff in several areas, but gaps and challenges remain. For example, the Army expanded hiring of board liaisons to meet its goal of 30 servicemembers per liaison, but as of February 2008, the Army did not meet this goal at 11 locations that support about half of servicemembers in the process. The Army faces challenges hiring enough liaisons to meet its goals and enough legal personnel to help servicemembers earlier in the process.

To address more systemic issues, DOD and VA promptly designed and are now piloting a streamlined disability evaluation process. In August 2007, DOD and VA conducted an intensive 5-day exercise that simulated alternative pilot approaches using previously-decided cases. This exercise yielded data quickly, but there were trade-offs in the nature and extent of data that could be obtained in that time frame. The pilot began with "live" cases at three treatment facilities in the Washington, D.C. area in November 2007, and DOD and VA may consider expanding the pilot to additional sites around July 2008. However, DOD and VA have not finalized their criteria for expanding the pilot beyond the original sites and may have limited pilot results at that time. Significantly, current evaluation plans lack key elements, such as an approach for measuring the performance of the pilot—in terms of timeliness and accuracy of decisions—against the current process, which would help planners manage for success of further expansion.

Major Differences between Current and Pilot Military Disability Evaluation Processes



Source: GAO analysis of DOD documents.

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today as you examine issues related to meeting the critical needs of returning wounded warriors. At present, over 30,000 servicemembers have been wounded in Operations Enduring Freedom and Iraqi Freedom.[1] Due to improved battlefield medicine, those who might have died in past conflicts are now surviving, many with multiple serious injuries such as amputations, traumatic brain injury (TBI), and post-traumatic stress disorder (PTSD). Beyond adjusting to their injuries, returning servicemembers can face additional challenges within the military. In February 2007, a series of *Washington Post* articles about conditions at Walter Reed Army Medical Center highlighted problems in the Army's management of care for injured servicemembers and in the military's disability evaluation system.

Since that time, various reviews and high-level commissions have identified substantial weaknesses in the care that servicemembers receive and the disability evaluation systems that they must navigate. For example, in March 2007, the Army Inspector General identified numerous issues with the Army's disability evaluation system and related care,[2] including a failure to meet timeliness standards for determinations, inadequate training of staff, and the lack of standardized operations and structure to care for returning servicemembers. Similarly, reports from several commissions highlighted long delays and confusion that ill or injured servicemembers experience as they navigate the military disability evaluation system, and their distrust of a process perceived to be adversarial.[3] The commissions referred to prior GAO work, including a March 2006 report in which GAO found that the services were not meeting Department of Defense (DOD) timeliness goals for processing disability

[1]The data include Active, Reserve, and National Guard servicemembers wounded in action from October 7, 2001, to February 2, 2008. Over two-thirds of these servicemembers are in the Army.

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

[3]Independent Review Group, *Rebuilding the Trust: Report on Rehabilitative Care and Administrative Processes at Walter Reed Army Medical Center and National Naval Medical Center* (Arlington, Va.: Apr. 2007); Task Force on Returning Global War on Terror Heroes, *Report to the President* (April 2007); President's Commission on Care for America's Returning Wounded Warriors, *Serve, Support, Simplify* (July 2007).

cases and that neither DOD nor the services systematically evaluated the consistency of disability decisions.[4] In October 2007, the Veterans' Disability Benefits Commission reported significant differences in disability ratings between DOD and the Department of Veterans Affairs (VA)—with VA often assigning higher ratings than DOD.[5]

In response to the deficiencies reported by the media, the Army took several actions including, most notably, initiating the development of the Army Medical Action Plan in March 2007. The plan, designed to help the Army become more patient-focused, includes tasks for establishing a continuum of care and service, automating portions of the disability evaluation system, and maximizing coordination of efforts with VA.

In May 2007, DOD established the Wounded, Ill, and Injured Senior Oversight Committee (Senior Oversight Committee) to bring high-level attention to addressing the problems associated with the care and treatment of returning servicemembers. The committee is co-chaired by the Deputy Secretaries of Defense and Veterans Affairs and also includes the military service secretaries and other high-ranking officials within DOD and VA. To conduct its work, the Senior Oversight Committee established workgroups that have focused on specific areas including the disability evaluation system. In particular, under the direction of the Senior Oversight Committee, DOD and VA are piloting a joint disability evaluation system.

In September 2007, we testified before this subcommittee on our preliminary observations with respect to Army, DOD, and VA efforts to improve health care and disability evaluations for servicemembers.[6] Our testimony today provides an update on these efforts and focuses on our ongoing work to (1) assess actions taken by the Army to help ill and injured soldiers obtain health care and navigate its disability evaluation process, and (2) describe the status, plans, and challenges of DOD's and

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

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

[6]GAO, *DOD and VA: Preliminary Observations on Efforts to Improve Health Care and Disability Evaluations for Returning Servicemembers*, GAO-07-1256T (Washington, D.C.: Sept. 26, 2007).

VA's efforts to implement a joint disability evaluation system. Our testimony is based on documents obtained from and interviews with Army, DOD, and VA officials. Specifically, we reviewed staffing data related to case management and disability evaluation initiatives established in the Army Medical Action Plan. We did not verify the accuracy of these data; however, we interviewed agency officials knowledgeable about the data, and we determined that they were sufficiently reliable for the purposes of this statement. We visited several Army sites—Walter Reed Army Medical Center (Washington, D.C.), Forts Sam Houston and Hood (Texas), Fort Lewis (Washington), and Forts Benning and Gordon (Georgia)—to talk with Army officials about efforts to improve the health care and the disability evaluation system for servicemembers and obtain views from servicemembers about how these efforts are affecting them. In addition, we reviewed the results of Army efforts to obtain servicemembers' opinions about the Warrior Transition Unit and the disability evaluation process. We also spoke with officials from DOD and VA to learn about their plans for implementing and evaluating the disability evaluation pilot. Our findings are preliminary. It was beyond the scope of our work for this statement to review the efforts underway in other military services. We discussed the facts contained in this statement with Army officials, and we incorporated their comments where appropriate. Our work, which began in July 2007, is being conducted in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

In summary, the Army continues to increase support to servicemembers undergoing medical treatment and disability evaluations, but faces challenges reaching or maintaining its goals. To provide a more integrated continuum of care for servicemembers, the Army has developed a new organizational structure called Warrior Transition Units. Within each unit, a servicemember is assigned to a team of three key staff—a primary care manager, a nurse case manager, and a squad leader—who manage the servicemember's care. Since September 2007, the Army has made considerable progress in staffing this structure, increasing the number of staff assigned to key positions by almost 75 percent. However, shortfalls continue to exist in some areas—11 of the 32 U.S. Warrior Transition Units had less than 90 percent of needed staff for one or more key positions. In addition, the Army is facing other challenges, which include replacing borrowed staff in key positions with permanently assigned staff without

disrupting the continuity of care for servicemembers and moving additional eligible servicemembers into the units without exacerbating existing staff shortfalls in some locations. Furthermore, another emerging challenge is the Army's ability to gather reliable and objective data on how well the units are meeting servicemembers' needs.

Some servicemembers may not recover sufficiently to return to duty. To support servicemembers who must undergo a fitness for duty assessment and disability evaluation, the Army is reducing caseloads and expanding hiring of key staff responsible for helping servicemembers navigate the process. For example, for evaluation board liaisons who help servicemembers track the process, the Army established an average caseload goal of 30 servicemembers per board liaison and hired more board liaisons to help meet this goal. However, almost one-third of treatment locations—which support about half of servicemembers in the disability evaluation process—have not met this goal. In addition, the Army assigned 18 additional legal staff to support the disability evaluation process in June 2007; however, current staffing levels are still insufficient for widespread legal support early in the process. The Army has other efforts underway to improve servicemembers' ability to navigate the disability process, such as conducting standardized briefings about the evaluation process, but reliable data on the effectiveness of these and other efforts are not yet available.

To address issues with both DOD and VA disability evaluations, including untimely and inconsistent decisions and servicemember frustration, the agencies have designed, and are piloting, a streamlined disability evaluation process. DOD and VA moved quickly to design and implement the pilot for eventual expansion to all servicemembers. To obtain the data for determining the pilot design and supporting the implementation decision, DOD and VA conducted an intensive 5-day exercise that simulated four alternative pilot approaches using previously-decided cases. While the simulation was a formal exercise and yielded useful information, the short time frames necessitated trade-offs between moving quickly and doing a more thorough evaluation, such as using a small number of cases instead of a larger number that better represented the relative workloads of the military services. DOD and VA began "live" implementation of the pilot—using actual cases—at three treatment facilities in the Washington, D.C. area in November 2007. DOD and VA may consider expanding the pilot to a few sites outside the Washington, D.C. area around July 2008, but have yet to finalize their criteria for expanding implementation beyond the original sites. Further, some key metrics, such as the timeliness and accuracy of final DOD and VA decisions, might lag

behind expansion time frames and dates for reporting on pilot progress to Congress. To date, DOD's and VA's pilot evaluation plan lacks key elements, such as an approach for measuring the performance of the pilot—for example, in terms of timeliness, accuracy, and consistency of decisions—against the current process, and for surveying and measuring satisfaction of pilot participants.

Background

DOD and VA offer health care benefits to active duty servicemembers and veterans, among others. Under DOD's health care system, eligible beneficiaries may receive care from military treatment facilities or from civilian providers. Military treatment facilities are individually managed by each of the military services—the Army, the Navy,[7] and the Air Force. Under VA, eligible beneficiaries may obtain care through VA's integrated health care system of hospitals, ambulatory clinics, nursing homes, residential rehabilitation treatment programs, and readjustment counseling centers. VA has organized its health care facilities into a polytrauma system of care[8] that helps address the medical needs of returning servicemembers and veterans, in particular those who have an injury to more than one part of the body or organ system that results in functional disability and physical, cognitive, psychosocial, or psychological impairment. Persons with polytraumatic injuries may have injuries or conditions such as TBI, amputations, fractures, and burns.

Over the past 6 years, DOD has designated over 30,000 servicemembers involved in Operations Iraqi Freedom and Enduring Freedom as wounded in action. Servicemembers injured in these conflicts are surviving injuries that would have been fatal in past conflicts, due, in part, to advanced protective equipment and medical treatment. The severity of their injuries can result in a lengthy transition from patient back to duty, or to veteran status. Initially, most seriously injured servicemembers from these conflicts, including activated National Guard and Reserve members, are evacuated to Landstuhl Regional Medical Center in Germany for treatment. From there, they are usually transported to military treatment facilities in the United States, with most of the seriously injured admitted to Walter Reed Army Medical Center or the National Naval Medical Center. According to DOD officials, once they are stabilized and discharged from

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

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

the hospital, servicemembers may relocate closer to their homes or military bases and are treated as outpatients by the closest military or VA facility.

As part of the Army's Medical Action Plan, the Army has developed a new organizational structure—Warrior Transition Units—for providing an integrated continuum of care for servicemembers who generally require at least 6 months of treatment, among other factors. Within each unit, the servicemember is assigned to a team of three key staff and this team is responsible for overseeing the continuum of care for the servicemember.[9] The Army refers to this team as a "Triad," which consists of a (1) primary care manager—usually a physician who provides primary oversight and continuity of health care and ensures the quality of the servicemember's care; (2) nurse case manager—usually a registered nurse who plans, implements, coordinates, monitors, and evaluates options and services to meet the servicemember's needs; and (3) squad leader—a nonconumissioned officer who links the servicemember to the chain of command, builds a relationship with the servicemember, and works along side the other parts of the Triad to ensure the needs of the servicemember and his or her family are met. The Army established 32 Warrior Transition Units, to provide a unit in every medical treatment facility that has 35 or more eligible servicemembers.[10] The Army's goal is to fill the Triad positions according to the following ratios: 1:200 for primary care managers; 1:18 for nurse case managers at Army medical centers that normally see servicemembers with more acute conditions and 1:36 for other types of Army medical treatment facilities; and 1:12 for squad leaders.

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

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

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

physical evaluation board (PEB) to make a determination of fitness or unfitness for duty. If found unfit, and the unfit conditions were incurred in the line of duty, the PEB assigns the servicemember a combined percentage rating for those unfit conditions using VA's rating system as a guideline, and the servicemember is discharged from duty. This disability rating, along with years of service and other factors, determines subsequent disability and health care benefits from DOD.[11] For servicemembers meeting the minimum rating and years of duty thresholds, monthly disability retirement payments are provided; for those not meeting these thresholds, a lump-sum severance payment is provided.

As servicemembers in the Army navigate DOD's disability evaluation system, they interface with staff who play a key role in supporting them through the process. MEB physicians play a fundamental role as they are responsible for documenting the medical conditions of servicemembers for the disability evaluation case file. In addition, MEB physicians may require that servicemembers obtain additional medical evidence from specialty physicians such as a psychiatrist. Throughout the MEB and PEB process, a physical evaluation board liaison officer serves a key role by explaining the process to servicemembers, and ensuring that the servicemembers' case files are complete before they are forwarded for adjudication. The board liaison officer informs servicemembers of board results and of deadlines at key decision points in the process. The military also provides legal counsel to servicemembers in the disability evaluation process. The Army, for example, provides them with legal representation at formal board hearings. The Army will provide military counsel, or servicemembers may retain their own representative at their own expense.

In addition to receiving benefits from DOD, veterans may receive compensation from VA for lost earning capacity due to service-connected disabilities. Although a servicemember may file a VA claim while still in the military, he or she can only obtain disability compensation from VA as a veteran. VA will evaluate all claimed conditions, whether they were evaluated previously by the military service's evaluation process or not. If the VA finds that a veteran has one or more service-connected disabilities with a combined rating of at least 10 percent,[12] VA will pay monthly

[11]Servicemembers who separate from the military with a DOD disability rating of 30 percent or higher receive health care benefits for life regardless of years of service.

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

compensation. The veteran can claim additional benefits over time, for example, if a service-connected disability worsens.

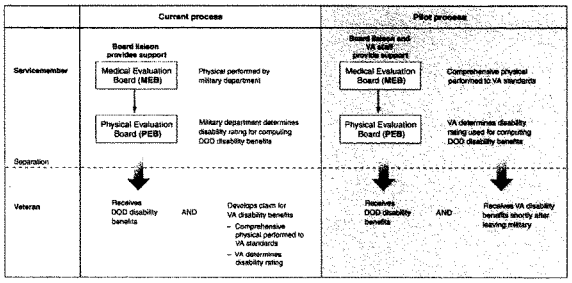
To improve the timeliness and resource utilization of DOD's and VA's separate disability evaluation systems, the agencies embarked on a planning effort of a joint disability evaluation system that would enable servicemembers to receive VA disability benefits shortly after leaving the military without going through both DOD's and VA's processes. A key part of this planning effort included a "table top" exercise whereby the planners simulated the outcomes of cases using four potential options that incorporated variations of following three elements: (1) a single, comprehensive medical examination to be used by both DOD and VA in their disability evaluations; (2) a single disability rating performed by VA; and (3) incorporating a DOD-level evaluation board for adjudicating servicemembers' fitness for duty. Based on the results of this exercise, DOD and VA implemented the selected pilot design using live cases at three Washington, D.C.-area military treatment facilities including Walter Reed Army Medical Center in November 2007.[13] Key features of the pilot include (see fig. 1):

- a single physical examination conducted to VA standards as part of the medical evaluation board;[14]
- disability ratings prepared by VA, for use by both DOD and VA in determining disability benefits; and
- additional outreach and non-clinical case management provided by VA staff at the DOD pilot locations to explain VA results and processes to servicemembers.

[13]The three pilot locations are Walter Reed Army Medical Center, Washington, D.C.; National Naval Medical Center, Bethesda, Maryland; and Malcolm Grow Air Force Medical Center, Andrews Air Force Base, Maryland.

[14]For the current pilot locations, examinations are conducted at the Washington, D.C., VA Medical Center.

Figure 1: Major Differences between Current and Pilot Military Disability Evaluation Processes



Source: GAO analysis of DOD documents.

The Army Continues to Increase Support to Servicemembers Undergoing Medical Treatment and Disability Evaluation, but Faces Challenges Reaching Stated Goals

The Army has made strides increasing key staff positions in support of servicemembers undergoing medical treatment as well as disability evaluation, but faces a number of challenges to achieving or maintaining stated goals. Although the Army has made significant progress in staffing its Warrior Transition Units, several challenges remain, including hiring medical staff in a competitive market, replacing temporarily borrowed personnel with permanent staff, and getting eligible servicemembers into the units. With respect to supporting servicemembers as they navigate the disability evaluation process, the Army has reduced caseloads of key support staff, but has not yet reached its goals and faces challenges with both hiring and meeting current demands of servicemembers in the process.

Army Has Made Considerable Progress in Staffing Its Warrior Transition Units, but Faces Shortfalls and Other Challenges

Since September 2007, the Army has made considerable progress in staffing its Warrior Transition Units, increasing the number of staff assigned to Triad positions by almost 75 percent. As of February 6, 2008, the Army had about 2,300 personnel staffing its Warrior Transition Units. In February 2008, the Army reported that its Warrior Transition Units had achieved "full operational capability," which was the goal established in the Army's Medical Action Plan. The Warrior Transition Units reported

that they had met this goal even though some units had staffing shortages or faced other challenges.[15]

Although encouraging, the Army is facing several challenges in fully staffing the Warrior Transition Units and ensuring all eligible servicemembers can benefit from the care provided in these units. For example, the Army established a goal of having at least 90 percent of Triad staff positions filled to meet the staff-to-servicemember ratios that the Army had established for its Warrior Transition Units.[16] As of February 6, 2008, the Army had surpassed this goal for 21 of the 32 units. However, the remaining 11 Warrior Transition Units had less than 90 percent of needed staff for one or more Triad positions—representing a total shortfall of 10 primary care managers, 44 nurse case managers, and 10 squad leaders. (See table 1.) Although most of these locations were missing only 1 or 2 staff, a few locations had more significant shortfalls. For example, Fort Hood needed almost 30 nurse case managers to meet the Army's 90 percent goal. Army officials cited challenges in staffing Triad positions, including difficulties in hiring physicians and other medical personnel at certain locations because salary levels do not provide the necessary incentives in a competitive market

[15]The Army's January 2008 assessment defined full operational capability across a wide variety of areas identified in the Army's Medical Action Plan, not just personnel fill. For example, the assessment included whether facilities and barracks were suitable and whether a Soldier and Family Assistance Center was in place and providing essential services. In addition, the commander assessed whether the unit could conduct the mission-essential tasks assigned to it. As a result, such ratings have both objective and subjective elements, and the Army allows commanders to change the ratings based on their judgment.

[16]The ratios are 1:200 for primary care managers; 1:18 for nurse case managers at Army medical centers that normally see servicemembers with more acute conditions and 1:36 for other types of Army medical treatment facilities; and 1:12 for squad leaders.

Table 1: Locations Where Warrior Transition Units Had Less Than 90 Percent of Staff in Place in One or More Triad Positions, as of February 6, 2008.

Location (size of Warrior Transition Unit population)	Additional Triad staff needed*		
	Primary care managers	Nurse case managers	Squad leaders
Fort Hood, Texas (957)	2	28	2
Walter Reed Army Medical Center, Washington, D.C. (674)	1		
Fort Lewis, Washington (613)	3	10	
Fort Campbell, Kentucky (596)	1	1	
Fort Drum, New York (395)	1	1	5
Fort Polk, Louisiana (248)	1		
Fort Knox, Kentucky (243)	1		
Fort Irwin & Balboa, California (89)		2	1
Fort Belvoir, Virginia (43)		1	1
Fort Huachuca, Arizona (41)		1	
Redstone Arsenal, Alabama (17)			1
Total Staff Needed	10	44	10

Source: GAO analysis of Army data.

Note: The staffing needed is based on the number of servicemembers in each Warrior Transition Unit, as of February 6, 2008.

*The number of additional staff needed to achieve the Army's goal of filling 90 percent of Triad positions at each location.

The Army is confronting other challenges, as well, including replacing borrowed staff in Triad positions with permanently assigned staff without disrupting the continuity of care for servicemembers. We previously reported in September 2007 that many units were relying on borrowed staff to fill positions—about 20 percent overall. This practice has continued; in February 2008, about 20 percent of Warrior Transition Unit staff continued to be borrowed from other positions.[17] Army officials told us that using borrowed staff was necessary to get the Warrior Transition

[17]These staff include the Triad—primary care managers, nurse case managers, and squad leaders—as well as other Warrior Transition staff such as platoon sergeants, behavioral health specialists, social workers, and administrative personnel.

Units implemented quickly and has been essential in staffing units that have experienced sudden increases in servicemembers needing care. Army officials told us that using borrowed staff is a temporary solution for staffing the units, and these staff will be transitioned out of the positions when permanent staff are available. Replacing the temporary staff will result in turnover among Warrior Transition Unit staff, which can disrupt the continuity of care provided to servicemembers.

Another lingering challenge facing the Army is getting eligible servicemembers into the Warrior Transition Units. In developing its approach, the Army envisioned that servicemembers meeting specific criteria, such as requiring more than 6 months of treatment or having a condition that requires going through the Medical Evaluation Board process, would be assigned to the Warrior Transition Units. Since September 2007, the Warrior Transition Unit population has increased by about 80 percent—from about 4,350 to about 7,900 servicemembers. However, although the percentage of eligible servicemembers going through the Medical Evaluation Board process who were not in a Warrior Transition Unit has been cut almost in half since September 2007, more than 2,500 eligible servicemembers were not in units, as of February 6, 2008. About 1,700 of these servicemembers (about 70 percent) are concentrated in ten locations. (See table 2.)

Table 2: Locations with 100 or More Eligible Servicemembers Not in a Warrior Transition Unit, as of February 6, 2008

Location	Total number of servicemembers eligible for a Warrior Transition Unit	Number of eligible servicemembers not in a Warrior Transition Unit	Percentage of total eligible servicemembers not in a Warrior Transition Unit
Fort Hood, Texas	1,331	374	28
Fort Carson, Colorado	603	240	40
Fort Bragg, North Carolina	666	199	30
Fort Gordon, Georgia	437	183	42
Fort Lewis, Washington	783	170	22
Fort Knox, Kentucky	359	116	32
Fort Campbell, Kentucky	711	115	16
Fort Drum, New York	500	105	21
West Point, New York	164	105	64
Tripler Army Medical Center, Hawaii	283	101	36
Total	5,837	1,708	29

Source: GAO analysis of Army data.

Warrior Transition Unit commanders conduct risk assessments of eligible servicemembers to determine if their care can be appropriately managed outside of the Warrior Transition Unit. These assessments are to be conducted within 30 days of determining that the servicemember meets eligibility criteria. For example, a servicemember's knee injury may require a Medical Evaluation Board review—a criterion for being placed in a Warrior Transition Unit—but the person's unit commander can determine that the person can perform a desk job while undergoing the medical evaluation process. According to Army guidance, servicemembers eligible for the Warrior Transition Unit will generally be moved into the units, that it will be the exception, not the rule, for a servicemember to not be transferred to a Warrior Transition Unit. Army officials told us that the population of 2,500 servicemembers who had not been moved into a Warrior Transition Unit consisted of both servicemembers who had just recently been identified as eligible for a unit but had not yet been evaluated and servicemembers whose risk assessment determined that their care could be managed outside of a unit. Officials told us that servicemembers who needed their care managed more intensively through Warrior Transition Units had been identified through the risk assessment process and had been moved into such units. As eligible personnel are brought into the Warrior Transition Units, however, it could exacerbate staffing shortfalls in some units. To minimize future staffing shortfalls, Army officials told us that they are identifying areas where they anticipate future increases in the number of servicemembers needing care in a Warrior Transition Unit and would use this information to determine appropriate future staffing needs of the units.

Another emerging challenge is gathering reliable and objective data to measure progress. A central goal of the Army's efforts is to make the system more servicemember- and family-focused and the Army has initiated efforts to determine how well the units are meeting servicemembers' needs. To its credit, the Army has developed a wide range of methods to monitor its units, among them a program to place independent ombudsmen throughout the system as well as town hall meetings and a telephone hotline for servicemembers to convey concerns about the Warrior Transition Units. Additionally, through its Warrior Transition Program Satisfaction Survey, the Army has been gathering and analyzing information on servicemembers' opinions about their nurse case manager and the overall Warrior Transition Unit. However, initial response rates have been low, which has limited the Army's ability to reliably assess satisfaction. In February 2008, the Army started following up with nonrespondents, and officials told us that these efforts have begun to improve response rates. To obtain feedback from a larger percentage of

servicemembers in the Warrior Transition Units, the Army administered another satisfaction survey in January 2008. This survey, which also solicited servicemembers' opinions about components of the Triad and overall satisfaction with the Warrior Transition Units, garnered a more than 90 percent response rate from the population surveyed.[18] While responses to the survey were largely positive, the survey is limited in its ability to accurately gauge the Army's progress in improving servicemember satisfaction with the Warrior Transition Unit, because it was not intended to be a methodologically rigorous evaluation. For example, the units were not given specific instructions on how to administer the survey, and as a result, it is not clear the extent to which servicemembers were provided anonymity in responding to the survey. Units were instructed to reach as many servicemembers as possible within a 24-hour period in order to provide the Army with immediate feedback on servicemembers' overall impressions of the care they were receiving.

Despite Hiring Efforts, Army Faces Challenges Providing Sufficient Staff to Help Servicemembers Navigate the Disability Evaluation Process

Injured and ill servicemembers who must undergo a fitness for duty assessment and disability evaluation rely on the expertise and support of several key staff—board liaisons, legal personnel, and board physicians—to help them navigate the process. Board liaisons explain the disability process to servicemembers and are responsible for ensuring that their disability case files are complete. Legal staff and medical evaluation board physicians can substantially influence the outcome of servicemembers' disability evaluations because legal personnel provide important counsel to servicemembers during the disability evaluation process, and evaluation board physicians evaluate and document servicemembers' medical conditions for the disability evaluation case file.[19]

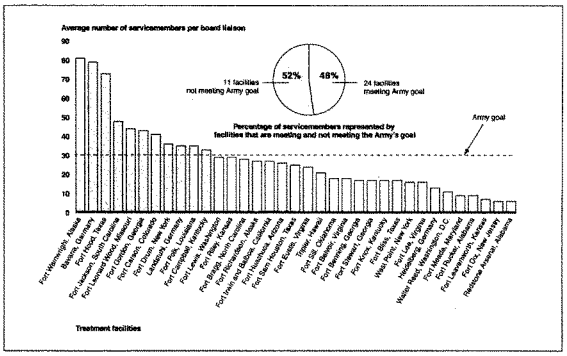
With respect to board liaisons, the Army has expanded hiring efforts and met its goals for reducing caseloads at most treatment facilities, but not at some of the facilities with the most servicemembers in the process. In

[18]The survey was distributed to 4,430 servicemembers, which represented about 60 percent of the total Warrior Transition Unit population at the time of the survey. Some servicemembers may not have received a survey because, according to an Army official, they were receiving care through a Community Based Health Care Organization, were on leave, or were undergoing treatment. Additionally, three units' survey responses were received too late to incorporate into the Army's analyses.

[19]Board physicians, unlike board liaisons and legal staff who are dedicated to serving servicemembers in the disability evaluation process, are part of the Warrior Transition Units.

August 2007, the Army established an average caseload target of 30 servicemembers per board liaison. As of February 2008, the Army had expanded the number of board liaisons by about 22 percent. According to the Army, average caseloads per liaison have declined from 54 servicemembers at the end of June 2007 to 46 at the end of December 2007. However, 11 of 35 treatment facilities continue to have shortages of board liaisons and about half of all servicemembers in the disability evaluation process are located at these 11 treatment facilities. (See fig. 2.) Due to their caseloads, liaisons we spoke with at one location had difficulty making appointments with servicemembers, which has challenged their ability to provide timely and comprehensive support.

Figure 2: Average Number of Servicemembers per Board Liaison at Treatment Facilities, February 6, 2008



Source: GAO analysis based on Army data.

The Army plans to hire additional board liaisons, but faces challenges in keeping up with increased demand. According to an Army official responsible for staff planning, the Army reviews the number of liaisons at each treatment facility weekly and reviews Army policy for the target number of servicemembers per liaison every 90 days. The official also identified several challenges in keeping up with increased demand for board liaisons, including the increase in the number of injured and ill servicemembers in the medical evaluation board process overall, and the difficulty of attracting and retaining liaisons at some locations. According

to Army data, the total number of servicemembers completing the medical evaluation board process increased about 19 percent from the end of 2006 to the end of 2007.

In addition to gaps in board liaisons, according to Army documents, staffing of dedicated legal personnel who provide counsel to injured and ill servicemembers throughout the disability evaluation processes is currently insufficient. Ideally, according to the Army, servicemembers should receive legal assistance during both the medical and physical evaluation board processes. While servicemembers may seek legal assistance at any time, the Office of the Judge Advocate General's policy is to assign dedicated legal staff to servicemembers when their case goes before a formal physical evaluation board. In June 2007, the Army assigned 18 additional legal staff—12 Reserve attorneys and 6 Reserve paralegals—to help meet increasing demands for legal support throughout the process. As of January 2008, the Army had 27 legal personnel—20 attorneys and 7 paralegals—located at 5 of 35 Army treatment facilities who were dedicated to supporting servicemembers primarily with the physical evaluation board process.[20] However, the Office of the Judge Advocate General has acknowledged that these current levels are insufficient for providing support during the medical evaluation board process, and proposed hiring an additional 57 attorneys and paralegals to provide legal support to servicemembers during the medical evaluation board process. The proposed 57 attorneys and paralegals include 19 active-duty military attorneys, 19 civilian attorneys, and 19 civilian paralegals. On February 21, 2008, Army officials told us that 30 civilian positions were approved, consisting of 15 attorneys and 15 paralegals.

While the Army has plans to address gaps in legal support for servicemembers, challenges with hiring and staff turnover could limit their efforts. According to Army officials, even if the plan to hire additional personnel is approved soon, hiring of civilian attorneys and paralegals may be slow due to the time it takes to hire qualified individuals under government policies. Additionally, 19 of the 57 Army attorneys who would be staffed under the plan would likely only serve in their positions for a

[20]According to Army officials, the Judge Advocates General's Corps has approximately 4,200 military and civilian attorneys and a significant portion of these can provide legal assistance to servicemembers. However, these officials also noted that these attorneys are not dedicated exclusively to the disability evaluation process and the extent to which these attorneys actually provide legal support to servicemembers during the disability evaluation process is unknown.

period of 12 to 18 months.[21] According to a Disabled American Veterans representative with extensive experience counseling servicemembers during the evaluation process, frequent rotations and turnover of Army attorneys working on disability cases limits their effectiveness in representing servicemembers due to the complexity of disability evaluation regulations.

With respect to medical evaluation board physicians, who are responsible for documenting servicemembers medical conditions, the Army has mostly met its goal for the average number of servicemembers per physician at each treatment facility. In August 2007, the Army established a goal of one medical evaluation board physician for every 200 servicemembers.[22] As with the staffing ratio for board liaisons, the ratio for physicians is reviewed every 90 days by the Army and the ratio at each treatment facility is reviewed weekly, according to an Army official. As of February 2008, the Army had met the goal of 200 servicemembers per physician at 29 of 35 treatment facilities and almost met the goal at two others.[23]

Despite having mostly met its goal for medical evaluation board physicians, according to Army officials, the Army continues to face challenges in this area. For example, according to an Army official, physicians are having difficulty managing their caseload even at locations where they have met or are close to the Army's goal of 1 physician for 200 servicemembers due not only to the volume of cases but also their complexity. According to Army officials, disability cases often involve multiple conditions and may include complex conditions such as TBI and PTSD. Some Army physicians told us that the ratio of servicemembers per physician allows little buffer when there is a surge in caseloads at a treatment facility. For this reason, some physicians told us that the Army could provide better service to servicemembers if the number of servicemembers per physician was reduced from 200 to 100 or 150.

[21]These 19 are intended to be active duty attorneys. The Army intends to assign active duty attorneys to the disability evaluation process for a limited time period out of concern for the attorney to gain experience in other legal practice areas.

[22]Although board physicians are part of the Warrior Transition Units, staffing targets for board physicians are based on the number of servicemembers in the disability evaluation process as opposed to the number of servicemembers in the Warrior Transition Units.

[23]Two of the Army treatment facilities not meeting the 200 to 1 servicemember to physician ratio—Fort Riley, Kansas, and Fort Knox, Kentucky—each had a ratio of 201 to 1.

In addition to increasing the number of staff who support this process, the Army has reported other progress and efforts underway that could further ease the disability evaluation process. For example, the Army has reported improving outreach to servicemembers by establishing and conducting standardized briefings about the process. The Army has also improved guidance to servicemembers by developing and issuing a handbook on the disability evaluation process, and creating a web site for each servicemember to track his or her progress through the medical evaluation board. Finally, the Army told us that efforts are underway to further streamline the process for servicemembers and improve supporting information technology. For example, the Army established a goal to eliminate 50 percent of the forms required by the current process. While we are still assessing the scope, status, and potential impact of these efforts, a few questions have been raised about some of them. For example, according to Army officials, servicemembers' usage of the medical evaluation board web site has been low. In addition, some servicemembers with whom we spoke believe the information presented on the web site was not helpful in meeting their needs.

One measure of how well the disability evaluation system is working does not indicate that improvements have occurred. The Army collects data and regularly reports on the timeliness of the medical evaluation board process. While we have previously reported that the Army has few internal controls to ensure that these data were complete and accurate, the Army recently told us that they are taking steps to improve the reliability of these data.[24] We have not yet substantiated these assertions. Assuming current data are reliable, the Army has reported not meeting a key target for medical evaluation board timeliness and has even reported a negative trend in the last year. Specifically, the Army's target is for 80 percent of the medical evaluation board cases to be completed in 90 days or less, but the percent that met the standard declined from 70 percent in October through December 2006, to 63 percent in October through December 2007.

Another potential indicator of how well the disability evaluation process is working is under development. Since June 2007, the Army has used the Warrior Transition Program Satisfaction Survey to ask servicemembers about their experience with the disability evaluation process and board liaisons. However, according to Army officials in charge of the survey, response rates to survey questions related to the disability process were

[24]GAO-06-362, p. 26.

particularly low because most surveyed servicemembers had not yet begun the disability evaluation process. The Army is in the process of developing satisfaction surveys that are separate from the Warrior Transition Unit survey to gauge servicemembers' perceptions of the medical and physical evaluation board processes.

DOD-VA Joint Disability Evaluation Process Pilot Geared Toward Quick Implementation, but Pilot Evaluation Plans Lack Key Elements

DOD and VA have joined together to quickly pilot a streamlined disability evaluation process, but evaluation plans currently lack key elements. In August 2007, DOD and VA conducted an intensive 5-day "table top" exercise to evaluate the relative merits of four potential pilot alternatives. Though the exercise yielded data quickly, there were trade-offs in the nature and extent of data that could be obtained in that time frame. In November 2007, DOD and VA jointly initiated a 1-year pilot in the Washington, D.C. area using live cases, although DOD and VA officials told us they may consider expanding the pilot to other locations beyond the current sites around July 2008. However, pilot results may be limited at that and other critical junctures, and pilot evaluation plans currently lack key elements, such as criteria for expanding the pilot.

Selection of Pilot Design Based on Formal but Quick 5-day Exercise

Prior to implementing the pilot in November 2007, the agencies conducted a 5-day "table top" exercise that involved a simulation of cases intended to test the relative merits of 4 pilot options. All the alternatives included a single VA rating to be used by both agencies. However, the exercise was designed to evaluate the relative merits of certain other key features, such as whether DOD or VA should conduct a single physical examination, and whether there should be a DOD-wide disability evaluation board, and if so, what its role would be. Ultimately, the exercise included four pilot alternatives involving different combinations of these features. Table 3 summarizes the pilot alternatives.

Table 3: Summary of Pilot Alternatives Considered by DOD and VA During August 2007 "Table Top" Exercise

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

Source: GAO analysis of information provided by DOD.

[a]Based on the table top exercise, alternative 2 was selected for implementation.

The simulation exercise was formal in that it followed a pre-determined methodology and comprehensive in that it involved a number of stakeholders and captured a broad range of metrics. DOD and VA were assisted by consultants who provided data collection, analysis, and methodological support. The pre-determined methodology involved examining previously decided cases, to see how they would have been processed through each of the four pilot alternatives. The 33 selected cases intentionally reflected decisions originating from each of the military services and a broad range and number of medical conditions. Participants in the simulation exercise included officials from DOD, each military service, and VA who are involved in all aspects of the disability evaluation processes at both agencies. Metrics collected included case outcomes including the fitness decision, the DOD and VA ratings, and the median expected days to process cases. These outcomes were compared for each pilot alternative with actual outcomes. In addition, participants rank ordered their preference for each pilot alternative, and provided feedback on expected servicemember satisfaction as well as service and organization acceptance. They also provided their views on legislative and regulatory changes and resource requirements to implement alternative processes, and identified advantages and disadvantages of each alternative.

This table top exercise enabled DOD and VA to obtain sufficient information to support a near-term decision to implement the pilot, but it also required some trade-offs. For example, the intensity of the exercise—

simulating four pilot alternatives, involving more than 40 participants over a 5-day period—resulted in an examination of only a manageable number of cases. To ensure that the cases represented each military service and different numbers and types of potential medical conditions, a total of 33 cases were judgmentally selected by service: 8 Army, 9 Navy, 8 Marine, and 8 Air Force. However, the sample used in the simulation exercise was not statistically representative of each military service's workload; as such it is possible that a larger and more representative sample could have yielded different outcomes. Also, expected servicemember satisfaction was based on the input of the DOD and VA officials participating in the pilot rather than actual input from the servicemembers themselves.

Based on the data from this exercise, the Senior Oversight Committee gave approval in October 2007 to proceed with piloting an alternative process with features that scored the highest in terms of participants' preferential voting and projected servicemember satisfaction. These elements included a single VA rating (as provided in all the alternatives tested) and a comprehensive medical examination conducted by VA. The selected pilot design did not include a DOD-wide disability evaluation board.[25] Rather, the services' physical evaluation boards would continue to determine fitness for duty, as called for under Alternative 2.

The Pilot Is Geared toward Quick Expansion, but Evaluation Plans Lack Key Elements

DOD and VA officials have described to us a plan for expanding the pilot that is geared toward quick implementation, but may have limited pilot results available to them at a key juncture. With respect to time frames, the pilot, which began in November 2007, is scheduled to last 1 year, through November 2008. However, prior to that date, planners have expressed interest in expanding the pilot outside the Washington metropolitan area. Pilot planners have told us that around July 2008—which is not long after the first report on the pilot is due to Congress[26]—they may ask the Senior Oversight Committee to decide on expansion to more locations based on data available at that time. They suggested that a few additional locations would allow them to collect additional experience

[25]The DOD Disability Advisory Council will conduct a quality control review of some service physical evaluation board decisions.

[26]Pursuant to the National Defense Authorization Act for Fiscal Year 2008, enacted January 28, 2008, the Secretary of Defense must submit an initial report on the pilot within 90 days after enactment. The report is to include a description of the pilot program's scope and objectives and the methodology to be used to achieve the objectives. Pub. L. No. 110-181, §1644(g).

and data outside the Washington, D.C. area before decisions on broader expansion are made. According to DOD and VA officials, time frames for national expansion have not yet been decided. However, DOD also faces deadlines for providing Congress an interim report on the pilot's status as early as October 2008, and for issuing a final report.[27]

While expanding the pilot outside the Washington, D.C. area will likely yield useful information to pilot planners, due to the time needed to fully process cases, planners may have limited pilot results available to guide their decision making. As of February 17, 2008, 181 cases were currently in the pilot process, but none had completed the process. After conducting the simulation exercise, pilot planners set a goal of 275 days (about 9 months) for a case to go through the entire joint disability evaluation process. If the goal is an accurate predictor of time frames, potentially very few cases will have made it through the entire pilot process by the time planners seek to expand the pilot beyond the Washington area. As a result, DOD and VA are accepting some level of risk by expanding the pilot solely on the basis of early pilot results.

In addition to having limited information at this key juncture, pilot planners have yet to designate criteria for moving forward with pilot expansion and have not yet selected a comparison group to identify differences between pilot cases and cases processed under the current system, to allow for assessment of pilot performance. DOD and VA are collecting data on decision times and rating percentages, but have not identified how much improvement in timeliness or consistency would justify expanding the pilot process. Further, pilot planners have not laid out an approach for measuring the pilot's performance on key metrics—including timeliness and accuracy of decisions—against the current process. Selection of the comparison group cases is a significant decision, because it will help DOD and VA determine the pilot's impact, compared with the current process, and help planners identify needed corrections and manage for success. An appropriate comparison group might include servicemembers with a similar demographic and disability profile. Not having an appropriate comparison group increases the risk that DOD and

[27]Under section 1644(g), the interim report must be submitted no later than 180 days after the date of the submittal of the initial report. Not later than 90 days after the completion of all of the pilot programs carried out under the act, the Secretary of Defense must submit a report setting out a final evaluation and assessment of the pilot programs. The final report is to include any recommendations for legislative or administrative action that the Secretary considers appropriate in light of the pilot programs.

VA will not identify problem areas or issues that could limit the effectiveness of any redesigned disability process. Pilot officials stated that they intend to identify a comparison group of non-pilot disability evaluation cases, but have not yet done so.

Another key element lacking from current evaluation plans is an approach for surveying and measuring satisfaction of servicemembers and veterans with the pilot process. As noted previously, several high-level commissions identified servicemember confusion over the current disability evaluation system as a significant problem. Pilot planners told us that they intend to develop a customer satisfaction survey and use customer satisfaction data as part of their evaluation of pilot performance but, as of February 2008, the survey was still under development. Even after the survey has been developed, results will take some time to collect and may be limited at key junctures because the survey needs to be administered after servicemembers and veterans have completed the pilot process. Without data on servicemember satisfaction, the agencies cannot know whether or the extent to which the pilot they are implementing has been successful at reducing servicemember confusion and distrust over the current process.

Concluding Observations

Over the past year, the Army has made substantial progress toward improving care for its servicemembers. After problems were disclosed at Walter Reed in early 2007, senior Army officials assessed the situation and have since dedicated significant resources—including more than 2,000 personnel—and attention to improve this important mission. Today, the Army has established Warrior Transition Units at its major medical facilities and doctors, nurses, and fellow servicemembers at these units are at work helping wounded, injured, and ill servicemembers through what is often a difficult healing process. Some challenges remain, such as filling all the Warrior Transition Unit personnel slots in a competitive market for medical personnel, lessening reliance on borrowed personnel to fill slots temporarily, and getting servicemembers eligible for Warrior Transition Unit services into those units. Overall, the Army is to be commended for its efforts thus far; however, sustained attention to remaining challenges and reliable data to track progress will be important to sustaining gains over time.

For those servicemembers whose military service was cut short due to illness or injury, the disability evaluation is an extremely important issue because it affects their service retention or discharge and whether they receive DOD benefits such as retirement pay and health care coverage. Once they become veterans, it affects the cash compensation and other

disability benefits they may receive from VA. Going through two complex disability evaluation processes can be difficult and frustrating for servicemembers and veterans. Delayed decisions, confusing policies, and the perception that DOD and VA disability ratings result in inequitable outcomes have eroded the credibility of the system. The Army has taken steps to increase the number of staff that can help servicemembers navigate its process, but is challenged to meet stated goals. Moreover, even if the Army is able to overcome challenges and sufficiently ramp up staff levels, these efforts will not address the systemic problem of having two consecutive evaluation systems that can lead to different outcomes.

Considering the significance of the problems identified, DOD and VA are moving forward quickly to implement a streamlined disability evaluation that has potential for reducing the time it takes to receive a decision from both agencies, improving consistency of evaluations for individual conditions, and simplifying the overall process for servicemembers and veterans. At the same time, DOD and VA are incurring some risk with this approach because the cases used were not necessarily representative of actual workloads. Incurring some level of risk is appropriate and perhaps prudent in this current environment; however, planners should be transparent about that risk. For example, to date, planners have not yet articulated in their planning documents the extent of data that will be available at key junctures, and the criteria they will use in deciding to expand the pilot beyond the Washington, D.C. area. More importantly, decisions to expand beyond the few sites currently contemplated should occur in conjunction with an evaluation plan that includes, at minimum, a sound approach for measuring the pilot's performance against the current process and for measuring servicemembers' and veterans' satisfaction with the piloted process. Failure to properly assess the pilot before significant expansion could potentially jeopardize the systems' successful transformation.

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

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

Appendix I: GAO Contacts and Staff Acknowledgments

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Mr. TIERNEY. Thank you, Mr. Bertoni.

General Schoomaker, would you care to make some remarks?

General SCHOOMAKER. Yes, sir.

STATEMENT OF LIEUTENANT GENERAL ERIC SCHOOMAKER

General SCHOOMAKER. Chairman Tierney, Congressman Shays, distinguished members of the subcommittee, thank you for inviting me to discuss really a total transformation that the Army has undergone in the way that we care for soldiers and families. We are truly committed to getting this right and to providing a level of care and support to our warriors and families that is equal to the quality of their service.

Accompanying me this afternoon is my colleague, the Army Adjutant General, Brigadier General Reuben Jones. As the Adjutant General, General Jones has oversight of the Army's Physical Evaluation Boards, the PEBs, and is actively involved with improvements in the disability evaluation system. He is here to answer any questions that you may have concerning the Army's role in streamlining the disability evaluation process.

I appreciate the continuing efforts of the committee and of the Government Accountability Office to help our wounded, ill, and injured service members. Your attention to their problems and your insights and observations play an important role in our continuing progress.

Mr. Bertoni and Mr. Pendleton work collaboratively and openly with our Army medical action planners to produce a good, independent assessment of our progress to date. Before we delve into the details of where we are today, I would like to emphasize the unprecedented nature of what the Army has accomplished over the last year.

We now have over 2,400 soldier leaders assigned as cadre to 35 warrior transition units that did not exist last February. These are 2,400 small unit leaders in jobs where last year at this time we had fewer than 400 cadre doing the work for almost an equivalent population of patients.

The most significant feature of these warrior transition units is a triad that consists of a primary care physician, a nurse case manager, and the squad leader working together to attend to the needs of each individual and their family.

In less than 1 year the Army has funded, staffed, and written doctrine to establish these new organizations. This is a truly amazing accomplishment. It is a true transformation in warrior care.

Another improvement in the care of soldiers is that a year ago our wounded, ill, and injured believed that their complaints were falling on deaf ears within the Army.

Now, with the assistance of this subcommittee—and I know, sir, that this was a specific interest that this subcommittee had—we have established a MEDCOM-wide ombudsman program with ombudsmen at installations across the Army, and we continue to hire more. In fact, my Command Sergeant Major, Althea Dixon, is not with me today only because she is addressing the newest crop of ombudsmen that have been hired and are being trained in San Antonio, Texas, many of whom are former NCOs who served in uniform and are experienced in the medical system.

Every one of our treatment facilities knows who their ombudsman is and how to find him or her. Many are retired NCOs, as I mentioned, or officers that work outside the local chain of command, but they have direct access to the hospital commander, to the garrison commander, the senior mission commander on our installations, and they know how to get problems fixed.

We have also established a 1–800 wounded soldier and family hotline. I believe your packets contain the card that we hand out generously. In fact, in meeting with the VA recently we showed them what we were doing, and they were so impressed that they have started a similar hotline of their own.

This offers wounded, ill, and injured soldiers and families a way to share concerns on any aspect of their care or administrative support, and I emphasize that it can be any aspect, not just inpatient medical care or outpatient care, but housing, pay, accompaniment of the family member, whatever it might be. We respond to these inquiries within 24 hours. So far we have received in excess of 7,000 calls.

As you may well know, despite these successes, there is much progress to be made. We are addressing concerns and providing treatment for those soldiers with concussive injuries and those with symptoms of post-traumatic stress.

We understand that these are great concerns to the American public, as well as for our soldiers and their families. We recognize the importance of prevention, timely diagnosis and treatment of concussive injuries and post-traumatic stress, and we are aggressively executing programs designed to educate, to prevent, to screen, and to provide care for deployment-related stress and injuries.

Congress jump-started us last year with supplemental funding for post-traumatic stress and traumatic brain injury research and care, and we are extremely grateful. We are putting them to good use.

We must continue to look at the physical disability evaluation system and ways to make it less antagonistic, more understandable and equitable for soldiers and his or her family, and to make it more user friendly. I applaud the efforts to pursue changes in the disability evaluation system as aggressively as possible.

The Army's unwavering commitment and a key element of our warrior ethos is never to leave a soldier behind on the battlefield or lost in the bureaucracy. We are doing a better job of honoring that commitment today than we were at this date last year.

In February 2009 I want to report back to you with GAO at my side that we have achieved a similar level of progress as we have over the last year, because, sir, I strongly agree with your commitment to sustained oversight and continuous improvement.

I am proud of Army medicine's efforts over the past 232 years, and especially over the last 12 months, to care for the soldier and his or her family. I am convinced that, in coordination with the Department of Defense, the Department of Veterans Affairs, the Congress, we have turned the corner on this issue.

Thank you for holding this hearing. Thank you for your continued support for our warriors for whom we are truly honored to serve.

Thank you.
[The prepared statement of General Schoomaker follows:]

UNCLASSIFIED

FINAL VERSION

STATEMENT BY

LIEUTENANT GENERAL ERIC B. SCHOOMAKER
THE SURGEON GENERAL OF THE UNITED STATES ARMY
AND COMMANDER, US ARMY MEDICAL COMMAND

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM
SUBCOMMITTEE ON NATIONAL SECURITY AND FOREIGN AFFAIRS

UNITED STATES HOUSE OF REPRESENTATIVES

SECOND SESSION, 110TH CONGRESS

ONE YEAR AFTER WALTER REED: AN INDEPENDENT ASSESSMENT OF CARE, SUPPORT, AND DISABILITY EVALUATION FOR WOUNDED SOLDIERS

27 FEBRUARY 2008

NOT FOR PUBLICATION
UNTIL RELEASED BY THE
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

Chairman Tierney, Congressman Shays, and distinguished members of the Subcommittee, thank you for the opportunity to discuss the total transformation the Army is undergoing in the way we care for Soldiers and Families. We are committed to getting this right and providing a level of care and support to our Warriors and Families that is equal to the quality of their service.

Secretary Geren, General Casey, General Cody, and the rest of the Army leadership are all actively involved with every stage of the Army Medical Action Plan and the transformation it embodies. Senior Army leadership has made it very clear that they are in lock step with the statement by Secretary of Defense Gates, "Apart from the war itself, this department and I have no higher priority."

What I would like to highlight for you today are some of the tangible impacts of the transformations made through the Army Medical Action Plan (AMAP). In doing this, I would first point out that, in some aspects, the concerns reported at Walter Reed Army Medical Center (WRAMC) were an unintended consequence of the extraordinary success of modern battlefield medicine. Thanks to improvements such as the Joint Theater Trauma system, state of the art evacuation system, and improved body armor, over 90 percent of those wounded in Iraq and Afghanistan survive, making this the highest survival rate in the history of warfare. As a result, there are many more wounded soldiers with complex injuries struggling to recover. In today's highly-motivated All-Volunteer Army, this translates to an unprecedented number of Soldiers determined to rejoin their units or to transition back to their communities as proud and productive veterans.

At WRAMC, where Soldiers are able to participate in the center's state-of-the-art rehabilitation programs, the result has been a population of outpatients six times greater than this premier medical center was designed to support. Many of these Soldiers or "Warriors in Transition" as we call them have displayed extraordinary courage and determination to return to the force or to become productive veterans. To tap this extraordinary determination, the framers of the AMAP realized the need to provide injured Soldiers a mission of their own codified in the Warrior in Transition Mission Statement: "I am a Warrior in Transition. My job is to heal as I transition back to duty or

continue serving the nation as a Veteran in my community. This is not a status but a mission. I will succeed in this mission because I am a Warrior and I am Army Strong." As a result, WRAMC, Army Medicine, and other Army organizations have been reorganized to support Soldiers and their Families to accomplish this goal.

First, and foremost, wounded, ill, and injured Soldiers are members of newly-designed military units under the command and control of the medical treatment facility commander. The new Warrior Transition Units (WTU) are patient-centered organizations, focused on the care, treatment, and compassionate disposition of their Soldiers. The WTUs exist to support the healing of our Soldiers. All 35 of our WTUs are now at full operational capability. The WTUs set the conditions for Soldiers to heal in a structured, supportive environment.

Integral to the structure of the WTUs is the "Triad of care" concept established to support every Warrior. The Triad is composed of a primary care manager, nurse case manager, and squad leader trained to meet the unique needs of each Warrior and Family. We've assigned 1 squad leader for every 12 Soldiers, 1 Primary Care Manager for every 200 Soldiers, and 1 nurse case manager for every 18 or 36 Soldiers depending on the medical complexity of the WTU. Each unit also has a dedicated Ombudsman outside of the WTU chain of command who reaches out to Soldiers and Families as an extra resource and problem-solver.

The organizational changes have made a lasting imprint on wounded Soldiers and their Families throughout this Nation. According to Major Steven Gventer, a Soldier wounded in Iraq by a rocket propelled grenade round who is currently commanding one of the companies that make up the Warrior Transition Brigade at Walter Reed, the changes brought about as part of the AMAP, "...did a great service to Soldiers. We have done everything possible for these Soldiers and are continuing to get better every day."

There are now more than 2,400 individuals assigned as cadre to the 35 WTUs which contrasts with less than 400 when previously organized as "medical hold" and "medical holdover" units. WTU cadre are trained specifically for this mission and they truly know the wounded, ill, and injured Soldiers and Families for whom they provide care and support. They escort troops to meetings, act as their advocates, and field their

calls. As Major Gventer puts it, "It's a job that entails just about anything and everything that allows the Warrior in Transition to focus on his or her mission, which is to heal."

Staff Sergeant Michael Thornton is assigned to the Warrior Transition Battalion at Fort Sam Houston, Texas. While serving with the 4th Infantry Division near Baghdad in September 2006, he sustained burns over 33 percent of his body when the vehicle he was traveling in hit a roadside bomb. He was transferred to what was then the Medical Hold Company to convalesce. In June 2007, the company to which he was assigned became a WTU as the AMAP was implemented. Staff Sergeant Thornton states that, since then,

> *Things flow more efficiently. It seems more organized. It's good to have dedicated leadership who handle just our issues. In the past, some wounded Soldiers were also serving as squad leaders at the Medical Hold Company. They had appointments too, so it's better to have dedicated leadership. This is the best place I've seen in the Army. We've got great docs and so many people who care about us. I've seen issues like a pay problem I had that was resolved with their help the same day. They go out of their way to take care of you and they're good at it.*

It has also been meaningful to see how the civilian health care community views the changes we have made. One expert assessment was recently made by William H. Craig, a civilian health care executive with 17 years experience who currently serves as Vice-President of Clinical Support for Cook Children's Medical Center in Fort Worth, Texas. Mr. Craig spent a week with the Warrior Transition Brigade at WRAMC, viewing firsthand how the Army has improved the transition process for outpatient Soldiers and to see if the Army's way might have application in the civilian health care world. Mr. Craig observed:

> *From a professional standpoint, I was most impressed with the Army's organizational and leadership efforts through the Warrior Transition Brigade. The Army has taken a process-based approach to managing Soldiers from the time they arrive at Walter Reed until they leave to return to duty or to civilian life. The Army developed a system through the Warrior Transition Brigade that incorporates both daily people-management needs and medical care needs of the soldier into an*

organizational structure that brings significant improvement to the transition process. It is impressive to see an organization like the Army, which I have always perceived to be very command-and-control-oriented in leadership style, actually be adaptive in its leadership style and incorporate a flexible approach based on the needs of this wounded Soldier population.

While my experience in the healthcare industry has shown we do a good job of case managing on the inpatient side, it seems to me our systems for outpatient case management are not as well developed as the Army's. When assessing the needs of their wounded Soldier population, the Army developed a concept I believe complements the medical resources of an organization like Walter Reed and effectively meets the Soldier's outpatient case management needs. This is referred to as the Triad of Care and incorporates three disciplines critical to managing the outpatient process once the soldier is discharged from inpatient status.

My week at Walter Reed with the Warrior Transition Brigade proved a point I have experienced many times in my career: if you give an organization the right level of resources combined with the right people to lead and execute, it can accomplish many great things.

We believe the Army Medical Action Plan is the right response at the right time and the right place for the United States Army. We are very proud of the hard work and committed effort to reach this point. We see the positive impact of our efforts every day as we encounter Soldiers and Families on the wards and in our clinics and across our installations. It is rewarding to see the progress and growth and we encourage you to visit our WTUs to meet and talk with our incredible Warriors.

Unfortunately, it can also be very frustrating when, despite all of our efforts, we have a few bad outcomes. We know that there are obstacles and bureaucracies that still must be overcome. We continue to face challenges that require blunt honesty, continuous self-assessment, humility, and the ability to listen to those in need. One particular concern of ours is the number of accidental deaths and suicides that have occurred in WTUs. Earlier this month we assembled a cross-functional Tiger Team within Headquarters Department of the Army (HQDA) to examine these serious

incidents and determine what steps we could take to reduce their frequency or eliminate them altogether. The team has completed their initial analysis of unexplained deaths and suicides and has recommended 81 initiatives, including a handful that can be implemented within 90 days. The team will continue this analysis and additional assessment of serious incidents not involving death. When they complete their work, I will be pleased to provide the committee with a briefing on their findings and recommendations.

This effort is an example of the Army's commitment to caring for our Warriors. We identified an area of concern and took swift action to address it. The same is true of a recent concern identified by National Public Radio (NPR). In a report first broadcast on January 29, 2008, NPR reported that the Army was blocking disability paperwork aid to Soldiers at Fort Drum. We immediately looked into these allegations with the Army team who participated in the March 2007 meetings with Veterans Benefit Administration (VBA) personnel supporting Fort Drum. Army team members indicated that they had issued no directives to VBA personnel and had been quite impressed with the level of support and cooperation from the VBA team at Fort Drum. These assertions are contradicted by VBA notes of the meeting uncovered several days after the initial report. Clearly there had been a miscommunication between Army and VBA personnel. We worked directly with VA Secretary Peake to resolve the misunderstanding. On February 12th, Secretary Peake and Secretary of the Army Geren signed a *Statement of Mutual Support* that reinforces our joint commitment to assisting Soldiers and their Families transitioning through the military Disability Evaluation System (DES). The *Statement* clarifies roles and responsibilities so that the best interests of the Soldiers are achieved.

Again, these actions illustrate that when problems are raised we are committed to taking swift corrective action as warranted by careful assessment. In an effort to uncover concerns and problems at the earliest stage possible, we monitor and evaluate our performance through over 18 internal and external means. We use third-party surveys from industry leading survey firms, conduct unit surveys and regular Soldier sensing sessions, review weekly metric dashboards with over 400 data points, and provide monthly status reports to Secretary Geren. In addition, we host numerous visits from Members of Congress and your staffs—in January alone we opened our WTU

doors to more than a dozen congressional visits. These visits give us a valued external perspective and allow us the opportunity to be as open and transparent in our operations as possible. Your feedback has been instrumental to our success.

In closing, I want to emphasize that it is the Army's unwavering commitment to never leave a Soldier behind on a battlefield...or lost in a bureaucracy. I want to assure the Congress that the Army Medical Department's highest priority is caring for our wounded, ill, and injured Warriors and their Families. I am proud of the Army Medical Department's efforts over the last 12 months and am convinced that in coordination with the Department of Defense, the Department of Veterans Affairs, and Congress, we have "turned the corner" toward establishing an integrated, overlapping system of treatment, support, and leadership that is significantly enhancing the care of our Warriors and their Families. Thank you for holding this hearing and thank you for your continued support of the Army Medical Department and the Warriors who we are honored to serve. I look forward to your questions.

Mr. TIERNEY. Thank you, General.

General Jones, do you care to make any remarks?

General JONES. No, sir.

Mr. TIERNEY. OK. Mr. Dominguez, if you would.

JOINT STATEMENT OF MICHAEL L. DOMINGUEZ AND PATRICK W. DUNNE

Mr. DOMINGUEZ. Thank you, Mr. Chairman, Congressman Shays.

I want to start off first by offering my condolences to you on the loss of your colleague, Congressman Tom Lantos. I was a graduate student in California when he was first elected to Congress, and I had the privilege of having Tom Lantos as my Congressman for a short while.

I am privileged to be here with Admiral Dunne, the Assistant Secretary from Veterans Affairs, and our presence together and our joint testimony symbolizes the close working relationship that is now, I think, the single greatest achievement of the work over the last year at the major policy level within the Department. Our two departments are now welded together in a goal of delivering seamless support to service members as they transition into veteran status.

I want to acknowledge General Schoomaker's presence here. While we have done a lot at the national policy level, the policy coordination level, the military services, symbolized here by these two gentlemen to my right, have really changed the situation on the ground through their aggressive work and enlightened leadership.

I want to recognize our GAO colleagues. We have endeavored in our efforts from the first to be open. We have recognized we needed help in understanding the problem and in trying to devise solutions to that. That is where all those boards and commissions came from. We have received that help. We are thankful for it. We have acted on it. And extra eyes on this problem continue to be needed, so GAO's involvement and continued involvement is welcome.

Admiral Dunne and I have addressed in our written testimony and we will cover today lots of specific initiatives that we put in place since last year, but allow me please in these comments to put those details in the context of some broad, sweeping changes.

The first big change that I would like to call your attention to is this integration of DOD and VA into a single collaborative team of problem-solvers committed to delivering a seamless continuum of care. It wasn't that way when we started, but it is that way now, and I think that extends all the way down through our organizations and out into the field.

The second major change I would like to highlight for you is this fundamental shift in our approach to care and management and support of armed forces member in long-term outpatient status. General Schoomaker made reference to that. That is a huge change. Outpatients are no longer a special project of a first sergeant, but now they are organized into units, into these warrior transition units, and their needs are addressed comprehensively and holistically. That is a big change in how we approach a problem.

Third, there has been a huge shift in our approach to psychological health. There has been a recognition over this last year that psychological fitness is as important to a warrior's mission as is physical fitness, and staying psychologically fit is part of the warrior's job, and it is part of the commander's job to ensure the warrior remains fit. That premise is changing a lot of what we are doing and changing a lot of our approach to at mental health care in the Department of Defense, and that is a huge difference now.

The fourth big change is recognizing the complexity of our processes and the sense of powerlessness people in the system can feel. We have placed a major emphasis on robust case management, customer care, and communication, and a robust, involved, ever-present military organization and chain of command is an essential piece of that. That, also, is a huge change.

So these are big changes that now have us moving in the right direction. We have only just started work, turning our institution in that direction, and much remains to be done.

The last big change we need, however, rests with the Congress, and that is achieving the clarity and simplicity in transition from service member to veteran requires a legislative rationalization of the roles of the two departments, DOD and DVA. I urge you to act on the President's proposal implementing the recommendations of the Dole-Shalala Commission in this regard.

Thank you. I look forward to your questions, sir.

Mr. TIERNEY. Thank you very much.

Admiral, do you care to make some remarks, as well, please?

Admiral DUNNE. Mr. Chairman, members of the committee, I appreciate this opportunity to appear before you today. The Department of Veterans Affairs and Department of Defense continue to make excellent progress toward ensuring today's active duty service members and veterans receive the benefits, care, and services they have earned. I would also like to take this opportunity to thank the committee for its support for these efforts.

I am especially pleased to be here today with Secretary Dominguez. Over the past year, Mike and I have had a unique opportunity to focus the attention of both departments on the needs of those we serve. We concentrated attention on the need for a seamless transition. I want to publicly thank him for his leadership. The partnership between the two organizations and the lines of communication are stronger than ever, as evidenced by the establishment and success of the Senior Oversight Committee.

The Senior Oversight Committee has been in operation since May of last year. I note, however, that substantial high-level cooperative efforts in the areas of health care and benefits delivery predate the SOC. VA and DOD participated in the Joint Executive Council since February 2002. The JEC was designed to remove barriers and challenges faced by veterans and to support mutually beneficial opportunities. The JEC succeeded in the areas of benefits, health care, and joint ventures. The JEC was instrumental in launching the benefits delivery and discharge project, locating VBA counselors at military treatment facilities and establishing the traumatic service members group life insurance program. Through January 2008, TSGLI has paid out more than 4,100 claims to the tune of more than $254 million.

The JEC was also successful in employing the joint incentive fund. The fund supported 66 projects worth $160 million. The JEC championed the VA/Navy collaboration on a North Chicago Joint Federal Health Care Facility, led the way in data sharing initiatives, and helped extend dental care benefits for the National Guard and Reserve members. In short, the JEC provided the starting point for the SOC. The SOC established the eight lines of action, which generally aligned with the issues needing resolution.

The outstanding VA and DOD staff reviewed the recommendations presented by the numerous reports, investigations, and commissions to come up with a comprehensive plan of action, and the SOC is overseeing the efforts to implement that plan.

For example, the case management decision resulted in VA standing up in office, hiring the first eight Federal recovery coordinators, and assigning them to military treatment facilities. The disability evaluation system pilot project is underway and using a single medical exam from which DOD can make fit/unfit to serve decisions, and VA may decide a claim for disability benefits if the individual is found unfit.

But we realize we have more work to do. Data sharing, for example, has presented challenges as we seek to transfer patient data between our two systems. We are already implementing the requirements for the National Defense Authorization Act passed last session, but the issue of a new disability benefits system as proposed by the President remains an open item, and so VA contracted for two studies which will prepare us to move forward in this area. The studies are due for completion in August, and they will deal with transition payments, compensation, and quality of life issues as recommended by the Dole-Shalala Commission.

The issue of rehabilitation medicine continues to evolve as we treat and evaluate the patients returning from the battlefield, entering acute care treatment, and initial rehabilitation in military treatment facilities before they transition to VA poly trauma centers and medical centers.

Be assured the SOC is prepared to come together whenever necessary to make decisions and eliminate the obstacles faced by the dedicated VA and DOD staff which oversee the efforts on each line of action. VA continues its commitment to address any issues regarding cooperation between the two departments, and our efforts continue to enjoy support at the highest levels.

This concludes my statement, and I look forward to your questions.

[The prepared joint statement of Admiral Dominguez and Admiral Dunne follows:]

STATEMENT FOR THE RECORD BY

THE HONORABLE MICHAEL DOMINGUEZ
PRINCIPAL DEPUTY UNDERSECRETARY OF DEFENSE FOR PERSONNEL AND READINESS

AND

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

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

27 February 2008

Good afternoon. Mr. Chairman, Ranking Member Shays, distinguished Members of the Subcommittee, we deeply appreciate your steadfast support of our military and welcome the opportunity to appear here today to discuss improvements implemented and planned for the care, management and transition of wounded, ill, and injured service members. We are pleased to report that while much work remains to be completed, meaningful progress has been made through improved processes and greater collaboration between the Department of Defense (DoD) and the Department of Veterans Affairs (VA).

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

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

Senior Oversight Committee

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

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

Major Initiatives and Improvements

The two Departments are in the process of implementing more than 400 recommendations of five high-level working groups, as well as implementing the Wounded Warrior and Veterans titles of the recently enacted National Defense Authorization Act, Public Law No. 110-181. We continue to implement recommended changes through the use of policy and existing authorities. For example, in August 2007, the Secretaries of the Military Departments were directed to use all existing authorities to recruit and retain military and civilian personnel who care for our seriously injured warriors. Described below are the major initiatives now underway.

Disability Evaluation System

The fundamental goal is to improve the continuum of care from the point-of-injury to community reintegration. To that end, in November of last year, a Disability Evaluation System (DES) Pilot test was implemented for disability cases originating at the three major military treatment facilities in the National Capitol Region (Walter Reed Army Medical Center, National Naval Medical Center Bethesda, and Malcolm Grow

Medical Center). The pilot is a service member-centric initiative designed to eliminate the often confusing elements of the two current disability processes of our Departments. Key features include both a single medical examination and single source disability rating. A primary goal is to reduce by half the time required to transition a member to veteran status and receipt of VA benefits and compensation.

The pilot addresses those recommendations that could be implemented without legislative change from the reports of the Task Force on Returning Global War on Terror Heroes, the Independent Review Group, the President's Commission on Care for America's Returning Wounded Warriors (Dole/Shalala Commission), the Veterans Disability Benefits Commission (Scott Commission), and the DoD Task Force on Mental Health. Its specific objectives are to improve timeliness, effectiveness, transparency, and resource utilization by integrating DoD and VA processes, eliminating duplication, and improving case management practices.

To ensure a seamless transition of our wounded, ill, or injured from the care, benefits, and services of DoD to the VA system, the pilot is testing enhanced case management methods and identifying opportunities to improve the flow of information and identification of additional resources to the service member and family. The VA is poised to provide benefits and compensation to the veterans participating in the pilot as soon as they transition from the military.

The pilot covers all non-clinical care and administrative activities, such as case management and counseling requirements associated with disability case processing, from the point of service member referral to a Military Department Medical Evaluation Board

(MEB) through compensation and provision of benefits to veterans by the VA. Assessment of the Pilot will consider:

- Performance measures – The pilot evaluation plan includes extensive quantitative and qualitative performance measures to ensure our service members obtain all benefits and entitlements due under both DoD and VA law. Although no service members have completely transitioned from the pilot to veteran status, we expect a reasonable sample population to have processed through by mid-June. We'll complete our initial analysis at that time and make a determination regarding expanding the pilot.
- Site assessment – The following criteria will be thoroughly analyzed by both Departments: resources, IT architecture development and fielding, case management effectiveness, training requirements, DES workload (for DoD and VA) in expansion areas, and costs;
- Case management – Most importantly, pilot expansion to a broader population will require training and certification of DES and VA administrative and case management personnel. It is anticipated that certification of the case managers and determination of the appropriate case manager staff size will be the overriding factors that limit or allow expansion of the pilot to other areas.
- Phased expansion – Unlike the pilot's Physical Evaluation Board phases, which are consolidated in the NCR, the medical assessment and MEB phases occur across the Departments at numerous Medical Treatment Facilities (MTFs) and VHA sites. Phased expansion of the pilot should allow MTF site preparation and training on a manageable timeline.

The pilot is part of a larger effort including medical research into the signature injuries of the war and updating the VA Schedule of Rating Disabilities (VASRD). Proposed regulations to update the disability schedule for Traumatic Brain Injury and burns were published in the Federal Register on January 3, 2008.

Psychological Health and TBI

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

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

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

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

To ensure all service members are screened appropriately for TBI, questions have been added to Post-Deployment Health Assessment and Post-Deployment Health Reassessment. That same information is shared with VA clinicians as part of an effort to facilitate the continuity of care for the veteran or service member.

To ensure appropriate staffing levels for PH, a comprehensive staffing plan for psychological health services has been developed based on a risk-adjusted, population-based model. To augment staffing levels, DoD has partnered with the Department of Health and Human Services (HHS) to provide uniformed Public Health Service officers in Medical Treatment Facilities to increase available mental health providers for DoD. DoD and the VA also continue to improve the Mental Health Self Assessment Program. Program expansions, documented in an updated report to Congress submitted in February 2007, included:

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

In November 2007, the Department of Defense Center of Excellence (DCoE) for Psychological Health and Traumatic Brain Injury was established as a national Center of Excellence for PH and TBI. It includes VA and HHS liaisons, as well as an external

advisory panel organized under the Defense Health Board, to provide the best advisors across the country to the military health system. The center facilitates coordination and collaboration for PH and TBI related services among the Military Services and VA, promoting and informing best practice development, research, education and training. The DCoE is designed to lead clinical efforts toward developing excellence in practice standards, training, outreach, and direct care for our military community with psychological health and TBI concerns. It also serves as a nexus for research planning and monitoring the research in this important area of knowledge. Functionally, the DCoE is engaged in several focus areas, including:

- Mounting an anti-stigma campaign;
- Establishing effective outreach and educational initiatives;
- Promulgating a tele-health network for clinical care, monitoring, support and follow-up;
- Coordinating an overarching program of research including all DoD assets, academia and industry, focusing on near-term advances in protection, prevention, diagnosis and treatment;
- Providing training programs aimed at providers, line leaders, families and community leaders; and
- Designing and planning for the National Intrepid Center of Excellence (anticipated completion in fall 2009), a building that will be located on the Bethesda campus adjacent to the new Walter Reed National Military Medical Center.

The FY 07 Supplemental Appropriation provided DoD $900 million in additional funds to make improvements to our PH and TBI systems of care and research. These funds are important to support, expand, improve, and transform our system and are being used to leverage change through optimal planning and execution. The funds have been allocated and distributed in three phases to the Services for execution based on an overall strategic plan created by representatives from DoD and the Services with VA input. Of the $600 million O&M Funds, $566 million (94 percent) has been distributed, including $315 million for PH and $251 million for TBI. The remaining balance is reserved for expansion of promising demonstration programs and for additional costs that emerge as the plans are executed.

Care Management

To improve care management, the complexities between our two care management systems are being reduced through the Federal Recovery Coordination Program, which will identify and integrate care and services for the wounded, ill and injured service member, veteran and their families through recovery, rehabilitation and community reintegration.

New comprehensive practices for better care, management, and transition are being implemented. These efforts include responses to requirements of the National Defense Authorization Act 2008 regarding the improvements to care, management, and transition of recovering service members. Progress is being made toward an integrated continuity of quality care and service delivery with inter-Service, interagency, intergovernmental, public and private collaboration for care, management and transition,

and the associated training, tracking, and accountability for this care. Our efforts include important reforms such as uniform training for medical and non-medical care/case managers and recovery coordinators, and a single tracking system and a comprehensive recovery plan for the seriously injured.

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

- Hired, trained, and placed eight Federal Recovery Coordinators (FRCs) at three of our busiest Medical Treatment Facilities as recommended by the Dole/Shalala Commission. Additional FRCs will be hired as needed beginning in May;
- Developed a prototype of the Federal Individual Recovery Plan (FIRP) as recommended by the Dole/Shalala Commission; and
- Produced educational/informational materials for FRCs, Multi-Disciplinary Teams, and service members, veterans, families, and caregivers.

We are also in the process of:

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

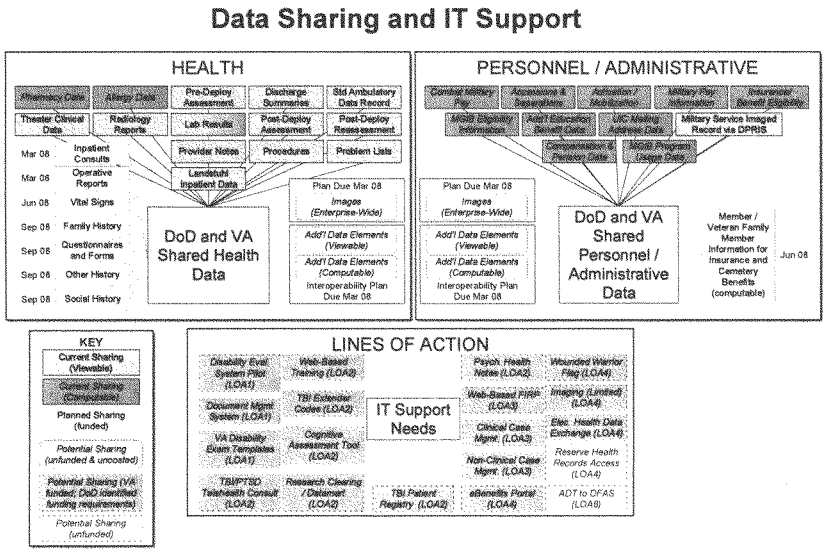
• Producing a Family Handbook in partnership with relevant DoD/VA offices;

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

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

Data Sharing Between Defense and Veterans Affairs

Steps have been taken to improve the sharing of medical information between our Departments to develop a seamless health information system. Our long-term goal is to ensure appropriate beneficiary and medical information is visible, accessible, and understandable through secure and interoperable information technology.



The SOC has approved initiatives to ensure health and administrative data are made available and are viewable by both agencies. DoD and the VA are securely sharing more electronic health information than at any time in the past. In addition to the outpatient prescription data, outpatient and inpatient laboratory and radiology reports, and allergy information, access to provider/clinical notes, problem lists, and theater health data have recently been added.

In December 2007, DoD began making inpatient discharge summary data from Landstuhl Regional Medical Center immediately available to VA facilities. The plan for information technology support of a recovery plan for use by Federal Recovery Coordinators was approved in November 2007. A single web portal to support the needs of wounded, ill or injured service members, commonly referred to as the eBenefits Web Portal, is planned based on the VA's successful eVet website.

Medical Facilities Inspection Standards

Progress has been made to ensure our wounded warriors are properly housed in appropriate facilities. Using the comprehensive Inspection Standards, all 475 military Medical Treatment Facilities (MTFs) were inspected and found to be in compliance although deferred maintenance and upgrades were cited. The Services are continuing an aggressive inspection of MTFs on an annual basis to ensure continued compliance, identify maintenance requirements, and sustain a world-class environment for medical care. In the event a deficiency is identified, the commander of the facility will submit to the Secretary of the Military Department a detailed plan to correct the deficiency, and the commander will periodically re-inspect the facility until the deficiency is corrected.

All housing units for our wounded warriors have also been inspected and determined to meet applicable quality standards. The Services recognize that existing temporary medical hold housing is an interim solution and have submitted FY 08 military construction budgets to start building appropriate housing complexes adjacent to MTFs. They will also implement periodic and comprehensive follow-up programs using surveys, interviews, focus groups, and town-hall meetings to learn how to improve housing and related amenities and services.

Transition Issues/Pay and Benefits

Service members transitioning from military to civilian life can also benefit from a collaborative effort between DoD, the Department of Labor, DVA, and and the military services. The DoD Pre-Separation Guide, which informs service members and their families of available transition assistance services and benefits, is now available at http://www.TurboTAP.org.

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

DoD and the VA have shared information concerning Traumatic Injury Service members Group Life Insurance (TSGLI) and implemented plans replicating best practices. The Army is now placing subject-matter experts at MTFs to provide direct support of the TSGLI application process and improve processing time and TSGLI payment rates. The VA Insurance provider's payment time, upon receipt of a certified claim from the branch of Service, averages between two and four days. DoD has been successful using Congressional authority from the NDAA allowing continuation of deployment related pays for those recovering in the hospital after injury or illness in the combat zone. This ensures no reduction in deployment pays while the Service member is recovering.

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

Conclusion

The Senior Oversight Committee and its Overarching Integrated Product Team continue to work diligently to resolve the many outstanding issues while aggressively

implementing the recommendations of Dole/Shalala, the NDAA, and the various aforementioned task forces and commissions. These efforts will expand in the future to include the recommendations of the DoD Inspector General's report on DoD/VA Interagency Care Transition, which is due shortly.

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

While we are pleased with the quality of effort and progress made, we fully understand that there is much more to do. We also believe that the greatest improvement to the long-term care and support of America's wounded warriors and veterans will come from enactment of the provisions recommended by Dole/Shalala. We have, thus, positioned ourselves to implement these provisions and continue our progress in providing world-class support to our warriors and veterans while allowing our two Departments to focus on our respective core missions. Our dedicated, selfless 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. We look forward to your questions.

Mr. TIERNEY. Thank you, Admiral.

Ms. McCollum, you are recognized for 5 minutes to begin the questioning.

Ms. MCCOLLUM. Thank you, Mr. Chair. I have two questions. I think one is quick, so I will go with that.

Are you aware if we are beginning to test soldiers prior to being deployed for mental cognizant capability? In other words, I have been told that there are tests available where you can measure someone ahead of time and then find out later on if they have received traumatic brain injury. Are we doing that?

Mr. DOMINGUEZ. Yes, Congresswoman, we have started that program in the Department of Defense to apply a cognitive baselining test to people deploying into the combat theater. It is not comprehensive yet. We are not doing it to everybody, but we are starting in both sessions and trying to get into the deployment cycle. I think the 101st Airborne Division, if I am right——

Ms. MCCOLLUM. If you could get my office and the committee some more information on that, I would like it. And when you see everyone being deployed having that available, that would be great. Thank you.

Mr. DOMINGUEZ. Happy to.

Ms. MCCOLLUM. I would like to move on to another area. In the report—and thank you, gentlemen, for your report-on page 5 under the disability evaluation system, item No. 1, your words, "GAO continues to have concerns in the hiring, training shortfalls," and goes on about lack of full utilization of judge advocates. Later on in the report you are talking about how the VA and the military still haven't come together on coming up with a seamless disability evaluation process, so I am concerned about that and I would like to hear from you in a minute what they need to do to correct this error, and if there is money in the President's budget to do whatever they need to do with computer software or hiring people or whatever is going to be required.

The reason why I am concerned, General Schoomaker, is a couple of weeks ago, listening to National Public Radio, as I do every morning, there was a story of Fort Drum in New York, where the soldiers had been allegedly told by the VA that the VA could not advise them through disability evaluation systems. Now you have characterized that as a miscommunication now, but the soldiers really felt that they were getting the short end of the stick here. It is well established, VA ratings are often higher than the ones that are given by the military service, as was pointed out in testimony that we had here several months ago.

But I want to walk through the facts, particularly in light of GAO's testimony today that 20 percent of the eligible service members at Fort Drum, approximately 105 wounded soldiers, are not in a warrior transition unit. You established an ad hoc group, Tiger Team, in 11 different hospitals and installations to cover the quality of rehabilitative care for our soldiers and the process of transitioning them from DOD to VA.

As the NPR story relates, a Tiger Team went to Fort Drum, New York and found the veterans benefit advisors at the installation performing very well. In fact, they were performing so well that the Tiger Team even qualified it as almost a best practice. Yet, the

message received at Fort Drum from the Tiger Team was the complete opposite. Though you told NPR there was no Army policy stating that a soldier could not receive outside advice in filing disability paperwork, that was exactly what your Tiger Team stated at Fort Drum. In fact, the VA official who attended the meeting wrote a memo the following day detailing the discussion under the heading "Major discussion points by attendees."

The first point states that the colonel from the Tiger Team said, "The Veterans Benefit Administration should discontinue counseling Medical Evaluation Board soldiers on the appropriateness of DOD, MEB/PEB ratings and findings. There is a conflict of interest. This activity should go on to any service organization, military Purple Heart at Fort Drum. They should assume the responsibility immediately."

So, General Schoomaker, I want to know how you could characterize this as a miscommunication. How is it that the Tiger Team could tell you that Fort Drum was doing a laudable job, but at the same time communicate to folks at Fort Drum, in what appears to be a fairly ambiguous manner, that their veterans benefit advisors should stop counseling injured soldiers on medical evaluation processes, especially after here in this committee there was an agreement that there was going to be work done to solve this problem, and it was going to seem seamless for the veteran?

General SCHOOMAKER. Well, ma'am, let me just real quickly review the facts in that case.

The team that you are referring to went to 11 facilities, installations and hospitals, around March 2007, almost a year ago, at the very outset of our problem at Walter Reed.

While we were standing up the Army medical action plan, the then Acting Surgeon General of the Army sent this team on the road. They were rapidly attempting to harvest best practices around the country.

Fort Drum happened to be about the last place they went, and their account of their encounter and their investigation of what was going on at Fort Drum was exactly as you depicted. It was one of the best that they had seen. In fact, they were extraordinarily laudable about what they saw the counselors doing and tried to harvest as many of those practices as possible for use within the bigger system.

When we heard about the story that NPR was going to float, I talked to, or my staff talked directly to people who were on the Army team, as well as senior supervisors within the VA at Buffalo who were at the meeting, and they recounted that no such discussion took place, and that it was a very, very collegial, very positive, very informative session in which there were no contentious issues, and nobody could recall this exchange taking place.

In fact, I talked personally to the colonel that is quoted in the memo to ask her did anything to awry in this meeting, and it was absolutely the opposite.

We tracked down as many members of the team as possible, and they all recounted exactly as I said.

Unfortunately, the memorandum was not surfaced before the story. It was not shared with the team before they left Fort Drum or my office or my predecessor's office before. In fact, that memo-

randum only surfaced the day after the story was given, and after I had already made comments to the effect that we weren't entirely sure how this could have happened this way because everybody who was at the meeting recounted it was an extraordinarily positive exchange, and we encouraged them to do what the VBA counselors were doing on behalf of our soldiers.

But as soon as that memorandum was surfaced, a memorandum written by a single attendee at that meeting, was never verified, never ratified by the other members who were in attendance there, I said, "OK, clearly there has been a miscommunication here and misunderstanding between them. Let's prevent this from happening."

We got a hold of Secretary Peake almost immediately. Secretary Peake very graciously said, "You know, there appears not to be the standardization and understanding around our counselors. Let's eliminate the possibility this could ever happen again." We immediately sat down and wrote a memorandum of——

Ms. MCCOLLUM. General, my time has expired here.

General SCHOOMAKER. Yes, ma'am.

Ms. MCCOLLUM. I am very confused.

Mr. TIERNEY. I will give the gentlewoman more time if you want it.

Ms. MCCOLLUM. Thank you. I am very confused on this, because there was actually a followup story the second day, or a couple days later, on NPR, and other people collaborated with what had happened. In fact, if I am remembering correctly, several of the men were actually kind of nervous about being identified even because they didn't want to move forward.

I have a document—they tried to put it up on the screen, sir, and they were unable to do so. If you need to see this, we can make sure you can see it, as well.

General SCHOOMAKER. Is this the memorandum, ma'am?

Ms. MCCOLLUM. Yes, it is.

General SCHOOMAKER. I have the memorandum.

Ms. MCCOLLUM. Saturday, March 31, 2007, summary of Tiger Team visits on March 30, 2007, at 3:45 p.m. On the first page, Colonel Baker, item No. 1, "Major discussion points by attendees." So the attendees would be the soldiers who were there, correct?

General SCHOOMAKER. No, ma'am. Not that I recall. I was not at the meeting, myself, but I understand——

Ms. MCCOLLUM. OK. But Colonel Baker says, "VA should discontinue counseling MED soldiers on the appropriateness of DOD EMB/PEB ratings and findings. There exists a conflict of interest. This activity should go to any service organization"—and it recognizes Military Order of the Purple Heart—"and Fort Drum should assume this responsibility immediately."

Now, that is in writing, and Colonel Baker says that major discussion points by attendees. That means people were discussing it, correct, if it is a discussion?

General SCHOOMAKER. Ma'am, I——

Ms. MCCOLLUM. Are you saying Colonel Baker is totally inaccurate in what he said, that he has fabricated what is on here?

General SCHOOMAKER. Ma'am, what I am telling you is that Colonel Baker has said she never said that; that there were discus-

sions in the room about whose lane should—you know, what work should be done by what counselors. The VBA counselors are very gifted in their knowledge of benefits for veterans within the Veterans Administration. They are not necessarily experts in the Medical Evaluation Board process. Those were all sorted out.

I mean, what I am telling you, not having been in the room, one member who attended that meeting wrote those minutes, and I said to Congressman McHugh from upstate New York and I said at the NPR counsel I very much regret that the recorder of those minutes didn't share it with anybody else until a year later and a day after the story popped. Had they been shared, I think we would have been able to, one, corroborate it, and, two, validate it.

Ms. MCCOLLUM. Mr. Chair, I am very disturbed by this. Since we are doing a lot of case work, way too much case work because too many people have been injured in the war in Iraq, and we thank them for their sacrifice, but I am hearing stories like this in my office of people afraid of challenging the system and that. I thought we had made it real clear after our last set of hearings here that we wanted this solution fixed and we wanted our veterans taken care of.

Thank you, Mr. Chairman.

Mr. TIERNEY. Thank you, Ms. McCollum.

Mr. Platts, you are recognized for 5 minutes.

Mr. PLATTS. Thank you, Mr. Chairman.

I first want to thank each of you for your testimony here today, but especially for your efforts on behalf of our wounded personnel who have been courageous in their service, and to our two generals in uniform, as well as our civilian leaders in the departments, as well as the GAO trying to oversee all that we are doing.

Clearly, as we found a year ago, we had some significant shortcomings in our system. I know each and every one of you have worked diligently to address some in the last 12 months and continue to do so. I want to express appreciation for your efforts.

I regularly interact with families and wounded personnel from my District, and what I often most clearly hear is gratitude for the care they are receiving. The one thing that came through last year and has been addressed in some of the testimony here today I want to start with is that transition, because that seemed to be what I took away from the hearing at Walter Reed a year ago was the soldier coming right out of the battlefield and the inpatient care was tremendous and the medical care outstanding, but the transition to either outpatient or from military to VA, from DOD to VA is where we broke down, and a lot of this effort has been about trying to address that.

Some of it is technology related, and I guess I would start with both of our Secretaries. That hand-off from DOD to VA, my understanding is that, while we are working on it, we still have some significant IT challenges of allowing it to be seamless so that the VA physicians get the up-to-date, reliable, accurate data. Can the two of you give me an update from your two different perspectives those handing off the material, and then VA with receiving it, where you see us today and where we are heading?

Mr. DOMINGUEZ. Thank you, sir. I would be happy to start.

I hope we don't have two different perspectives on this, because we have established a joint organization, you know, to drive this forward all the way across, not just in health care but in the administrative benefits, personnel information exchange, as well.

The physicians on the medical side are making enormous progress—and there is a table included in our testimony that highlights that—on sharing information now and electronic media, so it describes the information that is already now being exchanged.

More importantly, I think, in terms of the greater journey, we are committed to in our two Departments to building interoperable systems, so that the exchanges we have now with viewable information, so you can see the notes I took and what I wrote, but what we would like to do is move that into where it is computable data, inasmuch as we possibly can.

The MDA put us on that journey or ratified that journey, and we are on it.

Admiral Dunne.

Admiral DUNNE. Just to add on what Mike said, we are in accordance with NDAA, about to set up a program office which will look at how we put a program together to continue on what we are doing. We are on track for, by the end of this year, to have completely viewable health and personnel records that are needed to work with all our soldiers and veterans, and, as Mike said, we are working together. We don't have two different perspectives on it. We have two senior members of the SOC on each side, DOD and VA, whose job is to coordinate this efforts, to get our records first viewable and then interoperable.

Mr. PLATTS. Now, in the hearing last year the one issue was just a legal barrier of whether you could share the records. It sounds like you have overcome that. There was a concern expressed last year whether HIPAA and some other laws allowed you to share, but it sounds like that is not an issue today?

Admiral DUNNE. I think from time to time someone will raise that flag and question whether HIPAA or some other rule is an impediment. Most times so far we have been able to answer those questions and move on.

Mr. PLATTS. Because I am going to run out of time and I have several issues I want to cover, the next one deals with National Guard. With such a huge percentage of our troops being deployed being Guard or Reserves, and in Pennsylvania huge Army Guard, Air Guard units that have been deployed, and I have had the privilege of visiting them in theater and they are doing remarkable work, but when they come home, they don't come home to a typical base. They come home to communities across the State of Pennsylvania, across this country.

I know there has been the effort with the transitional assistance advisors that has been stood up, and really from the Guard side, but one of the challenges is how we are funding it.

I joined with the ranking member and the Chair of the subcommittee as well as the Chair and ranking member of the full committee earlier this week in a letter to Dr. Chu asking for DOD to look at dedicated funding for this transitional assistance. I know it is a letter we just sent out the beginning of this week. Is there any position you can share today of looking at this funding need,

because from my understanding the TAA system is being critical to helping Guard who are coming back to their home communities with some significant needs. Has DOD taken a position thus far on that request?

Mr. DOMINGUEZ. I would say, first, we are looking at this whole integration of reintegration for the Guard and Reserve. We set up a major task force under Assistant Secretary for Reserve Affairs Tom Hall to really take the Yellow Ribbon programs that Congress sponsored and that we were doing experiments in 15 States, and we are going to expand that to all 50 States now. So Tom Hall is leading that effort, working in close cooperation with Lieutenant General Steve Blum and the chiefs of the Reserve components.

With regard to the funding, this is a tougher issue because, while there is some level of funding that should be in the baseline for ongoing, sustained family support programs for the Guard and Reserve—and there was before and maybe that needs to be increased—the major requirement, the major increase in requirement is really driven by the fact that we are taking National Guard brigades and deploying them into combat and then bringing them home. So that challenge, the way we are now structured in the way we do the budgeting really is supplemental funding issue.

Now, I know that the appropriations committees are working with the administration and the Comptroller of the Department about moving away from supplementals and moving things into the base budget, so those things will get resolved, I think, in that discussion.

What I am sharing with you is some initial reactions. In terms of the Department's or the administration's position on this, we don't have it. I will certainly ensure we take a quick look at it. I deeply appreciate the problem we have in funding this long-term, sustained care need with money that comes from month to month almost.

Mr. TIERNEY. Thank you, Mr. Platts.

Mr. PLATTS. If I could conclude real quick——

Mr. TIERNEY. We have to, only because we have votes to go and I want to give everybody an opportunity to question.

Mr. PLATTS. OK.

Mr. TIERNEY. So 2 seconds or less.

Mr. PLATTS. I just wanted to emphasize that, whether it be Guard, Reserve, or active duty, the bottom line is baseline supplemental is that we get it done, and I appreciate your efforts.

Mr. TIERNEY. Thank you, Mr. Platts.

Mr. PLATTS. Thank you, Mr. Chairman.

Mr. TIERNEY. Mr. Hodes, you are recognized for 5 minutes.

Mr. HODES. Thank you, Mr. Tierney. Thank you very much. And I thank the panel for coming. I thank you all for your efforts to make things better.

I would like to address, Mr. Dominguez, a question to you. I just came back from Iraq last week, where I heard with great concern of an uptick in the level of suicides and other mental health problems in theater. I note in your written testimony that the Army has incorporated neurocognitive assessments as a regular part of its soldier readiness processing in select locations, and select Air Force units are assessed in Kuwait before going into Iraq.

How quickly do you plan to expand the program of neurocognitive assessments to everybody who is being deployed in theater? What do you know about the problem? My sense was that the extended deployments are taking an unimaginable toll on our brave troops, and we are seeing it in mental health problems and suicides in theater. I would like you to address that, if you would.

Mr. DOMINGUEZ. Direct, I first want to separate the two issues. The neurocognitive assessments won't give us any insight into tendencies to suicide and depression and those kind of issues. The neurocognitive assessment is really about brain function. It is intended to give us a baseline for how you respond in these different parts of brain function so that if there is a concussive injury or something like that we have a baseline to measure it against and see if we can document that.

Mr. HODES. Let me just followup. Understood. Does that mean that you are also assessing pre-deployment mental health status in terms of depression, tendency to depression, and any non-neurocognitive deficiencies which might lead to the magazine of health problems which we are now seeing.

Mr. DOMINGUEZ. Sir, the Surgeon General of the Army is much more qualified, I think, to deal with that, because it is his troops implementing his procedures that deal with that.

General SCHOOMAKER. Yes, sir. I completely concur with what Mr. Dominguez said. The neurocognitive assessment that is being done that was referred to earlier by Congresswoman McCollum refers to baseline assessment for concussion.

We have been and continue to assess symptoms of depression and the like prior to deployment and then immediately upon re-deployment, and then 90 to 180 days after re-deployment in what is known as a post-deployment health reassessment [PDHRA]. That derives from studies that we have conducted now that symptoms of post-traumatic stress arise in the 90 to 180-day window after re-deployment, not immediately upon re-deployment.

Mr. HODES. I appreciate that. In Iraq I learned that there are approximately 100 mental health professionals dealing with our troops there spread throughout the country. What attention is being paid by you to the uptick in mental health problems and suicides in theater?

General SCHOOMAKER. Sir, we can take the question for the record, but I think the number is closer to 200 mental health providers in Iraq, but the concern about suicide has gotten a lot of attention from the theater command, as well as the Army as a whole, and we have sent assessment teams down-range to look at root causes for the problem and continue to track suicide risks as they return from theater. The Army, with the lead by the Army G–1, Chief of Personnel for the Army, and with me in support, and our Chief of Chaplains and others are looking at a comprehensive suicide prevention program and are dealing with or advising our leadership as we speak about what we will do about this suicide risk.

Mr. HODES. How soon do you plan to deploy the suicide prevention program? And do you have any conclusions yet about why we are seeing this sharp uptick of suicide rate in theater?

General SCHOOMAKER. Sir, I am not qualified to talk about the in-theater suicide risk right now, nor how quickly. Clearly, the

Army has had an ongoing and continues to have an ongoing suicide prevention program and has for many, many years. It has been very successful. We see the trends that you described. It has alerted us to the issue and we are taking a very fundamental root cause and comprehensive approach to this, using a public health model to see if we can turn the tide.

Mr. TIERNEY. Mr. Hodes, thank you very much.

Mr. HODES. Thank you, Mr. Chairman.

Mr. TIERNEY. Gentlemen, let's see if we can get through this so we don't have to bring you back after the votes. I have essentially three categories here that I want to cover. The rest of it I think we have in the written documentation that you have been kind enough to provide.

The first has to do with personnel. What I would like to do is ask a question about a particular nature of personnel and then get the response from whoever feels qualified to answer, then reaction from Government Accountability Office and what you might add as a recommendation to how the situation gets addressed.

Legal staff—we have a problem there. The process is slow, according to the reports on that, very difficult to try and get it through so that we can hire people up in time. What are we doing about it and what does Government Accountability Office recommend we do about it?

General JONES. Sir, let me take the legal question. First of all, each soldier has access to counsel.

Mr. TIERNEY. I am going to say yes, we know, because we read the reports. Just what are we doing about it and go. Otherwise, we are going to have to have you back.

General JONES. Bottom line, sir, we have 57 members that the Army is planning to distribute to the field.

Mr. TIERNEY. Right. And do you have them all hired up and ready to go, because the information reports that we are falling short on the numbers, and one of the problems was that the process was so formal and so slow that you were having difficulty.

General JONES. No, sir. The plan has not been approved, but I was informed yesterday that it is at the Army level for approval.

Mr. TIERNEY. Is that a satisfactory response from GAO's point of view?

Mr. BERTONI. I would acknowledge that is the condition. I guess I don't know, sitting here, exactly what the fix is, but I would acknowledge that, of the 57 that are needed, I know there has been recent approval for 30 more. Half of those are civilian sector; the other half are military sector. On the civilian side I think we point to just the general Federal hiring policies for bringing in civilian sector employees. There may be some room there to look at those and see if there is some way to get some dispensation within those guidelines to fast-track the civilian sector.

On the military side, the biggest concern we have is that the Army's own policies of rotation is 12 to 18 months. Disability is very complex. It takes a long time to sort of overcome their learning curve. You could get an attorney in place who has been there for 12 to 18 months, very good, very adept at the issues, and they're gone. So, again, that is within the Army's control. I know there are needs all over the organization, but to the extent that

they are losing brain power and disability expertise, that is something that they should look at.

Mr. TIERNEY. General, could you address those and get back to us in writing as to what you think ought to be done with those?

General SCHOOMAKER. Yes, sir.

Mr. TIERNEY. I think they are both valid points, and I would like to hear what you recommend as to how we are going to address each of those and how quickly it can be done.

General SCHOOMAKER. Yes, sir.

Mr. TIERNEY. Thank you.

In terms of most case managers, it seems to be going as well as any of the positions on that, but we have a problem with doctors with a current ratio of 200 to 1. There were some comments from the doctors that they were overwhelmed because of the complexity of the issues they were dealing with, as well as the volume when surgeries occurred, and a recommendation from some of them that the number be reduced to 100 patients per doctor. How realistic is that, General? Are we moving in that direction, or can we not move in that direction? What is GAO's response to that?

General SCHOOMAKER. Sir, I would have to say that the ratio of 1 to 200 was taken as a very, very conservative, that is protective kind of ratio. I mean, our normal primary care provider ratios are in the range of 1 to 1,000 or 1 to 1,500, so we felt, in setting the goal at 1 to 200, that was very generous. I think we need to go back and look at that, based upon what we heard from the GAO.

Mr. TIERNEY. Thank you.

And, gentlemen with the GAO, is that just your repetition of complaints that you heard, or was that an in-depth analysis of GAO agreeing with the complaint?

Mr. BERTONI. I would say the noise we heard out there, I wouldn't say it is projectable to the force, as a whole. What we are trying to bring to the table is that, when we went to these various facilities, there were concerns about that ratio. Most of the time, that concern was based on when there were surges, particular units coming in during a surge of activity or individuals coming in to the process.

One of the things I do know that the military is doing is putting together these traveling med units where they can go ahead and deal with these surges. Perhaps that is one way to just expand these units and, at least for a short time, stop-gap measure, to alleviate the pressure. But, I think, certainly looking at that ratio, I don't know what it is, but there is some concern out there at times, and it behooves the military to look at it.

Mr. TIERNEY. Thank you. General, we appreciate your willingness to take a look at that. Next time we get together maybe we will have a response of what you found out on that.

The evaluation board liaisons are having some difficulty there. The goal has yet to be met. Are we on track to meet that any time soon, or is there a particular issue?

General SCHOOMAKER. Sir, I think the shortages were accurately reported and portrayed by the GAO. We have hiring actions out on all of them. Our populations of WTUs, as the GAO report describes, and as you have seen over the last year, we have continued to grow, to move the population into the WTU in a very, very delib-

erate and rational fashion. In fact, I think your packets contain the decision matrix we used to decide whether a soldier should remain out in a unit and not a part of the WTU or moved over.

As the unit gets larger, then we add additional PEBLOs, but I think GAO captured it. These are tough hiring actions, and the training is difficult.

Mr. TIERNEY. Just briefly, the apparent issue of getting eligible service members into the transition units, what are we doing about that? Do you agree with GAO's assessment on that? And if so, what are we going to do?

General SCHOOMAKER. I think we have been very responsible about this, to be candid with you. Let me just go back and put it into context, the fact that the Army and the services have always had soldiers with a variety of injuries and illnesses, and I need to emphasize at this point what the Secretary said earlier, that these are wounded, ill, and injured soldiers. These are not just all combat wounds. In fact, the majority of our soldiers, I would say, across the WTUs, are not as a consequence of wounds in combat. They are illnesses and injuries on training ranges and motor vehicle accidents, cancers, heart disease—all the things that we are prone to.

The Army has always had soldiers distributed out through its companies, platoons, battalions who are in a range of recovery and treatment, and what we have done is to systematically move them in in accordance with whether they are going to be in it a long time, whether it doesn't look like they are going to get back immediately to that unit, whether that unit is going to deploy or not deploy. We don't want to leave a deploying unit with a large number of these soldiers.

We have done it very systematically. Those that have remained out there I think, if you look at our decision matrix, are generally soldiers who are not going to be in long-term recovery. They are not in any unit that is going to deploy. They are not at risk for alcohol problems or family violence or suicide, and so we have left them out there. Frankly, this is a decision made with the consent of the commander of the unit. They are very receptive to that.

Mr. TIERNEY. Do you want to add anything to that, GAO, Mr. Pendleton?

Mr. PENDLETON. Yes, sir. The Army put some guidance out about this in December which said that this is envisioned to be the exception rather than the rule, that someone would stay outside their warrior transition unit. There are 40 percent or more folks that are outside at a couple locations.

Mr. TIERNEY. Did you say 40 percent?

Mr. PENDLETON. Yes, which doesn't sound like the exception to me. However, I have to tell you this number is not going to be zero. I mean, as General Schoomaker points out, some people probably ought to stay with their unit. They might have had a severely injured knee but they can do desk work, that kind of thing. But I think the Army needs to stay on this, sir.

Mr. TIERNEY. OK. Maybe, General Schoomaker and Mr. Pendleton and Mr. Bertoni can work on that. Next time we come back we will see whether that 40 percent number is a bit high and what it is made of. We will go a little deeper into that.

General SCHOOMAKER. Yes, sir. I think, Mr. Pendleton, you depicted a regional thing. I think across the Army it is probably under 10 percent.

Mr. PENDLETON. I think it is 22.

General SCHOOMAKER. Never argue with an accountant.

Mr. PENDLETON. Right.

Mr. TIERNEY. But I am interested in knowing whether the 22 percent number is a good number for us or not. I would appreciate you digging down a little deeper on that at GAO and let's be certain that they are getting them over there if they need to be put over there on that.

Just very quickly, on the squad leaders, are we having any difficulty getting people to go into that position, or do they feel they are on a promotion track and being respected in the military if they take that assignment?

General SCHOOMAKER. Yes, sir. The feedback we get back, the Army is very aggressive about getting very well-qualified NCOs. We now have a special pay for them. We have sent all the right signals, I think, that this is a career-enhancing and not a career-ending step for them.

Mr. TIERNEY. OK. And last—my question may take a little longer than that—is the evaluation process, itself. We have the Medical Evaluation Board, we have the Physical Evaluation Board. I am always curious to know why they can't be done as one. I look at the pilot program, which still separates them out as separate entities on that and then moves on to the Veterans Administration evaluation from there.

Would you quickly go through for me what it is you are doing in the pilot program exactly on that, why you chose that model as opposed to any of the others that you could have, why we only have one pilot program going, what happens if that doesn't pan out. Have we lost all that time? And why are we having a problem with the matrix or indices as a way of measuring that, no comparative group to work against, or whatever, and what about all the other services. Is it just the Army, or are we dealing with everybody, and where are we going on that?

Mr. DOMINGUEZ. Sir, the pilot involves all the services.

Mr. TIERNEY. Good.

Mr. DOMINGUEZ. With regard to the input from the GAO on the evaluation criteria, I will be happy to look at that. We were going to spend a couple days here in mid-March diving through where they are in that pilot and what the next steps might be, so we will put that on the table to wrestle through.

I would also ask the Director of Program Analysis and Evaluation to give me his own look at how our experiment is constructed to see whether it is adequate to the decision.

The key elements of the pilot are that we do in the Federal Government one comprehensive medical examination, one disability rating from the VA. In both of those cases they are VA provided to VA standards. We do enhanced case management and communication on steroids, so a lot of——

Mr. TIERNEY. That is not a good word for this committee.

Mr. DOMINGUEZ. Sorry. So there is an enhanced case management aspect of it.

There is an early engagement of the VA in the case which helps them reach early conclusions and rapid delivery of benefits, so those are the aspects of the pilot.

We didn't do the MEB and PEB and try and combine them, because they are, in our view, two separate processes, and they are different parts of this winnowing process.

Many people are referred to a MEB that are not referred to a Physical Evaluation Board, so the physicians look at them and say, "Yes, you are going to be good to go. Go back to work."

Mr. TIERNEY. The definition people keep giving me on these is that the Medical Evaluation Board evaluates in order to identify a medical condition that may render a service member unfit, and then the Physical Evaluation Board determines if the member is fit or unfit. It seems to me there is not a lot of leap between one and the other one.

Mr. DOMINGUEZ. Well, there is. Maybe General Jones can add on this. But the Physical Evaluation Board is where you get in commanders in the personnel community, and this is where you look. This is the people who make judgments about whether we can find you a place in our service to continue to serve, in spite of the fact that you are not able to meet the demands of your grade and MOS. So there are lots of those calls. Eighty of 800 amputees have been returned to service that way. That is not a physician's call; that is a commander and a personnel chief's call.

Mr. TIERNEY. I understand. Thank you.

The questions that you saw in the GAO report that were raised about having an example to compare against all of those, are you wiling to work with the GAO in trying to address those concerns?

Mr. DOMINGUEZ. I am certainly going to address those concerns they raised. We will look at them. I will have to satisfy myself and my boss, our two bosses, about whether we need to take that extra diligence necessary for the kind of decision that we are approaching here.

You know, one of the things to keep in mind is what we did so far was simple. We just took two steps out of the process that were redundant within your same Federal Government, and we were doing those two steps separately because we happened to be two separate Federal agencies. So just pulling that out, which is the core piece of the change in the process, seems to me to be relatively straightforward and unobjectionable. But I will look at what they have suggested and will evaluate it and——

Mr. TIERNEY. The concern out here is that we are going to end up down the road at the end of the pilot program back at the beginning.

Mr. DOMINGUEZ. Yes.

Mr. TIERNEY. I think that would be very disconcerting to you and Members of Congress and particularly the individuals involved on that, so we may have some written questions. I know Mr. Shays is going to have some written questions and I may have some additional also in terms of why we are not running more than one pilot and why we are not doing some of those things with all of you gentlemen on that.

Mr. DOMINGUEZ. Right.

Mr. TIERNEY. I want to thank you for coming in here today, again, Admiral Dunne and General Schoomaker, for changing your schedules, all of you for the diligent work that you have done and the cooperative effort with looking at that and the willingness to sit here and respond to our questions. We are all trying to get on the same page with this. We will have additional hearings. Some of you will probably be participants in that, as well, and we look forward to it.

We thank you all for your great work and service. Thank you.

Meeting adjourned.

[Whereupon, at 3:25 p.m., the subcommittee was adjourned.]

[Additional information submitted for the hearing record follows:]

CHARRTS No.: HOGR-01-001
House Government Reform Committee
Hearing Date: February 27, 2008
Subject: One Year After Walter Reed
Congressman: Congressman Tierney
Witness: HON Dominguez
Question: #1

GAO Evaluation of Senior Oversight Committee

Question: The GAO, on pages 21-23 of its written testimony, lays out a number of concerns about the lack of key elements in the evaluation plans of the Senior Oversight Committee with respect to the disability evaluation pilot, including the lack of a control group to assess performance of the pilot. Please tell the Subcommittee if the Senior Oversight Committee agrees with the GAO's assessment and critiques. If it does agree, what is the plan for implementing needed improvements? If it does not agree, please tell the Subcommittee why.

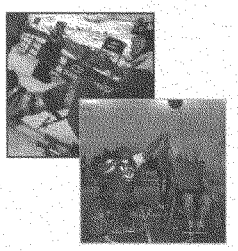
Answer: We do not believe that a control group is necessary since activities outside of the national capitol region are presently operating under the old (control) situation. Moreover, the new process (see attachment) eliminates redundancies, a change whose benefits should be readily apparent.

We continue to work with the Department's Program Analysis and Evaluation Directorate to structure an evaluation of other aspects of the pilot whose costs and benefits demand a higher standard of proof.

NATIONAL CAPITAL REGION

Disability Evaluation System (DES)

Pilot Fact Sheet



Our Nation's top Defense and Veterans Affairs leaders have joined together to improve the health care services and benefits America provides to Service members, Veterans and their families. DoD and the VA are implementing jointly the new **Disability Evaluation System (DES) Pilot.** The DES Pilot is part of a larger effort to promote continuous improvement of the disability evaluation process and the allocation of benefits for Service members and Veterans. The DES Pilot shortens, simplifies, and improves the process for evaluating wounded, ill, or injured Service members who may continue to serve. Additionally, it provides an avenue for those who can no longer serve by compensating, separating, and transitioning them to the care of the VA.

DoD and VA have created a shared vision to: **"Honor our Service members and Veterans by providing wounded, ill, or injured personnel and their families world-class care commensurate with their sacrifices and service to the Nation."** Working together, DoD and VA are committed to ensuring the welfare of American Service members and Veterans by protecting their health and livelihood throughout their entire military career, as well as into their family and community life.

DES PILOT GOALS

- **Streamline and expedite** disability recovery and processing to create improved, faster access to medical treatment, evaluation, and delivery of compensation and benefits;
- Ensure a **seamless transition** of our wounded, ill, or injured from the care, benefits, and services of DoD to the VA system;
- Provide **individualized, integrated, interagency and intergovernmental support** for Service members and Veterans throughout the process of treatment, rehabilitation, recovery, evaluation, transition, and reintegration; and
- Ensure **quality case/care management** to improve the coordination of medical and rehabilitative care, and ensure access to all needed resources for Service members, Veterans and their families.

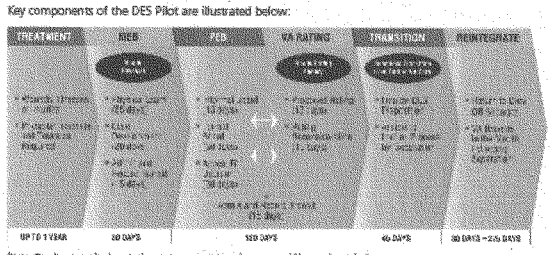
DES Pilot Highlights

The DoD / VA DES Pilot addresses the need to simplify and restructure how Service members are evaluated for continued service and qualify for benefits as a result of wounds, illnesses, or injuries. The DES Pilot simplifies the process by eliminating duplicate practices of the Departments. It shortens the process by engaging the VA as soon as a Service member is referred for possible disability evaluation. It also integrates new case management features to ensure a smooth transition for members who must move to the care of the VA.

- **Single Comprehensive Medical Examination:** The Service member will undergo one evaluation—conducted by VA certified physicians—as opposed to two separate exams.
- **Single-sourced Disability Rating:** The Service member will undergo one disability rating—conducted by VA disability evaluators—as opposed to two, separate disability ratings.
- **Faster Disability Processing:** The Service member will transition to benefits and compensation available through the VA immediately upon disability separation or retirement. DoD will use the VA certified medical exam and disability rating to determine the Service member's fitness for duty and military benefit eligibility. The VA will administer the exam and establish the rating while the Service member is on active duty to enable immediate access to VA benefits upon separation.
- **Increased Transparency:** The Service member can request to see their proposed VA disability rating prior to separation.
- **Enhanced Case Management:** Collocated DoD and VA case managers will work together throughout the process to provide seamless, consistent care and service to the Service member / Veteran.

DES Pilot Process and Timeline

Key components of the DES Pilot are illustrated below:



(Note: Timeline in each phase is the maximum anticipated—most could be much quicker)

For additional information on the DES Pilot, please contact the **DES Pilot Support Team** at **despilot@osd.pentagon.mil**

CHARRTS No.: HOGR-01-002
House Government Reform Committee
Hearing Date: February 27, 2008
Subject: One Year After Walter Reed
Congressman: Congresswoman McCollum
Witness: HON Dominguez
Question: #2

Pre-Deployment Neuro-Cognitive Baseline Assessments

Question: Please provide the Committee with information and policies regarding the use of pre-deployment neuro-cognitive baseline assessments to screen mental health and traumatic brain injuries.

Answer: In finalizing a baseline neuro-cognitive assessments policy, we have taken great effort to balance the operational, scientific and resource considerations. The risks of implementing pre-deployment neuro-cognitive assessments are repeatedly evaluated because the available screening tools are not 100% sensitive and specific. Additionally, the challenge of integrating the assessment into existing processes and systems comes with a significant cost. Therefore, we have proceeded slowly but deliberately in implementing this policy. The Army has already done pre-deployment baseline assessments on over 40,000 soldiers and the Air Force is working with the Army to establish its own process for pre-deployment assessments. Efforts also are underway to integrate the assessment process into Theater systems to ensure that the results of the baseline assessments can be viewed after a combat-related event that may result in injury.

To this end, we have staffed interim guidance with all the Services to provide neuro-cognitive baseline assessments within 12 months of deployment. We anticipate publishing the policy by July 2008. Ultimately, we intend to incorporate neuro-cognitive assessments into the annual Periodic Health Assessment so a neuro-cognitive assessment at the time of the pre-deployment assessment would be unnecessary.

CHARRTS No.: HOGR-01-003
House Government Reform Committee
Hearing Date: February 27, 2008
Subject: One Year After Walter Reed
Congressman: Congressman Davis, Congressman Shays
Witness: HON Dominguez
Question: #3

Independent Assessment of Impatient Electronic Health Records

Question: I understand that last summer a contract was awarded for an independent assessment of inpatient electronic health records in the Departments of Veterans Affairs and Defense. And that this contract will provide recommendations for the scope and elements of a joint inpatient medical record. What is the status of this assessment? When will the recommendations be available? What does each of you see as the major challenges to implementing a joint record?

Answer: The assessment has been divided into two phases. The first six-month phase was completed on January 30, 2008. During that phase, the contractor assessed the business practices relevant to an inpatient electronic health record (EHR) in both Departments to identify common and unique features that will influence a joint approach to an inpatient EHR. The assessment concluded that, from a functional process perspective, a joint approach was feasible. The outcome of the second six-month phase of the assessment will conclude on July 31, 2008, and there will be a report on an analysis of technical solution alternatives and a prioritized set of recommendations. This report will be used by the Department of Defense (DoD) and the Department of Veterans Affairs (VA) leadership to make a decision on the technical approach.

The potential challenges that will need to be addressed in a joint approach to an inpatient EHR are being identified and considered as part of the assessment. Therefore, it is premature to make a prediction on the specifics with regard to the challenges that we will face. However, we believe we have some insights on potential challenges. For example, both Departments already have significant information technology in place. The inpatient EHR will replace some applications and will have to exchange data with others. This type of transition is not uncommon but is more complicated with two organizations. Synchronization of funding will also be required for any joint activities related to acquisition, development/integration, testing, implementation, maintenance and operations. The specifics may be influenced by the technical solution and by the management structure for accomplishing those activities. Joint project management structures and process must also be optimized for the selected joint technical approach. DoD and VA have considerable experience working together on joint information sharing projects that will form a valuable foundation but the complexity of this project adds additional challenges in coordination and decision making.

DoD and VA are committed to identifying the optimal joint technical approach for inpatient electronic health records. We see this assessment as a major tool in accomplishing that goal.

CHARRTS No.: HOGR-01-004
House Government Reform Committee
Hearing Date: February 27, 2008
Subject: One Year After Walter Reed
Congressman: Congressman Davis, Congressman Shays
Witness: LTG Schoomaker
Question: #4

Paper to Electronic Conversion

Question: Does the current medical evaluation board systems within DOD still rely on paper forms and records? For example, the Committee learned in 2005 that there were over 28 forms required in the Army for the Medical Evaluation Board alone. How many of these forms are still transferred through the system in paper form? What are DOD and the Army doing to integrate their own systems?

Answer:
Yes, the current medical evaluation board system still relies on paper forms and records. However, the Army is making great strides in converting from paper to electronic systems.

The forms used in the medical evaluation board (MEB) process, consisting of both administrative and clinical documentation, also are necessary for the physical evaluation board (PEB) decision making process. Through a Lean Six Sigma initiative at Walter Reed, the Army reduced the number of forms required from 38 to 18. The results were shared throughout the Army in March 2008.

Two Army Medical Action Plan initiatives are underway to integrate processes within the physical disability evaluation system (PDES): the Automated Physical Profile Initiative and the Automated Medical Evaluation Board (MEB) Initiative. The Automated Physical Profile Initiative provides a vehicle to initiate a dialogue between the Soldier, the medical provider, and the Soldier's Commander on medical conditions or injuries that may impact the Soldier's rehabilitation. The goals of this initiative are to: (1) enhance medical readiness reporting; (2) allow Unit Commanders to identify medically non-deployable Soldiers earlier so that appropriate re-assignments can occur prior to the unit's deployment; and (3) provide the capability to route the profile electronically to initiate MEB proceedings. Pilot testing began at Fort Bragg, North Carolina, in January 2008, and the initiative is expected to be fielded throughout the Army by July 2008.

The Automated MEB Initiative will significantly reduce our reliance on paper by automating much of the workflow process. This web based application will be accessible 24 hours a day. It will capture all of the data elements required for a MEB and route them electronically to the PEB. The Army Physical Disability Agency will use the same system to ensure interoperability between the MEB and PEB sub-processes of the PDES. The goals of this initiative are to: (1) reduce user errors caused by manual entry of forms; (2) provide a real time status of the MEB; (3) integrate administrative and clinical documentation requirements for MEB processing; and (4) improve overall process cycle time. Pilot testing is scheduled to begin

July 2008.

CHARRTS No.: HOGR-01-004
House Government Reform Committee
Hearing Date: February 27, 2008
Subject: One Year After Walter Reed
Congressman: Congressman Davis, Congressman Shays
Witness: HON Dominguez
Question: #4

Paper to Electronic Conversion

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Answer: Each Service handles their Medical Evaluation Boards differently with different systems and levels of paper requirements. The Department of Defense (DoD) has a hybrid paper-electronic system. The medical treatment records used to help assess the member's condition(s) are in the military health system electronic health record systems. However, the National Archives and Records Administration approved medical record is paper, not electronic. We are addressing the status and complexity of the business process reengineering to streamline and simplify the Disability Evaluation System (DES) process before simply making the forms electronic. We don't want to make an inefficient paper system into an inefficient computerized system. All Services are reviewing their processes during the DES pilot for ways to streamline the process and eliminate the no value added steps. Members from all Services are working to integrate computerized solutions to eliminate redundancy at the DoD level. Many options are being considered to integrate DoD and the Department of Veterans Affairs systems in this process also.

CHARRTS No.: HOGR-01-005
House Government Reform Committee
Hearing Date: February 27, 2008
Subject: One Year After Walter Reed
Congressman: Congressman Davis, Congressman Shays
Witness: LTG Schoomaker
Question: #5

Appropriations to the National Guard

Question: The Chief of the National Guard Bureau reports an $86 million dollar shortfall in Army National Guard programs that serve wounded warriors, and soldier and family support. This represents funds not included in the Army budget for the Guard. How is it that the Department does not see fit to share Congressional appropriations with the National Guard to cover what they need for their wounded and families?

Answer: The Army is committed to providing Soldiers and Families of all Components a quality of life that is commensurate with their quality of service. As part of this commitment, the Army is aggressively pursuing a program currently known as the Army Medical Action Plan (AMAP) that will provide a continuum of integrated care and services for our wounded and their Families from point of injury, illness or disease to return to duty or transition back to their community. Funding for this program is primarily provided through GWOT supplemental appropriations. The AMAP will provide improved care for Wounded Warriors and Warriors in Transition through a patient centered health care system, Soldier and Family Assistance Centers, and improved Warrior Transition Unit facilities, designed to serve all Soldiers, Active, Reserve, and Guard. The Army has submitted the requirements for these programs to the Office of the Secretary of Defense for inclusion in the FY09 GWOT supplemental. Once appropriated, the Army will distribute funding received to the respective component.

CHARRTS No.: HOGR-01-005
House Government Reform Committee
Hearing Date: February 27, 2008
Subject: One Year After Walter Reed
Congressman: Congressman Davis, Congressman Shays
Witness: HON Dominguez
Question: #5

Appropriations to the National Guard

Question: The Chief of the National Guard Bureau reports an $86 million dollar shortfall in Army National Guard programs that serve wounded warriors, and soldier and family support. This represents funds not included in the Army budget for the Guard. How is it that the Department does not see fit to share Congressional appropriations with the National Guard to cover what they need for their wounded and families?

Answer: The notion that the Department of Defense (DoD) does not "see fit to share" appropriations with a particular element of the Nation's combat team is without merit. Since 2001, DoD has used the supplemental budget vehicle to fund a majority of the requirements of the wars in Iraq and Afghanistan which impact both Active and Reserve component personnel alike. A similar holistic approach is being taken regarding the care of the Nation's wounded, ill, and injured Service members. This past year, for example, supplemental budgets funded the Army's Medical Action Plan, and provided $900 million to fund traumatic brain injury and Post Traumatic Stress Disorder care and research. This same supplemental process will be used to support the Guard's identified shortfall, which includes family programs such as the Transitional Assistance Advisors, and programs affecting the Guard's readiness. At the same time, the members of the National Guard will benefit from the same supplemental appropriations process as do those in the Active force.

CHARRTS No.: HOGR-01-006
House Government Reform Committee
Hearing Date: February 27, 2008
Subject: One Year After Walter Reed
Congressman: Congressman Davis, Congressman Shays
Witness: HON Dominguez
Question: #6

Transitional Assistance Advisors

Question: The Department of Veterans Affairs (VA) and the National Guard Bureau collaborated to create Transitional Assistance Advisors (TAAs). The purpose of the TAA program is to provide a person in each state or territory to serve as the statewide contact to assist members in accessing treatment, benefits, assistance with obtaining TRICARE entitlements, and access to community and state resources. Since its inception in 2005, the TAA program has become an essential service to the Guard community, providing continuum of care information for members of the National Guard (Guard). Neither VA, the Army, nor the Department of Defense (DoD) has shared their budgets to support this Guard program on a regular basis. Why doesn't the VA or DoD fund these TAA personnel?

Answer: The implied premise that DoD does not share appropriations with the Guard is without merit. The Department provides funding in support of the Transitional Assistance Advisors program in addition to other programs which benefit members of the Guard as part of the development of DoD budget requests, since the military services are responsible for appropriately resourcing each of their Service components.

The Department is unequivocally committed to serving the members of the Guard. In fact, Guard Service members are part of the Warrior Transition Units (WTUs), and the Guard is placing Liaison Teams at each WTU (or group of WTUs, depending on population) to assist Guard Service members and their families, and to ensure the successful transition of wounded Guard Service members. Liaisons will serve as subject matter experts to resolve pay, awards, and promotion issues specific to Guard Service members, as well as provide transition assistance and direct coordination between the Service members' home states and military units.

Additionally, the Fiscal Year (FY) 2008 National Defense Authorization Act directs the Secretary to establish a national combat veteran reintegration program, to be called the Yellow Ribbon Reintegration Program. This program will provide Guard and Reserve Service members and their families with sufficient information, services, referral, and proactive outreach opportunities throughout the entire deployment cycle. This program will consist of informational events and activities for Service members of the Guard and Reserve components, their families, and community members to facilitate access to services supporting their health and well-being through the four phases of the deployment cycle: (1) Pre-Deployment, (2) Deployment, (3) Demobilization, and (4) Post-Deployment-Reconstitution. Funding for the Yellow Ribbon Reintegration Program is being requested in the Department's FY 2009 Global War on Terror Supplemental request.

The Department continues to work toward the establishment of a world-class seamless continuum of care that is efficient in meeting the needs of our wounded, ill, and injured Service

members. To that end, DoD has, and will continue to, work with State governors, their adjutants general, the State family program directors as well as with the military services and components to ensure an integrated support program is delivered to the Guard and Reserve Service members and their families.

CHARRTS No.: HOGR-01-007
House Government Reform Committee
Hearing Date: February 27, 2008
Subject: One Year After Walter Reed
Congressman: Congressman Davis, Congressman Shays
Witness: HON Dominguez
Question: #7

Proposed Standardized Psychological Health Care Program

Question: Recent news stories relate the increasing number of Guard seeking post-deployment mental health care, as well as the disproportional number of Guard and Reserve suicides. I understand that the National Guard Bureau has proposed a standardized psychological health care program to the Secretary of Defense to assist members of the National Guard and their families in their home states. This program would include placing a Director of Psychological Health at each of the 54 joint state headquarters, to act as the focal point for coordinating and addressing the mental health care needs of National Guard. I understand that the Secretary has not yet supported this program. Why is that?

Answer: The concept for a Director of Psychological Health at each of the 54 State Joint Force Headquarters (JFHs) originated in the Report of the Department of Defense's Mental Health Task Force. The Secretary has endorsed this recommendation from the Task Force and the Department allocated $8 million of the $600 million fiscal year 2007/2008 supplemental for psychological health/traumatic brain injuries to support Directors of Psychological Health at each of the 54 State JFHs. However, current law prohibits the use of Defense Health Program (DHP) funding to augment National Guard staff.

The intent of the Director of Psychological Health program is to monitor and advise the leadership on availability, accessibility, quality, and effectiveness of the continuum of mental health care, monitor the psychological health of the Service members and family members, ensure communication and share best practices, and manage the development and coordination of training materials. Because the Director of Psychological Health program is not involved in the direct provision of health care, DHP funds cannot be used.

We now are evaluating alternative mechanisms that are within the fiscal constraints of using DHP funds to better support the Reserve component in psychological health and traumatic brain injury.

CHARRTS No.: HOGR-01-008
House Government Reform Committee
Hearing Date: February 27, 2008
Subject: One Year After Walter Reed
Congressman: Congressman Davis, Congressman Shays
Witness: HON Dominguez
Question: #8

Guard Resources

Question: This Committee has heard from GAO over the years about administrative issues concerning the National Guard. Whether it is personnel, pay or financial systems, the lack of DOD attention and structure dedicated to serving the National Guard, in sickness or in health, has been lacking. In the face of the number of Guard serving in the GWOT, and they are no longer a strategic reserve, this is appalling. Lack of DOD department or service funding directed at IT connectivity, standardized training of National Guard personnel in new medical procedures at Guard state headquarters is problematic, and degrades all departmental efforts. What are you going to do to see that the National Guard state headquarters are provided the same services, the same personnel training, the same connectivity, that active-duty wounded receive at their bases?

Answer: It is unfortunate that the information provided to the Committee by the Government Accountability Office regarding administrative issues surrounding the National Guard (NG) has left a negative impression of the Department of Defense's commitment to serving the members of the NG. In fact, NG Service members are part of the Warrior Transition Units (WTUs), and the NG is placing liaison teams at each WTU (or group of WTUs, depending on population) to assist NG Soldiers and families and to ensure successful transition of wounded NG Soldiers. Liaisons will serve as subject matter experts to resolve pay, awards, and promotion issues specific to NG Soldiers, as well as provide transition assistance and direct coordination between the Soldiers' home states and military units. These liaison teams will routinely report NG specific issues to the National Guard Bureau (NGB) in order to ensure 100% visibility of issues and appropriate changes to policy.

The NG will provide each liaison team with the tools necessary to be successful in responding to NG Soldier issues (i.e., laptop, air-card and mobile phone). It is essential that these liaisons be able to communicate electronically with State Joint Force Headquarters, community resources, and NGB. They will be required to track and maintain accountability of all NG warriors in transition and will maintain/transmit reports detailing Soldier issues and steps taken to resolve such issues. Additionally, the NG will provide a travel budget as required to conduct state visits, unit visits and family visits. Liaison teams responsible for multiple WTUs will be required to travel regularly to each assigned WTU.

The Army Wounded Warrior program assists and advocates for seriously wounded Soldiers and their families throughout their lifetime. The NG is putting programs in place at the state level to work closely with Soldiers, families and community resources to assist returning wounded warriors in accessing community resources related to employment, spousal employment (in situations where Soldiers may no longer be the primary earner), vocational

training, higher education and affordable housing. The NG will employ counselors to assist wounded warriors after they have returned home.

Further, the Fiscal Year 2008 National Defense Authorization Act directs the Secretary to establish a national combat veteran reintegration program, to be called the Yellow Ribbon Reintegration Program, to provide NG and Reserve members and their families with sufficient information, services, referral, and proactive outreach opportunities throughout the entire deployment cycle. This program shall consist of informational events and activities for members of the Reserve component of the Armed Forces, their families, and community members to facilitate access to services supporting their health and well-being through the four phases of the deployment cycle: (1) Pre-Deployment, (2) Deployment, (3) Demobilization, and (4) Post-Deployment-Reconstitution. Such activities and services may include, but are in no way limited to, the following: marriage counseling, suicide prevention, substance abuse awareness and treatment, financial counseling, and employment assistance.

CHARRTS No.: HOGR-01-009
House Government Reform Committee
Hearing Date: February 27, 2008
Subject: One Year After Walter Reed
Congressman: Congressman Davis, Congressman Shays
Witness: HON Dominguez
Question: #9

Compliance With DOD Housing Standards

Question: In your last written testimony provided to the Subcommittee in September 2007, you indicated that when DOD housing standards are not met for any individual, that installation commanders must notify their military service headquarters. How does the Secretary of Defense ensure service compliance?I understand from the testimony you provided our Subcommittee for our last hearing, that "quality, periodic inspections of DOD medical facilities will be conducted at least annually." What constitutes a quality inspection? Why only annual inspections?

Answer: With the personal involvement of the Military Services' leadership and the robust funding that has been provided to installations for medical hold housing, the Department does not expect that any Service member will be assigned to a medical hold housing unit unless it complies with the Department of Defense (DoD) Standards, including any special features based on the Service member's medical needs. Since DoD standards were issued on September 18, 2007, the military services' headquarters have not been notified that any wounded, ill, or injured member has been assigned to housing that does not meet these standards. The Department will ensure Service compliance with this notification process through periodic reviews. Furthermore, as part of the semi-annual inspections required by statute, the Services will be required to document any instance where a member was housed in a unit that did not meet DoD standards.

The Department defines a "quality inspection" of a military medical treatment facility as an inspection of all building components and systems to assess whether they meet acceptable industry standards for safe operation and maintenance of facilities in accordance with the Joint Commission for Accreditation of Healthcare Organizations' standards, and Americans with Disability Act requirements.

Periodic inspections are a reliable measure of the facilities state of condition to judge if enough sustainment dollars are being expended to keep the facilities in good order. This includes correction of urgent deficiencies to maintain safe operation, and the development of short-term and long-term maintenance projects to identify funding requirements.

CHARRTS No.: HOGR-01-010
House Government Reform Committee
Hearing Date: February 27, 2008
Subject: One Year After Walter Reed
Congressman: Congressman Davis, Congressman Shays
Witness: HON Dominguez
Question: #10

National Center of Excellence for PTSD and TBI

Question: Can you tell us more about the National Center of Excellence for PTSD and TBI? Can you each please tell me what training standards have been developed and who will receive training?

Answer: The Defense Center of Excellence (DCoE) is leading a collaborative effort toward optimizing psychological health and TBI treatment for the Department of Defense (DoD). While it is a "national" center, the official name is the Defense Center of Excellence for Psychological Health and Traumatic Brain Injury. "Psychological health" includes addressing post traumatic stress disorder (PTSD). The DCoE, in collaboration with Defense activities and other federal and civilian programs, is establishing quality standards for clinical care; education and training; prevention; patient, family, and community outreach; advocacy; related research; and program excellence. Department civilian and military leaders consider psychological health and care of traumatic brain injuries (TBIs) extremely important to the sustained health of the Armed Forces. This was a driving factor in establishing the DCoE.

The training and education component integrates functions of the Defense and Veterans Brain Injury Center (DVBIC), as well as the Center for Deployment Psychology (CDP). DVBIC was originally established to improve and increase the body of knowledge of TBI. It has a participating network of military, Department of Veterans Affairs, and two civilian sites, and has worldwide contacts with TBI experts who participate in expert panels and in research. The CDP provides the primary training and education component for the DCoE with a multi-Service (Army, Navy, Air Force) consortium. Under the umbrella of the DCoE, these programs will expand to provide training and education to additional audiences, including health care providers, military leadership, warriors, and military families.

The CDP was developed in 2006 to train military and civilian psychologists, psychiatrists, social workers, and other behavioral health professionals to provide high quality deployment-related behavioral health services to military personnel and their families. The CDP accomplishes this mission through a series of innovative education and training programs, teaching and consultation at existing military training programs and community outreach. The core of the CDP training efforts is a 2-week intensive training course held approximately five times per year at the Uniformed Services University of the Health Sciences. The material included in this course was selected to cover topics identified through a needs assessment conducted by the planning group that established the CDP. The materials are updated to incorporate new data and clinical information. Included in this program is training in evidence-based approaches for assessing and treating PTSD and TBI. The CDP also conducts workshops throughout the United

States ranging from half-day didactic seminars on various topics to 3-day programs that will train professionals in specific skills and techniques to treat the needs of military personnel and their families.

TBI training is directed at a number of stakeholders to include providers, patients, families, commanders, and related community. Provider training continues to be developed and provided by request to medical treatment facilities as well as hosting several conferences and breakouts at other military training events. There has been training incorporated into the curriculum of pre-deployment medical training as well as in-theater medical training. Moreover, there are over 80 multi-media products and state-of-the-art interfaces (Web and tele-medical), that are developed to enhance family and patient education which is also being done by multi-disciplinary TBI teams. Development also has begun on family curriculum with the congressionally mandated TBI Family Caregiver panel.

CHARRTS No.: HOGR-01-011
House Government Reform Committee
Hearing Date: February 27, 2008
Subject: One Year After Walter Reed
Congressman: Congressman Davis, Congressman Shays
Witness: LTG Schoomaker
Question: #11

Centralization of Medical Records

Question: GAO has reported that neither DOD nor the military services systemically evaluate the consistency of disability decisions made during medical evaluation boards. We would assume this is the case because these records are not kept in a central location or entered into one IT program so that records can be compared. Why doesn't DOD keep this information centralized so comparisons can be made, or metrics created to set performance standards?

Answer: The Army does maintain records on all disability decisions in one central location and database maintained by the Army Physical Disability Agency (USAPDA), and has done so for more than 15 years. The Agency reviewed cases for adjudicative accuracy during this timeframe, but did not examine statistical consistency between Physical Evaluation Boards (PEBs). As a result of the findings in the March 2006 GAO report and the March 2007 Department of the Army Inspector General reports on the physical disability evaluation system, the Agency initiated a more rigorous and precise process to analyze the consistency of our decisions. This methodology, developed for us by the Center for Army Analysis (CAA), enables us to compare disability determinations across a wide range of variables. Initial analysis conducted by CAA determined that the Agency's findings over the time period from October 2005 through May 2007 were consistent when analyzed for variation by component, gender, age, and location. The analysis did identify variations in rated conditions, requiring further analysis to determine if differences in ratings across our PEBs were valid or resulted from inconsistencies in rating policies or procedures within the Agency. This further analysis will continue as long as the Army rates conditions. On 30 Aug 07 this Agency provided the consistency study methodology and results to the GAO.

CHARRTS No.: HOGR-01-011
House Government Reform Committee
Hearing Date: February 27, 2008
Subject: One Year After Walter Reed
Congressman: Congressman Davis, Congressman Shays
Witness: HON Dominguez
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Answer: The medical community does not make disability decisions, but only presents medical opinions and recommendations based on clinical assessments. Each Service has different medical retention standards based on their Services mission requirements, thus consistency of medical evaluation boards is best compared within the Service by medical professionals from their Service who have the knowledge and understanding of their own medical standards. The Disability Advisory Council is developing an annual report to look for performance and variances in some targeted areas at the Department of Defense (DoD) level. Data from medical treatment records is centralized in DoD, but administrative actions such as those related to the Disability Evaluation System (DES) are not. The need for centralized information accessibility collected through various systems for the DES process has been recognized and substantial efforts are underway to find the best way to collect and analyze it. While automation is the best solution, some data must still be requested from the Services. Data collected from the DES Pilot is being used to develop performance measures.

CHARRTS No.: HOGR-01-012
House Government Reform Committee
Hearing Date: February 27, 2008
Subject: One Year After Walter Reed
Congressman: Congressman Davis, Congressman Shays
Witness: HON Dominguez
Question: #12

TDRL Mental Health Standards

Question: The Committee has heard from many soldiers that are placed on TDRL: some have serious brain trauma, some mild TDRL and others differing mental health issues. It appears there is a lack of mental health standards for TDRL. What are the Department standards for placing a soldier with brain or mental issues on TDRL?

Answer: Any Service member that incurs a traumatic brain injury (TBI), or any other mental health disability, in the line-of-duty and is determined to be medically unfit for their particular office, grade, rank, or rating as a result of the TBI will undergo a Physical Evaluation Board (PEB).

The PEB is a Service specific fact-finding board that evaluates all cases of physical disability on behalf of the Service in accordance with title 10, United States Code, chapter 61. The PEB investigates the nature, cause, degree of severity, and probable permanency of the disability concerning the Service member referred to the board. The board evaluates the physical condition of the Service member against the physical requirements of their particular office, grade, rank or rating.

Once the PEB determines that a Service member with TBI is unfit for further military service then a determination is made as to the severity of the condition via the Department of Veterans Affairs Schedule for Rating Disabilities via 38 Code of Federal Regulations, Part 4. If the TBI is ascertained to be 30% or more disabling and not permanent in nature, the Service member would then be placed on the Temporary Disability Retirement List (TDRL).

All Service members placed on the TDRL were found unfit by the PEB and are entitled to permanent disability retirement except that the disability is not stable for rating purposes. "Stable for rating purposes" refers to whether the condition will change within the next five years to warrant a different disability rating. However, stability does not include latent impairment--what might happen in the future. When placed on the TDRL, the law requires the Service member to undergo a periodic medical reexamination within 18 months at a minimum followed by PEB evaluation. This periodic examination is accomplished to decide whether a change has occurred in the disability for which the Service member was temporarily retired. The Service member may be retained on the TDRL or a final determination may be made. While the law provides for a maximum tenure of 5 years on the TDRL, there is no entitlement to be retained for the entire period.

CHARRTS No.: HOGR-01-013
House Government Reform Committee
Hearing Date: February 27, 2008
Subject: One Year After Walter Reed
Congressman: Congressman Davis, Congressman Shays
Witness: HON Dominguez
Question: #13

SECDEF Assistance to Army Wounded

Question: Over the past six years, DOD has designated over 29,000 service members involved in Operation Iraqi Freedom and Operation Enduring Freedom as wounded in action, almost 70% of these wounded are Army active duty, Guard or Reserve soldiers. What direction or assistance has the Secretary of Defense provided the Army given that they are shouldering the care of the majority of the military wounded?

Answer: In Operation Iraqi Freedom approximately 54% of those wounded in action return to duty within 72 hours of an injurious event, and approximately 39% of those wounded in Operation Enduring Freedom return within 72 hours.

Our Army is organized, well trained, and equipped to fight and win the Nations wars and to take care of our wounded, ill and injured Service members and their families that are casualties of war. The Army has the bulk of the wounded warriors, is the biggest benefactor of the Department's implementation of over 400 recommendations from major studies on wounded warrior care, and is most affected by the implementing directives that affect our wounded warriors. All wounded warrior care recovery, rehabilitation and reintegration programs that have been created and operational changes mandated are designed to assist every one of our wounded warriors and their families regardless of branch of Service.

The Senior Oversight Committee (SOC) was created to orchestrate and implement the recommendations of the five wounded warrior care commissions and the provisions of the Fiscal Year 2008 National Defense Authorization Act. The SOC's focus has been the holistic improvement of the programs, procedures, and processes affecting wounded warrior care, recovery, and reintegration. Examples of which include the redesign of the Disability Evaluation System process which introduced the single physical concept. The Center of Excellence was created to be the collecting point for world-class techniques of treatments for traumatic brain injury. The work of Federal Recovery Coordinators mandated to provide personal overall management to individual wounded warrior cases. Instituting advanced electronic transfer of medical records from the area of operation to all echelons of medical treatment. Creating and mandating tougher facility programs and directives designed to take care of the wounded warrior whether they be Soldiers, Sailors, Marines, Airmen, or Coast Guardsmen.

CHARRTS No.: HOGR-01-014
House Government Reform Committee
Hearing Date: February 27, 2008
Subject: One Year After Walter Reed
Congressman: Congressman Davis, Congressman Shays
Witness: HON Dominguez
Question: #14

DOD - VA Joint Recovery Coordinator Program

Question: The Senior Oversight Committee has indicated that DOD and VA will establish a joint Recovery Coordinator Program no later that October 2007. Can you tell us about this program and whether or not you followed the recommendations contained for the program in the Dole/Shalala Commission Report?

Answer: In response to the recommendations from the Dole-Shalala Commission Report, a Federal Recovery Coordination Program (FRCP) was initiated in October 2007. The Deputy Secretaries of the Department of Defense (DoD) and the Department of Veterans Affairs (VA) signed a Memorandum of Understanding on August 31, 2007, that established a joint DoD/VA FRCP to implement the recommendations on coordinators and plans. A Memorandum of Understanding was signed on September 19, 2007, by the Under Secretary of Defense for Personnel and Readiness, DoD, the Under Secretary for Health, VA and the Deputy Secretary of Health and Human Services, that establishes overarching guidance on the role and contribution of the Public Health Service in the FRCP. In the early stages of program development, a FRCP Team comprised of Public Health Consultants, DoD representatives and VA representatives was established at VA headquarters. The FRCP assigns a Federal Recovery Coordinator (FRC) to serve the more seriously wounded, ill or injured Service members or Veterans who are not likely to return to duty and will require lifelong support. During Phase 1 of program implementation, FRCs were trained and placed at Walter Reed Army Medical Center, Brooke Army Medical Center and National Naval Medical Center, Bethesda. The role of the FRC is to guide the wounded, ill or injured Service members or Veterans and their families through the continuum of care from recovery through rehabilitation to reintegration, promoting the timely delivery of services and support to ensure "the right care is provided by the right person at the right time and place."

CHARRTS No.: HOGR-01-015
House Government Reform Committee
Hearing Date: February 27, 2008
Subject: One Year After Walter Reed
Congressman: Congressman Davis, Congressman Shays
Witness: HON Dominguez
Question: #15

Appeals

Question: Committee staff have heard that there are concerns about the new pilot in terms of the right to appeal and the appeal process. What checks does the new pilot contain to ensure the right of appeal remains the same as it does under the current system?

Answer: The Disability Evaluation System Pilot is constructed to ensure that Service members continue to enjoy the right to a full and fair hearing (appeal) before separation, as required by 10 United States Code 1214. The pilot also features complete transparency of rating information which will ensure that Service members' legal counsels has all the information from which to advise their clients. In addition, the pilot has built in additional checks to ensure Service members have formal board appeal and review rights in accordance with the regulations of the Military Department concerned. Finally, unlike the current Department of Defense and Department of Veterans Affairs (VA) systems, Service members can also ask for a disability "ratings reconsideration" of all or specific claim medical conditions from the VA while still on active duty, before final separation.

CHARRTS No.: HOGR-01-016
House Government Reform Committee
Hearing Date: February 27, 2008
Subject: One Year After Walter Reed
Congressman: Congressman Davis, Congressman Shays
Witness: HON Dominguez
Question: #16

Personality Disorder Diagnosis

Question: You have also told this Committee that DOD has recognized the difficulty of diagnosing personality disorders, especially when other mental health or stress issues are present, and that DOD is currently revising its regulations to eliminate personality disorders as a basis for separating wounded soldiers from service. What are these regulations?

Answer: Separation policy (Department of Defense Instruction 1332.14, "Enlisted Administrative Separations") is currently under formal revision. Although the Department is not totally eliminating personality disorders as a basis for separating wounded Service members from Service, the proposed changes to this issuance are significant and include: revision of policy pertaining to separations for personality and behavioral disorders to require additional psychiatrist or Ph.D-level psychologist corroboration of diagnoses and assurances that any disabling mental health diagnoses have been ruled out prior to proceeding with a personality disorder separation, and adding requirements for personality disorder discharges for those with service in combat or imminent danger areas to be reviewed and personally endorsed by the Surgeon General of the Service concerned. The Department is presently coordinating these new policies to add rigor and confidence to any diagnosis of personality disorder in the face of other mental health issues.

CHARRTS No.: HOGR-01-017
House Government Reform Committee
Hearing Date: February 27, 2008
Subject: One Year After Walter Reed
Congressman: Congressman Davis, Congressman Shays
Witness: HON Dominguez
Question: #17

Creation of Federal Recovery Coordinators

Question: The Dole/Shalala Commission recommended the creation of Federal Recovery Coordinators be created to supplement existing case managers employed by the military services and the VA and enhance the continuum of care for a wounded veteran throughout his or her lifetime. En your response to our last hearing's questions for the record, you stated that "It is not yet evident that this Recovery Coordinators will be needed for any one but the most grievously injured." On what basis are you making this claim?

Answer: The basis of this claim is that Federal Recovery Coordinators (FRCs) are assigned to serve the more seriously wounded, ill or injured Service member or Veteran who is not likely to return to duty and will require lifelong comprehensive, inter-disciplinary long term care, support, and service delivery during recovery, rehabilitation and reintegration. This patient population presents with conditions such as traumatic brain injury, amputations, burns, or visual impairment. Some patients in this group are polytrauma patients who have sustained injuries to more than one physical region or organ system, one of which may be life threatening and which results in physical, cognitive, psychological, or psychosocial impairments and functional disability. These wounded, ill and injured Service members, Veterans, and their families are faced with a life-changing event that requires long-term treatment which results in increased family issues, changes to life styles, and increased administrative requirements as compared to those patients where the clinical expectation is that the patient will return to duty or be medically retired without requiring long term specialized care. Approximately 65% of our wounded, ill and injured Service members treated in our military treatment facilities that are transferred to medical hold programs, warrior transition units, or community based health care organizations return to duty. Those medically retired from these health care organizations generally do so without conditions that require long-term specialty or polytrauma level care. Our assumption is that the majority of our wounded, ill or injured Service members or Veterans who are assigned a FRC will require a personal support system and long-term specialty care for the remainder of their lives or until they are successfully reintegrated into the community.

CHARRTS No.: HOGR-01-018
House Government Reform Committee
Hearing Date: February 27, 2008
Subject: One Year After Walter Reed
Congressman: Congressman Tierney
Witness: LTG Schoomaker
Question: #18

Use of Temporary Positions in Warrior Transition Units

Question: According to the GAO testimony from last September, the Army had filled 19% of Warrior Transition Unit positions using "borrowed" personnel. This was supposed to be a temporary solution until permanent staff became available. At the February 27, 2008 hearing, GAO reports that the percentage of borrowed personnel in the WTUs remains at 20%. Given the personnel strains on the Army more generally, what is the plan for filling these positions with permanent staff?

Answer: As stated, 19% of WTU cadre positions were filled with Borrowed Military Manpower (BMM) in September 2007. Since that time, the Human Resources Command (HRC), the US Army Reserve Command (USARC) and the National Guard Bureau (NGB) have continued their efforts to provide required personnel to fill documented authorizations as quickly as possible. As a result, only 13.85% of the personnel currently assigned to WTUs as cadre members are BMM. Despite this decrease, BMM will always be necessary to handle temporary surges in the WTU patient population because such surges do not warrant the assignment of additional personnel full time. The goal, however, is to minimize the use of BMM, except to handle unanticipated surges in patient load.

CHARRTS No.: HOGR-01-019
House Government Reform Committee
Hearing Date: February 27, 2008
Subject: One Year After Walter Reed
Congressman: Congressman Tierney
Witness: LTG Schoomaker
Question: #19

SOC Disability Pilot

Question: You made a statement at the February 15, 2008 House Armed Services Military Personnel Subcommittee hearing casting some aspersions on whether the SOC disability pilot could ultimately be successful. You stated that the program's design was based on I 940s-era models, which was also stated by the Dole-Shalala Commission, and that moving forward with the pilot under these circumstances would only change a bad process into a "fast bad process." Please elaborate on your critique based on your experiences? In other words, if you were completely in charge of revamping the disability evaluation process anyway you saw fit, what would it look like?

Answer: Two primary points of friction currently exist in the disability evaluation process. The first point of friction is the two different ratings Soldiers receive—one from the Army Physical Evaluation Board (PEB) based on the Soldier's unfitting condition(s), and one from the Department of Veterans Affairs (VA) for all the medical conditions the Soldier incurred or aggravated as a result of military service. The Army should only determine whether a Soldier is fit or unfit for continued military service and provide appropriate compensation for the early termination of a Soldier's military career. Determining the final disability rating and the compensation based upon that rating should be left to the VA. The second point of friction is the 30% threshold for securing lifetime medical benefits for Warriors and their Families. This threshold generates an enormous amount of anxiety for Soldiers and Family members as they face an uncertain future. It also establishes a confrontational relationship between the Soldier and the Department of Defense. I would like to see this threshold eliminated and a more cooperative process established.

CHARRTS No.: HOGR-01-020
House Government Reform Committee
Hearing Date: February 27, 2008
Subject: One Year After Walter Reed
Congressman: Congressman Tierney
Witness: LTG Schoomaker
Question: #20

Army Physical Evaluation Board Liaison Officers and Nurse Case Manager Positions

Question: What are the Army's plans to permanently fill the 57 physical evaluation board liaison officers and nurse case managers positions cited in the GAO testimony?

Answer: As of March 11, 2008, 170 Physical Evaluation Board Liaison Officer (PEBLO) positions were filled with personnel specifically trained in the skills required to support Warriors in Transition (WTs). All open PEBLO positions are currently being advertised. The Army intends to fill these positions as soon as possible to achieve our goal of reducing PEBLO case loads from the current average ratio of 1:50 to 1:30.

As of March 11, 2007, 391 of 377 required Nurse Case Manager (NCM) positions were filled, resulting in an Army-wide ratio of NCMs to WTs of 1:23. The enhanced hiring authority afforded by Congress in Section 1636 of the National Defense Authorization Act for 2008 (Public Law 110-181) provides the Army the opportunity to be more competitive in hiring critical health care professionals. To further underscore the importance of these efforts, the Assistant Secretary of the Army for Manpower and Reserve Affairs has established a Tiger Team to develop effective strategies for successfully recruiting and retaining personnel required to staff Warrior Transition Units.

CHARRTS No.: HOGR-01-021
House Government Reform Committee
Hearing Date: February 27, 2008
Subject: One Year After Walter Reed
Congressman: Congressman Hodes
Witness: LTG Schoomaker
Question: #21

Mental Health Specialist POCs in Iraq and Afghanistan

Question: Please provide the committee with the number of mental health specialists currently serving in theater in Iraq and Afghanistan.

Answer: There are currently 200 mental health providers and technicians (150 Army and 50 Air Force) deployed in support of Operation Iraqi Freedom; and approximately 30 mental health providers and technicians (7 Army, 21 Air Force and 2 Navy) deployed in support of Operation Enduring Freedom. This number represents 119 officers and 111 enlisted behavioral health personnel.

CHARRTS No.: HOGR-01-022
House Government Reform Committee
Hearing Date: February 27, 2008
Subject: One Year After Walter Reed
Congressman: Congressman Davis, Congressman Shays
Witness: LTG Schoomaker
Question: #22

MTF Housing Complaints

Question: How many MTF housing complaints have come into Army headquarters over the last year?

Answer: Since June 2007, the Army's Wounded Soldier and Family Hotline and Ombudsman Program have assisted 27 Soldiers with housing-related problems. Complaints relating to military housing/barracks range from an inability to get on-post housing to requests to move to a different barracks room. As a key element of the Army Medical Action Plan, the Army has aggressively pursued quality housing for our Warriors in Transition. WTU Barracks inspections are conducted regularly by WTU unit leaders. The Army will begin a WTU certification process in late Fiscal Year 2008 which includes WTU barracks inspections. In addition, we have established the Wounded Soldier and Family Hotline as an avenue for our wounded, ill, or injured Soldiers and their Family members to raise concerns or complaints. Finally, we have placed ombudsmen at installations throughout the Army to serve as additional problem solvers for Soldiers and Families. Through these latter two entry points, we formally track concerns, respond within 24 hours, and closely monitor for trends.

CHARRTS No.: HOGR-01-023
House Government Reform Committee
Hearing Date: February 27, 2008
Subject: One Year After Walter Reed
Congressman: Congressman Davis, Congressman Shays
Witness: LTG Schoomaker
Question: #23

DoD and VA Evaluation Stanfdards

Question: Evaluating a wounded soldier as fit for duty versus the VA evaluation for quality of life can be quite a different set of standards. What concerns or thoughts do you have about the joint evaluation pilot? What changes need to happen for a joint pilot to be successful?

Answer: The DoD/VA Disability Evaluation System (DES) pilot is in its infancy. Data is being collected to determine the pilot's effectiveness and measure Soldier satisfaction, but it is still too early to draw any conclusions. The pilot benefits Service members because they receive a single, comprehensive physical and have a single rating source. Because Service members have their VA rating prior to discharge, Service members benefit from knowing what their future VA compensation will be. I also expect this pilot will reduce the time it takes for Soldiers to receive their VA benefits, which is a worthwhile accomplishment.

My concern is that, under current law, the Soldier still receives two ratings – one from the Army Physical Evaluation Board (PEB) based on the Soldier's unfitting condition(s), and one from the Department of Veterans Affairs (VA) for all the other medical conditions the Soldier incurred or aggravated as a result of military service. The Army should only determine whether a Soldier is fit or unfit for continued military service and provide appropriate compensation for the early termination of a Soldier's military career. Determining the final disability rating and the compensation based upon that rating should be left to the VA.

To best determine the pilot's effectiveness, we need to expand the pilot beyond the National Capital Region (NCR) to more remote areas that do not have the NCR's resources.

CHARRTS No.: HOGR-01-024
House Government Reform Committee
Hearing Date: February 27, 2008
Subject: One Year After Walter Reed
Congressman: Congressman Davis, Congressman Shays
Witness: LTG Schoomaker
Question: #24

On Required Proof for Soldiers with Possible PTSD

Question: The Army Times has published stories about the Army Physical Disability Agency that indicates that soldiers that are seeking treatment or evaluation for PTSD, must prove that they witnessed a "traumatic event" in theater, as proof they have PTSD, putting the burden of proof on the stressed soldier. Can you comment on what proof the Army asks for with evaluating a solder for PTSD?

Answer: The Army does not require Soldiers experiencing symptoms associated with Posttraumatic Stress Disorder (PTSD) to "prove" that they were exposed to an extreme traumatic stressor. The exposure is a required element for the diagnosis of PTSD in accordance with the Department of Veterans Affairs schedule for rating disabilities. Without this element a Soldier may have symptoms similar to PTSD, but another diagnosis would be applied. The Army requires that there be supporting evidence that the extreme traumatic stressor element of the diagnosis occurred. Such evidence comes in many forms including the nature of physical injuries that the Soldier may also have suffered; awarding of a Purple Heart, valor medals, or a combat-related badges; statements from the Soldier's commander/fellow Soldiers; or, police or investigation reports (in noncombat cases such as assault, training injury, motor vehicle accident, aviation accident). The ability to communicate with unit commanders and others with whom the Soldier served has facilitated gathering of supporting evidence. The individual Soldier may assist the process by providing assignment locations and points of contact that may have supporting information. However, there is no "burden of proof" placed on the individual Soldier. Note, there exist no substantive differences between supporting evidence required by the Army and VA.

CHARRTS No.: HOGR-01-025
House Government Reform Committee
Hearing Date: February 27, 2008
Subject: One Year After Walter Reed
Congressman: Congressman Davis, Congressman Shays
Witness: LTG Schoomaker
Question: #25

Army Inspector General Yearly Probe and Counselor Training

Question: The Army Inspector General is in the midst of a yearlong, ongoing probe of the service's medical retirement system, and has so far, identified 87 problems that need to be fixed. One of the major findings is the lack of inconsistent training for counselors helping soldiers through the system, inadequate record keeping and a failure to follow new policy pushed down from the Department of Defense. Can you comment on each of these findings?

Answer: The Army incorporated the recommendations contained in the March 6, 2007, Army Inspector General report on the Army Physical Disability Evaluation System (APDES) into the Army Medical Action Plan (AMAP).

The AMAP addressed the issue of consistent training of personnel by developing a certification and training program for Physical Evaluation Board Liaison Officers (PEBLOs). PEBLOs review Physical Evaluation Board records for completeness and counsel Warriors in Transition (WTs) on the status of their cases. To further enhance counseling, the AMAP established dedicated legal counsel at installations with the largest number of WTs undergoing a Medical Evaluation Board (MEB) or PEB. These legal counselors receive specialized training in the APDES so they can serve as advocates and help WTs and their Families better understand the process. Additionally, physicians with experience in the MEB process are assigned at a ratio of 1 to every 200 WTs undergoing an MEB. These physicians manage the process to ensure thorough and efficient completion of all medical requirements of the MEB and appropriate referral to the PEB. PEBLOs, MEB physicians, and APDES legal counsel all receive up-to-date and thorough training to ensure consistency in their understanding of the APDES and to enable them to best serve Soldiers.

As APDES policy and requirements change, all personnel assigned to assist WTs and their Families receive refresher training to ensure they understand new policies. Additionally, WTU staff receives up-to-date training on the APDES so that they are able to assist WTs and Families and provide them with accurate and consistent guidance.

To improve record keeping, the Army is enhancing its Medical Evaluation Board Internal Tracking Tool (MEBITT) and Physical Disability Computer Assisted Processing System (PDCAPS). Both were developed years ago with less advanced technology and were in need of redesign to include digitization of records. Tied to MEBITT and PDCAPS is a website called MyMEB/PEB where all WTs and Families can go for information on the status of their Board action, as well as to find current information on the APDES process. Additionally, the Army is now participating in the National Capital Region Disability Evaluation System Pilot, a joint

project begun in November 2007. Following initial evaluation, if deemed successful, the pilot will be expanded this summer.

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House Government Reform Committee
Hearing Date: February 27, 2008
Subject: One Year After Walter Reed
Congressman: Congressman Davis, Congressman Shays
Witness: LTG Schoomaker
Question: #26

Walter Reed Town Hall Meetings

Question: I understand that Walter Reed has Monday welcome briefs and Thursday town hall meetings. Can you tell us what issues are being raised at these town hall meetings? Does every medical treatment facility have these meetings? What are some of the current themes you are hearing from soldiers and their families?

Answer: The Thursday Town Hall meetings at Walter Reed have been moved to Monday. The Monday "welcome brief" functions as an orientation for newly arrived Families. Information pertinent to new Family members is presented by the Soldier and Family Assistance Center Director, who introduces the Soldiers and the Family members to principal representatives of various services.

As part of the Army Medical Action Plan, all Senior Commanders conduct similar Town Hall meetings at least monthly on every installation with a Warrior Transition Unit. They are a forum for Warriors in Transition and their Families to express concerns to the most senior leaders on each installation, and they serve as a means of informing these leaders of areas that require their attention. Senior Commanders are responsible for and committed to taking action in those areas in which improvement is required. The themes raised at these forums have shifted from concerns about basic needs and broad, systemic issues—such as care of family, living conditions, and insurmountable bureaucracies—to narrower, more personal, patient-centered themes. This shift reflects the improvements in information sharing and education that begins the moment a Warrior in Transition and his or her Family arrives at one of our military treatment facilities.

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Witness: LTG Schoomaker
Question: #27

Walter Reed Soldier Family Assistance Center

Question: At our September 2007 hearing, you testified that the Soldier Family Assistance Center at Walter Reed was a success. Can you tell us what services are available to families? Are there Soldier Family Assistance Centers at all Army medical treatment facilities? How do you know these centers are a success? Do you allow families and soldiers to evaluate them?

Answer: The Army established Soldier Family Assistance Centers (SFACs) to provide support to Warriors in Transition and their Families at installations with Warrior Transition Units (WTUs). SFACs serve as a single point of entry for many services, including:

1. Military personnel processing assistance
2. Child care and school transition services
3. Education services
4. Transition and employment assistance
5. Legal assistance
6. Financial counseling
7. Stress management and Exceptional Family Member support
8. Substance abuse information and referral
9. Installation access and vehicle registration
10. Management of donations made on behalf of Service Members
11. Coordination of federal, state, and local services
12. Pastoral care
13. Coordination for translator services
14. Renewal and issuance of identification cards
15. Lodging assistance

There currently are 34 SFACs operating at locations with WTUs. Due to the low number of Warriors in Transition at Fort Rucker, SFAC services are available, but they are being provided through installation activities not dedicated exclusively to Warriors in Transition and their Families. Should the population of Warriors in Transition increase significantly at Fort Rucker, we will reconsider the establishment of a dedicated SFAC.

Installation Management Command (IMCOM) manages all SFACs other than the one at Walter Reed, which is managed by the Army Medical Command (MEDCOM). As part of an ongoing customer satisfaction program, Warriors in Transition and their Family members are encouraged to fill out customer satisfaction comment sheets. The completed sheets are compiled monthly and reviewed by IMCOM and MEDCOM leadership. From these comments, Army leaders are able to identify both best practices and areas for improvement. We are finding that recent SFAC comments have been overwhelmingly positive. Similar to the themes at Town Hall Meetings, concerns have shifted from broad, systemic issues—such as care of family and living

conditions--to narrower, more personal concerns like pay and Identification cards.

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Witness: LTG Schoomaker
Question: #28

Army Service-Specific Data Sharing Efforts with VA

Question: GAO has reported that the Army has service-specific efforts under way to improve the sharing of data between its military treatment facilities and the VA. Can you tell us what these efforts are and have they been successful? What challenges remain?

Answer: Two Army military treatment facilities (Walter Reed AMC- Washington DC and Brooke AMC- Ft. Sam Houston) scan paper patient records and send them together with electronic patient records to receiving VA PolyTrauma Centers. The Army is sharing digital radiographic images with the VA from one facility (William Beaumont AMC- Ft. Bliss) with plans to expand to additional hospitals (Evans ACH- Ft. Carson, Walter Reed AMC- Washington DC and Landstuhl RMC). The Army supports DoD VA Enterprise level efforts including the Federal Health Information Exchange (FHIE), the Bidirectional Health Information Exchange (BHIE), the Clinical Data Repository/Health Data Repository (CHDR), and the Laboratory Data Sharing Initiative (LDSI). In weekly meetings between participating VA and DoD facilities, VA representatives report success in receiving data required to assist in treatment of transfer patients. Remaining challenges include the development of a robust infrastructure capable of transferring a quickly growing volume of patient information between DoD and VA facilities.

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